Second North Yorkshire Falls Conference – 23/10/15

Aims and Objectives

The vision for the North Yorkshire Falls Conference 2015 was:

- To inform delegates of the progress that has been made since the last conference in September 2014
- To prepare to implement the emerging vision for falls services going forward, based on a review of the latest evidence and examples of best practice
- To identify the priorities in each CCG area for reducing the number of falls experienced by the frail and older population and the number of falls related injuries
- To identify the barriers and solutions to taking these priorities forward in each CCG area

Attendees

There were a total of 98 people at the conference (including speakers). 18 from the Airedale, Wharfedale and Craven locality, 19 form Hambleton, Richmondshire and Whitby, 25 from Harrogate and rural District, 9 from Scarborough and Ryedale. 16 from the Vale of York and 11 others (mostly people with a North Yorkshire wide remit). There were a wide range of professions represented including health and social care staff, commissioners, care home staff, housing wardens, equipment services staff, voluntary organisation representatives, the Yorkshire Ambulance Service, leisure/exercise professionals.

Presentations

The morning consisted of presentations Councillor David Chance chaired the event after providing some information on falls in the North Yorkshire context and giving some examples effectiveness and good practice.

Presentations included:
Helen Williams, Innovation and Improvement Manager, Vale of York CCG, gave a presentation on the Vale of York Bone Protection Service
Sue Hayward-Giles, Assistant Director, CSP, presented the Chartered Society of Physiotherapy's Falls Economic Model.
Stephen Miller, Public Health Intelligence Analyst, North Yorkshire County Council, gave a presentation explaining some of the data relating to falls in North Yorkshire
Kathryn Hodgson, Clinical Lead Falls and Osteoporosis, South Tees Hospitals NHS Foundation Trust, talked about the Hambleton and Richmondshire Falls Service.
Sam Haward, Delivery Manager, Hambleton, Richmondshire and Whitby CCG brought everyone up to date on the work that has been done in North Yorkshire so far and the purpose of the day.
A final presentation was given by Dr Lincoln Sargeant Director of Public Health for North Yorkshire, highlighting why falls is a public health issue.

The afternoon session was led by Gail McCracken Falls Coordinator, who talked about the work that had been on-going since the last conference including the "products" (assessment tools, quality standards, performance framework and gap analysis) that have been developed for North Yorkshire some of which were to be discussed in the workshops.

Workshops

There were two workshops in the afternoon, the first one was to look at the products and discuss the benefits and obstacle for each. Delegates were able to choose which one of these they wanted to join:

- Screening/Trigger Tool
- Multi- Factorial Falls Assessment (MFFA)
- Quality Standards for Hospitals
- Quality Standards for Care Homes, Extra Care Housing and Domiciliary Care

The second workshop was for delegates to look at how they would overcome the commissioning/contracting barriers to turn the vision for falls services into a reality. This was done in CCG localities and delegates were assigned to the appropriate workshop depending on where they normally worked.

Emerging Themes

Each workshop was led by a facilitator with someone to capture the discussions (a scribe).

There was a great deal of lively discussion but there were some themes which came up repeatedly.

<u>Benefits of the products</u>

Enable a consistent approach
Opportunity to openly share information
Training benefits/helps to identify training needs
Keeps falls as a high priority on the prevention agenda
Focus on prevention

<u>Obstacles to using the products</u>

Difficult to share information across different agencies
Inconsistency across North Yorkshire e.g. some areas have falls teams others don't
Need to establish a shared responsibility
Focus needs to be on prevention rather than cure
Rurality and lack of transport
Time
Version control
Duplication
Consistency of training

Airedale, Wharfedale and Craven Locality

Potential solutions

Link SystmOne across health

Better use of 3rd sector – joined up working

Improve awareness of current services

Targeted prevention work

Training

GP involvement

Share information – too time consuming for one agency to undertake alone - and avoid duplication

Hambleton, Richmondshire and Whitby Locality

Potential solutions

Create a falls champion in each setting

Collaborative working

Need a consistent approach

Central point for updating/version control

Living Well Co-ordinators

Exercise classes

Links between hospital and community

Education on staying well and mobile – self-help

Work around dementia and mental health

Harrogate and Rural District Locality

Potential solutions

Sharing care records – use secure e-mail

Duplication of tools

Keeping service up to date/version control

Educate patients on falls before screening

Standardise falls information

Dementia/Learning Disabilities friendly

Contracting and service specifications

CQUINs

Scarborough and Ryedale Locality

Potential solutions

Link with another priority e.g. frailty

Tool is a frailty assessment not just a falls assessment

What happens after assessment?

Awareness raising

Raised awareness needs to come with the right investment in services as demand may rise

Vale of York Locality
Potential solutions
Need version control
Invest in prevention
Risk assessment at first point of contact
One point of contact/training within organisations
Auditing to ensure it's making a difference
Sharing information across services/disciplines

For all comments see Appendix 1

Conclusion

The "products" were generally thought to be helpful and assist everyone to maintain a consistent approach but there are concerns about version control.
There needs to be much more focus on prevention rather than just responding to people who fall.
Training, consistently across the county, needs to be put in place
Time to carry out assessments and interventions is a concern but may be helped by sharing information between agencies more effectively. Joining up IT would help with this. Making falls prevention and assessment a shared responsibility will help.
Many people don't know what services are already available locally so more awareness raising/information would be beneficial.
The rurality of the county and lack of transport are seen as barriers

Next Steps

A paper on the falls agenda will be taken to the Locality Transformation Boards to gain their support in taking this work forward. It will then be up to the localities to decide how to make it happen.

Appendix 1

Write up from workshops

Workshop 1

Screening/Trigger Tool – to identify older people who may be at risk of falls	
Facilitator: Enid Feather Scribe: Phil Derych	
Discussion	N/A
Benefits	• Enables a consistent approach • Creates a 'bench mark' for organisations to use as a guide/base • Mutual familiarity of the approach between organisations • Opportunity to openly share information • Easy to use; appropriate for all audiences, not just professionals • Training benefits • Provides a 'common' language • Prevents reinvention of the wheel – multiagency understanding • Profile raising: enhances trust/respect towards professionals • Improves service for users • It has different/various uses – can adapt language to fit different audiences • Provides a base for spreading info to public knowledge • Introduces a SOCIAL model rather than only a MEDICAL one • Alternative approach • SAGA information kit (can make use of) • Could link with the Chartered Society of Physiotherapy
Obstacles	• Difficult to maintain effective communication; difficult to carry info across to different agencies and uphold partnerships/links, consistent approach • Is it too repetitive? For example, if one individual went through 6 hospital admissions they'd be asked the same questions each time (does it lose patient/individual focus?) • Timed Up and Go (TUG) is difficult to implement – if someone has just recently had a fall, they will get different results to when they feel physically active (validity/reliability issues). For example, whether or not the individual is using a walking aid or not affects results • TUG not a feasible tool in particular circumstances (obstacles in home etc.) • Difficulty in finding out truthful info (about drinking habits, how person feels etc.) • Dependent on specific details • Forms – where do they go? How are they analysed? Can we prevent info being lost? • Information is not pooled properly electronically • Establishing how to monitor and measure info effectively – to prevent losing info • Inconsistency in 'passages' across North Yorkshire – some areas have Falls teams, others don't; there are different gaps in

	different CCG areas • Mutually agreed definitions of a 'fall' • Sensitivity of patients – not wanting to confess they've had a fall (feeling ashamed or that they're 'failing', wanting to self-preserve image, worrying that they may be taken away from their home and into care etc.) – participant perception is a big issue – one that doesn't encourage the use of TUG • Personal circumstances – someone with Dementia couldn't follow TUG questions • Community Rehabilitation team have Falls Assessment responsibility and gain an overwhelming responsibility – need to establish shared responsibility • Alcohol – how to sensitively ask questions to retrieve accurate and truthful answers • Danger perception of fall victims – some might report a slight trip, others might actually fall and say "it was just a slip" or not report it • Increased older population, particularly in Harrogate – 65 or above could be too low for the 'older person' age barrier – could make it 75 or older to have a more manageable cohort (then work down from 75 if need be)? It is also being questioned in Harrogate whether the criteria should be switched from 1 fall in a year to '2 falls in 6 months' to try and compromise the criteria/cohort to make more manageable • Equal opportunities for each patient (needs to be need-led), but not necessarily prescribe the same treatment for each patient (person-centred). • Focus needs to be on prevention rather than cure – need to target people before they become an 'older person' rather than after they become more vulnerable (to make time for behaviour change) • Establishing a standard procedure • Rurality & lack of transport – targeting those with low incomes, also • Time-consuming – need to identify need before implementing/changing a service • Changing a person's long-term habits • Different services across NY • Not wanting to confess a fall • Social V medical needs led approach • Clarification of falls service user perceptions • Rurality/transport service gap issue affecting choice • Income affects choices
Potential solutions	• Public Health Campaign (via Falls, Alcohol and Winter Health work streams); also link with Stronger Communities (if awareness is fully raised, and consistently, people will be more motivated towards behaviour change or seeking help/taking part in TUG)

Multi-Factorial Falls Risk Assessment – an assessment that identifies the risk factors for an individual and should lead to a range of interventions to eliminate or reduce these risks	
Facilitator: Hazel De Wit Scribe: Abigail Burns	
Discussion	N/A
Benefits	• Latest up to date guidelines • Good prompt for assessment • Audit trail • Trusted assessors to access interventions • Shared info • Shared agreed benchmarking of current tools • Stem from GP (Selby District Social Prescribing) • Holistic approach • Comprehensive • Everyone's responsibility • Do what you can and refer on • Potential to reach wider audience with more assessors • One stop shop for signposting • Look at statistics/performance • Having interventions imbedded with clear pathway to follow • Easier to communicate info to others • How about LD? • Age limit? • How will acute Trust link up? • Time consuming process, takes away from care delivery • RA tool – set at high literacy level. What are the outcomes for the tool? E.g. escalation to where – what options to choose from? • Time consuming to process – takes away from delivery –s is the 5 page RA tool in excel better? • GPs need mobile device as most is at community visits in care homes • Postcode lottery for services to escalate to e.g. care homes • Who will train care staff? • Mobility checklist best by specialist rather than care staff? • Can't be prescriptive about review dates e.g. monthly. Consider review after each fall incident • Poor communication as to the draft product and local falls service • Tool is intimidating and lengthy • Timing for use of tools and reviews are key • Training element needed • Could web based RA tool be offered? • Provider barriers to adopt it when already have tools that work e.g. by a national train • Needs sign-posting element to resources/equipment • Who will own it/update it?

	• Will GPs review 6 monthly (medication)? • What outreach comes from acute trust e.g. A&E follow up? • Something to deliver against • Allows benchmarking • Consistent • Ways we can prevent • Focus of attention to areas that could be missed • Training of front line staff • Champions within a team
Obstacles	• Version control • Interactive as NICE changes ownership in a control manner • Keeping pathways current • Recording of data and how used • Lack of IT • Sharing data/data protection • Duplication • Assessor capacity • Training – consistency • Positive collaboration i.e. all on board • Diff CCGs and diff pathways • Time to do the assessment, especially if you don't have a specialist team • Gap – no question about social impact of fall/fear of falling • Access for on-health community provider • Data protection • Training • Length of document • Duplication of work already taking place • How we train front line staff • Not just falls, about prevention + wellbeing • Meeting Care Act legislation • Could become a tick box exercise • Needs to be by a sustainable national body, checks and balances, consequences for not achieving • Funding • Commitment • Leadership – who will be co-ordinating across organisations • Reticence for change within living environment + person who has capacity
Potential solutions	• Build links and routes of communication with vol. services + onward organisations • Educational talks re falling/falls history • Falls prevention

Quality Standards (Hospitals)	
Facilitator: John Turner/Sam Haward Scribe: Claire Lawrence	
Discussion	• South Tees - tick all the boxes • Friarage – not enough falls assessment in A&E • TEWV – falls working group, assessment in place but not sure fully utilised except on elderly wards • Airedale – good falls care currently, incorporated NICE guidance, falls steering group • York – Physio currently leading falls work, tend to be small projects rather than an overarching strategy
Benefits	• Resounding yes to the question 'is it helpful to have a clear set of standards?' All Trusts had standards at some level but they are incomplete. • Drives improvement • Raise profile within Trusts and CCG groups • Airedale receptive in principle • MFFA is an intervention as well as an assessment
Obstacles	• Felt the hip fractures 'best practice tariff' already covered standards for individual patients as there are financial penalties for not achieving – however the same standard of falls care needs to be in place where the fracture isn't of the hip i.e. a package of standards. Action: cross check with emerging guidance. Driver/incentive – CQUIN? Is there a role for this? Risk assessment within 24 hours? • A&E CQUIN (North East/Newcastle) • Airedale Community CQUIN • Focus on the 7 priority areas within the MFFA • Needs to be pulled together by multi-professions • Issues in Scarborough as no GP champion for falls. Evidence isn't very strong for making it a priority in this area due to interpretation of data – possibly under reporting? • Action: better understanding needed of what is being reported as a fall as not consistent across the Trusts. However if any changes are brought in then it could be hard to benchmark. • Airedale community services – flow is seamless but feel its underutilised • Scarborough and TEWV – patchy. Are individuals getting the right services? Are there any physical activity programmes? • Actions from the standard are difficult to embed within the workforce • Training is a potential barrier – time for staff to be trained even if delivered on-line • The role of falls coordination is very different within each trust – breadth of roles • Do the guidelines reference enough to what happens outside of hospital? Are there progressive standards that increase over time?

Potential solutions	• Need to work community to hospital as well as hospital to community. Also need to empower the person to be proactive. • FLS/bone health is a gap this tool does not address – could there be separate guidance for emergency care and inpatients? One issue is that it's not within the culture or clinical standards of A&E/urgent care! Shouldn't we want to change this? Where could an individual have an assessment? Should A&E provide discharge details? Want to see a standard system or one where different standards are at least linked clearly. Big emphasis on hip fractures which are already captured in the best practice tariff. • Can this standard be linked to the community standards? Can discharge be supported as ward staff feel nervous about this area of work

Quality Standards for Care Homes, Extra Care Housing and Domiciliary Care – to assist these services in preventing and managing falls	
Facilitator: Gemma Umpleby Scribe: Helen Perry	
Discussion	• What already exists – CQC standards – but doesn't specifically involve falls
Benefits	• Helps you know what to do • Everyone working to same standard • People know what to expect from care • Helps with planning – know what to work towards • Shows commitment to falls prevention and how important it is • Focus on prevention? Meeting care act legislation • Looks/identifies training and development • Prevents silo working/consistency • Question raised: who will ensure implementation and up to date national responsibilities are met? • Sets out legal side • Prevent falls by making professionals (relatives & families) focus on them + put measures into place that may not have been – guide staff through what to do • Helps understand context around falls + other issues – environment, other health issues • Gives clear responsibilities and actions • Improved knowledge re process and equipment available to support • People will know who to call for advice/support e.g. falls team • Keep fall high priority on prevention agenda/put measures in place • Encourages MDT involvement • Maintain focus
Obstacles	• Requires robust training and monitoring • Time/paperwork/lack of consistency • Keeping it up to date

	• Resistance to change – staff involvement • Increased workload • Takes away initiative from professionals and choice • Tick box exercise • Not user friendly – particularly family/friends/clients • Duplicates work • Needs classroom based training – any funding available? • Quality of training that exists • Providers (national) may already have a corporate successful method • Needs to be led by care act • At risk of becoming a tick box exercise and loss of focus • Funding – who will fund training, equipment, identified continuous monitoring • Increase workload/time/flow? Practicable • Choice/consent – people may refuse advice • Paper format V technology/ hand held devices on community? • Risk of processing at point of assessment and not referring on to service • Lack of knowledge of services available and how to contact them
Potential solutions	N/A

Workshop 2 (in CCG localities)

Airedale, Wharfedale and Craven CCG area	
Facilitator: Enid Feather Scribe: Phil Derych	
Discussion	• Aware of tool – incorporated into documents • Trained in tool • Multiagency Service Development Group could work on Falls but needs better coordination; Multifactorial Falls Prevention Service • Gaps in service/commissioning and contracting issues
Potential solutions	• Linked System One (Health) – having to do a narrative as they are not yet linked electronically • Better use of 3rd sector • Improve awareness of services already running • Reduce instances of falls – increase in (staff) resource – targeted prevention work • Training – tools (what & how to use) • GP involvement • Better use of the views of service users • Encouraging compliance of patients (approach and communication) • Share information – too time-consuming for one agency to undertake alone • Avoid duplicating & wasting time by reinventing the wheel – e.g.

	avoid 'tramlines', parallel projects – we often have the same audience or client base, but we don't share info properly or duplicate each other – need consistent approach – same way of portraying info Linked on system one • Joined up working within 3rd sector – we can buddy and mentor, building confidence – we see people for benefits checks – can help identify fallers • Awareness of services in the community post MFFA including VCS, Health, Social care • Longer term contracts would enable better planning and economies of scale i.e. at the moment HIA works on 1 – 3 year type contracts • Hospital falls prevention service/team which liaises closely with community services • Multi agency roll out of training to use the tools • Direct/named contact • Education and training with older people as a social activity – model already developed through an ICTP in East Lanc • Awareness service already in place prior to MFFA – notify services (to put in place pre and post hospital if appropriate) • Putting it on system 1 asap so all teams can access the assessments to reduce duplication/save time

Hambleton, Richmondshire and Whitby CCG area	
Facilitator: Sam Haward Scribe: Abigail Burns	
Discussion	• Decreases revolving door clients and incidents of falls • GP/DN referral route • Prevents silo working (individual providers) • Increases awareness • Good governance structure to its production • Educates carers and service users • Reflect current best practice/guidance • Screening Tool: Capacity Flooding A&E Trigger Tool • MFFA: Positivity about Time to use it • Hospital Standards Use of A&E Good Links from hospital to community setting • Care Homes Positivity as a starting point Issues with training for staff in care homes • Refinement/generally correct, however how do we cross all these areas?

	• How do we get the tool to speak to all? • Pathway process • Embed links • Prior to this – education on staying well and mobile – self help • Gail + START Frat Gap analysis • Cultural change – housing to be able to ask trigger questions • Get up and go – MCSP – Saga publication • Level 1 – no nothing, level 2 preventative, level 3 MFFA • MFFA: Social care? (FRAT), District – yes, Fast response – yes, Physio/OT therapists, Community Matrons?, GPs – no, Housing – yes (needs some training) • Reeth – evaluation and rollout over 75's? • Mobility clinic – good point to screen • • Referral not received – why? • Patients who bounce – stop – refer • Social events i.e. coffee/lunch clubs – talks/education • Who do we refer to? • Exercise pathway – what it is and who it would benefit • ST – most hospitals Pathway is right Work to do on quality Commitment Sharing improvement and quality People who don't break a hip – how are they supported? Gaps in fracture liaison/bone health • Extra care/care homes • Potential duplication • Map current assessment • Contract impact assessment • Training on use and understanding (Karen Wilson CEO of ICG) • Use and share • National chains – not being involved, how do we bring them in (Janine Tranmer) • HUDDLE – concept and what it can do • Prevention – mixed economy of need
Potential Solutions	• Living Well Officers • Staying Steady / home hazard / external mobility • Exercise classes • Create falls champion in each setting • Collaborative working • Need consistent approach – provider & CCG • Evidence based • Central point for updating/version control – who owns it? • Influence national agenda • Action – map prevention. ADL under £100 trusted assessor • Flow from hospital to community and vice versa • Work around dementia and mental health (Karen Bibbings)

	• Plain English • Patient Safety Huddle – already exist • extra

Harrogate and Rural District CCG area	
Facilitator: Hazel De Wit Scribe: Helen Perry	
Discussion	• IT – IG – how to share, are systems compatible avoiding duplication? • Patient expectations – making sure that the information is available and timely. Pre-empt impact on existing services e.g. increase demand, keeping person informed. • Capacity of service • Mental health considerations. Is the tool dementia friendly? • Quality standards – compliance, duplication • Practicalities of TUG • Compliance to complete • About finding connections that motivate the person to do walking/exercise classes • Sign up • Vanguard to force change • Gap – what happens after acute care episode? • Safety HUDDLE • Collect relevant data evidencing numbers of falls • IT cloud – Vanguard • Linking with Ham Rich Whit • MFFA on system 1 • Consulting patients about changes and possible interventions • Does the patient want the intervention? • Education and make it clear what impact it will have • Sharing success stories and best practice • Gaps – acute care what happens next • Pathways • Issues about flooding A&E • Issues with training for staff in care homes • Hospital standards • Service capacity • Vanguard?
Potential Solutions	• Sharing care records – GP's can default to share? • GCSX – email health and social care • Duplication of tools e.g. health and social care/home providers • Use as a benchmark/tool for improvement • Making sure intervention services from MFFA are aware they are on MFFA • Keeping services up to date/ Version control • Patients perception of a fall – education on falls before screening • Falls leaflet/info (standardise across all providers) • TUG – question alternative, ?GP

	• Screening tool and MFFA can be modified to suit needs of the client type • Dementia friendly/learning disabilities friendly? • Contracting and service specs • CQUIN's • CQC involvement • Make it user friendly – time to use it?

Scarborough and Ryedale CCG area	
Facilitator: John Turner Scribe: Claire Lawrence	
Discussion	• Central Scarborough has a relatively young population demographic, however it is forecast to change and there is a drive to put prevention measures in place now but difficult to justify the investment based on current figures/lack of evidence. In fact some stats show Scarborough is improving so hard to get issue taken seriously. Difficult to convince commissioners as the problem is not immediate. • Action – how is data recorded? Are falls always recorded? • Scarborough doesn't have a fall team – where do risk assessments go? • Housing perspective – difficult to adapt properties due to the types of housing in the town and in private ownership.
Potential solutions	• Could we hang falls on another priority such as dementia or cardiovascular disease? • Coastcall is a service run by Yorkshire Coast Homes and it supports its residents who have fallen in their homes but do not need to go to A&E - however quality of data is unreliable as falls are self-reported and open to interpretation of the caller who may be afraid of falling or using the stairs rather than have had a fall. Are there other local organisations may have additional information on falls that didn't result in an injury? • NICE guidelines – ask how many times have you fallen in the last 12 months • Start to change perceptions now and thinking about what future services might look like/cost. Start working on integrating areas of work – need some mapping/gap analysis. Could a community directory be developed? What VCS is there? This has been done in the past (Community Hub?) and not been kept up to date. Could Stronger Communities be the key point for organisations to feed information in? • Recognition that the tool is a frailty assessment not just a falls assessment. • We underuse our politicians – what stories/hooks are there? • Care service contracts – include clauses about falls. • Standards about non-care settings – wider than health • Action: to look at tools (pared down version or ask if individuals they have had an assessment • In your home solutions e.g. information prescription

	• Assessment but what happens next? Cross check with referral? MECC • Living Well is due to link with Fire Service • Is there a fear that prevention leads to a loss of key roles? • Awareness raising for the public re fear of falling, not just information after a hip fracture? Need real stories to illustrate. Patient champions? Carer champions? • Statistics tend to drive the finance • Link to isolation agenda. Morbidity data around fear of falling? Difficult to collect data as many reasons, including loss of confidence rather than a medical condition • Surveys about fear of falling already done? National/international models? Age UK? NICE guidance? • Changing cultures/awareness. Roadshows/marketing. Raised awareness needs to come with the right investment in services as demand in service may be raised. • Look at all the stakeholders • Scoping, research, local docs – focus on Scarborough

Vale of York CCG area	
Facilitator: Christine Pearson Scribe: Paul Ramskill/Megan Hale	
Discussion	• NY falls rate is 10% - rate of injuries will increase rapidly over coming years with NY to see an 11% increase • Reduce incidents of falls • Reduce harm caused by falls • How might we overcome difficulties? • Don't know what falls pathway is in York • Depends on which area of York – it isn't something which is prioritised as performing in 10% • Number of admissions in York is quite high • Falls team doesn't exist anymore. No integrated communication. Barrier to overcome – what out there and how do we get in touch? • Gap in who sees those multi fallers/specialised cases – physio do not have the capacity to follow up • Community physios are not on same system and cannot transfer information through other than by paper • Don't have capacity to meet needs – community therapy • Falls practitioners not falls teams • Value of assessment being able to be transferred into community (IT) • Emergency response to falls • What happens to fallers who don't meet the clinical guidance of a fall? • Communications transferred to managers not then transferred to staff • Difficulties communicating between organisations – and within a

	single organisation • Excess cold, housing stock risk • Are we all using the screening tool? • Where to focus funding for falls? • Where would info go in different areas? • Electronic frailty index – is it being used? How do tools currently being used compare? • IT constraints • Collaboration issues – positive attitudes are required • CCG areas and local provision do not match • Concerns of only one year funding for social prescribing in Selby District and already CCG funding being reduced for it • Social impact of fall/fear of falling not included • Lack of communication • Prevention, currently addressing when people are already in the system • BRE – assessing housing stock, assessing risks in housing, mapping the city where risks are. £1.4m falls hazards, costs to NHS. Soon to be an evidence based document released • Options are only as good as your knowledge • GPs in care homes • Electronic frailty index (falls is a sub-section of frailty) • Confusion about what tools should be used
Potential solutions	• Need to promote to homes ECP – Kyle Donvand ? CCG trialled with 8 care homes – for calls not deemed emergency but from people in need of assistance (June 2015) • Be Independent (social enterprise) are working with fallers. 9 fallers/day under the radar – not accessing information, referred by social care, hospital, private. No access to data – carry out a basic risk assessment. Breaking confidentiality by passing people on • Social prescribing e.g. exercise classes can pick people up that are under the radar – via third sector. Exercise classes finished in August with no feedback. Pick up issues from assessments such as social isolation, falls, depression etc. About confidence, addressing social isolation, follow up 3 and 6 months • Loneliness and social isolation projects, projects short term funding, quality standards that people follow • Standards in homes, extra care and domiciliary • Figures broken down to own home, street, care homes in relation to falls • Portal to give out information • Form needs to be written into private contracts • Need version control of MFFA • Need proactive interventions before people approach services – pays to invest in prevention – fund adaptions? • Risk assessments at first point of contact e.g. if someone can pick up on fear of falling = signpost to get measures to prevent

	this. Connection with cold temps • One point of contact/training within organisations • Needs incentivising • Need auditing to ensure it's making a difference • Having a resource attached so you know which service can be referred to – similar to Reed codes • Sharing information across services/disciplines is time saving • Direct from/with GP means the pathway is immediate/clear • Direct referral to agency • Quality standards of falls risk assessments (benchmarking – passing on info) • Person has a hard copy of their MFFA to share with all professionals • Include MFFA in patient passport • Need quality standards that everyone signs up to • Start at 40 years old (pre injurious falls) • SPA – point of contact

Appendix 2

Delegates names and contact details

See North Yorkshire County Council Website

Appendix 3

Presentations

See North Yorkshire County Council Website