Meeting Date	**22 November 2022**	**Agenda Item**	**4.6**
Report Title	**Falls Prevention Quality Priority Update**		
Report Author	Eleri D'Arcy – Falls Quality Improvement Lead		
Report Sponsor	Angharad Higgins and Hazel Powell		
Presented by	Eleri D'Arcy		
Freedom of Information	Open		
Purpose of the Report	This paper identifies the Falls Prevention quality improvement work that is in progress across the Health board and highlights the impact of these on current falls rates and performance.		
Key Issues	• SBUHB lowest inpatient falls rate across Wales • Continued reduction in SBUHB inpatient falls incidents evident over last 3 years • Number of over 65s presenting at front door services with fall is increasing • Chair and vice chair of Falls Prevention Overarching Steering Group now identified – well positioned to focus on frailty and admission avoidance • Falls rates now calculated (manually) at ward level providing valuable insight and target for QI work • Substantial QI plan across all sectors • Good engagement from third sector and partner agencies • Launch of Regional Falls Prevention Taskforce November 2022 • Falls Summit organisation in process to take place December 2022 • Informatics remains a risk since launch of Datix Cymru in April 2022 as dashboard no longer meeting requirements for falls data analysis		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **NOTE** the sustained improvement in falls reduction; and			

	• **NOTE** the targeted work the Service groups are taking and the work the Falls Quality Improvement team is taking on focussed activities across the Health board to reduce falls.

Falls Prevention Quality Priority Update

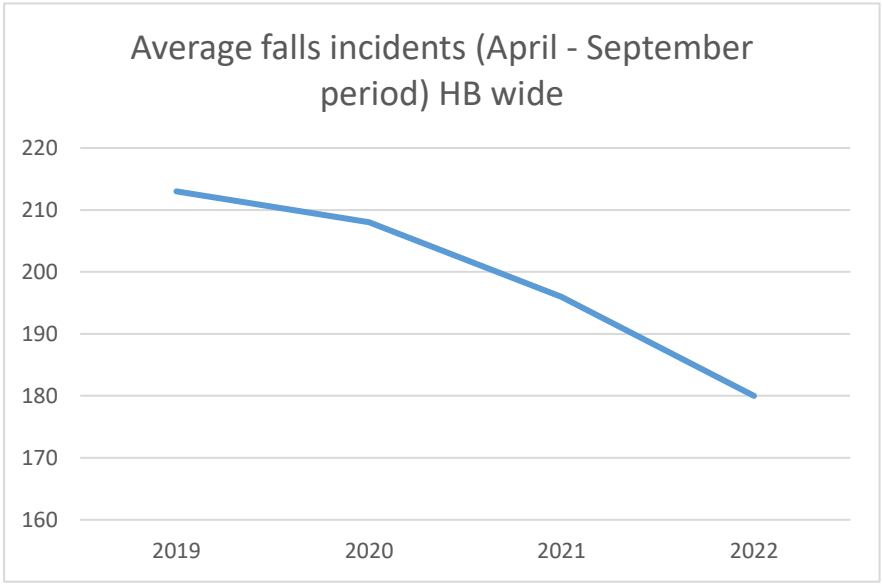
1. INTRODUCTION

Falls Prevention is one of five Health Board Quality Priorities. In order to support this priority investment was made a Quality Improvement Lead appointed and in post in January 2022. The work of this Quality Priority is pulled together under the Overarching Falls Prevention Steering group which reports to both Management board and the Quality Priorities Programme Board. This paper sets out the Health Board's current position in relation to falls incidents and rates and provides background and context to the progress made to date. It will give an overview of the quality improvement initiatives in place an or planned to demonstrate the commitment to reducing falls.

2. BACKGROUND

The GMOs (Goal Method Outcome) for Falls prevention is a reduction of 10% in inpatient injurious falls.

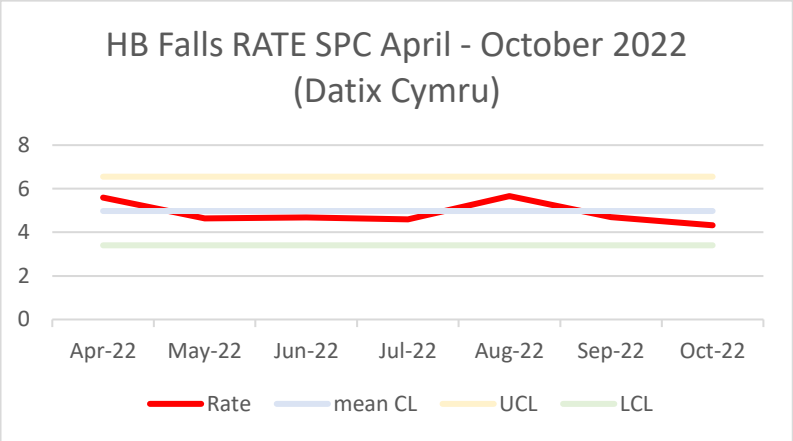
As a Health board our year on year inpatient falls incidents have reduced (using annual April-September as comparative figures). The rate at which this reduction is reported, is increasing, demonstrating sustained improvement (see graph 1).



Graph 1: annual reported falls incidents

Given the data above, a trajectory goal of an average of 162 falls by the end of September 2023 is predicted and would reflect a 10% reduction from the same period last year.

Most recent data is shown as the Falls rate (falls/1000 bed days) in Graph 1 below. With the exception of August 2022 overall a reduction in falls rate from 5.6 to 4.3 over this period.



Graph 2: SBUHB overall Falls Rate /1000 bed days April – October 2022

Benchmark with other Health Boards

When compared to other Health boards within Wales, SBUHB has the lowest inpatient falls rate at 6.01/1000 bed days (see Table 1 below). SBUHB also has the fewest number of inpatient falls reported with severe harm and have the second lowest incidents of inpatient falls resulting in Hip fracture.

Hospital	Occupied bed days	total over 65	% over 65	Total number of reported falls in inpatients	falls rate	Outcome of severe harm	Severe harm or death involved a hip fracture
Betsi Cadwaladr Uni	545537	408550	74.9	4398	8.06	60	7
Hywel Dda Universit	213887	165486	77.4	2898	13.5	27	30
Swansea Bay Local	397095	244032	61.5	2389	6.01	22	16
Cardiff & Vale Univer	502151	300559	59.9	3258	6.5	32	27
Cwm Taf University I	0	0		0	0	0	0
Aneurin Bevan Unive	410430	303424	73.9	3729	9.1	57	33

Table 1: Health board comparisons of falls incidents, falls rates and falls related Serious incidents for 2019.

Service Groups' Position

Falls rates for service groups and individual sites can be found in appendix section of this report.

Morriston Service Group has seen an overall reduction in falls since April 2022. There are several targeted activities in place including, development of Falls forum, launch of Baywatch (system to improve operationalisation of enhanced observation) December 2022, development of patient transit risk project (reducing risk to

inpatients when transferred to radiology/outpatients and inter site). Work is also underway to develop a Fracture Discharge Service to reduce length of stay in hospital for patients who have had a hip fracture as a result of a fall. This service will enable patients presenting with a fragility fracture (fall related) at the front door (Emergency department/Minor injuries/Singleton Assessment unit) to receive timely care and rehabilitation at home in order to avoid admission to hospital.

NPTSSG (Neath Port Talbot and Singleton Service Group) has also seen a reduction in falls rates since April 2022. There are several targeted activities within this service group including engagement with new Falls audit, engagement with new bed rail audit, adoption of Hot debrief tool (rapid falls incident debrief to maximise learning as recommended by Royal College of Physicians).

Mental Health & Learning Disabilities Service Group has seen an increase on falls since April 2022. The majority of these falls are occurring within Older Persons division as well as Learning Disabilities. There are several targeted activities planned for this service group including audit of the application of the Multifactorial Falls Risk Assessment. Projects requiring support from the Quality Improvement team include project on sleep hygiene which is appropriate due to the high proportion of falls occurring at night and scrutiny of the acuity model used to determine staffing levels in order to ensure both physical and cognitive risk factors are recognised.

Primary Care, Communities and Therapies service group have maintained a low inpatient falls rate. Focus in PCCT is around community provision and falls prevention strategy. A working party has been set up to look at falls prevention service provision and training needs analysis in order to develop a training plan for all staff.

Inpatient Quality Improvement update:

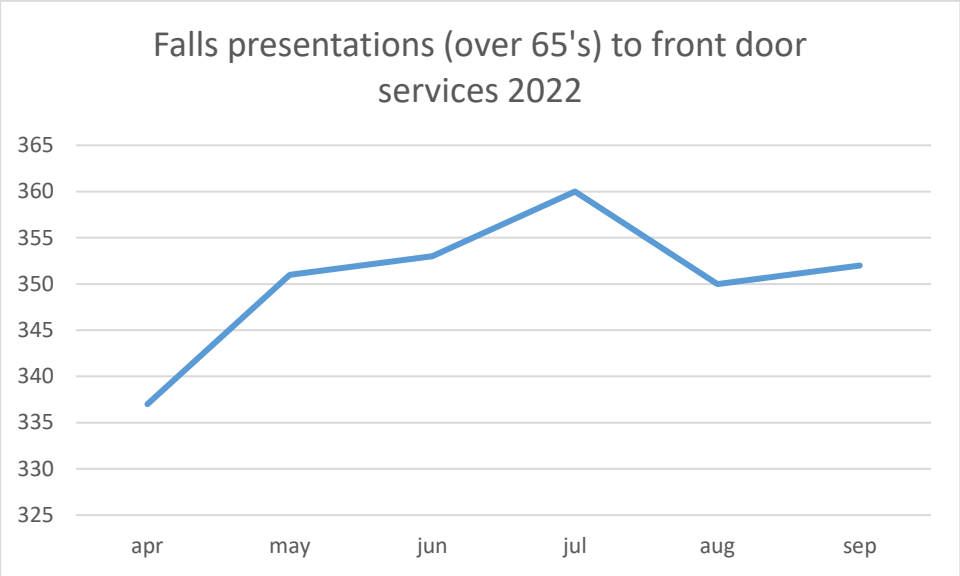
In addition to supporting the above activities, the Falls Quality Improvement team is also leading on focussed activities across the Health board:

Ward level falls rate data now available allowing the service groups and quality improvement team to target ward based interventions including quality assurance, quality improvement focus and training education programmes.

Development of both bed rail audit and falls audit completed and trialled. This will inform baseline data for all quality improvement work at ward level.

Community update:

Many falls that occur in the community are unreported. It is predicted that over 300,000 older people will fall at least once, in their own homes, in Wales, this year. An indication of falls that cause harm in the community is the presentation of those patients to our front door services including Morristons Accident and Emergency department, Singleton Hospital Assessment Unit and NPTHs minor injuries unit.



Graph 3: community falls requiring medical input by front door services

The number of front door presentations for falls is increasing, therefore the number of frail patients within our inpatient settings, at a risk of falls, is greater. However, our inpatient falls incident rate is dropping providing some reassurance that falls prevention strategy is having an impact.

Community Quality Improvement update:

There are a number of QI projects focussed around community falls prevention. Previously SBUHB has not had a falls steering group within PCCT and therefore progress has been limited. An overarching steering group will begin to pull the falls agenda together across all settings including community.

A series of podcast episodes talking about falls prevention have now been released and are available on you tube. These are aimed towards the public and staff and include a series of interviews with experts incluing podiatry, pharmacy, age concern, alzeimers society, continence team, Royal National Institute for the Blind. Series 2 is due for release in January 2023.

The Delta project is an admission avoidance concept currently implemented within the Afan Valley cluster only. Service users with a lifeline system installed within their home have access to a ‘pick up’ service. This reduces long lies which are well

documented to have severe health impacts to individuals and result in increased costs to the Health board. This initial project has seen a reduction in falls related conveyance from approximately 50% to 15%. This project is currently run in the Afan Valley cluster only.

An intergenerational project was tested during Falls Awareness week in October 2022. This included an interactive Falls Crime scene and education on Falls prevention. WAST (Welsh ambulance trust) have proposed a joint approach to scaling this project up to provide intergenerational learning on Falls Prevention across all Primary schools in Swansea Bay.

The Early Supported Discharge team and the Virtual Wards have developed a fracture discharge service targeting fragility fractures at the front door supporting admission avoidance. It also supports patients with hip fractures to be discharged from hospital before they are clinically optimised to provide medical and therapy support at home thus avoiding risks associated with extended admissions. A responsive therapy led rehabilitation and care team with wrap around medical and multi-disciplinary support will provide more opportunity for patients to receive necessary care at home without the need for admission to hospital. This service is in its infancy however has secured funding to scale up to a regional service by end of Q4 2022/2023.

A regional Falls Prevention Taskforce commences 17/11/2022 bringing together community, third sector, voluntary and charitable organisations and partner organisations including emergency services. This will be the first regional falls prevention taskforce in Wales and will link directly with the National and 4Nations Falls Prevention Taskforces already in operation.

SBUHB is working with the 4Nations Falls Prevention Taskforce to develop a training catalogue with peer reviewed free and with cost training available both locally and Nationally. From this a training and development structure will be launched throughout the Health board.

A Falls Summit, planned for December 2022, will bring together key decision makers and stakeholders from across all aspects of the health board to develop a focussed strategy for falls prevention.

3. GOVERNANCE AND RISK ISSUES

The governance structure for the Falls Prevention Quality Priority has been reviewed and realigned to bring community and inpatient work streams together. SBUHB will be the first Health board to adopt this structure, throughout Wales and it is anticipated this will improve communication, shared learning and will improve admission avoidance pathways and increase hospital flow.

Funding ends for Delta Project end of November 2022. To note, a funding shortfall risks the continuation of this service.

Since the launch of Datix Cymru there is no longer access to falls data on the ward to board dashboard. As a result, data analysis is a manual process with related risk for human error but significantly does not allow for data visibility at ward level. Creating a live dashboard which is visible at all levels will improve ownership over falls rates and likely see improvement in performance.

4. FINANCIAL IMPLICATIONS

Funding ends for Delta Project end of November 2022. To note, a funding shortfall risks the continuation of this service.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the sustained improvement in falls reduction; and
- **NOTE** the targeted work the Service groups are taking and the work the Falls Quality Improvement team is taking on focussed activities across the Health board to reduce falls.

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 is one of the Health Boards Quality Priorities. Falls are the highest reported incidents for the Health board and Nationally. Falls are a leading cause of mortality in older persons and have a high financial cost to the HB as well as high personal cost to individuals.

Financial Implications

Funding in place for Falls Quality Priority Lead. Known funding requirement of £85k to continue and expand Delta project.

Legal Implications (including equality and diversity assessment)

There are litigation risks through clinical negligence associated with falls management within the HB.

Staffing Implications

None

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

An intergenerational approach to falls prevention education has been adopted and due for expansion. Co-production activities with partner agencies addresses the long term approach to falls prevention work.

Report History	Quality and Safety Committee November 2022
Appendices	Appendix 1 - HB and Service Group Falls Rates appendix for pt safety commitee nov 2

	Appendix 2 - Presentation