NHS North of England
North East Regional Falls Task Group
part of North of England Falls Network

Recommendations for Good Practice and Audit of Existing Services Against Recommendations:
Falls Services former North East Strategic Health Authority, now part of NHS North of England

2014 Re-Audit
Purpose of this Document

The purpose of this document is to:

1. Provide consensus recommendations for the organisation and delivery of Falls Services across the North East. These recommendations were originally drawn up by the North East Regional Falls Task Group in 2009 as part of the Safer Care North East Strategy led by the Strategic Health Authority and have been revised by the same group for the 2014 Audit.

2. Highlight areas of particularly good practice across the North East, allowing services to learn from each other.

3. Highlight for a particular service which areas may be a priority for further development.

Introduction

In 2009, as part of the Safer Care North East Strategy, the Safer Care North East Falls Task Group established a consensus view to agree **Recommendations for Good Practice for a Whole Systems Falls Service** under the headings:

1. Organisational Issues.
2. Services Delivered.
3. In-patient / Hospital Falls.
4. Care Homes.
5. Training.
6. Information.
7. Quality Metrics.

Falls Services audited themselves against these standards in 2010. This is a re-audit against the same standards which have been reviewed and updated by the North East Regional Falls Task Group. The membership of the North East Regional Falls Task Group consists of key individuals from the Falls and Bone Health Services across the North East of England and representatives from the North East Ambulance Service, Pharmacy Services and the Voluntary Sector.

The Falls Services rated themselves against individual recommendations and provided narrative comment to further describe their service. Neighbouring trusts then met to discuss their ratings and adjustments were made as appropriate.
Good Practice Recommendations

The Good Practice Recommendations agreed by the North East Regional Falls Task Group are as follows:

1. Organisational issues
   i. Falls Strategy which all organisations (health - hospital and community, social care, voluntary sector, commissioning boards and others) have ownership of and are working to achieve.
   ii. Individual or group who have responsibility for Falls Strategy / other Falls initiatives and the enthusiasm, time and mandate to implement them, including close links with local commissioners / commissioning boards.
   iii. Formal communication mechanism between all organisations involved in Falls / Falls Prevention / Falls Service Delivery.
   v. Referral mechanism into Falls Services that gives access to range of health and social care professionals, the voluntary sector and older people themselves, and includes consideration of Mental Capacity Assessment as appropriate.
   vi. Standardisation of documentation.
   vii. Good links with community initiatives as ‘step-down’ from Falls Service.
   viii. Good links with local Telecare services.
   ix. Good links with community pharmacy services.
   x. Older people themselves have a key role in planning, implementing and delivering Falls Services.
   xi. Robust referral pathway from the Ambulance Service.
   xii. Robust referral pathway from the Emergency Department.
   xiii. Robust referral pathways from Walk-In Centres / Urgent Care Centres / Minor Injury Units.
   xiv. Robust referral pathways from Orthopaedics (including Fracture Clinic) and other services e.g. Medical Admissions Unit, Neurology, where fallers present.
   xv. Osteoporosis link nurse (or similar) working closely with Fracture Clinic / Orthopaedics and the Falls Services.

2. Services Delivered
   i. Multifactorial assessment and intervention following NICE guidelines.
   ii. Specialist Falls and Syncope Service.
   iii. Falls Services screen for and treat osteoporosis following NICE guidance.
   iv. Falls Services delivered in the community, close to / in older people’s own homes.
   v. Falls Services routinely offer access to care home residents, including services delivered on care home premises.
   vi. Community based targeted strength and balance exercise programme following evidence-based protocols.
3. In-patient / Hospital Falls
   i. Commitment to falls prevention at board / senior management level.
   ii. Commitment of front line manager to implement risk reporting and falls
       assessment and intervention protocols.
   iii. Multi-disciplinary falls prevention group as defined by National Patient Safety
       Agency (executive lead, doctor, nurse, physiotherapist, occupational therapist,
       facilities, governance/risk, training and development, pharmacy, primary care,
       social care, patient representative) responsible for implementing and
       monitoring the effectiveness of falls prevention initiatives.
   iv. Mechanism for implementing root cause analysis for serious falls.
   v. Accurate and complete falls reporting (e.g. via Datix).
   vi. Contribute to the National Hip Fracture Database.
   vii. Falls assessment documentation coupled with interventions to prevent falls / refer
       for further assessment.
   viii. Protocol for use of bed rails.
   ix. Post-Falls Protocol including management of injury.
   x. Staff training in falls risk reporting / assessment of falls risks / falls prevention
      interventions / referral pathways using Royal College of Physicians e-learning
      package or own package of equivalent standard.

4. Care Homes
   i. Training package for care homes on falls prevention and on when and how to
      refer to falls services.
   ii. Good links with care homes to encourage uptake of training and referral to
      falls services.
   iii. Falls services routinely offer access to care home residents, including
      services delivered on care home premises – see above.

5. Training
   i. Training for health and social care staff including home care agencies and
      other groups as locally appropriate, in management of falls, and on when and
      how to refer to falls services.
   ii. Training package around inpatient falls – see above.
   iii. Training package for care homes – see above.
   iv. Training package for sheltered housing schemes and day care on falls
      prevention and on when and how to refer to falls services.

6. Information
   i. Provision of falls prevention information for older people and their carers.

7. Quality metrics
   i. Data collection that allows development of clinically relevant quality metrics.
Audit of Falls Services Against Good Practice Recommendations: Outcomes

Services / areas rated themselves broadly against the Good Practice Recommendations using the following scale:

- outstanding good practice; - established good practice; - some areas of good practice; & - something similar / work in progress; Gap - not available.

The outcomes are summarised in the tables below according to trusts. Data are presented as stand-alone ratings for 2014 (Table 1) and compared with 2010 ratings (Table 2). Inclusion of North Tyneside and Hexham in the Northumberland Healthcare NHS Foundation Trust (NHCFT) grouping for 2014 accounts for some of the apparent declines in outcomes in 2014 compared with 2010. There were no baseline 2010 data for Northumberland, Tyne and Wear NHS Foundation Trust (NTW) or Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) for comparison.

The information represents the knowledge of service provision in their area by the members of the Regional Falls Task Group. Please be mindful that the ratings reflect the opinions of those making them and caution should be exercised when drawing cross-trust comparisons. However, many of the raters in 2014 are the same individuals who audited the services in 2010, giving more robustness to the intra-trust comparative data.

Areas of service delivery are summarised as:

County Durham and Darlington NHS Foundation Trust (CDDFT)
Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
North Tees and Hartlepool NHS Foundation Trust (NTHFT)
Northumberland Healthcare NHS Foundation Trust (NHCFT) – includes North Tyneside and Hexham.
Gateshead Hospitals NHS Foundation Trust (GHFT)
South Tees Hospitals NHS Foundation Trust (STHFT)
City Hospitals Sunderland NHS Foundation Trust (CHSFT)
South Tyneside NHS Foundation Trust (STFT).

CDDFT, NUTH, NTHFT, STHFT, STFT provide both hospital and community services in their areas.

For GHFT and CHSFT, STFT provide some community services.

For NHCFT area, some services have been provided by the North Tyneside Falls Prevention Pilot Project.

The Newcastle Falls and Syncope Service (in NUTH) takes referrals from across the North East.

Mental Health Trusts are included for the first time:
Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).
Conclusions

- The audit demonstrates a high standard of good practice across all trusts and in all domains of the audit.

- There are 112 reports of improvements in practice and only 16 reports of decline in standards. Five new areas of good practice are included in the audit for the first time. Overall improvement in falls and bone health good practice is demonstrated across all trusts and in all domains of the audit.

- Consistent improvements have been demonstrated in referral mechanisms and in particular referrals from the Emergency Department (ED). Referrals from the ED to Falls Services have been a particular focus across the region supported by a CQUIN written by the North East Regional Falls Task Group.

- Improvements in incorporating Bone Health into Falls Assessments have also been demonstrated, although two trusts have issues with the provision of an osteoporosis link nurse.

- Particular gaps remain in links with community pharmacy, links with public health, training for sheltered housing staff and in referral pathways from walk-in centres / minor injuries / urgent care centres.

- Next steps for Falls Services and their trusts should be to maintain existing good practice and to plan to improve areas where the Good Practice Recommendations are not as fully implemented.
Table 1: Audit of Falls Services Against Good Practice Recommendations: 2014 results

**KEY:**  ✔✔✔ - outstanding good practice;  ✔✔ - established good practice; ✔ - some areas of good practice; & - something similar / work in progress; Gap - not available; t = Newcastle Falls and Syncope Service takes tertiary referrals from across the region.

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<tr>
<th>1. Organisational issues</th>
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### 2. Services Delivered

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### 3. In-patient / Hospital Falls

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4. Care Homes

Training package for care homes on falls prevention and on when and   |       |      |       |       |      |       |       |      |     |      |
| how to refer to falls services                                      | 2014  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | N/A | N/A |
| Good links with care homes to encourage uptake of training and     |       |      |       |       |      |       |       |      |     |      |
| referral to falls services                                         | 2014  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | N/A | N/A |
| Falls services routinely offer access to care home residents,     |       |      |       |       |      |       |       |      |     |      |
| including services delivered on care home premises – see above     | 2014  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | N/A | N/A |

5. Training

Training for health and social care professionals including home care |       |      |       |       |      |       |       |      |     |      |
<p>| agencies and other groups as locally appropriate in management of   | 2014  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | ✓✓  | N/A |
| falls and on when and how to refer to falls services                |       |      |       |       |      |       |       |      |     |      |</p>
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<th>STFT</th>
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<th>TEWV</th>
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<td>✓</td>
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<tr>
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<td>Gap</td>
<td>✓</td>
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<td>&amp;</td>
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<td>✓</td>
<td>Gap</td>
<td>&amp;</td>
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6. Information

Provision of falls prevention information for older people and their carers

| 2014 | ✓   | ✓   | ✓    | ✓    | ✓    | ✓     | ✓     | ✓    | ✓   | ✓    |

7. Quality metrics

Data collection that allows development of clinically relevant quality metrics

| 2014 | ✓   | ✓   | ✓    | ✓    | ✓    | ✓     | ✓     | ✓    | ✓   | ✓    |
### 1. Organisational issues

| Falls Strategy which all organisations (health - hospital and community, social care, voluntary sector, commissioning boards and others) have ownership of and are working to achieve | 2010 | ✓ | & | ✓✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | - | - |
| | 2014 | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | ✓ | ✓ |
| Individual or group who have responsibility for Falls Strategy / other Falls initiatives and the enthusiasm, time and mandate to implement them, including close links with local commissioners / commissioning boards | 2010 | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | - | - |
| | 2014 | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | ✓ | ✓ |
| Formal communication mechanism between all organisations involved in Falls / Falls Prevention / Falls Service Delivery | 2010 | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | - | - |
| | 2014 | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | ✓ | ✓ |
| Good links with Public Health Physicians / Health and Wellbeing Boards | 2010 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - | - |
| | 2014 | ✓ | ✓ | ✓ | ✓ | ✓✓ | ✓✓ | ✓ | ✓ | N/A |
| Referral mechanism into Falls Services that gives access to range of health and social care professionals, the voluntary sector and older people themselves, and includes consideration of Mental Capacity Assessment as appropriate | 2010 | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | - | - |
| | 2014 | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | ✓ | ✓ |
| Standardisation of documentation | 2010 | ✓✓ | ✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | - | - |
| | 2014 | ✓✓ | ✓ | ✓✓ | ✓✓ | ✓✓ | ✓✓ | ✓ | ✓ | ✓ |
| Good links with community initiatives as 'step-down' from Falls Service | 2010 | ✓✓ | ✓ | ✓✓ | ✓ | & | ✓✓ | ✓ | - | - |
| | 2014 | ✓✓ | ✓ | ✓✓ | ✓ | ✓✓ | ✓✓ | ✓ | ✓ | N/A |
| Good links with local Telecare services | 2010 | Gap | Gap | & | Gap | Gap | & | Gap | - | - |
| | 2014 | Gap | Gap | & | Gap | Gap | & | Gap | N/A |
| Good links with community pharmacy services | 2010 | Gap | Gap | & | Gap | Gap | & | Gap | - | - |
| | 2014 | Gap | Gap | & | Gap | Gap | & | Gap | N/A |
| Older people themselves have a key role in planning, implementing and delivering Falls Services | 2010 | Gap | ✓ | ✓ | ✓ | & | ✓ | ✓ | - | - |
| | 2014 | Gap | ✓ | ✓ | ✓ | & | ✓ | ✓ | N/A | ✓ |
### Commitment to falls prevention

#### 2. Services Delivered

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Year</th>
<th>CDDFT</th>
<th>NUTH</th>
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<th>STFT</th>
<th>CHSFT</th>
<th>STFT</th>
<th>NTW</th>
<th>TEWV</th>
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<tbody>
<tr>
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<td>Robust referral pathways from Walk-In Centres / Urgent Care Centres / Minor Injury Units</td>
<td>2010</td>
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<td>✔</td>
<td>&amp;</td>
<td>N/A</td>
</tr>
<tr>
<td>Robust referral pathways from Orthopaedics (including Fracture Clinic) and other services e.g. Medical Admissions Unit, Neurology, where fallers present</td>
<td>2010</td>
<td>✔</td>
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<td>Osteoporosis link nurse (or similar) working closely with Fracture Clinic / Orthopaedics and the Falls Services</td>
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<td>NUTH</td>
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<td>Staff training in falls risk reporting / assessment of falls risks / falls prevention interventions / referral pathways using Royal College of Physicians e-learning package or own package of equivalent standard</td>
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4. Care Homes

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<th>NUTH</th>
<th>NTHFT</th>
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<td>Falls services routinely offer access to care home residents, including services delivered on care home premises – see above</td>
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5. Training

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<th>Training for health and social care professionals including home care agencies and other groups as locally appropriate in management of falls and on when and how to refer to falls services</th>
<th>CDDFT</th>
<th>NUTH</th>
<th>NTHFT</th>
<th>NHCFT</th>
<th>GHFT</th>
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| Training package for care homes – see above        |       |      |       |       |      |       |       |      |     |       |
| 2010                                              | ✓     | ✓    | ✓     | ✓     | ✓    | &     | ✓✓    | ✓    | &   | -     |
| 2014                                              | ✓✓    | ✓    | ✓     | ✓     | ✓    | ✓✓    | ✓✓    | ✓✓   | ✓✓  | N/A   |

| Training package for sheltered housing schemes and day care on falls prevention and on when and how to refer to falls services |       |      |       |       |      |       |       |      |     |       |
| 2010                                              | ✓     | &    | ✓     | ✓     | ✓    | &     | ✓✓    | ✓    | &   | -     |
| 2014                                              | ✓     | Gap  | ✓     | ✓     | ✓    | &     | ✓✓    | Gap  | &   | N/A   |

### 6. Information

| Provision of falls prevention information for older people and their carers |       |      |       |       |      |       |       |      |     |       |
| 2010                                              | ✓     | ✓    | ✓✓    | ✓✓    | ✓    | ✓✓    | ✓✓    | ✓✓   | ✓   | -     |
| 2014                                              | ✓✓✓   | ✓    | ✓✓✓   | ✓✓    | ✓    | ✓✓✓   | ✓✓✓   | ✓✓✓  | ✓   | ✓✓✓   |

### 7. Quality metrics

| Data collection that allows development of clinically relevant quality metrics |       |      |       |       |      |       |       |      |     |       |
| 2010                                              | ✓     | ✓    | ✓     | ✓     | ✓    | ✓     | ✓     | ✓    |     | -     |
| 2014                                              | ✓✓    | ✓✓   | ✓✓    | ✓✓    | ✓✓   | ✓✓    | ✓✓    | ✓✓   | ✓   | ✓✓✓   |
Notes on Audit of Falls Services Against Good Practice Recommendations

Key: County Durham and Darlington (CDDFT); Newcastle (NUTH); North Tees and Hartlepool (NTHFT); Northumberland (NHCFT), includes North Tyneside and Hexham; Gateshead (GHFT); South Tees (STHFT); Sunderland (CHSFT); South Tyneside (STFT); Tees, Esk and Wear Valleys (TEWV); Northumberland, Tyne and Wear (NTW).

1. Organisational issues

- Falls Strategy which all organisations (health - hospital and community, social care, voluntary sector and others) have ownership of and are working to achieve
  - NUTH: Awareness of NE Regional Falls and Fracture Prevention Strategy. Some implementation.
  - NTW: NE Regional Falls and Fracture Prevention Strategy discussed within Trust Falls Management and Prevention Meeting and influencing review of clinical pathways incorporating partnership working.
  - TEWV: Initial work underway with regards to link for falls strategy across multiple organisations.
  - NHCFT: Lost some of the robust links between acute and community services in Northumberland. Trying to create strategic links for service as a whole.

- Individual or group who have responsibility for Falls Strategy / other Falls initiatives and the enthusiasm, time and mandate to implement them, including close links with local commissioners / commissioning boards
  - CHSFT: City wide and Hospital based Strategy Group. Strong leadership from both Falls Coordinator and Consultant Geriatrician.
  - STHFT: Close working between Clinical Lead and hospital senior nurse. Consultant Geriatrician and Consultant Rheumatologist are members of Falls Strategy and Osteoporosis Steering Groups.
  - NUTH: High profile falls and osteoporosis services taking lead in falls and fracture prevention within NUTH and in wider health and social care community. Key priority for CCGs. Good working links between NUTH clinicians and CCGs. Also leadership / service development contributions from NEAS and 3rd Sector organisations (HealthWORKS: Staying Steady Exercise Programme). Newcastle Falls Network no longer meeting regularly. NUTH falls coordinator post established with remit including dissemination of training and best practice.
  - NTHFT: Trust has Falls High Impact Action Group.
  - CDDFT: CDD wide monthly meeting takes place, also locality based meetings which include voluntary social services and NEAS. Osteoporosis Steering group established across primary and secondary care.
  - GHFT: Multi-agency steering groups which span across Health and social /primary care. Aim of both groups are to develop falls strategies and plan and deliver falls prevention initiatives and service improvements for both health and social/primary care. Close working between falls team and risk management in the Acute trust. Reducing Harm from Falls Steering Group meets monthly. Aim to implement recommendations from Patient Safety First documents. Falls Prevention identified as a priority for Acute trust SafeCare Council.
  - NHCFT: North Tyneside Falls Prevention Service Integrated Care Pilot; multi-organisational service involving NUTH acute trust, CCGs, General Practice, Social
Services, NEAS, Age Concern and Newcastle University. Monthly steering group meetings, regular updates for GPs. Lead Consultant for Falls Northumbria Hospitals.

- **STFT**: Falls strategy group with representation from the acute trust, community services, NEAS, Physio and occupational therapy. In the process of inviting representatives form voluntary sector, GP and public health.

- **TEWV**: Have falls service development group who have developed a falls strategy, falls pathway and investigate all falls resulting in harm. Have links with commissioners through falls CQUINs. Have developed a post falls proforma. Informal links with community falls services.

- **NTW**: Trust Falls risk prevention and Management meeting chaired by Group Nurse Director with a multidisciplinary membership and close links with Trust board who receive regular updates regarding activity in relation to falls and work plan to help with falls prevention and reduction.

**Formal communication mechanism between all organisations involved in Falls / Falls Prevention / Falls Service Delivery**

- **CHSFT**: City wide and Hospital based Strategy Group with multi-agency representation.

- **STHFT**: Clinical lead chairs multi-agency falls and osteoporosis strategy group which meets quarterly. The group uses the Regional strategy as a working document and has created an implementation plan in line with this.

- **NUTH**: Informal links only (although well established). Newcastle Falls Clinical Network no longer meeting regularly.

- **NTHFT**: Community falls services operate as a north of Tees service which are integral to the Community Integrated Assessment Team (CIAT). Data is maintained/accessed via SystmOne.

- **GHFT**: Falls strategy groups for both Acute and Social/primary care. Both groups are multidisciplinary/multi agency. Community staff work into the acute trust falls service. Robust links with Gateshead Council Housing service who provide home safety adaptations, e.g. additional handrail, minor works to external steps/paths as part of falls prevention.

- **CDDFT**: Falls Prevention Service in place, working closely with community, health and social care and voluntary agencies.

- **STFT**: As above.

- **TEWV**: Initial work on forming links.

- **NTW**: Currently developing links with acute care falls clinics as part of in patient and community falls pathways.

**Good links with Commissioners and Public Health Physicians / Health and Wellbeing Boards**

- **STHFT**: Operational manager for falls and osteoporosis service has good links with CCG and public health commissioners and health and wellbeing board. CCG lead a member of strategy group.

- **NUTH**: Good links with new CCG commissioners. Public health difficult as constantly changing lead.

- **NHCFT**: Working with CCG commissioners for North Tyneside to establish Falls Pathway similar to existing Northumberland pathway.

- **NTHFT**: North Tees as above.

- **CDDFT**: Service has been going through review with the commissioners, gaps have been identified and funding was agreed through the AOP however this has currently been frozen.
- STFT: Commissioner nominated to be a link with strategy group.
- TEWV: Links with commissioners re CQUINs.
- NTW: Current links with commissioners regarding inpatient and community falls pathways.

- **Referral mechanism into Falls Services that gives access to range of health and social care professionals, the voluntary sector and older people themselves, and includes consideration of Mental Capacity Assessment as appropriate**
  - CHSFT: 2 referral and assessment tools: ‘Trigger Tool’ (NEAS) for quick referral and more detailed assessment for community matrons / district nurses to allow to manage falls as well as refer.
  - STHFT: Pathway in place for staff to be able to refer from A&E, AAU, ambulance and GP referral. Stage 2 multi-factorial assessment/intervention tool carried out by community staff and can use to refer as required. Self – referral accepted and from voluntary sector if concerns raised and discussed.
  - NUTH: Well established referral mechanisms from GPs, community health and social care professionals, NEAS, secondary care: ED, EAU, IP Wards, Fracture /Bone Clinic, Telecare and patients. Electronic referral and triage to tertiary referral and day hospital specialist falls assessment services. Two separate mechanisms but both now within same organisation.
  - NHCFT: Well organised referral mechanism, including self-referral. North Tyneside Community Falls Prevention Service refers to Age Concern-run strength and balance training classes; Social Services refer to the Service and vice versa. Commissioned direct referral route agreed via Falls Pathway in Northumberland.
  - GHFT: ‘Trigger Tool’ used for NEAS referrals. Open system of referrals from GP’s, community staff including matrons and district nurses, rapid response and urgent care teams. Electronic referral system developed for GP referral.
  - NTHFT: Use FRAT (Stage 1) and Multifactorial Falls Assessment Tool (Stage 2) recommended by NICE guideline as referral form. Falls services receiving referrals from Primary and Secondary Care and other community services etc. All referrals to CIAT come through a Single Point of Access (SPA).
  - CDDFT: Community based falls service with robust working links to Health & Social Care, Warden services, Care homes and voluntary agencies.
  - STFT: Currently open system of referral from GPs, community matrons, rapid response team in A+E and from other areas within acute trust using a number of referral tools. Standardised referral form and falls pathway developed to be used across primary and secondary care.
  - TEWV: Pathways in use across older people’s services and learning disability services. Referrals taken from community for patients with enduring mental health problems and known to our services.
  - NTW: Developing links as part of inpatient and community falls pathway with falls services and other health and social care providers.

- **Standardisation of documentation**
  - All: Standard documentation for referrals from NEAS.
  - CHSFT: Standard documentation across community / hospital services.
  - NUTH: many different referral forms - no standardisation. Not really an issue.
o GHFT: Standardised document and Falls Risk Assessment tool used across acute trust. Standardised Home Safety assessment used by OT across acute trust and community teams.
o NHCFT: Acute and Community no longer share.
o STHFT: Standardised documentation across Acute, Community and Social Care. Tools available on SystmOne. Standardising practice across H&R also.
o NTHFT: Both areas use same referral forms and procedures.
o CDDFT: Five areas all use SAP. Standardised local referral forms, slightly altered for professional/non-professional referrals, i.e. we ask for more detail from professionals referring into the service.
o STFT: As above.
o TEWV: All documentation standardised and robust. This is regularly audited for compliance against NICE guidelines and ‘How to reduce falls in mental health inpatients’.
o NTW: Developing links as part of in patient and community falls pathway with falls services and other health and social care providers.

- **Good links with community initiatives as ‘step-down’ from Falls Service**
o NUTH: Well established consistently used links with step-down exercise programme (Staying Steady). Resource limitations currently restrict timely access to this programme in some geographical areas.
o NHCFT: Good links with community activities provided by Age UK.
o CHSFT: Health Trainer / Community Development Workers.
o STHFT: Exercise network in place identifying available exercise opportunities. Good links with postural stability classes in community run by sports development in Redcar and Cleveland. Classes have suffered from financial savings within the Council. Gap exists within Middlesbrough for Postural Stability classes.
o NTHFT: Close working relationships with local authority reablement services.
o CDDFT: Good links established eg Established links with AGE UK Co Durham who provide exercise classes. Useful step-down for some of our clients. Also links with Age Concern befriending service and benefit advice. All clients receive a pack with useful information about falls prevention and contact details for useful agencies on discharge. PSI x2 weekly for 6 weeks courses are run by our physiotherapist as part of the patient’s step-down process.
o STFT: Our community falls nurse specialist sits alongside our intermediate care team thus our patients can move along their pathway to have therapy and support provided as necessary.
o TEWV: Developing links with Intermediate Care Services.
o GHFT: Links with Gateshead Council Exercise practitioners who run ‘exercise of Referral’ scheme. Looking into developing PSI groups.

- **Good links with local Telecare services**
o NUTH: Established direct referral pathway from community care alarm service directly to falls services. Much fewer referrals in past 6 months (staff changes).
o NHCFT: Acute and Community teams refer directly to TeleCare Services.
o NTHFT: Established direct referral pathway from community care alarm service directly to falls services. Community Falls Services can directly refer for Telecare services.
o CDDFT: Good established links with Telecare Provider, all requests for fall detectors are referred to us and we frequently request Telecare for complex fallers. Six week review appt is a joint Telecare / falls team visit.
GHFT: Links with Telecare firmly established. Telecare use electronic referral to falls service for those clients who have used their lifeline alarms system several times as the result of a fall. Telecare member of social/primary care falls strategy group.

STFT: Good links established with referrals from acute and community services for Telecare.

STHFT: take direct referrals from Connect in Middlesbrough and process developing for Redcar and Cleveland. Trial in place for people attending A&E to have 6/52 free Telecare trial in Middlesbrough.

TEWV: Links with Telecare for community patients. Small project around Telecare for inpatient units.

NTW: Establishing links with providers as part of in patient and community pathways and obtaining information regarding services for professionals, service users and carers which will support care planning interventions.

- **Good links with community pharmacy services**
  - NUTH: Good links around management of osteoporosis.
  - STHFT: Identified pharmacy contacts with strategy group and agreed instances we may contact them. Have pharmacy lead on distribution list for strategy group.
  - NTHFT: Exploring possibilities.
  - CHSFT: Exploring possibilities.
  - STFT: Further work needed.
  - GHFT: Further work needed.
  - CDDFT: Further work needed.
  - TEWV: Further work required regarding this.
  - NTW: Further work required regarding this.

- **Older people themselves have a key role in planning, implementing and delivering Falls Services**
  - CHSFT: Monitor patient outcomes / patient feedback questionnaire.
  - STHFT: Patient satisfaction questionnaire including falls related outcomes, focus groups, discovery interviews. Have LiNK/ HealthWatch members on strategy group.
  - NUTH: Focus groups and extensive patient feedback in Staying Steady Exercise Programme. Patient representative on steering group being explored.
  - NHCFT: Older people review literature and contribute comments on services.
  - NTHFT: Patient feedback – see above. Also working on patient satisfaction questionnaire. Hartlepool use local groups of older people ‘Encore’ who provide falls prevention information in song and sketch format.
  - CDDFT: CQUIN all patients are asked to contribute comments on our services.
  - STFT: Voluntary sector e.g. Age UK to be invited to attend strategy meetings. Our Carer and Patient Involvement team recently undertook a collection of patient stories from patients and their families who had accessed our community falls service.
  - TEWV: Patient carer group involved in development of leaflets in MHSOP.
  - GHFT: Age UK actively involved in social/primary care falls strategy group. SOTW Carer and Patient Involvement team recently undertaken patient stories with patients who had accessed Occupational Therapy as part of falls service intervention.

- **Robust referral pathway from the Ambulance Service**
  - All services have this except North Tyneside – being addressed. Electronic version of process via Logistics Desk has increased referral rates.
  - CDDFT: Agreed documentation and central e-mail referral process working well.

STFT: Currently being established.

NTHFT: Have established referral system already in place. Referrals are sent electronically through the Single Point of Access.

**Robust referral pathway from the Emergency Department**

- STHFT: Tool utilising CQUIN questions implemented. Referrals fluctuate and continue to promote.
- NUTH: New documentation and better liaison has increased referrals x3 and doubled numbers of patients offered appointments in Falls Services. Further increases in referrals since interface team / admissions avoidance staff involved in referral pathway.
- NTHFT: Links established with A&E therapy teams at both site (UHH and UHNT). The team assesses patients in A&E, EAU and MAU and refer to falls services if necessary and with patients consent. Gap for orthopaedics. A&E pathway is currently in place.
- NHCFT: Falls nurse practitioners screen casualty referrals daily (Mon – Fri) at WGH, ED to consultant referral at NTGH screened by falls nurse, and ED to consultant referral at HGH.
- CHSFT: Falls coordinator has trained all staff in ED to use the trigger tool and refer although number of referrals are often spasmodic and not representative of attendance in A&E.
- GHFT: Referrals to OT in Falls team for people who fall via OT OOH service for A & E. Links established with A & E staff increased referrals to the Falls team but numbers still not representative of numbers presenting. Falls screening assessment now incorporated into new cas card. Acts as referral to falls service – section re patient consents to referral included in assessment. Falls service receive information re patients attending A & E as the result of a fall on daily basis. This information captures those patients who have attended over the previous 24 hours. Falls service use telephone screening to gain further information and to triage appropriate referrals.
- CDDFT: Fracture Liaison service established across County Durham and Darlington, also established good practice at Sunderland Royal as part of Joint initiative with Sunderland Falls Service. All falls referred to RIACT team.
- STFT: Rapid Response Team in A+E (qualified elderly care staff nurse/PT and OT) can refer directly to falls clinic/nurse led service but work ongoing to make this more robust as patients still missed.

**Robust referral pathways from Walk-In Centres / Urgent Care Centres / Minor Injury Units**

- NUTH: as above, part of same mechanism but without admissions avoidance nurse input.
- GHFT: Good links with walk-in centre. Further work required re development of robust referral pathway.
- NTHFT: Receive some referrals from One-life (Minor Injuries Unit In Hartlepool).
- STHFT: Urgent care centre refers patients. No referral pathway set up from walk in centres. At present discussions have been held and felt fallers do not tend to access walk in centres.

**Robust referral pathways from Orthopaedics (including Fracture Clinic) and other services e.g. Medical Admissions Unit, Neurology, where fallers present**

- STHFT: Robust referral mechanism for orthopaedics and fracture clinic to refer to osteoporosis nurse who will refer to falls team as required. In patient tool assesses falls
risk and case managers can refer as required. Referral pathways from A&E and MAU (for over 65s).
  o NUTH: Much improved pathways from all of these areas.
  o NTHFT: see above.
  o CDDFT: Recently established Fracture Clinic link with Sunderland Royal, also receiving appropriate low trauma fractures via Durham Fracture Liaison Service, these are primarily seen for Osteoporosis risk but falls risks are also addressed if required. Also some links via Community Matrons – work to do on linking with MAU.
  o GHFT: Referrals form Orthogeriatrics and general Orthopaedics. Robust referral pathway and joint working with Community Orthopaedic Rehab Team. New Orthogeriatrician appointed who will work into orthopaedics and into falls service
  o STFT: Robust pathway for inpatient fallers. Referral pathways developed for those attending A+E who are discharged and followed up in fracture clinic.

- **Osteoporosis link nurse (or similar) working closely with Facture Clinic / Orthopaedics and the Falls Services**
  o NUTH: Fracture Liaison Nurse based in Fracture Clinic – DEXA at time of Fracture Clinic attendance and refer to falls services as needed. Also Orthogeriatric Service review all IP Fracture on Orthopaedics and refer to falls services as needed.
  o CDDFT: Fracture liaison service – community based with links to fracture clinic.
  o NHCFT: Fracture liaison nurse only in North Tyneside. North Tyneside Community Falls Prevention Service – all attendees at the Service are FRAX-screened with treatment/DEXA referral according to need. No link service at WGH or HGH.
  o GHFT: Fracture Liaison Nurse covers all orthopaedic wards including Orthogeriatrics. Also runs Osteoporosis clinic with physician and directs appropriate referrals to the team. All patients attending falls service are assessed using FRAX with treatment being started/referred for DEXA as appropriate.
  o STFT: Osteoporosis service has strong links with orthopaedics and fracture clinic but part of falls and osteoporosis service.
  o STFT: Trauma nurse covers all orthopaedic wards, liaises with fracture clinic and participates in Orthogeriatric ward round. All patients seen in falls clinic are FRAX screened. Current vacant post.
  o TEWV: Osteoporosis risk assessment carried out as part of falls pathway. Good links with community osteoporosis service.

2. Services Delivered

- **Multifactorial assessment and intervention following NICE guidelines**
  o NUTH: MDT teams based in two day units (Melville and Belsay) and community (medical input to community teams via day units). Falls and Syncope Service (FASS) assessment includes physio and access to other services as needed. FASS also works jointly with day units to access MDT input.
  o NHCFT: Locality based Community Rehab Teams. North Tyneside Community Falls Prevention Service – multifactorial, multidisciplinary community based service; proactive case finding from GP case notes and triaged according to need.
  o CDDFT: Specialist teams in North Durham, Darlington, and Easington. RIACT and DN teams cover other areas. Combined forms used by all teams.
  o STHFT: MDT assessment by specialist falls team. Multifactorial assessment / intervention tool for inpatients and community.
- **NTHFT**: Multifactorial assessment and intervention in patient’s homes, care homes and other community settings (e.g. day centres).

- **GHFT**: Consultant led falls service. MDT assessment by Specialist Falls team based in acute hospital. Multifactorial intervention in patient’s home and care homes.

- **STFT**: Multifactorial and multidisciplinary falls assessment and intervention for inpatients and community via Consultant led falls service in day hospital or community team.

- **NTW**: Falls risk assessment standardised for both inpatient and community services across the organisation and available on the electronic health care record which is based using NICE guidelines.

- **TEWV**: Falls pathway in use. Compliant with NICE guidance and is audited regularly. Incorporates multi-factorial risk assessment and post falls proforma.

**Specialist Falls and Syncope Service**

- **NUTH**: Acute Trust Falls and Syncope Service (FASS) – particular expertise on syncope and vestibular dizziness; plus also MDT falls, osteoporosis screening, links with day units / community teams for more extensive MDT input. Both Day Units include basic syncope investigations.

- **STHFT**: Have agreed pathway and multidisciplinary falls team but this has no medical input. Blackout service and Consultants in Elderly Care see patients with blackouts/unexplained falls. Direct referral limited by due to Commissioning restrictions.

- **NTHFT**: Consultant led falls clinic at both UHH and UHNT for medical fallers. Community falls teams can directly refer patients in if possible syncope is identified from multifactorial assessment.

- **NHCFT**: Consultants / Specialist Nurse Practitioners.

- **GHFT**: Consultant led Syncope and CSM clinics in acute hospital. MDT Falls team have well established links with day hospital and all community rehab teams including urgent care team.

- **CDDFT**: Specialist service provided by acute sector in Sunderland, Hartlepool and Durham hospitals. We have direct referral access to Hartlepool and Sunderland but not yet to Durham.

- **STFT**: Consultant led falls and syncope clinic in acute hospital accepting inpatient and community referrals.

**Falls Services screen for and treat osteoporosis following NICE guidance**

- **NUTH**: Services have robust referral mechanism to osteoporosis service with direct fast track referral pathway to Fracture Clinic scanner agreed for Falls and Syncope Service. City-wide programme to identify at risk patients from GP records.

- **STHFT**: Falls Service screen, assess and refer for osteoporosis management utilising FRAX and NICE/NOGG guidance. Direct links to Osteoporosis Nurse for any referrals.

- **GHFT**: Osteoporosis screening as part of standardised documentation. FRAX screened and/or treated per NICE/NOGG. Robust links with Fracture Liaison Nurse and Osteoporosis service.

- **CDDFT**: All patients referred to the Falls Service have a bone health screening as part of the initial assessment (questionnaire). Follow up referrals for dexa scans are requested via patients GP. FRAX used.

- **STFT**: All patients attending the falls clinic are FRAX screened and treated according to NICE/NOGG guidance. In patient fractures also screened and treated. Access to on site DEXA scanning.
Osteoporosis risk assessment carried out as part of falls pathway. Good links with community osteoporosis service.

- **Falls Services delivered in the community, close to / in older people’s own homes**
  - NUTH: Community Response and Rehabilitation Team delivers MDT falls assessments in people’s own homes with links to Day Units for medical reviews.
  - NHCFT: Locality based Community Rehab Teams. Robust service in Northumberland delivering exercise in people’s own homes, community classes and in care homes.
  - GHFT: Falls assessments in Care Homes, Promoting Independence Centres and patients’ own homes with Clinic attendance for medical assessment/review if required.
  - STHT: Falls team deliver services in patients own homes as well as local primary care hospitals and clinic bases.
  - NTHFT: Community falls teams provide assessment and intervention in people’s own homes including domiciliary rehab plans with links to rehabilitation Day Units. Can refer in to falls classes if significant gait and balance issues are identified or if rehab difficult in patients own home.
  - CDDFT: There is a combination of home visits and community based clinics. House-bound patients are seen by relevant clinicians at home and in care homes.
  - STFT: Nurse-led falls service assessing patients in their own home with links to PT and OT from intermediate care team. Can refer directly to consultant led falls clinic.
  - TEWV: Not routinely offered unless enduring mental and physical health problems.

- **Falls Services routinely offer access to care home residents, including services delivered on care home premises**
  - NUTH: All services open to care homes residents. Community teams deliver services in care homes. Specific falls and fracture prevention guidance drawn up jointly with GPs. Nurse delivered proactive assessment and intervention in care homes with higher hospital admission rates. Additional Care Homes Liaison nurse liaises directly with day unit falls services.
  - NHCFT: From community falls team and domiciliary physio.
  - GHFT: Multidisciplinary assessment routinely offered to care home residents. Assessment carried out either in care home or in medical clinic as appropriate.
  - NTHFT: Falls services provide Multi-factorial Falls Assessments to care home residents.
  - CDDFT: Training package offered to care home staff. Fallers are seen in care homes by falls teams as required.
  - STHT: Care home patients assessed and treated as routine. All services offered in patients’ own home also offered in care homes as needed.
  - TEWV: Not routinely offered unless enduring mental and physical health problems.

- **Community based targeted strength and balance exercise programme following evidence based protocols**
  - NUTH: Well established Staying Steady Exercise Programme (36 weeks) but only funded for 230 places pro rata per annum.
  - NHCFT: Locality based Community Rehab Teams. 12 weeks of exercise offered. Referral to Age Concern strength and balance training classes.
  - STHT: Falls team provide 12 week FAME exercise class and home exercise programmes following the Otago programme. Network of appropriately trained people who can deliver postural stability or chair based exercise classes. It is coordinated by the Falls Team and includes sports development staff, physiotherapists and other
Health and Social Care Staff who have completed Postural Stability Instructors or Chair-Based Leaders exercise courses. Sports development provide 24 week programme but have suffered cuts with only one class remaining.

- CDDFT: Otago exercises in community in Darlington. CDD Easington PSI six week courses are held as part of step-down process for suitable patients in a local community setting.
- STFT: This service was stopped when the priorities of our partner charitable and local authority services changed and they were no longer able to commit to it.
- GHFT: Home exercise programme carried out by physiotherapy and rehab assistant. Gateshead council has network of appropriately trained staff delivering PSI and chair based exercise programmes.
- TEWV: Not routinely offered unless enduring mental and physical health problems. This is routine in inpatient settings. Standardised and evidence based.

3. In-patient / Hospital Falls

- **Commitment to falls prevention at board / senior management level**
  - NUTH: Monthly updates on falls and fracture rates at Board Level with Inpatient Falls Task Force held to account if targets not met. Root cause analysis of injurious falls.
  - NTHFT: Executive team see falls in the top 3 risks to the trust and as such have invested a substantial amount of financial resource into the purchase of falls sensors for the acute trust.
  - NHCFT: Quarterly report to Trust Board on Inpatient Falls.
  - STHFT: Annual report presented at Management group and Trust board level. Commitment from Chief Executive and Deputy to reduce falls and support the work underway.
  - GHFT: Inpatient incidents/analysis via Datix presented at Patient Quality Risk and Safety Committee and also at SafeCare Council. NHSLA triannual adult falls risk assessment performed. Findings presented to falls strategy team. CQUIN standards in place for inpatient falls.
  - STFT: Work plan in place regarding inpatient falls, CQUIN action plans in place, information presented to the patient safety committee and the board.
  - CDDFT: Commitment at Trust Board. Falls Group report to Safety Committee on a monthly basis which is chaired by Executive Director of Nursing.
  - NTW: Trust Falls risk prevention and Management meeting chaired by Group Nurse Director with a multidisciplinary membership and close links with Trust board who receive regular updates regarding activity in relation to falls and work plan to help with falls prevention and reduction.
  - TEWV: Falls monitored monthly through quality assurance group. All serious injuries linked to a fall are taken through SUI process as Level 3 or 4 and investigated by falls development team. Inpatient incidents/analysis via Datix. Quarterly falls service development group for MHSOP meetings. Robust falls driver diagram which drives our work and service development.

- **Commitment of front line manager to implement risk reporting and falls assessment and intervention protocols**
  - NUTH: High priority at management level across trust.
  - NTHFT: Implementation of a trust falls sub-group with key people from each directorate to support senior Nurse Lead for Older People to implement change through their own directorate.
STHFT: Strong commitment from Senior Nurse in Trauma and Clinical Lead for Falls. Monitor and report on compliance with falls policy and lead Fall Prevention work within the trust. Risk assessment tool been updated in line with FallSafe work. DATIX in place across the trust and reporting audit completed.

GHFT: DATIX implemented across Foundation Trust. Falls Team involved from inception to identify information recorded re falls. SOTW have now implemented DATIX incident reporting system.

NHCFT: Compliance with falls policy monitored through regular audit.

STFT: Commitment from front line managers regarding robust reporting service across hospital and community services.

NTW: Trust Falls risk prevention and Management meeting chaired by Group Nurse Director with a multidisciplinary membership including frontline managers.

TEWV: Strong commitment from senior level.

- **Multi-disciplinary falls prevention group as defined by National Patient Safety Agency** (executive lead, doctor, nurse, physiotherapist, occupational therapist, facilities, governance/risk, training and development, pharmacy, primary care, social care, patient representative) responsible for implementing and monitoring the effectiveness of falls prevention initiatives
  - NUTH: Committed group meeting definition meets monthly.
  - NHCFT: Weekly meetings; with monthly working group meetings.
  - STFT: Commenced June 2013.
  - NTHFT: All falls irrespective of falls type are reviewed and discussed within trust-wide falls group. Group is multi-professional and covers both acute and community as well as physicians.
  - STHFT: Multi-disciplinary falls prevention group including all relevant parties in place meeting regularly with implementation plan in line with FallSafe programme.
  - NTW: Meeting on a quarterly basis.
  - TEWV: Falls monitored monthly through quality assurance group. All serious injuries linked to a fall are taken through SUI process as Level 3 or 4 and investigated by falls development team. Inpatient incidents/analysis via Datix. Quarterly falls service development group for MHSOP meetings. Robust falls driver diagram which drives our work and service development.

- **Mechanism for implementing root cause analysis for serious falls**
  - NUTH: Well established mechanism. Commended as being excellent by North of Tyne Commissioners.
  - NHCFT: Weekly meetings to discuss any SUI or RCA’s as the result of falls.
  - GHFT: Falls team review falls DATIX on daily basis. Severe incidents co-ordinated by falls team and lead subsequent RCA’s. Findings of RCA’s presented to falls strategy team tri-annually as part of adult falls risk assessment report.
  - STFT: All falls with injury have a full RCA and any serious are managed as a serious incident (SI) – Patient Safety Committee and Board receive RCA and SI reports.
  - STHFT: RCA process in place for all falls causing fracture. RCA documentation reviewed and RCA training in place to support staff. Mechanism in place for RCA to be collated and reviewed by Hospital Falls Strategy group.
  - CDDFT: RCA process in place for all falls causing fracture. RCA documentation reviewed and RCA training in place to support staff. Mechanism in place for RCA to be collated and reviewed by Falls Group, Safety Committee and Divisional Governance Meetings.
- NTW: Reporting mechanism in place with identified clinical staff to assist in reviews of falls.
- TEWV: All serious injuries linked to a fall are taken through SUI process as Level 3 or 4 and investigated by falls development team. Monitored monthly via head of service via SUI dashboard.

**Accurate and complete falls reporting (e.g. via Datix)**
- NUTH: Datix with manual data cleaning by falls coordinator.
- NTHFT: Falls reporting is promoted and reported upon through all patient safety forums and trust / directorate dashboard.
- STHFT: DATIX used across trust. Trust produces detailed monthly reports to Governance Committee, Chief Executive and Director of Nursing and Patient Safety. DATIX updated to improve reporting and analysis. Hospital Falls Strategy Group review data and recommend actions as required. Annual report analyses falls and feedbacks to board level.
- NHCFT: Developing new system to include NPSA recommendations.
- GHFT: Using DATIX with good success. System now adapted to include mandatory field for falls score.
- STFT: Two reporting processes currently in place DATIX web for community based staff, incident form completion in acute care. Falls data provided through Inpatient falls group.
- NTW: Safeguard system in place with weekly reports to management teams.
- TEWV: Datix used across trust.

**Contribute to the National Hip Fracture Database**
- All trusts except STFT do.
- STFT: follow up data for NHFD previously completed by Dr. Suba Thiru. Following mat leave and part-time working now a ‘gap’. Line manager looking at other options.

**Falls assessment documentation coupled with interventions to prevent falls / refer for further assessment**
- STHFT: Assessment updated to meet most recent evidence including FallSafe, NPSA and How To Guide. Tool for 65 years and over and under 65. Tool triggers falls care plan and reviewed daily. Further assessment from Falls Team on discharge. Peer/MDT review for multiple falls.
- NHCFT: Assessment triggers falls care plan.
- GHFT: Falls team active involvement with management of falls in hospital. Falls Risk assessment tool used across all inpatient services. Tool includes pointers to appropriate interventions/investigations
- STFT: Falls risk assessment tool used across acute and community based services. Care standard developed for falls in acute care, rolled out 6 simple steps approach and high risk evaluation form along with new policy Sept 2012. Safety Thermometer rolled out with monthly ward and board reports. Intentional Rounding implemented.
- NTHFT: FRAT assessment tool is now integral to a full assess, plan, implement and evaluate format which is integral to the risk assessment pack within all adult documentation.
- NTW: Falls risk assessment tool available with details of referrals to other providers for further assessment.
TEWV: Falls pathway used. All inpatients assessed for falls on admission. Intervention plans around falls management in place. Falls recorded as part of safety thermometer.

- **Protocol for use of bed rails**
  - NUTH: Protocol meeting NPSA standards implemented across trust.
  - NHCFT: New matrix to be piloted; protocol meeting NPSA standards implemented across trust.
  - GHFT: Bedrail policy in place. Bedrail risk tool updated.
  - STFT: Policy in place.
  - NTHFT: Adhere to Trust Falls Management and bed rails policy.
  - STHFT: Bed rails risk assessment tool incorporated into inpatient falls risk assessment tool. Falls Management policy includes bed rails policy.
  - NTW: Bed rail policy in place.
  
- **Post-Falls Protocol including management of injury**
  - NUTH: Protocol meeting NPSA standards implemented across trust.
  - NHCFT: Protocol meeting NPSA standards implemented across trust.
  - GHFT: Post fall protocol well updated and downloadable from DATIX system. Previous audit showed 90% of staff completed the post fall protocol.
  - STFT: Policy in place.
  - NTHFT: Adhere to Trust Falls Management and bed rails policy.
  - STHFT: Post fall protocol in place in line with NPSA guidance. Includes top to toe survey. Developing pathway to guide staff how to get someone up off the floor. Hoverjack purchased for acute trust to enable patients to be flat lifted off the floor.
  - NTW: This is incorporated within the Falls Prevention and Management Policy.
  - TEWV: Post falls proforma meeting NPSA standards implemented across trust. This is linked to slips, trips and falls policy and is audited yearly.

- **Staff training in falls risk reporting / assessment of falls risks / falls prevention interventions / referral pathways using Royal College of Physicians e-learning package or own package of equivalent standard**
  - NUTH: Actively exploring adding RCP e-learning modules to current training / replacing current training with relevant RCP e-learning modules.
  - STHFT: RCP e-learning used as mandatory training for all clinical staff who contribute to falls risk assessment process, to be completed every two years. Also falls awareness for all staff every three years.
  - NHCFT: Mandatory staff training using RCP e-learning modules.
  - GHFT: Training on falls prevention/falls management/falls risk provided as rolling programme to both qualified and support staff. Competency based workbook implemented in targeted clinical areas by Practice Development team. Consideration being given to introduction of RCP e-learning package.
  - NTHFT: Falls training is based around high to low risk areas. Basic training is workbook. Advanced is face to face and delivered in more depth.
  - STFT: Integrated training programme for both community based staff and acute care staff.
  - NTW: Training established but currently under review as part of new pathways.
  - TEWV: e-learning available for all staff. Training rolled out for falls pathway and post falls proforma. Falls are incorporated into physical healthcare training.
4. Care Homes

- **Training package for care homes on falls prevention and on when and how to refer to falls services**
  - NUTH: Previously Falls Training for care home staff provided as part of Newcastle Care Homes Project. Project not continued from April 2012 due to funding / staffing issues. Limited training available from Staying Steady team.
  - STHFT: Training package and tools for care homes delivered by Falls Team who provide advice and referral pathway.
  - NHCFT: Programme in Northumberland.
  - GHFT: Direct referrals accepted from care home staff. All care homes have falls prevention resource pack. Falls assessments undertaken in care homes. Falls awareness sessions for care home staff offered on request basis at present. Falls prevention pack in process of being reviewed/updated.
  - CDDFT: Training package offered and delivered to care homes consists of half day session looks at bone health, falls prevention and assessment tools. Followed by all residents being assessed with support from the Falls Coordinator. This is not currently consistent across CDD. Working with commissioners to look at this.
  - CHSFT: Training aimed at all staff across primary care including nursing homes, voluntary agencies, domiciliary care i.e. anyone who comes into contact with the elderly can access the training free of cost.
  - STFT: Agreement reached to have training delivered with support through NEAS. Falls Resources packs provided for care homes along with training DVD.

- **Good links with care homes to encourage uptake of training and referral to falls services**
  - NUTH: Previously excellent links, including planning group involving care home managers, as part of Newcastle Care Homes Project. Project not continued from April 2012 due to funding / staffing issues.
  - NHCFT: Excellent links as part of FISHNETS – not now maintained.
  - GHFT: see above.
  - NTHFT: Postural stability exercises in care homes.
  - STHFT: Good links – training and support targeted to care homes with high referral/falls rates. New protocol being developed to include quarterly falls meetings.
  - CDDFT: Good links established and working well.
  - STFT: As above.

- **Falls Services routinely offer access to care home residents, including services delivered on care home premises**
  - (As above).

5. Training

- **Training for health and social care professionals and others in management of falls and on when and how to refer to falls services**
  - STHFT: Fantastic Training Package aimed at all health and social care staff.
  - NTHFT: Training programme developed and delivered to health and social care professionals. A more in depth training programme for qualified staff is being developed.
o NUTH: Previous city-wide training delivered jointly with NEAS to health and social care professionals 2010. Subsequent ad hoc training only.

o CHSFT: see above.

o GHFT: Provided on an ad hoc/request basis. Work ongoing to develop standardised training sessions for health and social care staff. A more in depth training programme for qualified staff is currently being piloted. Consideration being given to using adapted RCP e-learning package.

o CDDFT: Various packages available for groups including Health & Social care, voluntary agencies, Care home staff, warden services.

o NHCFT: Provided on an ad hoc/request basis in Northumberland. North Tyneside Falls Prevention Service – ongoing education for GPs and associated teams of community nursing and physiotherapy teams.

o STFT: Integrated training programme, covering risk of falls, risk assessment process, government strategies, physiological aspects of ageing, post fall protocols for inpatients and incident reporting.

o NTW: Training established but currently under review as part of new pathways.

• Training package around inpatient falls – see above

• Training package for care homes – see above

• Training package for sheltered housing schemes and day care on falls prevention and on when and how to refer to falls services
  o NTHFT: Activity coordinators in sheltered housing.
  o STHFT: Pilot undertaken in sheltered housing. Falls awareness events held in sheltered housing and other community locations.
  o CDDFT: Wardens work closely with falls service.
  o CHSFT: see above.
  o GHFT: Falls service attend warden’s meetings to raise awareness re falls prevention and to highlight referral pathway to team.

• NEAS contribute to training on initial management of fallers and referral mechanisms to falls services across the region and across various non-hospital sectors.

6. Information

• Provision of falls prevention information for older people and their carers
  o STHFT: Superb provision of information distributed by Falls Team to all inpatient and community staff, GP practices, health promotion teams and libraries.
  o NHCFT: Excellent FISHNETS web site now discontinued. North Tyneside Community Falls Prevention Service – paperless service apart from individualised care plan printed out and given to older people and their carers. Printed falls prevention information, leaflets detailing home exercises for those with gait and balance problems and written conservative advice for neurally mediated disorders and orthostatic hypotension.
  o GHFT: Falls workbook provided as part of older persons attendance at Gait and Balance exercise group. Leaflets available in community services, acute staff currently reviewing patient information provided. Falls clinic information available. STARS information given to patients attending falls clinic where appropriate. Falls service to develop website via acute trust.
- NTHFT: Both CCGs have falls prevention leaflets that have been disseminated to patients, carers and other health and social care services.
- NUTH: Specialist information around cardiovascular falls. General leaflets in day units / exercise classes. Information on Falls and Syncope provided on Trust Internet Site.
- CDDFT: Information provided by falls teams to patients and carers, a combination of national and local information. Also within Easington a pack is sent to referred patients/carers who do not meet criteria but who can then access falls prevention info and can self refer if concerned.
- STFT: Leaflets available in community services, acute staff to review patient information processes. Falls clinic information available.
- NTW: Service user and carer information leaflets available.
- TEWV: Service user and carer information leaflets available.

7. Quality metrics

- **Data collection that allows development of clinically relevant quality metrics**
  - NUTH: Outcomes collected for Staying Steady Exercise Programme and ED patient referrals. Datix entries used to monitor in-patient falls and injuries.
  - STHFT: Falls Team developing a set of quality metrics including use of outcome measures to demonstrate reduced falls risk. Benchmark with NPSA figures. Falls is one of the CQUIN measures.
  - NTHFT: Datix entries ask for more detailed information relating to falls and key risks. Reports are pulled from Datix specific to directorates and down to ward areas focusing in cause of fall, patterns, age profile, days, etc.
  - CDDFT: Developing key outcome measures to be collected consistently for falls and osteoporosis.
  - NHCFT: North Tyneside Community Falls Service clinical information housed on SystmOne database facilitating easy collection and analysis of relevant metrics.
  - STFT: Data collection through DATIX provides information regarding falls relating to no harm, minor harm, major harm events. Falls information produced in productive ward areas, specific issues relating to falls discussed through clinical risk meetings.
  - GHFT: Falls, both inpatient and A & E attendance as a result of a fall, is one of the acute trusts CQUIN measures/targets.
  - NTW: Data collected and used within clinical governance frameworks.
  - TEWV: Datix entries ask for more detailed information relating to falls and key risks. Reports are pulled from Datix specific to directorates and down to ward areas focusing on cause of falls, patterns, age profile, length of stay etc.
Organisations contributing comments:

County Durham and Darlington NHS Foundation Trust (CDDFT)
Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH)
North Tees and Hartlepool NHS Foundation Trust (NTHFT)
Northumberland Healthcare NHS Foundation Trust (NHCFT) – includes North Tyneside and Hexham
Gateshead Hospitals NHS Foundation Trust (GHFT)
South Tees Hospitals NHS Foundation Trust (STHFT)
City Hospitals Sunderland NHS Foundation Trust (CHSFT)
South Tyneside NHS Foundation Trust (STFT)

Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV).

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