Meeting Date	**23 May 2023**	**Agenda Item**	**3.2**
Report Title	**Quality Priority - Falls Prevention**		
Report Author	Eleri D'Arcy, Falls Quality Priority Lead		
Report Sponsor	Hazel Powell, Deputy Director of Nursing and Patient Experience Gareth Howells, Director of Nursing and Patient Experience		
Presented by	Eleri D'Arcy, Falls Quality Priority Lead		
Freedom of Information	Open		
Purpose of the Report	To provide an update on work to progress the goals, methods and outcomes of the Falls Prevention quality priority and plans to mainstream elements of this work in the future.		
Key Issues	• Reduction in injurious falls per 1000 bed days achieved • Review of current GMOs and progress to date. • GMOs for 2023/2024 • Recommendations to embed falls prevention practices within service groups and ensure continued progression of the priority		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☒	☒	☐
Recommendations	Members are asked to **note** the report and the following: In order to progress Falls Prevention Quality Priority work and embed it as business as usual, Service Groups (SG) must take a lead and ensure: ▪ Engagement with SGs Appointed Falls Champions and develop reporting systems in order to monitor performance ▪ Establish robust SG level governance structures and report on Falls via their quality and safety groups ▪ Share learning at HB wide Overarching Falls Steering Group ▪ Adopt the Falls Audit and report compliance ▪ Regularly report training compliance to the overarching Falls Prevention Service Group ▪ Overarching Falls Steering Group to monitor action and improvement plans			

Quality Priority – Falls Prevention

1. INTRODUCTION

Falls Prevention has been identified as a Quality priority by the Health Board at a time where the national messaging is *Falls Prevention is everyone's business.* Falls are the highest cause of incidents within the Health Board and nationally it is the second leading cause for accidents in the home. It is estimated approximately 130,000 older people will fall at least once in Wales this year. There are high individual/personal and socio-economic cost to falls, with a cost to the NHS as a whole of £2.3 billion annually.

This paper outlines how the quality priority will be implemented and monitored across the HB and how it will be embedded as normal practice moving forward.

2. BACKGROUND

Falls occur at all ages across the lifespan and are an inevitable part of a bipedal gait and physical activity. It is estimated 30% of adults aged over 65 years will fall per year [2], for whom the consequences are more serious, despite concerted efforts of researchers and clinicians to understand, assess and manage their risks and causes.

In addition to personal distress, falls and fall related injuries are a serious healthcare problem because of their association with subsequent morbidity, disability, hospitalisation, institutionalisation and mortality [1,3,4]. Across Europe, total deaths and disability-adjusted life years due to falls have increased steadily since 1990 [5]. The number of falls and related injuries will likely further increase [6], partly due to an ageing population, but also because of increasing prevalence of multi-morbidity, polypharmacy and frailty among them.

Knowing and understanding the impact of falls for individuals and the HB, it is imperative the overarching aim within the Falls Prevention Quality Priority is to reduce falls incidence and reduce harm from falls. In 2022/2023 there were over 2000 falls incidents in our inpatient services, increasing hospital length of stays, increasing pressure on the health board system, as well as social services and other partners. There are a number of ways in which to do this. Table 1 details the GMOs (Goal Method Outcome) set at the start of 2021/2022 with RAG rated progress update alongside each activity.

GOALS		Comments
Go1	Falls integration across the wider HB (Primary Care and Community services and secondary care)	HB wide governance structure now in place. Regional Falls Prevention Taskforce Launched Falls Overarching Group in place
Go2	Reduced falls and harm in hospital and across Primary Care and Community services.	Baseline data from 2021/2022 is av 208 incidents/month. Target 10% reduction at 187/month. Current incident rate of 178/month. Falls resulting in serious harm in 2021/2022 was 24. Target (reduction by 10%) was set at 21 for 2022/2023. Currently reported 18 (April 2023 data not yet added)
Go3	Reduction of falls per 1000 bed days across SBUHB.	Baseline data falls rate 6.0/1000 bed days (NAIF 2020). Current HB fall rate at 4.5/1000 bed days
Go4	Develop HB Falls Investigation Tool and Causal Factors Matrix	In progress – National guidelines to adopt hot debrief from RCP 2022
Go5	Development of Strategic Quality Improvement Plan (SQuIP)	Programme of works in place
Go6	Develop/Educate clinical workforce	Development of induction programme – advised Falls training to be mandatory. SGs to provide evidence of training compliance.
Go7	Prevent frailty, promote bone health and reduce falls and injuries	Input to hip fracture database
Go8	Improve Outcomes for people who have sustained fracture neck of femur #NOF	Compliance with National Audit of Inpatient Falls

METHODS		Comments
Me 1	Establish governance and reporting structures to deliver improvements against the priority across the Health Board.	Completed
Me 2	Multi-disciplinary Strategic Frailty Board/Group to oversee HB wide approach Primary Care and Community Services Falls Group to be established to oversee Falls Injury Prevention Quality Priority. Engagement with WAST and General Practice is key to understanding falls prevalence within PC&CS. .	Completed
Me3	Recruit Therapist or Nurse to oversee Falls Injury prevention across SBUHB. Re-evaluate support for older people to develop care plans/pathways for patients who are susceptible to falls/undergone a fall. Will work closely with HFIPSG to assist with developing strategy/HB priorities	Completed
Me4	HFIPSG to review HB evidence to identify priorities for HB agenda in hospital falls assessment, prevention and management of injurious falls.	Completed
Me5	As part of mandatory training - education of clinical staff to: identify and advise people at risk of falls and manage patients who have fallen	Advise as mandatory – request for future consideration
Me6	Develop HB Falls Investigation Tool to link with the Causal Factors Matrix, which is integral to DATIX to support causal factor analysis within Service Groups across SBUHB.	Not yet developed with DatixCymru. Falls investigation tool in progress as part of WNCR development.
Me7	Commence bone protection analysis for patients who sustain a hip fracture and ensure this is communicated to GP. Promote public health campaigns re: healthy lifestyle and physical activity.	Public health campaigns – involvement with National campaign development
Me8	Use of Falls Care Bundle. Engagement with GPs, District Nurses and WAST re: Falls Prevention Pathway. Identify “Falls Injury Prevention Champions” across the UHB.	Falls champions identified and registered. Engagement through HB wide steering group and Regional taskforce.
Me9	Early diagnosis and intervention of patients sustaining #NOF Appropriate post-operative management and care of repair of #NOF. Input data to maintain National Hip Fracture Database, to monitor and compare with other Health centres across Wales.	Fracture liaison team in place. Compliance with NAIF and National Hip fracture database
Outcomes		**Comments**
Ou1	Form part of a programme of quality priorities within the 2021/22 Annual Plan aimed at improving the health and wellbeing of patients and the community.	achieved
Ou2	Deliver improvements against the relevant Health and Care Standard (2.3 Falls Prevention).	Partly achieved. MRFA (risk assessment) 63% compliance (not inc MH&LD)
Ou3	Specialist Falls Practitioner working across the HB re: falls prevention programmes (across Primary Care and Community services and secondary care).	achieved
Ou4	Strategic oversight and governance of Falls Injury Prevention across Primary Care and Community Services and secondary care.	achieved
Ou5	Agreement of Fall Mandatory training and achievement of 90% compliance.	Not achieved. Not accepted as mandatory training
Ou6	Reduce number of injurious inpatient falls and manage appropriately patients who have fallen to decrease inpatient length of stay. 10% annual reduction of injurious falls within inpatient setting.	Achieved. Baseline data from 2021/2022 is av 208 incidents/month. Target 10% reduction at 187/month. Current incident rate of 178/month (av)
Ou7	Identify causes of inpatient injurious falls. Learning from falls, decrease in incidents, complaints and concerns.	Partly achieved. Introduction of Hot debrief in 2 sites
Ou8	Enhanced understanding of risk stratification and early assessment of patients to avoid falls taking place.	achieved

Ou9	Increase in post-operative outcomes for patients with #NOF. Decrease in mortality rates following #NOF. Reduce inpatient LOS and further potential harm.	Partly achieved. Fracture Discharge pathway reporting decrease in LOS for #NOF pts
Ou10	Falls Injury Prevention Champions across primary and secondary care to increase awareness of falls/injury prevention.	achieved
Ou11	Increased patient experience. Decrease in number of bed days following patient falls.	Partly achieved. Currently unable to fully measure

Table 1: GMOs set 2021/2022

A number of HB wide data sets will demonstrate the impact of the above GMO work streams to date.

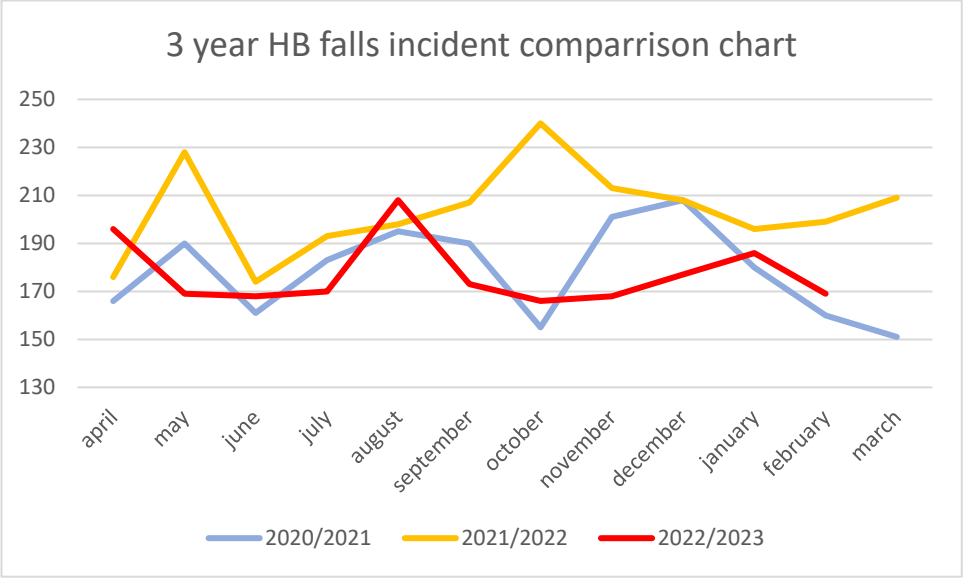
Health Board Falls Prevention performance overview

Falls incidents:

Falls incidents included in this data set is reflective of inpatients only. This is due to inconsistent and complex reporting mechanisms in community settings. Incidents not reported through DatixCymru are not yet available.

All falls incidents with or without harm caused have been used for completeness. The accuracy of reporting severity of harm following fall is currently 52% i.e. in 28% of incidents 'no harm' was reported when post investigation found harm evident. Reporting accuracy will form part of a Training Quality Improvement project detailed in the work stream.

The baseline data for falls was taken from 2021/2022 where there were 2502 falls or an average of 208 falls per month. The target was to reduce the falls incidents by at least 10% to below 2251 or an average of 187 per month. The HB is on target to achieve this goal with a current monthly average of 178 falls for this financial year.



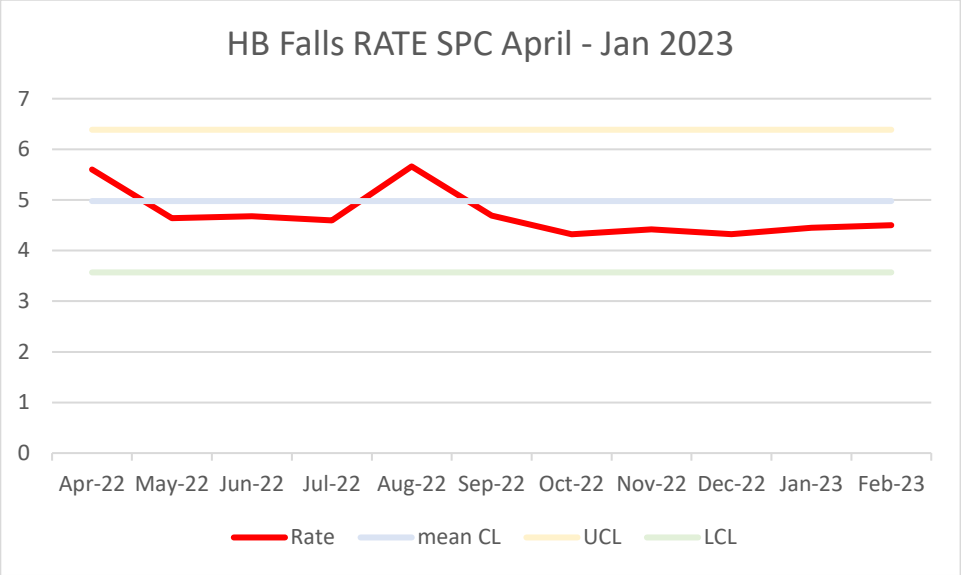
Graph 1: *Comparison data for inpatient falls incidents over the previous three years (2020 – 2023) (note awaiting March 2023 data).*

Graph 21 shows that 2022/2023 data (red) tracks below previous years with the exception of August 2022 where there was a significant rise in falls. This rise appears attributable to a rise in incidents at Morriston Hospital and is not reflected across data from other Service Groups. IPC data has been reviewed for the same period and rise cannot be clearly attributed to any IPC issues including Covid-19 rates. Staffing rates have also been reviewed looking at the number of

unfilled nursing shifts through August – whilst no obvious site wide staffing issues at this time, spikes in unfilled nursing shifts correlate with wards where we see an increase in falls related serious injuries; further analysis required.

Falls Rates:

Using the Nationally recognised falls rate per 1000 bed days unit more accurately reflects current performance; taking into account increases in number of patients within the system.

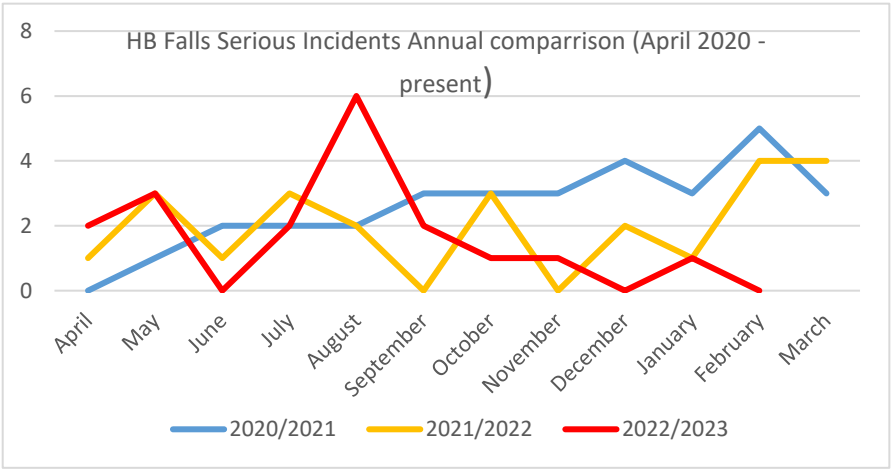


Graph 2: *HB Inpatient Falls Rate 2022/2023 (note awaiting March 2023 data)*

The HB falls rate in 2021/2022 was 5.3, a 3% decrease from the previous year. 2022/2023 however is on target to see an 18% decrease and currently has an estimated annual falls rate of 4.3. Graph 2 shows the continued progress to reduce the falls rate across the HB.

Serious Harm from Falls:

Falls where serious harm has occurred in hospitals, are referred to the Serious Incident team where a decision as to if the incident is reportable to Welsh Government is made. All falls resulting in a hip fracture are reported to Welsh Government.



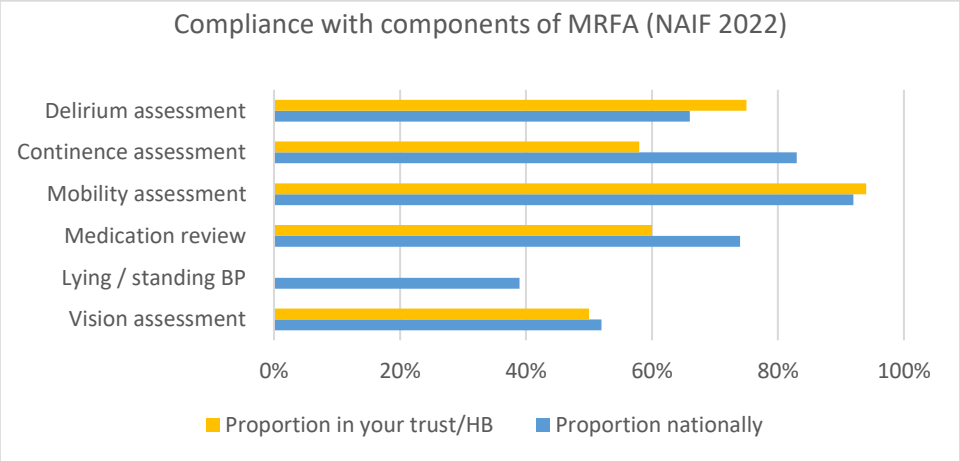
Graph 3: HB Annual comparison of falls incidence causing serious harm.

Since moving to Datix Cymru in April 2022 it is now more achievable to audit reporting accuracy. In regard to falls causing serious harm 61% were initially reported inaccurately at a lower harm rating. This could be due to education of reporting severity matrix and or time delay in clinical investigation outcomes.

National Audit of Inpatient Falls 2022

The most recent report for the National Audit of Inpatient Falls (NAIF) was published in October 2022 and includes Clinical data from 2021 and Facilities data for 2022. SBUHB has continued to actively participate in the audit annually. The process involves review of approximately 60 sets of clinical notes taken at random from across the Health board. This does not therefore provide wholly accurate information but does provide useful insights.

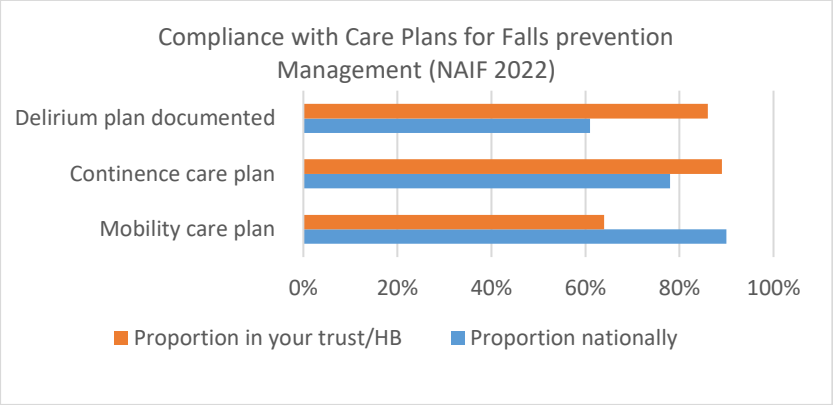
A clear focus of NAIF and a new KPI for 2023/2024 is the completion of a robust Multifactoral Falls risk assessment (MRFA) for all patients aged over 65 years of age.



Graph 4: *Compliance with components of MRFA as reported in NAIF 2022*

Most sites with the exception of MH&LD now utilise the Welsh Nursing Care Record. NAIF suggests a compliance with MRFA at 42% however this only looks at the data included in the audit. An audit of more recent WNCR data suggests a compliance rate of 63%. However, National Institute for Health and Care Excellence guidelines (NICE CG161) state the assessment should be completed within the first 4 hours of admission to hospital. Currently, the average time the initial MRFA is completed is approximately 41 hours. Component focussed quality improvement projects are scheduled for 2023 details of which can be found in the Falls Prevention QI workstream. Progress of which will be reported through the Overarching Falls Prevention Steering Group and through Quality and Safety reports.

Additionally, the NAIF report highlighted progress made with Care planning, with improvement noted from previous year.



Graph 5: *Compliance with Care Plans (NAIF 2022)*

It is anticipated we will see an improvement in Mobility Care planning in the next audit due to the increase in 7 day therapy provision across SBUHB. An improvement on the use of flat lifting equipment is also anticipated due to investment in equipment and training in acute sites during 2022.

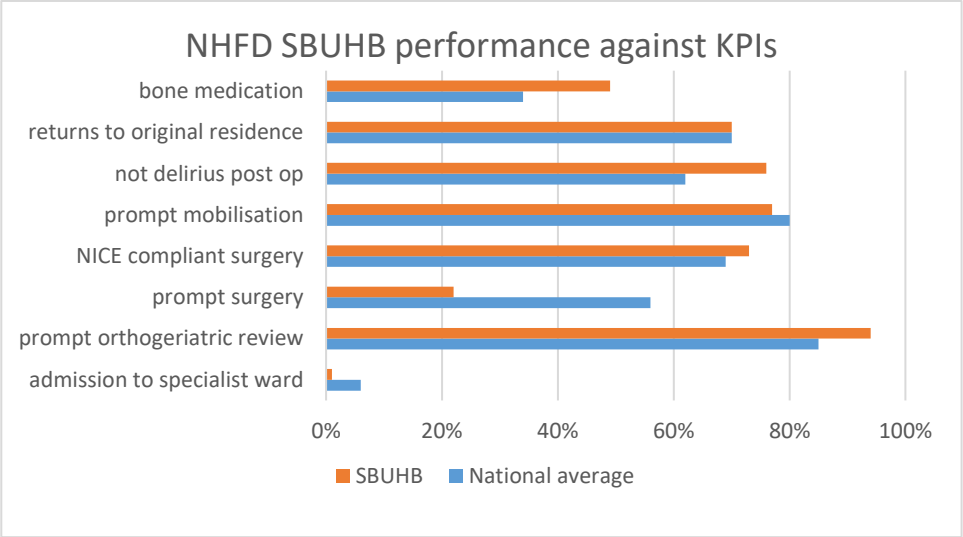
Additional areas requiring particular focus are the roll out of the Hot Debrief tool; this has started in NPTH and SGH but is yet to be utilised consistently across all clinical areas. Hot Debrief asked to be added to WNCR, awaiting approval and implementation. An improvement in analgesia prescription and administer is required following a fall resulting in hip fracture; a national average of 120 minutes is recorded however this is taking 420 minutes in SBUHB on average.

The KPIs the NAIF report 2023 are below and will be included into the SBUHB Quality Priority GMOs:
1 High-quality MFRA prior to the fall
2 Check for injury before moving
3 Flat lifting equipment used to move the patient from the floor where fracture is suspected
4 Assessment by a medic within 30 minutes of the fall

The National Hip Fracture Database:

The National Hip Fracture database (NHFD) is inputted into via the Health Boards Fracture Liaison Team. 169 hospitals from across the UK contribute to this.

Key recommendations from the 2022 report (using data from 2020 and 2021) are to use the NHFD as a driver for Quality Improvement; fast access to appropriate specialist wards; improve access to bone screening and bone health medication; and reduce inequalities in health care provision.

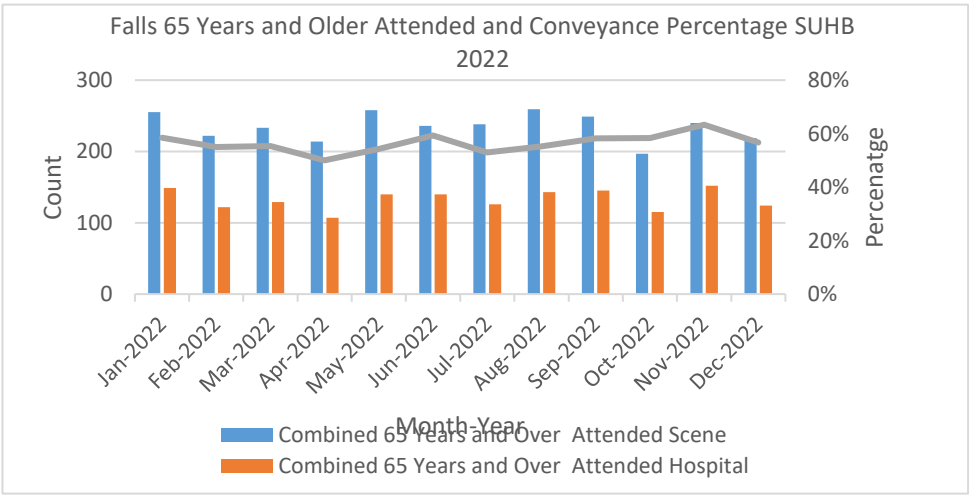


Graph 6: *National Hip Fracture Database 2022 KPIs National performance compared with SBUHB*

Particular areas of focus required are access to prompt surgery and prompt admission to specialist ward where SBUHB performance is lower than the national averages. To note as the data is taken from 2020/2021 significant improvements have already been made including the introduction of a 7-day therapy service focussing on the mobilisation of patients post hip fracture. Therefore' further data cleansing will take place prior to commencement of QI projects. The above KPIs are to be included in the Falls Prevention GMOs for 2023/2024.

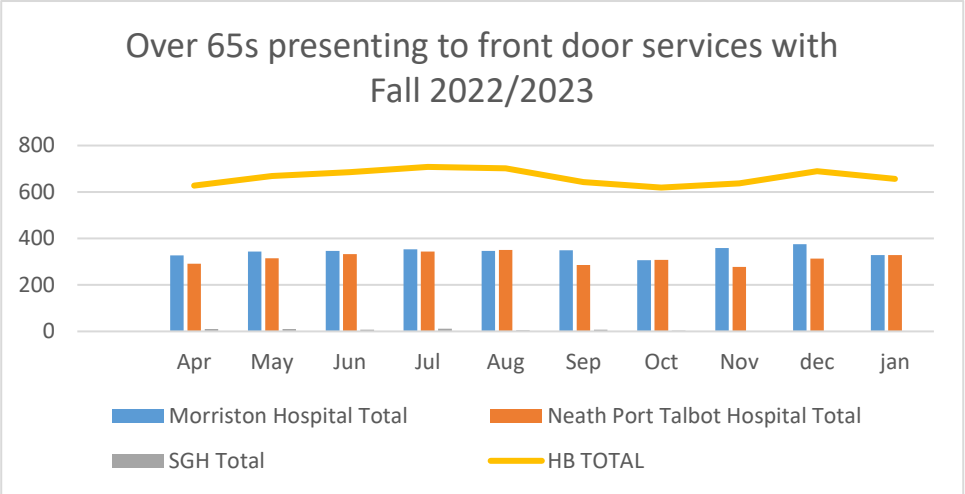
Community Falls Incidents

Understanding the number of falls occurring in the community is difficult however Welsh Ambulance Service have provided data showing the number of call outs to falls they attend. In 2022, WAST received approximately 5800 call outs for falls in SBUHB and approximately 60% of these were attended. The conveyance rate average is 56% which is on par with the national average.



Graph 7*: WAST data – Over 65 years of age Falls calls attended and conveyed to hospital 2022*

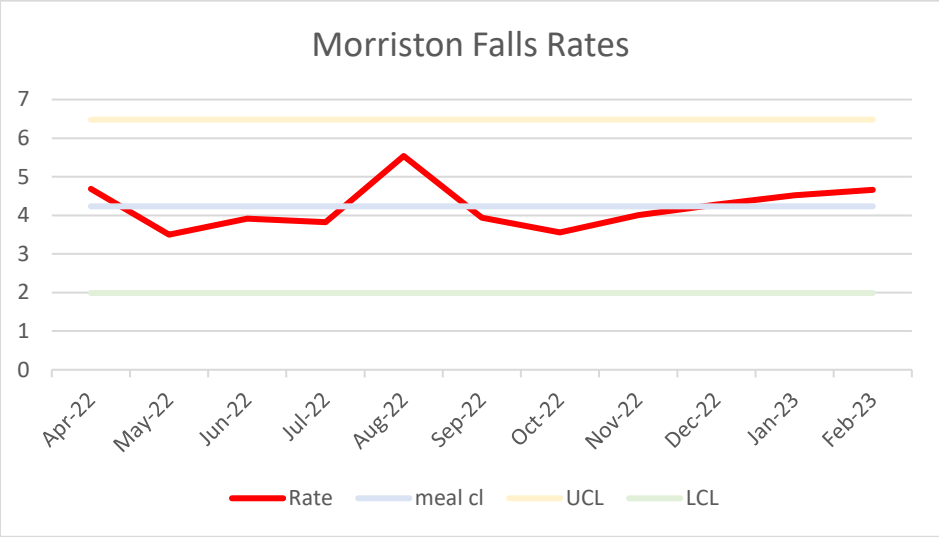
The WAST data has stayed fairly consistent over the last three years. We have however seen an increase in presentations to front door services of falls in the over 65 years population. Anecdotally, emergency departments are stating more patients are presenting who have made their own way to hospital (possibly due to response rates worsening) and therefore is increasing the risks held in the front door services. This is a measure that could reported on and monitored via the service group feedback in Quality and safety groups.



Graph 8: *Number of patients over 65 presenting to front door service with a fall 2022/2023.*

Service Group Performance in Falls Prevention

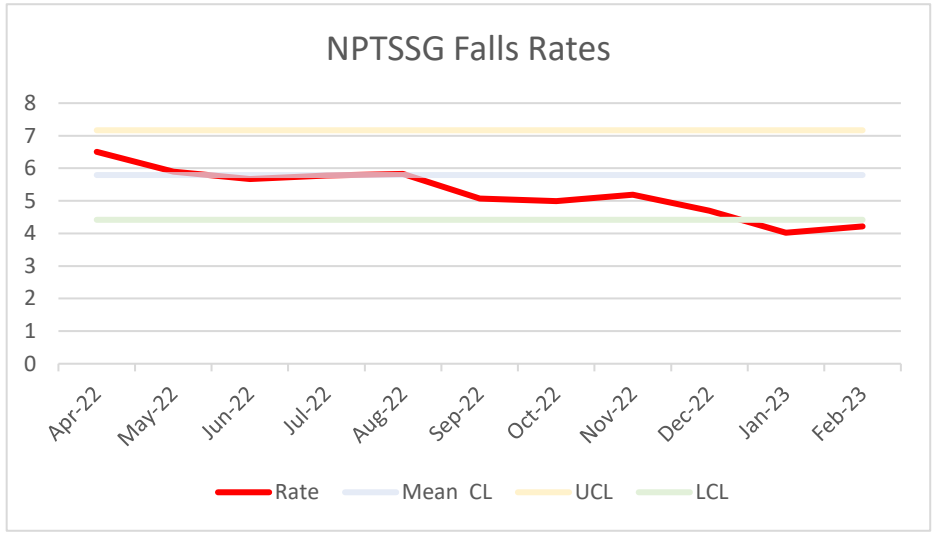
Morriston Service Group



Graph 9: *Morriston Falls rates 2022/2023*

Morriston SG Key messages
Good engagement with Overarching Falls Prevention Steering Group
Completion of 7th annual falls report
Restructure of Falls forum to develop QI focus
Launch of Baywatch initiative QI project
Planning phase of Patient transit QI project

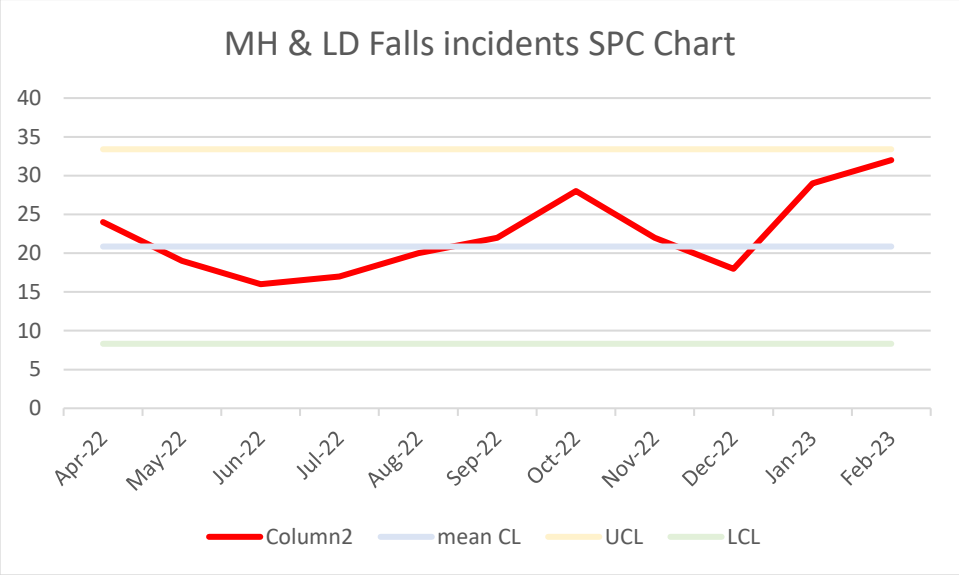
NPT and Singleton Service Group



Graph 10: *NPTSSG Falls Rates 2022/2023*

NPTSSG key messages
Good engagement with Overarching Falls Prevention Steering Group
Focussed ward based training completed
Hot Debrief roll out to SGH
Trial of Falls Audit tool
Planning phase of Volunteer Programme Quality Improvement project

Mental Health and Learning Disabilities Service Group



Graph 11: *MH&LDSG Falls Rate 2022/2023*

MH&LD SG Key messages

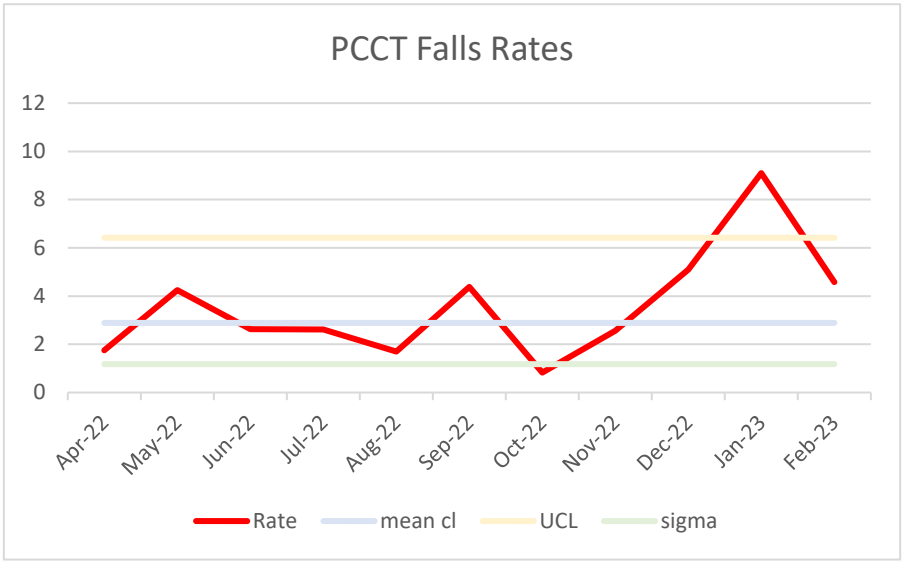
Restructure of SG level Falls Group in 2022

Audit of MRFA compliance

Planning phase of quality Improvement project re: sleep hygiene

Planned engagement with NAIF audit 2023

Primary Care, Community & Therapies Service Group



Graph 12: *PCC&TSG Falls rate (Gorseinon Hospital only)*

PCC&T SG Key messages

Falls rate increase analysed and attributed to 2 individual patients

Engagement with Improvement Cymru as part of Safe Care Collaboration Project – Aim to reduce conveyance to hospital through 'iSTUMBLE education programme' in care homes

QI pilot project 'Delta' completed ended Oct 2022 – funding to continue not achieved

QI pilot project with WAST – Therapy response service repeated in 2022. Funding not achieved for expansion

Planning phase of QI project with Helpforce – volunteer service providing strength and balance exercise sessions

In order to ensure continued improvement the GMOs for 2023/2024 have been revised:

Goal	Method	Outcome
↓ inpatient falls and harm from falls across HB	• Build on Quality improvement programme. Embed Falls audit programme. • Develop dashboard for ward use • Embed reporting structures from service groups Targeted QI input to high falls rate wards • Develop HB Falls Investigation Tool & Causal Factors Matrix • Develop/Educate clinical workforce • Development of Strategic Quality Improvement Plan • Build on Quality Improvement plan now in place • Engagement with Improvement Cymru and participation in Safe Care Collaboration Consider training to be mandatory • Complete ongoing post falls training • Contribute to National work stream for falls prevention training in community	Reduce number of fall related SIs by a further 10% (*baseline 20:.* ***Target 18 in 2023/2024)*** Reduce number of falls by further 10%*(baseline 178 av falls/month:.* ***Target 160 av falls/month)*** All sites to maintain falls rate below national average of 6.6/100 bed days Evidence of impact of QI work streams to be shared through falls steering group Improved assurance for falls investigation. Improved quality of shared learning
Improve Outcomes for people who have sustained fracture neck of femur #NOF	• Expansion of Fracture liaison service to ensure Early diagnosis of #NOF. Continue to input data to maintain National Hip Fracture Database. Development of community Fracture Discharge service • Commence bone protection analysis for patients who sustain a hip fracture and ensure this is communicated to GP. • Promote public health campaigns re: healthy lifestyle and physical activity.	↑ in post-op outcomes ↓ in mortality rates ↓ inpatient LOS post #NOF. Improvement in all #NOF KPIs to minimum of National Average
↓ conveyance rate following fall	• Joint work with WAST • Safe collaboration engagement • Utilise volunteer service • Target nursing/care homes • Community pathway review	Reduction in conveyance to hospital rate by 10%. *(Baseline 58%.* ***Target 48% conveyance rate)*** Reduction in re-admittance (within 6 months) rate for falls at front door services *(Baseline 6%,* ***Target 4% fall readmission rate)***
Embed Falls prevention across all service groups	• Reporting template to be agreed and embedded. • Reduce reporting duplication • Membership and TOR reviewed to reflect wider team Consideration of maintenance of improvement planning • Ongoing Falls audit programme • Annual Falls Summit	Falls overarching steering group full quorate at all meetings. Shared learning between all SGs. Streamlined reporting Agreement of Fall Mandatory training & achievement of 90% compliance. Learning from falls, decrease in incidents, complaints and concerns.

Table 2: *Revised GMOs for 2023/2024*

Conclusions:

The Falls Prevention Quality Priority had an overall aim to reduce falls incidence by 10%. This has been achieved and GMOs revised to reflect the progress made and new targets set. Quality Improvement is now integral to all Falls projects across the health board. Focus continues on preventative work and will begin to shift to embedding the Falls Prevention work in normal business.

3. GOVERNANCE AND RISK ISSUES

There is now a robust governance structure in place and service groups are asked to ensure Falls prevention is an agenda item on quality and safety and or operational groups at SG level.
HB wide reporting has been agreed.

The following risks have been identified:

1. Digital Informatics – Dashboard not yet in place effecting Service Groups ability to have access to real time falls data and therefore take accountability and influence change in a more timely way.
2. Falls training not mandatory – it is recommended that falls prevention online training (accessed via ESR) is made mandatory

4. FINANCIAL IMPLICATIONS

Through the Quality Improvement programme there are a number of projects that may require additional funding however details for this will follow through individual project groups.

Consideration of a band 4 workforce working as Falls co-ordinators across the HB which may improve patient experience and provide further assurance. Further benchmarking required before formal business case submitted and consideration over governance structures required.

5. RECOMMENDATION

Members are asked to **note** the report and **approv**e the following:

In order to progress Falls Prevention Quality Priority work and embed it as business as usual, Service Groups must take a lead and ensure:

- Engagement with SGs Appointed Falls Champions and develop reporting systems in order to monitor performance
- Establish robust SG level governance structures and report on Falls via Q&S group with mechanism to escalate issues as they occur
- Share learning at HB wide Overarching Falls Steering Group
- Adopt Falls Audit and report compliance
- Bi-monthly report training compliance to Overarching Falls Prevention Service Group
- Overarching Falls Steering Group to monitor action and improvement plans

References

1. GanzDA, LathamNK. Prevention of falls in community-dwelling older adults. NEnglJMed2020;382:734–43.

2. JamesSL, LucchesiLR, BisignanoC*etal.* The global burden of falls: global, regional and national estimates of morbidity and mortality from the global burden of disease study 2017. InjPrev2020;26:i3–11.

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6. National Instiute for Health and Care Excellence(NICE).2019 Surveillance of Falls in Older People: Assessing Risk and Prevention (NICE Guideline CG161). London: National Instiute for Health and Care Excellence, 2019

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☐
	Dignified Care	☐
	Timely Care	☐
	Individual Care	☐
	Staff and Resources	☐
Quality, Safety and Patient Experience		
Falls prevention Quality Priority reports directly to Q&S group and Patient safety Group. The overall aim is to reduce falls incidence and reduce the harm patients are caused through falls.		
Financial Implications		
No financial implications noted in this report.		

Legal Implications (including equality and diversity assessment)	
Each service group have Falls Prevention Meetings/Forums and these feed into a HB wide Overarching falls Prevention Steering Group. This reports to both the Quality Priority Programme Board and Q&S governance structures. As project is open for FOI we should be able to provide robust data.	
Staffing Implications	
Falls prevention champions have been identified across all HB areas; role to be developed through QI programme.	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
The focus of the Falls QP work is prevention. The Quality Improvement programme ensures integration with partner agencies including social services and third sector services. There is collaboration with both partner agencies and Improvement Cymru to progress QI work streams.	
Report History	Regular falls prevention QP reports submitted via Management Board. Overview of Falls Prevention QP shared at Patient Safety Committee Nov 2022. This report was Shared at Management Board March 2023
Appendices	None