NHS
Greater Glasgow and Clyde

Staying Safe, Strong and Steady

Our Falls Reduction and Management Strategy 2022-2027

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1. Strategy- Setting the scene

1.1 Background

A fall is defined by WHO as an event which results in a person coming to rest inadvertently on the ground or floor or other lower level. not as a result of a major intrinsic event (such as stroke or epilepsy) or overwhelming hazard (i.e. being pushed) Gibson et al 1987.[1]

It is known that there are several possible consequences of a fall these include:

- Physical e.g. fracture, hypothermia, head injury and sometimes death,
- Psychological e.g. social isolation, anxiety/depression and increased dependency.

Each of these consequences can lead to increased demand on health and social services.

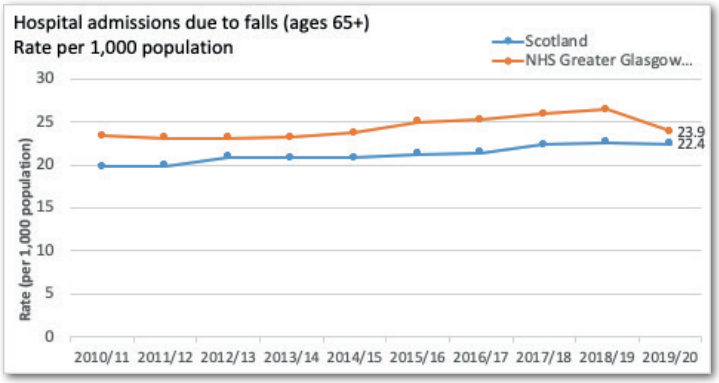
Each year 1/3 of people over 65 experience one or more falls. This increases to nearly 50% in those over 80 living in the community. Between 10% and 25% of those who fall will sustain a serious injury such as those mentioned above.[2] There are over 300,000 admissions to hospital due to fragility fractures in the UK every year (NICE 2019). The likelihood of a fracture or serious injury is related to bone health, with low bone mineral density increasing the risk of bony injury. Injuries caused by falls are a leading cause of admission to hospital and death for those aged over 75. Fear of falling can result in inactivity,deconditioning, loss of confidence and increased risk of falls in older people. It can also result in reduced social interactions leading to isolation or loneliness.

1.2 Frailty and Falls

It is estimated that nearly 10% of over 65's in Scotland are frail, with 42% being classed as pre-frail. (ISD Scotland)[3] Frailty can be defined as '.. the inability to withstand illness without loss of function' (Prof. G. Ellis)[4] Frailty is not age dependant, although more prevalent in older people it is a risk in younger people who have chronic conditions/disabilities. Increasing levels of frailty result in lower resilience to illness and injury. It is known that people who are living with frailty have a higher risk of falls. There is both a national and local focus on improving the identification of frailty within the population. Within NHSGGC there is an integrated approach with regards falls and frailty prevention and management with the Falls Prevention and Management programme, including this strategy being part of the overall Frailty programme agenda.

1.3 Situation in NHSGGC

It is projected that the NHSGGC population for ages 65+ is expected to increase substantially over next 5 to 10 years. It is thought there will be increases of 8.9% by 2025 and 20.7% by 2030 and finally an increase of around 30% by 2040. It is also know that within NHSGGC our hospital admissions due to falls are consistently higher than in other areas in Scotland.
This highlights the need within NHSGGC to try and develop an approach that not only tackles the management of falls but equally focusses on prevention.



1.4 Falls in Hospital

Falls reduction is one of the top priorities for NHS boards in Scotland. Reducing harm from falls has been part of the Scottish Patient Safety Program - Acute Adult Portfolio (SPSP-AA) since 2013.[5] It is also an important part of the Care Assurance System with Acute Standard 2 within NHSGGC being a 25% reduction in all falls and a 20% reduction in falls with harm within our acute inpatient areas.[6] Falls remain a common cause of harm to patients in acute hospitals with as many as 27,000 falls (6.7 per 1,000 occupied bed days) recorded in Scotland every year. In the 12 months between July 2019-July 2020 there were 8912 falls across all NHSGGC acute sites. Many factors contribute to the risk of falls in
hospital. A fall with harm in hospital can have a detrimental impact on the outcome for a patient, with increased length of stay and after-effects of injury resulting in distress for both patient and family and an increased risk of requiring ongoing care and support on discharge. Due to this falls can result in increased costs for healthcare organisations. Effective risk assessment and intervention can help prevent patients from falling thus ensuring they are safely cared for during their time as an inpatient.

1.5 Falls in Care Homes

Falls in care homes can present a significant issue due to the multi pathology and frailty of residents. It is estimated that 40% of hospital admissions from care homes are as a result of a fall. There is also an increased risk of care home residents sustaining an injury, with 25% suffering a serious injury.[7] The risk of a care home resident suffering a hip fracture compared to a community dwelling individual is 10 times higher and their post fracture mortality rate is 33% by 4 months post fracture. These statistics illustrate the challenges that are faced by care home operators when trying to prevent falls and ensure their residents safety. There are also challenges with regards to ensuring all care home staff are adequately trained to ensure they have the skills to risk assess and develop falls action plans for their residents. In order to assist with this the Care Inspectorate and NHS Scotland produced the Managing Falls and Fractures in Care Homes for Older People – good practice resource, this gives a standardised and evidence based toolkit for care home staff to be able to have the resources to self-manage residents at risk of falls.[8] However it is also acknowledged that there will be occasions where care home staff require access to specialist resources.

1.6 Falls in Prison

In it's 2014 book on Prisons and Health the World Health Organisation highlight that there have been increases in both the number and proportion of older prisoners.[42] This they report is due to a number of factors including the increasing age of the general population, increasing number of arrests and convictions of older adults and the impact of criminal justice policies – such as life or long term imprisonment. The prison environment in itself can contribute to functional decline as they tend to designed with a less frail population in mind and therefore can curtail function and reduce physical activity – resulting in a risk of deconditioning. This alongside the prevalence of multi-morbidities and socio-economic factors can lead to premature aging within the prison population. This increasing level of frailty alongside other risk factors around the environment, furnishings and potential vitamin D deficiency can all contribute to an increased risk of falls occurring. A study of older women prisoners in the US demonstrated that 51% had fallen within a 1 year period. Prison healthcare teams working in partnership with the Scottish Prison Service and other community services have a key role in addressing and mitigating these risks where possible.

1.7 Falls in People living with Learning Disability

Falls are a key area covered within the NHS Scotland People with Learning Disabilities in Scotland : 2017 Health Needs Assessment Update.[9] People with learning disabilities experience similar or higher rates of falls than older adults without learning disabilities in the general population. Thirty-nine percent of adults with learning disabilities experience at least one fall per year. People with learning disabilities also experience a number of co-morbidities more commonly, which compound the serious risk of injury from falls. People with learning disabilities for example, have a higher prevalence of osteoporosis and associated fracture risk, and are twice more likely to experience hip fractures.

Risk factors for falls in people with learning disabilities are individual to the person, and may be multi-factorial. Poor balance or gait is associated with falls in the population of people with learning disabilities. Individual falls assessment is recommended to consider a wide range of factors e.g. epilepsy (seizures and medication side effects), sensory impairment, and the environment. People with learning disabilities are also more likely to experience frailty associated with ageing earlier (50 years onwards), and should have access to falls services for older adults at a younger age.

People with learning disabilities require reasonable adjustments, to have equitable access to fall and fall injury prevention and management services. Resources are available to guide implementation of these reasonable adjustments. [43, 44, 45]

1.8 Falls at Home or in the Community

The cause of falls in the older population is known to be multi-factorial and includes issues such as frailty/inactivity, medication, eyesight, alcohol/substance misuse and cognitive issues, but there is a growing evidence base for falls prevention interventions. It has been shown that completing a multi-factorial falls risk assessment and devising an individualised action plan can reduce a persons' risk of having a further fall by up to 1/3. A key part of this multi-factorial approach is the completion of a medication review with modification/withdrawal. It is known that certain medications can increase the risk of falls. Evidence shows that review is required to identify these fall risk inducing drug (FRID's) and deprescribing should be considered where possible. It is also recommended that prior to prescribing FRID's fall history/risk should be considered in order to make appropriate prescribing decisions. [34] Another area where there is good evidence base is exercise. The evidence shows that by participating in a targeted strength and balance exercise programme for >50hours this can lead to a 42% reduction in relative falls risk. (Sherrington et al).[10]

In the last few years the Scottish Government have published several documents pertaining to the delivery of falls prevention services within Scotland. These include:

1. The Prevention and Management of Falls in the Community – A Framework for Action. Promoting a consistent approach to community falls prevention/management and the importance of opportunistic identification of fallers by having a level 1 conversation when older people came in to contact with health and social care agencies. It also recommends the use of multi-factorial falls risk assessment and tailored multi-factorial action plans.

   https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2014/10/prevention-management-falls-community-framework-action-scotland-2014-15/documents/prevention-management-falls-community-framework-action-scotland-2014-2016/prevention-management-falls-community-framework-action-scotland-2014-2016/govscot%3Adocument/00459959.pdf [11]

2. The Active and Independent Living Programme 2016-2020

   https://www.gov.scot/publications/allied-health-professions-co-creating-wellbeing-people-scotland-active-independent/pages/4/[12]

3. Falls and Fracture Prevention Strategy for Scotland 2019-2024 (Draft)

   https://www.gov.scot/publications/national-falls-fracture-prevention-strategy-scotland-2019-2024/pages/6/ [13]

4. The Care About Physical Activity Programme was an improvement programme led by the care commission focussing on improving physical activity levels with those receiving care in particular care home residents. It demonstrated good results with a decrease in likelihood and rate of falls and a decrease in use of medical services due to a fall. This highlights the benefit of promotion and facilitation of increased physical activity and how that can lead to positive outcomes for even the frailest of our populations.

   http://www.capa.scot/ [14]

By taking a whole system approach and encouraging evidence based practice across our communities and services within NHSGGC it is hoped that:-

- The devastating effects that falls has on the older person can be lessened
- We can facilitate people to live more active and independent lives in their communities.
- There will be a reduction in the future care and financial burden on statutory services

2. Our New Vision

2.1 Introduction to our new Falls Strategy Driver Diagram.

To encompass all that we hope to achieve within this strategy an overall Vision has been developed.

"To equip the population of GGC with the skills and knowledge to allow them to lead healthy active lives and lower their falls risk. When a fall does happen we will ensure that our population will have access to evidence based care with integrated pathways to allow for seamless transition between services both statutory and non –statutory"

In order to deliver on this vision there are several key areas of focus that have been identified. These key "Drivers" for change are detailed in the following Falls Strategy Driver Diagram and will form the basis for future strategic and local improvement programmes.

2.2 Falls Strategy

NHS Greater Glasgow and Clyde

Vision

To equip the population of GGC with the skills and knowledge to allow them to lead healthy active lives and lower their falls risk.

When a fall does happen we will ensure that our population will have access to evidence based care with integrated pathways to allow for seamless transition between services both statutory and non -statutory

Multi-agency intervention and communication	IT systems / interface	Locally agreed multiagency integrated pathways and procedures	Shared trainingand education
	Pathways into and out of hospital		Build relationships between and awareness of services
Early intervention and prevention	Opportunistic falls conversations	Self-management resources	Consistent health promotion messaging
	Early identification of risk factors	Access to multifactorial assessment where required	
Community engagement	Co-design with communities	Personal stories	Collaboration with local communities and services
			Develop inclusive and accessible services
Falls management	Referral pathways	Standardised assessments	Digital health and telecare
	Targeted intervention	Evidence based practice	Clear Standard Operating Procedures
Learning culture	Learning from adverse incidents/events	Training/education	Information sharing
	Risk Assessment	Data collection, reporting and analysis	QI approach

3. Multi-agency Intervention and Communication

There is already some great work and developments with regards to falls prevention and management across many services and partner agencies within NHSGGC. Some examples of which are highlighted within this strategy. It is the aim of this strategy to build on, and ensure there are mechanisms to share the learning from existing good practice as well as highlight areas for improvement.

As those at risk of falls can be known to a multitude of services as part of their journey it is essential that processes are in place that promote multi-agency working. This is in keeping with the aims of the Scottish Governments Health and Social Care integration agenda.[15] This strategy will focus on several key aspects where improvements/solutions could be made in the future.

3.1 IT Systems / Interface

A key aspect to delivering on effective multi-agency communication is having an IT structure that allows for effective information sharing across agency and professional boundaries for the benefit of the patient. There are several benefits to this in that it cuts duplication of effort for both patients and staff as it cuts the need for asking and collating the same information. Additionally, if information around falls risk is shared this should improve safety of care and aid treatment planning/goal setting. This aim is consistent with one of the main areas of focus of the current NHSGGC digital strategy - "Building a fully shareable Electronic Health and Care record".[16] Whilst we strive towards achieving this goal there are things that can be done to improve access and sharing of information currently in NHSGGC.

Where it Works Well

The use of EMIS by our mental health services, community falls service and some of our partnership community rehab teams allows sharing of information, facilitates discussion and reduces impact of duplication of referrals allowing safe transition for people through our services. Within our acute services the development of Digital Clinical Notes will support staff with the completion of falls risk assessments and formulation of person centred care plans.

What could we do differently in NHSGGC?

1. Maximise the use of clinical portal and promote the benefits of access to partner agencies e.g. social work services, who are able to gain access. Services should be encouraged to upload relevant assessments/summaries onto Portal.
2. E-Health is working towards improving accessibility to information stored in portal which should make it easier for users to find the relevant information in a timely way.
3. Utilising existing web resources e.g. Staffnet/NHSGG web pages to allow access to generic prevention and management information and service details to aid decision making.
4. Utilising videoconferencing applications such as MS Teams or NHS Near Me to facilitate "virtual ward rounds" where different professions/teams are involved in a person's care.
5. Work with both local and corporate e-health departments to ensure stakeholder engagement in the commissioning of digital systems.

3.2 Pathways into and out of Hospital

Evidence shows that the risk of falls can increase at transition points in a person's care journey. In particular when moving into a place of care e.g. hospital or when being discharged back out into the community.[17] Approximately 1 in 5 older adults will experience an adverse event following discharge from hospital of which falls is one.[18] It is therefore essential that there is a consistent and coordinated approach to planning for these transitions. This should include clear communication channels to ensure all relevant information is shared with those being tasked with caring for that person. Clear pathways that can be utilised to ensure consistency of care is another key element.

What Could we do Differently in NHSGGC?

1. Utilise Clinical Knowledge publisher to map out pathways and ensure access to referral details.
2. Ensure an MDT approach is taken when facilitating discharge from a place of care. Involvement of community services in discharge planning should be encouraged with case conferences being used to plan discharges for our most vulnerable people.
3. Ensure sharing of multifactorial risk assessments and any action plans to enable identification of treatment priorities.
4. Where a person has suffered an in-patient fall in our hospitals this should be communicated to our community services as this has shown to increase the risk of fall on discharge.
5. On admission efforts should be made to consider involvement of community services as part of the holistic assessment as this can aid decision making around safety for early discharge or identify key barriers to safe discharge planning.
6. Ensure the use of ACP's is considered for those people who are at high risk of falling/ sustaining harm from falls.

3.3 Locally Agreed Multi-agency Integrated Pathways and Procedures

NHSGGC covers a large geographical area with varying rural and urban landscapes and with 6 HSCP's it must be acknowledged that there is variability in the services and pathways available to support those at risk of falls. Locality planning and localisation of services are key aspects of the Scottish governments Improving Public Services Policy and is essential to meet the needs of local populations/ communities.[19] However whilst this flexible approach is essential there still requires to be a minimum expectation of delivery of key care pathways such as Falls Prevention and Management as set out in the Scottish Governments The Prevention and management of Falls in the Community (2014).[11]

Where it Works Well

Your Voice community connectors have been working alongside other community services e.g. OT to support those who fall reintegrate into their communities and build confidence thus reducing fear of falling. By working together with other agencies this achieves better outcomes for the people involved.

What Could we do Differently in NHSGGC?

1. Develop a minimum standard of care/pathway for different stages of the care journey. This is demonstrated in the pathway section of this strategy. These should be used by local areas/ services as a guide when benchmarking and identifying areas for improvement.
2. Ensure there is consistency of approach to the assessment of those at risk of falls across our pathways e.g. develop guidance on content of a Multi-factorial Assessment (MFAx).
3. Ensure our pathways are integrated with the identification of Frailty and bone health services.
4. Better understand how these pathways feel to the people who are using them ensuring seamless transition between services/agencies as required.

3.4 Shared Training and Learning

The provision of training and education is covered in more detail within the Learning culture section of the strategy. It is however key that a cross agency view is taken with regards to this as this will help achieve better understanding of all aspects of Falls Prevention and Management and everyone's role in it. Interdisciplinary training is an ethos that is being utilised more and more within our Higher Education Providers and should be replicated across the system.[20]

3.5 Build Relationships Between and Awareness of Services

Multiagency working and having clear referral pathways are 2 of the main focusses within this strategy and are essential to building effective future falls prevention and management systems. The ethos of health and social care integration is a key starting point for improving relationships and understanding between all agencies involved in this agenda.

Where it Works Well

When planning the reopening of the previous IRH Falls Clinic it was identified that this was an opportunity to bring services who were involved in delivering falls prevention and management within the Inverclyde area together. This includes representatives from RES, CFPP, ARC, leisure and 3rd sector community connectors Inverclyde Voice. This has opened up dialogue, improved understanding of roles and service delivery and facilitated discussion with regards for referrals and future pathway developments.

What Could we do Differently in NHSGGC?

1. Create more opportunities for teams/different services to come together. This may be through joint meetings, in-services or networking events.
2. Encourage the use of multiagency reviews e.g. case conferences or virtual ward models.
3. Consider having a yearly falls prevention and management learning event to allow showcasing of work, identifying new ideas/priorities and allow services dedicated time to learn about what other areas/sectors are doing.
4. Utilise events like Falls Awareness week as a platform for increasing the profile of services involved in Falls Prevention and Management across the NHSGGC area.

4. Early Intervention and Prevention

4.1 Early Intervention and Prevention

Early intervention/prevention is a key focus of the Scottish Governments Framework for supporting people through Recovery and Rehabilitation during and after the COVID-19 Pandemic.[21] This document talks about the need for an emphasis on prehabilitation which is a term that encompasses early intervention and preventative models. The Scottish government The Prevention and Management of Falls in the Community 2014 identified 2 key stages which was reflective of this approach Stage 1 which was focussed on supporting health improvement and self-management and stage 2 which was focussed on identifying individuals at risk of falls and/or fragility fractures.[11] It is therefore essential that we have mechanisms in place to both educate the general population of NHSGGC on self-management and preventative interventions but also have in place mechanisms to identify as many of our population that are at risk of falling and offer them evidence based and individualised interventions where appropriate. This could be done by focussing on the below key drivers.

4.2 Opportunistic Falls Conversations

We know that people who have had a fall are unlikely to discuss this with a health and social care professional – with reports suggesting only 20-25% of falls being reported to a health professional. However it is more than likely that these people are having contact with many services whether that is health, social care or third sector. This results in missed opportunities to intervene and modify risk factors before the person has another fall. By equipping staff with the knowledge and confidence to have basic conversations around falls risk including fear of falling there is potential to identify more of those who are at risk of having a fall or further falls. This is an approach that was encouraged in The Prevention and Management of Falls in the Community.

Where it Works Well

Reablement carers in Glasgow City have undertaken Falls Awareness Training and the level 1 falls screening has been embedded in Homecare assessment paperwork.

What Could we do Differently in NHSGGC?

1. We will ensure that all staff will be aware that it is everyone's responsibility to have conversations around falls risk whenever possible.
2. We will work towards this being offered at every point of contact with those at risk of falls. For example community services, clinic visits and community groups etc.
3. Ensure staff have the skills and confidence to initiate those conversations and have the knowledge of onward referral pathways where required.
4. Supplement opportunistic falls conversations with questions that enquire about fear of falling.

4.3 Early identification of Risk Factors

As falls are multi-factorial in nature we know that there are many risk factors that contribute to an individual's overall risk of falling. These risk factors can be external e.g. environmental issues or internal e.g. certain health conditions, some of which are non-modifiable. However there are a large amount of risk factors that can be modified to allow the person to live more safely for longer. Up to 50% of those who have never fallen can have a fear of falling, which can lead to changes in gait and increased falls risk. The earlier that we can intervene then the more likely the person can self- manage their risk and can implement steps to prevent future falls.

What Could we do Differently in NHSGGC?

1. Utilise opportunities to engage with people earlier in their journeys for example during primary care health checks.
2. Work with partners such as leisure services to identify those who would benefit from some risk factor modification.

4.4 Self- management Resources

The NHS Scotland Healthcare strategy decrees that services should adapt to become more anticipatory, preventative and person centred. Many people don't want or need formal input from health and social care services. It is essential therefore that there is a method for everyone to have access to the key information that they require to make positive steps towards reducing their falls risk.

What Could we do Differently in NHSGGC?

1. Ensure that all our sites – hospital and community- have information available to issue, to aid people to self-manage. This may be in the form of leaflets, web resources or digital apps.
2. Have a central falls self-management hub web resource which would ensure that no matter where an individual lives across NHSGGC they can be directed to and have access to appropriate, approved and evidence based self-management resources.
3. Ensure all staff are aware of how to access information around self-management for the people in their care.
4. Ensure that access to support with self-management is available to anyone who may require it, this maybe through formal or informal services.
5. Ensure that these resources and are inclusive and accessible to all who maybe at risk. This may require scoping development of reasonable adjustments for certain groups e.g. learning disabilities.

4.5 Access to Multi-factorial Assessment Where Required

We know that the evidence shows that having access to a multi-factorial assessment can go a long way to reduce a person's risk of falls. This will be discussed more fully further on in this document. It is also known that there has been issues with uptake of this assessment following opportunistic identification. It is essential therefore that there is an option of choice as to how to access this support with self-assessment being available for those who do not wish formal assessment.

What Could we do Differently in NHSGGC?

1. Ensure that there is an option for self-assessment if traditional assessment is declined. This is already available via NHS Inform's Falls Assistant resource, however to be more inclusive a paper based resource should be developed/made available.

   🌐 **fallsassistant.org.uk**

4.6 Consistent Public Health Messaging

The WHO describe falls as a "major public health problem….the second leading cause of unintentional injury death, after road traffic injuries".[1] However for such a large problem there has been a gap in major public health campaigns around this subject with the exception of the Scottish Governments ALIP "The Super Six" balance challenge initiative which was embraced by services across the country and further afield.[12] Evidence shows that mass media campaigns can be effective in helping tackle public health issues.[22] This is mostly due to improving knowledge around certain issues and increasing awareness of services that are available.
However it has also be shown that it can positively affect behaviour change. It could therefore be argued that by investing in a sustained public health messaging campaign around the prevention of falls and frailty that this could lead to a positive outcome with regards to increased awareness of self-management interventions, services that can help and finally a reduction in the number of falls across GGC.

Where it Works Well

The Scottish Governments ALIP Super 6 Test Your Balance Challenge was produced with a number of partners to raise awareness of the importance of strength and balance exercise and that this is one way of preventing falls. There were resources including a pocket resource and posters. This was utilised by a number of services across the country and further afield and the Chartered Society of Physiotherapy have gone on to produce a video resource of the exercises. csp.org.uk

5. Community Engagement

"If we are serious about driving up standards, it is clear there is a need to give patients a louder, more systemised voice which would tell us what we need to know about our performance."
NG Dewhurst, President, Royal College of Physicians of Edinburgh 25/02/13

5.1 Collaboration with Local Communities and Services

Delivering person-centred care is a key strategic priority for the NHS set by the Scottish Government. It is a key part of the 2020 Vision for Health and Social Care, with the idea of working in partnership with patients to design services for the future being a prominent aim for Health and Social Care services.[23] This approach has led to the adoption of lots of key approaches with both the "What matters to me?"and the Talking Points approach aiming to turn the traditional clinician led model on its head. [24 25] These approaches put the patients' needs and wishes at the forefront of service and treatment planning and allow for truly patient centred goals to be generated.

5.2 Co-design with Communities

Coproduction is another key area which has seen some traction within Scotland with the work of third sector agencies in particular The Alliance being at the forefront of developing these skills within statutory services.

5.3 Personal Stories

Patient feedback has long been the main form of patient involvement whether that be in the form of a questionnaire or more recently the use of Care Opinion to gain independent feedback.[26] Both of these are valid ways to garner opinion and to allow services to audit satisfaction levels etc but have limited two way dialogue and do not involve patients or representatives being actively involved in service redesign or improvement.

The use of patient stories is an approach that allows services/organisations to see a true picture of patients' experiences of a service and they can offer a powerful tool when looking at service improvement. Their use is advocated in the NES document Listen, Learn, Act 2013.[27]

5.4 Develop Inclusive and Accessible Services

Within the NHSGGC prevention of falls strategy it is hugely important that a patient centred approach is adopted in particular around how we redesign falls' services for future generations. The Scottish Governments Framework for supporting people through recovery and rehabilitation during and after the COVID-19 Pandemic promotes a person centred approach to remobilising/ redesigning rehab services and a key part of that is ensuring our services are inclusive and accessible to all who benefit. [21]

Where it Works Well

This approach has been taken in NHS Fife with great success. They were able to recruit the daughter of a patient who had been involved in a serious incident to tell her dad's story. Through engaging in this process the lady has now become an integral part of the falls prevention leadership team within NHS Fife. She takes the role of patient representative and has been instrumental in a number of quality improvement projects that have been carried out which has had the effect of reducing their falls with harm rate significantly. It has also allowed her to feel that she has been able to make positive changes resulting from a negative event.

How Could Service User and Carer Involvement be Improved within GG&C?

There are lots of opportunities where service user involvement could be instigated in NHSGGC, some suggestions are listed below:

1. The use of patient stories would allow a better understanding of the "human cost" of falls which allows for a powerful message to be used in the training of staff and the public as well. These could be easily embedded into all current training sessions delivered as well as the board wide Learnpro modules that are part of mandatory training.
2. Consider testing use of the Fife approach. The suitability of this approach through the 4/5 harm review and SAER processes in order to process and gather some patient stories. If by engaging with patients and their families people identify themselves as willing to be part of the ongoing service development and quality improvement agenda then their recruitment as lived experience volunteers or involvement on short life working or focus groups should be explored. It would be pertinent to identify a site where this approach could be tested using a pdsa model to quickly iterate and capture learning.
3. The use of a targeted engagement approach could be beneficial especially around the community preventative work. This could be done with third sector partners and also utilise the engagement officers and forums within all partnership areas.
4. Targeting carer's groups/centres would allow carers to give views on issues and services available to people who fall within NHSGGC, with the NHSGGC corporate and acute carers groups being key partners in taking forward this work stream.
5. Utilising some of the public Newsletters to encourage information sharing but also to encourage a 2 way conversation around how falls prevention and services are being delivered.
6. Promoting a "What and who matters to me approach" around falls conversations during all consultations.
7. Have a coordinated approach to national events such as Falls Awareness Week as a way of encouraging engagement with support from the Communications department.
8. Work with corporate communications and the Patient Experience Public Involvement (PEPI) team to develop a framework for engagement that can be tested, iterated on and rolled out across NHSGGC to progress the work of the Falls Prevention and Management Work stream. This would also integrate with the developing communication plan to ensure that a joined up and consistent approach is taken forward.

6. Referral Pathways

The Scottish government have made access to rehabilitation a key focus as we recover and remobilise following the COVID 19 pandemic. They have outlined the importance of referral pathways to rehabilitation services for all people who have been negatively affected by the COVID19 pandemic restrictions. The principles of this document apply to those who fall or are at risk of falls as we know that the pandemic has had a negative impact on our vulnerable frail adults the most, with deconditioning being a major side effect of enforced decreases in physical activity levels. Age UK report that 26% of people surveyed felt that they couldn't walk as far and 18% felt less steady. Whilst Public Health England have produced some predictive modelling which estimates that 110,000 more older people will have a fall per year as a result of reduced strength and balance.[28 29]

Whilst across NHSGGC there are widespread pathways in place for the care of those who fall or are at risk of fall, through this strategy we aim to reflect a continued focus on improving availability of pathways to all who need them.

What Could we do Differently in NHSGGC?

1. Ensure that referral pathways are clear and reflect the needs of people who have fallen or are at risk of falling across all stages of their journey and incorporate all appropriate agencies.
2. Ensure that referral pathways are as accessible as possible to those who require to use them in order for care to be delivered in a seamless approach for the person who has fallen or who is at risk of falls.
3. We will ensure that where possible a standardised approach to assessment will take place, with consistent evidence based content for both our initial falls conversations (level 1) and our multifactorial assessments (level 2). This will ensure that there is assurance of approach across our services.
4. We will work to develop a central repository for pathway mapping to ensure that all staff will have access to this information wherever they work. This will be done by utilising specific algorithms/flowcharts to visually demonstrate available pathways and will have agreed governence structures to ensure information is up to date and accurate.
5. We will ensure that when looking at developing future pathways that they are shaped by current best evidence. This will ensure that we continue to maintain the highest standards of care.
6. We will continue to work with colleagues from national bodies e.g. HIS and with other boards across Scotland and other subject experts to ensure that our approach is consistent with the overall approach of NHS Scotland/Scottish Government.
7. We will ensure that whatever the setting there are clear protocols and procedures in place so that all staff will know both the immediate actions after a fall and then what the appropriate post fall pathway is for the person.
8. Ensure that pathways are in place to allow access to psychological/mental health support for those experiencing psychological distress as a result of Fear of Falling.
9. We will strengthen referral pathways between falls and bone health services.

6.2 Digital Health and Telecare

During the COVID 19 pandemic there has been a rapid implementation of digital health technologies in order to offer an alternative approach and choice to accessing health and social care services. This approach is being spearheaded by the Technology Enabled Care Programme within the Scottish Government.[30] The focus of which is "outcomes for individuals in home or community settings are improved through the application of technology as an integral part of quality, cost effective care and support to look after more people at home". This is also the approach within NHSGGC with a "Digital as Usual" focus being the aim or our current digital strategy.[16] Within falls prevention there has been developments particularly around utilising apps and websites to aid access to falls prevention information and self-assessment of risk.

Telecare services are available in areas of NHSGGC and are key partners within the falls prevention and management programme. The term telecare is defined by the Scottish Government as "… the provision of care services at a distance using a range of analogue, digital and mobile technologies.[31] These range from simple personal alarms, devices and sensors in the home, through to more complex technologies such as those which monitor daily activity patterns, home care activity, enable 'safer walking' in the community for people with cognitive impairments/ physical frailties, detect falls and epilepsy seizures, facilitate medication prompting, and provide enhanced environmental safety". It is estimated that around 20% of people in Scotland over 75 have input from telecare/community alarm services.[32] One of the key focusses just now is the move from analogue telecare services to digital services. There are also focusses on data and designing services for the future.

Where it Works Well

NHS Inform has an area dedicated to falls prevention which provides in depth evidence based information to allow citizens to become more informed as to how they can reduce their falls risk. This includes a tool 'Falls Assistant' that allows people to self-assess their falls risk and get access to tailored advise.

What Could we do Differently in NHSGGC?

1. Ensure that all areas have pathways in place to allow for referrals to be made from telecare services directly into the most appropriate service.
2. Explore how telecare data could be utilised better to inform the falls prevention and management programme but also to look at using the data in a preventative manner as an early indicator of functional decline.
3. Promotion of telecare/digital health solutions across our pathways.
4. Ensure that we engage with the National TEC programme to ensure that our approach is consistent with the national approach.

Our vision for referral pathways in reflected in the patient pathway section of the strategy.

7. Learning Culture

7.1 Learning from Adverse Events

"There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times."

The Healthcare Quality Strategy for Scotland, Scottish Government 2010 [33]

Unfortunately falls remain a common cause of harm for people in our hospitals and communities accounting for approximately 1/3 of all in patient safety incidents. It is essential that where harm does occur whilst under the care of services that there are processes in place to adequately investigate, identify any learning and most importantly share this learning. This will help improve the delivery of safe and effective care.

Where it Works Well

Within our hospital settings we have a robust process for reviewing such incidents in the HFPC's 4/5 harm review and reporting pathway. It aims to review all the circumstances surrounding the fall and looks at levels of compliance with paperwork, processes and NHS guidelines and policy. This allows a full analysis of each incident and then highlights any recommendations to be made in order to quality assure pre and post fall care and identify areas for improvement. The fall is also given a categorisation of either avoidable or unavoidable, which is important as at times even where all processes have occurred correctly and the best care has been given falls can occur due to the frailer patients with more complex co-morbidities that now make up most of the inpatient population.
If a fall is classified as avoidable it establishes that some improvement work needs to be carried out but it can also help senior staff and H&S staff's decision making regarding SAER and RIDDOR reporting.

What Could we do Differently in NHSGGC?

1. Ensure that all falls that occur whilst a person is under care or services are reported through appropriate risk management systems e.g. Datix for NHS staff. Reports should be completed timeously and include as much relevant information as possible which will aid the subsequent review of the incident.
2. All services should have an identified process for the timely review of falls incidents by senior staff.
3. A "no blame" approach should be utilised with a focus on identification of learning points and contributing factors.
4. As these events can be traumatic for all involved reviews should be carried out in a supportive manner – with staff and patients/families having access to wellbeing support if required.
5. It would be beneficial for all involved if a thorough analysis of the patients' story could be taken so that any learning or feedback from family/patients can be taken in the form of a patient story.
6. Feedback and learning should be shared as soon as possible with the individuals/teams involved to encourage reflection and debriefing to take place.
7. Established systems require to be in place for review of learning themes at HCSP/Acute, divisional and sector levels.
8. A system is established for ensuring that any actions identified from review process are completed and that this is monitored through clinical and governance groups.

7.2 Risk Assessment

The importance of appropriate risk assessment and interventions to falls prevention whether in hospital, care home or in the persons home is well known. In their Falls in older people: assessing risk and prevention guideline (2013) Nice state that:

"Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment".[34]

They also highlight that whilst in hospital those over 65 or between 50-64 who have increased risk due to underlying health conditions should be considered at risk of falls and assessed appropriately.

Evidence shows that by completing a MFAx and subsequent interventions a person's risk of a fall can be reduced by around 1/3.

Where it Works Well

In response to the HIS 2018 SPSP Falls Driver Diagram Falls bundle paperwork was produced. This incorporates a falls risk assessment, basic safety measures and an intervention check list which allows staff to accurately assess a person's falls risk regularly (weekly), on admission, transfer to new ward or when there has been a change in the patient's condition. Where risk is identified staff are then prompted to complete the relevant evidence based interventions. Compliance is monitored through the CCATT audit process.

What Could we do Differently in NHSGGC?

1. Ensure that all who are involved in the care of those at risk of falls are aware of the processes in place for assessing falls risk.
2. All services have an appropriate evidence based risk assessment in place and where this is not possible or appropriate there is an understanding of how to access this on behalf of the person.
3. Any risk assessment must then have an evidence based intervention plan put in place to mitigate/lessen risk of falls.
4. Risk assessments should be monitored/reviewed and updated where appropriate in line with appropriate local protocols. Utilisation of staff wellbeing resources and spiritual care services should be considered.
5. Risk assessments and management plans should be person centred and completed with the person at risk wherever possible
6. Risk assessments should be shared with the person and those important to them (family/carers). It should be accessible to all members of the MDT and wider agencies where appropriate. Every opportunity should be taken to communicate where risk is deemed high as part of team safety huddles/MST meetings or when communicating with family/carers. This is especially important during transitions of care between environments or local teams/services.
7. Develop a Community of Best Practice to allow the sharing of good practice, the development of improvement ideas and promote innovation.

7.3 Training and Education

Ensuring that all staff have a good knowledge of falls prevention interventions is key to achieving the goal of reducing in patient and community falls. Falls training sessions have been shown not only to increase healthcare staff's knowledge but can also be a cost effective way of tackling falls in hospitals.[35] However, the form of delivery is also important as if this is delivered in a negative way it can lead to staff feeling fearful and over cautious.[37] Having an appropriately trained workforce is key to achieving the NHS goals of safe and effective care. [36] It is also key for staff morale/ well-being, for organisation's to invest in their personal development as it is known that this can lead to greater staff satisfaction and productivity.

Where it Works Well

NHS GGC have produced 6 falls related e- training modules which are held on the Learnpro platform. These have been made mandatory for the majority of clinical staff in the organisation. Compliance with these is monitored through the Acute Health and Safety team and generally sits around 90%.

What Could we do Differently in NHSGGC?

1. It is hoped to build on the current Learn pro's and ensure that the training available meets the needs of all staff across care pathways. Additional content including Fear of Falling and the prevention of deconditioning should be considered.
2. We will work alongside NES and colleagues nationally to make a wider range of resources available to support falls learning across all settings. We will strive to utilise inclusive plat forms such as TURAS that are accessable to all learners.
3. We will ensure that everyone working with people at risk of falls has access to basic falls prevention training utilising agreed resources to ensure consistency of delivery.
4. Working with Higher Education Institutes to incorporate falls prevention and management within all relevant student learning programmes. Opportunities should be explored with regards to partnerships to aid future research, development and evaluation.
5. Improved collaboration with Practice Development and Practice education services within organisations to promote the importance of falls prevention/management knowledge.
6. Invest in workforce development in particular around exploration of extended roles for AHP's and nurses in our communities to specialise and support our broader systems.

7.4 Data Collection, Reporting and Analysis

The measurement of falls and falls prevention activity by teams is a very important aspect of our Fall's prevention and management strategy. In GG&C the business intelligence team in conjunction with senior management developed the Care Assurance Improvement Resource (CAIR) dashboard that pulls together data from across acute and HCSP partnerships allowing accurate reporting number of falls, numbers of attendances at A&E, number of admissions, numbers of inpatient falls including falls with harm and number of hip fractures. It also allows analysis of referral pathways to allow accurate sharing and reporting of activity in particular with regards to national programmes of work e.g. Scottish Ambulance Service (SAS) falls pathway establishment and the SPSP in-patient falls programme. The dashboard pulls data from a number of electronic systems used within GG&C including our risk management system - Datix, thus allowing the collating of all available data sources into one place. This data is then accessible to senior staff and managers throughout NHS GG&C both in acute and partnership services allowing accurate comparison for benchmarking, strategic planning and service improvement.

Where it Works Well

The Hospital Falls Prevention Coordinators (HFPC) report figures to the safety huddles on a Friday "Falls Friday". This is then discussed with charge nurses to highlight the amount of falls in their areas etc and can highlight "hotspot" areas where targeted improvement approaches can be offered. The HFPC manually pull data from Datix and other systems producing a weekly report on falls activity.

What Could we do Differently in NHSGGC?

1. In order to accurately benchmark our progress and measure the effectiveness of any improvement work that is being tested it is essential that this core data is available. The information held on any dashboard is reliant on accurate inputting into the systems that it pulls through from – "right data in, right data out". Raising awareness of this with our staff will assist the successful use of the CAIR and partnership dashboards going forward.
2. Enhancing the CAIR dashboard to allow more analysis of falls figures as well as correlation with known risk factors will assist with the Quality Improvement Approach that is being promoted through this strategy.
3. To reflect the key messages of our strategy it is essential that we focus our approach to data collection to allow capturing of all relevant falls prevention and management activity. This will require expanding the metrics of data to include from all relevant partner organisations. A short life working group has been convened to develop a measurement framework that will sit alongside this strategy.
4. Working with e-health and business intelligence to maximise the data available for extraction from the systems in use e.g. utilising clinical coding in EMIS systems to allow for enhanced reporting.
5. Using a "data for improvement" approach it is essential that data is reported and shared with staff and teams in an accessible manner.
6. To ensure governance and monitoring it is essential that the agreed key measures are regularly reviewed at HSCP/Acute divisional and sector levels.

7.5 Information Sharing

With the care of those at risk of falls involving staff and services across multiple agencies it is essential that there are adequate systems in place to ensure that relevant information can be shared to ensure safe and effective care for the person at risk of falls. There are a number of key considerations in particular around GDPR regulations, Caldicott principles and consent.

Where it Works Well

NHS GGC e-health department have been working with SAS to enable access to the Key Information Summary (KIS) via clinical portal for paramedics to improve information available for treatment planning and decision making around need for conveyance to hospital.

What Could we do Differently in NHSGGC?

1. Ensure information sharing protocols are in place for all services involved in delivering care.
2. Work towards having systems that are accessible to partners working across different stages of care delivery. This could include enhancing the use of Clinical Portal.
3. Where possible, all relevant information should be shared with all people involved in the care of a person at risk of falls (with their consent). This should be in a format that is accessible.
4. Information sharing is managed in line with all relevant local policies and legal requirements.

7.6 QI Approach

Quality Improvement (QI) has been defined in many ways but a recurring description is "a systematic approach that uses specific techniques to improve quality".[38]
This is a key aspect of the NHSGGC Healthcare Quality Strategy – the Pursuit of Healthcare Excellence (2019).[39] It is vital that a QI approach is promoted within our falls prevention and management services to ensure that we deliver the best quality, efficient and effective care to those who access our services.

Where it Works Well

The NHS GGC clinical effectiveness team have recently delivered SIFS (Scottish improvement Foundation Skills to the staff in the CFPP and Hospital Falls Teams. This has led to a number of valuable projects being carried out. The model of improvement approach is supported strategically with NHS GGC.

What Could we do Differently in NHSGGC?

1. People delivering our services are encouraged to innovate and make changes to improve service experience/delivery.
2. Staff should have an understanding of QI methodology/approaches allowing them to safely test out new ways of working. This should include making training and resources accessible to all.
3. Ideas and initiatives that lead to improvement are communicated and shared with other areas. A focus on learning from others and dissemination of good practice is key to raising standards of care.
4. Collaboration with our communities and partner agencies using design led tools to ensure all improvements have the user at the centre.

8. A Targeted Approach to the Treatment of Falls within NHS GG&C

The following pathways are already in place or can be used as a benchmark for planning future service delivery. They allow the identification of those at risk of falls and their journey through services. The pathways broadly demonstrate the journey of people who fall however it is acknowledged there may be local variation dependent on services available within each HSCP.

The journeys have been split into 4 potential service user categories:

- Fit person who has fallen
- The person who has had repeat falls
- The person who is at high risk of falls (and is identified as frail)
- Hospital faller.

These 3 categories are a representation of the most likely presentations of those at risk of falls within the community, although it must be emphasised that the source of referral for each service user group could vary with referrals coming from GP's, hospital discharges and other specialist services. The categories help target appropriate services to individual needs to achieve the best outcomes. With the aim to reduce the risk of falls and prevent further deterioration of an individual across the categories. The "Lifecurve" is a useful tool to help identify where a person is on their aging journey and can be used to assist in identifying activities, services, and products that will help them either maintain or even recover,their current abilities. A multi-factorial risk assessment and tailored action plan should be completed for each individual. This should be achieved by the delivery of a multi-factorial falls risk assessment and the formulation of a falls action plan which is tailored to the needs of the individual. All services involved in delivering care to those at risk of falls will also promote the improved uptake of physical activity and aim to promote the National Physical Activity Guidelines [2].

[1] *The ADL LifeCurve, ADL Research and Newcastle University's Institute For Ageing 2018* [40]

[2] UK Chief Medical Officers' Physical Activity Guidelines 2019 [41]

8.1 Example Journeys for Those Who Have Fallen or are at Risk of Falls within GGC

8.1a "Fit Faller" – Early Intervention

Jean is a 75 year old lady who lives by herself and is independent with her Activities of Daily Living (ADL's). She does not currently use a walking aid and she is still able to get out but feels that she is starting to slow down physically and is beginning to lose her confidence. She is not known to any community rehab or social services and attends her GP practice sparingly. She does not have any tele-care equipment at home. She regularly attends various groups in the community and meets her friends weekly to play bridge. She is able to use public transport to complete her own shopping. On attending her GP practice for an unrelated matter, she was questioned on whether she had fallen and she admitted that she had suffered a fall a couple of months ago whilst doing her housework. She reported that she simply over-balanced and fell onto her carpeted floor. She had not sustained any injury and had not told anyone about the fall until now, but admitted that on looking back it had maybe knocked her confidence. Following on from this conversation with her GP this is the journey that she went on.

Jean would be positioned at the start of the life curve. Through input, improving her fitness and quality of Life it would be hoped to ensure that she followed the optimal curve of functional decline. This should allow Jean to continue to contribute to the community and feel useful.

Opportunistic conversation held with Jean – risk factors covered around sight, mobility, ADL's etc

Formal referral to services not required

Jean signposted to Single point of access for falls prevention self-management via patient facing web site or supplied with paper based info at GP surgery

Falls self -management info hub allows Jean access to all appropriate falls information and links to local community preventative services

Self refer to leisure

Community connectors

CSP Falls and physical activity

Falls Assistant app

Up and about leaflet

NHS Inform falls page

8.1b Repeat Faller

Betty is an 85 year old lady who lives at home alone. She has a 1/day care package to assist with her morning personal care. She is mobile using a walking stick within her home environment, but feels that this is deteriorating and she is getting more and more unsteady. She is mostly housebound unless family members can assist her out of the house. She currently still manages in the kitchen but is finding this more and more of a struggle. She has a community alarm which she has had to press a couple of times recently due to having fallen and being unable to get herself off the floor, although she has been lucky and has not required an ambulance or attendance at Accident and Emergency (A&E). She feels that her functional abilities have decreased due to the falls that she has had and she reports to be fearful of falling again which is curtailing her activity. This increased use of her tele-care service was identified as an issue and a level 1 conversation was carried out. Following on from this conversation this is the journey that she went on.

Betty would be positioned here on the life curve as she was starting to struggle with preparing meals and had issues with her personal care. With intervention it would be hoped that Betty would be re-enabled to allow her to return to her previous function thus reducing her dependency and allowing her to live at home for as long as possible.

Level 1 conversation carried out by tele-care staff and issues identified with Betty' change in mobility and function

With Betty's consent referral is made to appropriate community service

Betty receives a multifactorial assessment

A personalised plan is then jointly formulated with Betty

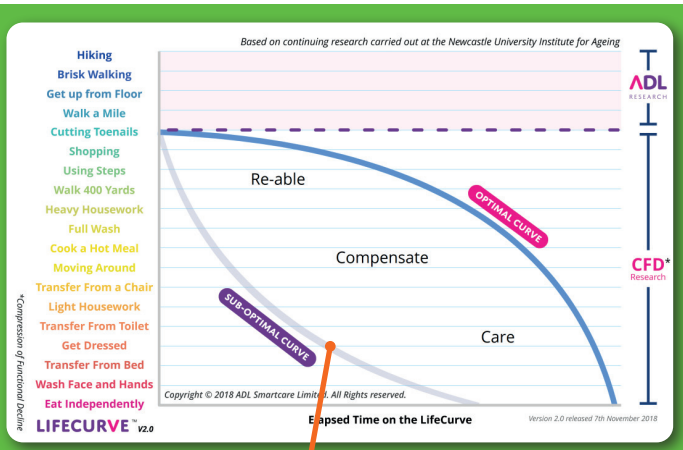
Assessment and plan should be shared and uploaded to appropriate systems

Betty's Personalised plan may include

- Referral to other services
- Self - management resources
- Home care services
- Psycho-education and anxiety management
- Signpost to other services
- Rehab delivered
- Equipment supplied

8.1c High Risk or Frail Care Home Faller

John is a 90 year old gentleman who resides in a Nursing Home in Glasgow. He requires assistance with his transfers and uses a Wheeled Zimmer Frame (WZF) but is mainly transported around the home in a wheelchair. He has mild cognitive impairment so struggles a little with retaining information and following instructions. He is prone to UTI's and can become a little confused and disorientated when he is suffering from an infection. Unfortunately during one of these episodes he attempted to get out of his bed one night without calling for the staff and fell to the ground. He sustained no acute injury but complained of general increase in aches and pains. The care home staff contacted an ANP at Flow Navigation Centre who completed their assessment and it was decided that John did not require admission to hosptial. This is the journey that he went on.



John would be positioned towards the bottom of the life curve as he is already quite dependant. However, with input to ensure his ongoing safety and prevent future falls John should be able to good quality of life and perhaps increase his opportunities for physical activity, in line with CAPA.

Call made to NHS GGC Flow Navigation Centre as per Care Home Falls Pathway

ANP carried out an NHS Near Me consultation and agreement was reached that admission was not necessary

Care home staff complete a review using resources from Care Inspectorate Managing Falls Resource

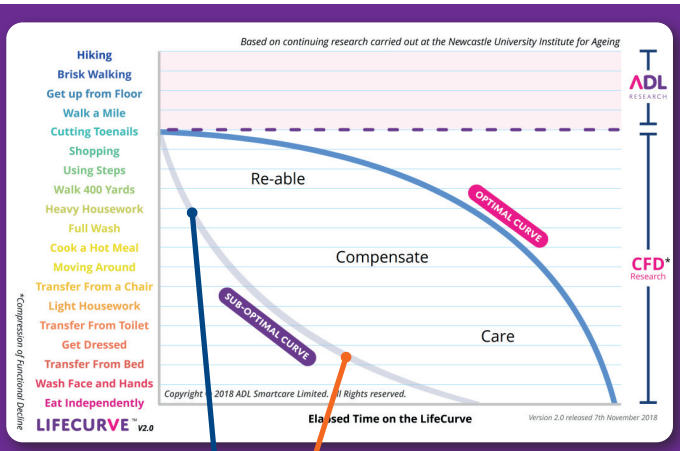
If appropriate John would be referred to appropriate services

Care home supports available to allow John to be supported safely

- Access to GGC info on Care Home Collaborative website
- Medication Review
- Named AHP support
- Training for care home staff
- CAPA support /resources
- GGC Care home hubs

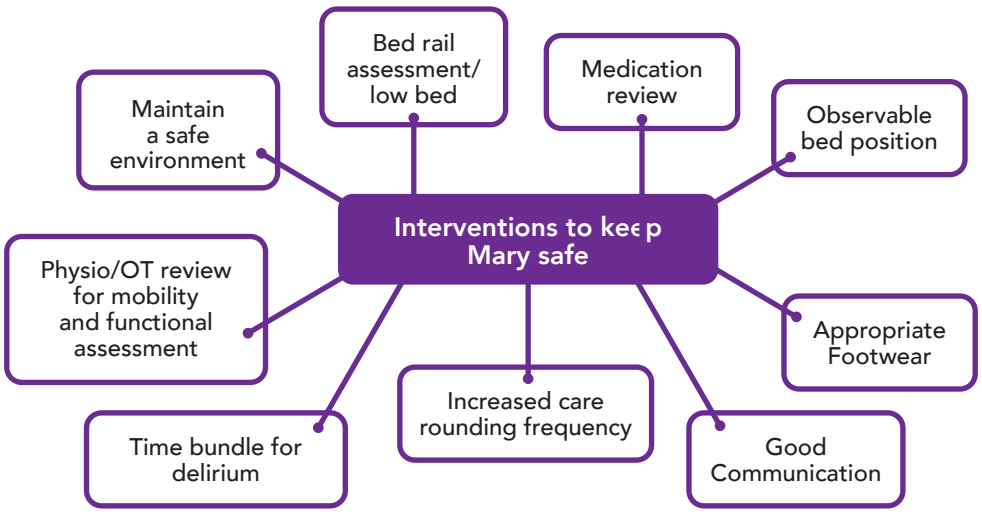
8.1d Hospital Faller

Mary is a 70 year old lady who lives with her husband and pet dog. She is normally independent at home but has a cleaner to help with heavy domestic tasks and she relies on her husband to drive her places as she has limited exercise tolerance. Mary suffers from Chronic Obstructive Pulmonary Disease (COPD) which she normally self manages with the support of her GP. Mary has no history of falls. Unfortunately, Mary became acutely short of breath and had an increased cough she also displayed signs of confusion. Following a consultation with her GP it was decided that she required to be admitted to hospital. Following admission this is the journey she went on.

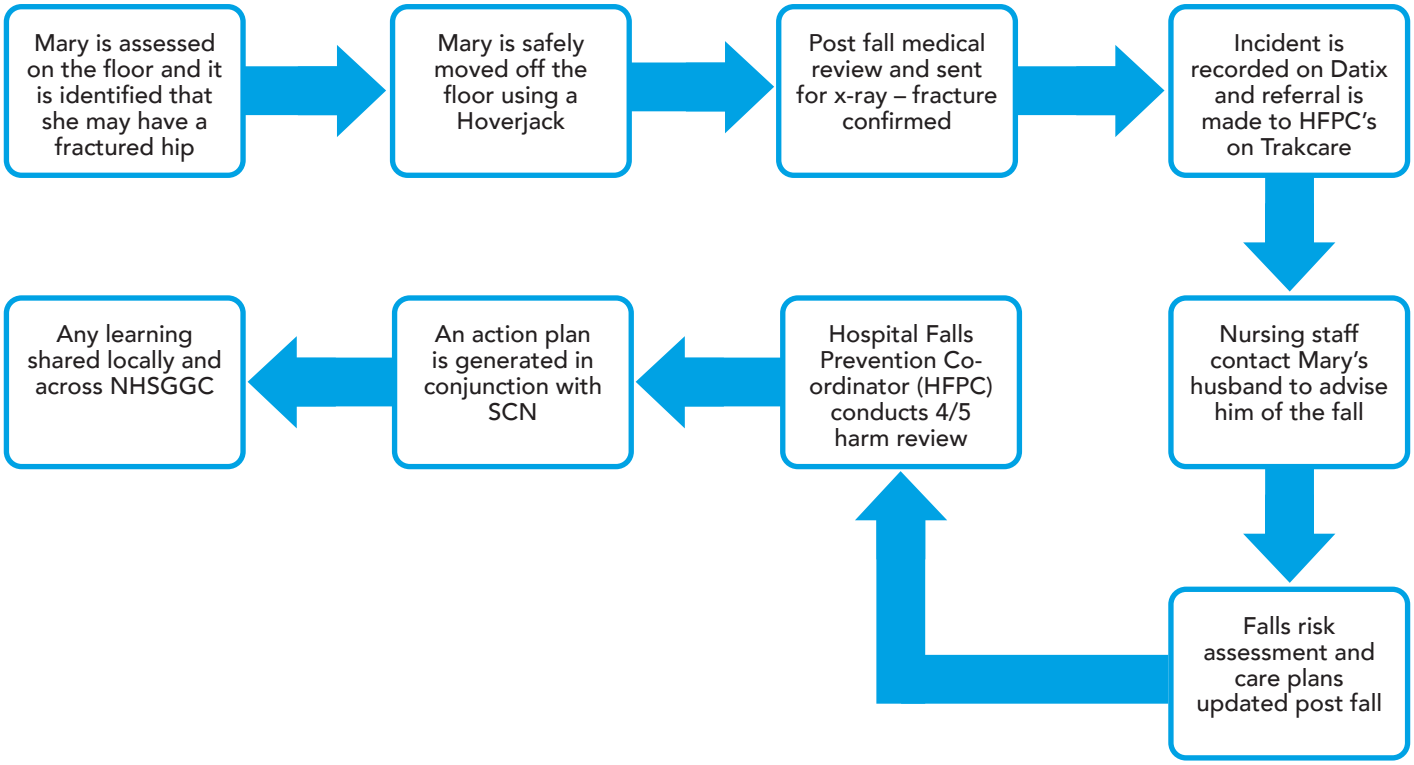


Mary normally sits at the top of the life curve as despite having a long term condition (LTC)she is normally fairly independent. However due to her acute medical issues at the time of admission to hospital she had slipped further down the life curve as her functional abilities have deteriorated.

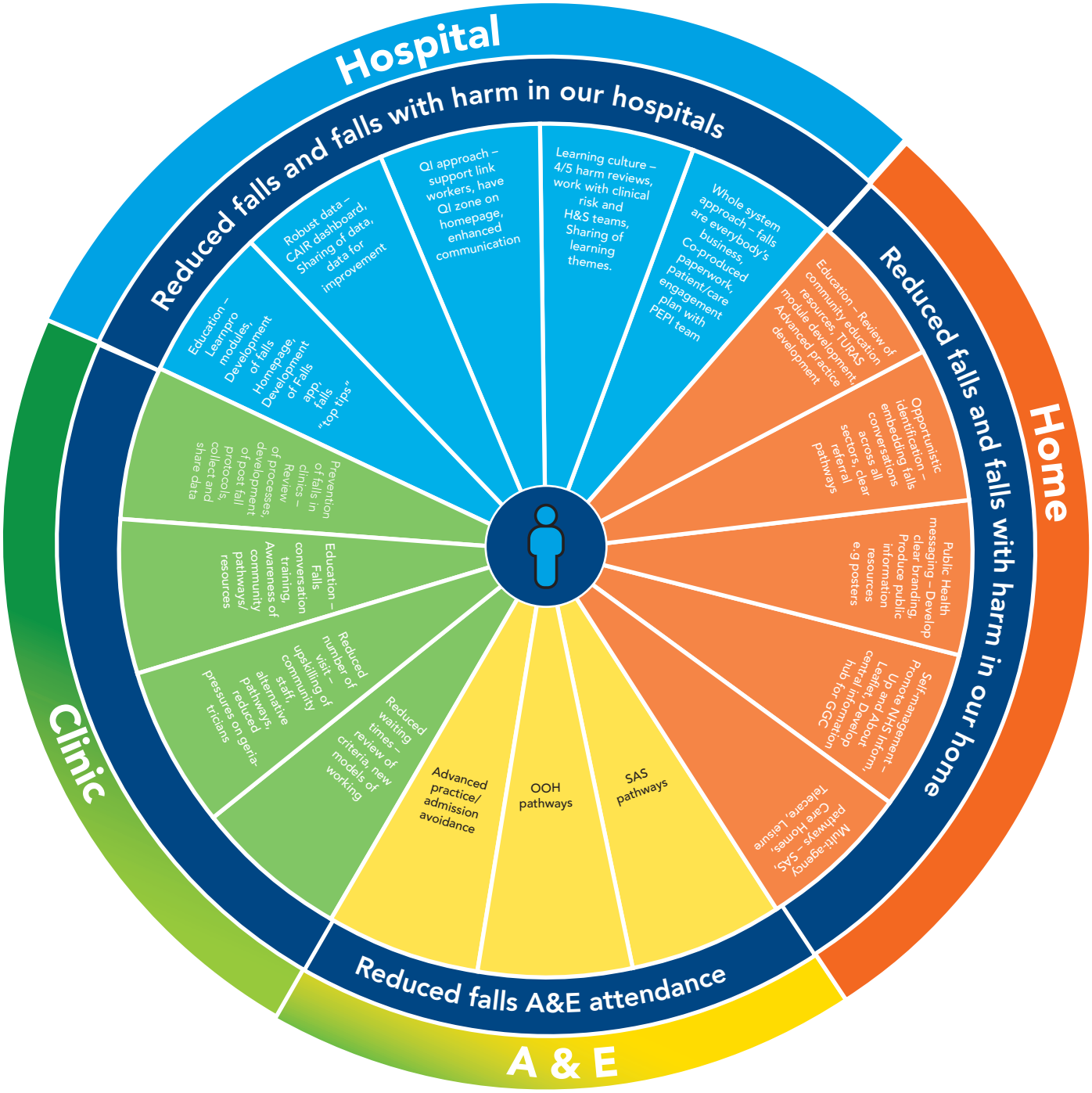
On admission nursing staff complete the falls risk assessment → A 4AT is completed due to Mary presenting with new confusion → Mary is identi-fied as a risk of falls → Appropriate falls prevention interventions were put in place → Nursing staff regularly review Mary's risk assessment and adjust as required



Unfortunately despite Mary receiving good care during her stay she got up one night to attempt to go to the toilet. Mary forgot to press her call buzzer as "she didn't want to bother the nurses". Mary was found on the floor as the nurses were alerted by another patient. What happened next is detailed below.



9.1 Person-Centred Model for Strategy



9.2 Community-Led Falls Prevention and Management Model

10. Moving Forward - Our 5 Year Plan

In order to progress with the key aims and objectives of this strategy an implementation plan has been produced. Some of the key actions and time frames for delivery are illustrated below.

Year 1

- Baseline assessment of staff knowledge and confidence in management falls
- Establishing a single point of access to resources and eventually service pathways across the range of NHSGGC hospital and community services
- Ensuring that Local Falls Networks are in place that represent the body of falls prevention and management work across hospital and community settings, in and out of hours
- Ensuring robust data capture and reporting to provide the necessary assurances to the Board that Falls are being well managed across NHSGGC
- Participation of demonstrator sites in implementation of National SPSP programme for falls

Year 2-3

- Create a community of practice / interest group where those involved with falls across NHSGGC services
- Spread learning from participation in National SPSP programme to 50% of in patient areas
- Agree a set of resources in different formats that meet accessibility requirements of the population
- Undertake a map and gap analysis of local service provision, creating local Action Plans to improve local service provision
- Identify opportunities to utilise and improve data and reporting

Year 4-5

- Within years 4 and 5 we would expect to see those actions leading to a measurable reduction in falls as managers develop a better understanding of falls issues in their areas and gaps in service provision are filled.
- Created and addressed through Local Falls Networks to improve service provision in line with the Falls Strategy
- Created and addressed through the Falls Steering Group to improve those areas where NHSGGC response is required. Work may be carried out through commissioned Short Life Working Groups or directly by group members

11. How will we know if we have made a difference?

11.1 Governance

This strategy has been developed and the implementation will be overseen by the NHS GGC Falls Prevention and Management Steering Group. This is a cross sector, multi-agency group which meets every 8 weeks. An action plan will be formulated and progress monitored. This will then report into the board wide Frailty Group and the AHP director who is strategic lead for falls.

11.2 Measurement

Measurement is a key aspect of any strategy. It is acknowledged that there is variability in the ability to collect and measure data across our teams and partnerships. However some key measures for consideration are listed below as a means to chart progress.

- In-patient falls - We require to monitor and report on this to Healthcare Improvement Scotland for both the Excellence in Care and Scottish Patient Safety Programme.
  The measures used are - Number of falls, Number of falls with harm, Falls rate per 1,000 bed days and Falls with harm rate per 1,000 bed days. The aim is to achieve a 20% reduction in falls and a 30% reduction in falls with harm by September 2023.
- Number of patients requiring to attend our Falls clinics.
- Number of people who have had a fall being conveyed to our hospitals.
- Number of falls related admissions from our care homes.
- Care Assurance Standards (CAS) - We will also monitor quality of care through our board Care Assurance Standards

11.3 What next?

It is intended that this strategy is used by our 6 partnerships as a basis to formulate local action plans on how to implement some of the recommendations. This is essential for the operationalisation of this strategy. However, within some of the areas where possible and desirable a "once for GGC" approach will be taken to try to ensure standardisation, consistency and equitability across the region.

12.0 Falls Strategy Summary

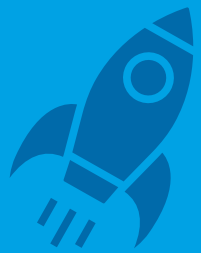
NHS Greater Glasgow and Clyde

Vision

To equip the population of GGC with the skills and knowledge to allow them to lead healthy active lives and lower their falls risk. When a fall does happen we will ensure that our population will have access to evidence based care with integrated pathways to allow for seamless transition between services both statutory and non -statutory

Mission

Working with local and national partners to ensure delivery best quality of care and use of resources to prevent and manage falls.



Key Objectives

- Implement SPSP falls Driver Diagram and Change package in all in patient areas.
- All staff will have access to high quality learning resources
- Reduction in hospital admissions as a result of a fall
- Ensure equitable access to services in and OOH
- Ensure systems are in place to promote a learning culture
- Development of Workforce plan

Strategic Aims

Develop a whole system approach to falls prevention and management.

Promote a "Falls is everyone's business" ethos

Ensure evidence based practice and quality improvement are embedded

Our Priorities

Reduce in patient falls and falls with harm per 1000 bed days

Reduce falls risk in the community

Reduction of conveyance to hospital via SAS

Have clear and accessible pathways for all care home and residential homes.

Reduce out-patient demand by utilising community based services

Integrate falls prevention into the wid-er frailty programme

Developing a skilled workforce

Improve public health messaging and promote self-management with-in our communities.

Key enablers

- IT/digital health
- Finance
- Innovation
- Our staff
- Our communities
- Our Partners
- Data/ Intelligence

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