NAIF trust / health board benchmarking (Version 1.1 – Live from December 2025)

Trust Name:

Section 1 - Policy and processes

QUESTIONS	AUTOMATED FEEDBACK	FURTHER INFORMATION
1.01 Is there a NAIF clinical lead at your trust / local health board?		
☐ Yes ☐ No	**YES** / **NO** NAIF includes all NHS inpatient settings – acute, community and mental health trusts. One clinical lead should be appointed for each trust or health board.	Please see the *'Responsibilities of the Clinical Lead'* document for further information on the requirements for this role.
1.02 **Does your trust or health board use a falls risk screening tool?** *Definition: A tool that aims to predict a person's risk of falling, either in terms of **'at risk/not at risk'**, or in terms of **'low/medium/high risk'**, etc.* *A multi-factorial fall risk assessment (MFRA) is not a risk screening tool, this is an assessment tool. If your trust / health board only uses MFRA (and does not stratify patients by risk), answer no to this question.*		
☐ Yes ☐ No	**YES** This is **NOT** recommended by NICE NG249, Standard 1.1.1 which states: "Do not use fall risk screening (prediction) tools to predict inpatients' risk of falling in hospital". Your trust / health board should move to regarding all patients aged 65 years or older as being at risk of falling in hospital and manage their care according to the recommendations with comprehensive falls assessments. **NO** Regarding all patients aged 65 years or older as being at risk of falling in hospital and manage their care with comprehensive falls management is in line with NICE NG249 recommendations. Your trust /health board is commended for this approach.	

1.03	Does you trust or health board you have a system for assessing the extent of the gap between actual and reported falls?		
	☐Yes ☐No	**YES** It is good practice to regularly review falls reporting. See further information for detail on how to do this. Your trust /health board is commended for this approach. **NO** It is recommended that your trust / health board review how fall reporting practices are routinely evaluated. See further information for details on how to do this.	Help guidance on how to complete this can be found on page 24-27 of the Implementing Fall Safe document here.
1.04	With regards to the reporting of falls resulting in hip fractures. Does your trust / local health board:		
	Select ONE option only		
	☐Report all as severe harm ☐Report as another degree of harm depending on the circumstances of the fall	**REPORT ALL AS SEVERE HARM** This approach is recommended as severe harm is defined as when **at least one** of the following apply: • permanent harm/permanent alteration of the physiology • needed immediate life-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment • has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions • has limited or is likely to limit the patient's independence for 6 months or more Your trust /health board is commended for this approach. **REPORT AS ANOTHER DEGREE OF HARM DEPENDING ON THE CIRCUMSTANCES OF THE FALL** Severe harm is defined as when **at least one** of the following apply: • permanent harm/permanent alteration of the physiology	LFPSE guidance here: NHS England » Policy guidance on recording patient safety events and levels of harm. FAQ section specifically questions, 9,10,11,12

		- needed immediate life-saving clinical intervention - is likely to have reduced the patient's life expectancy - needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment - has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions - has limited or is likely to limit the patient's independence for 6 months or more This approach risks underestimating the impact of the injury on the patient. Hip fracture is a very serious injury and it is unlikely that any older person with a hip fracture does not meet at least one of these criteria. It is recommended your trust / health board reviews this approach.	
1.05	**Has your trust or health board carried out an audit of the clinical appropriateness of bedrail use for individual patients within the past 12 months?**		
	Select ONE option only		
	☐Yes we have carried out an audit ☐We use bedrails but have not carried out an audit ☐We do not use bed rails at all	**YES, WE HAVE CARRIED OUT AN AUDIT** Regular review of bed-rail use is recommended. See further information for detail. It is recommended your trust / health board continues to undertake bed rail audits at least once a year. **WE USE BEDRAILS BUT HAVE NOT CARRIED OUT AN AUDIT** Regular review of bed-rail use is recommended. See further information for detail. It is recommended your trust / health board conduct a bedrail audit in the next 12 months. **WE DO NOT USE BED RAILS AT ALL** Bed rail audit is not indicated if there are no bed rails. Revisit this question if bed rails are introduced.	Guidance - Bed rails: management and safe use

1.06	Does your trust or health board have flat lifting equipment for safe manual handling available on all sites?		
	☐Yes ☐No	**YES** Flat lifting equipment allows staff to raise the patient in the supine position and transfer to bed or trolley safely and comfortably. This is important where hip fracture is suspected. Your trust /health board is commended for providing this. Trusts / health boards should ensure staff are appropriately trained to use flat lifting equipment and that staff with such training are available 24/7. **NO** Flat lifting equipment allows staff to raise the patient in the supine position and transfer to bed or trolley safely and comfortably. This is important where hip fracture is suspected. It is recommended that your trust / health board explores how to ensure there is access to flat lifting equipment for all inpatient sites. See further information for details. Trusts / health boards should ensure staff are appropriately trained to use flat lifting equipment and that staff with such training are available 24/7.	Flat lifting equipment allows staff to raise the patient in the supine position and transfer to bed or trolley safely and comfortably. Guidance: <mark>National Patient Safety Agency. Rapid response report: Essential care after an inpatient fall</mark> (2011)
1.07	Does your trust provide patients and relatives access to education and information for falls prevention that is readily available to all inpatients (to evaluate this, conduct a spot check of 25% of wards in your trust/ health board)?		
	*For the purpose of this question, written information is considered to be a physical booklet **or** web-based information accessed via posters with a QR code visible on the wards. This may be a trust / health board specific document or the NAIF leaflet.*		
	☐Yes ☐No	**YES** It is important that information on how to prevent falls is available to inpatients and their relatives / carers. Your trust /health board is commended for providing this. **NO** It is important that information on how to prevent falls is available to inpatients and their relatives / carers. It is recommended your trust / health board plan how to ensure written information is available.	See NAIF patient information booklet (more formats of the resource are available here)

1.08	Is regular training in fall prevention and post fall management "mandatory" for all applicable clinical staff in your trust / health board?

Clinical staff: doctors, nurses, allied health professionals and health care assistants.
Applicable: clinical staff who work in an area where patients aged over 65 will be treated. Not applicable: staff who work only in clinical areas where no people aged over 65 will be seen (such as paediatrics or obstetrics).
Examples:
Applicable = renal, haematology, surgery, medical, trauma.
Not applicable = child health, midwife, obstetrician.
Repetition of training at least every 3 years is considered as "a regular basis".

| ☐Yes ☐No | **YES**
 We recommend regular mandatory training to ensure staff meet competency requirements for safe clinical care. See further information for details.
 Your trust /health board is commended for providing this.

 NO
 Regular mandatory training is necessary to ensure staff meet competency requirements for safe clinical care. See further information for details.
 It is recommended that your trust / health board review training policies. | Statutory training is that required by law or legislation (statute), such as health and safety, infection control, fire safety, and safeguarding etc. Falls training is not required by law.

 Mandatory training is that required by an organisation, based on its policies and standards. This may include topics such as information governance, equality and diversity, manual handling, resuscitation, and basic life support. Many organisations include falls as mandatory training.

 Resources:
 Training statutory and mandatory \| Advice guides \| Royal College of Nursing (rcn.org.uk)

 Carefall and Fallsafe eLearning

 Supporting best and safe practice in post-fall management in inpatient settings |

Section 2 - Leadership and service provision

QUESTIONS	AUTOMATED FEEDBACK	FURTHER INFORMATION
2.01	**Does your trust or health board have an Executive Director who has specific roles/responsibilities for leading falls prevention and management?** *Although this can be part of a wider remit (e.g. for patient safety) you should not tick yes if this is a purely nominal role and they have had no active input or interest in falls policy/procedures/working groups.*	
☐Yes ☐No	**YES** It is recommended that a member of the executive board has a specific responsibility for falls. Your trust /health board is commended for providing this. **NO** It is recommended that a member of the executive board has a specific responsibility for falls. Your trust / health board should review who holds responsibility for inpatient falls prevention and management.	
2.02	**Does your trust or health board have a Non-executive Director (or other Board member) who has specific roles/responsibilities for leading falls prevention (can be as part of a wider remit for patient safety)?** *Although this can be part of a wider remit (e.g. for patient safety) you should not tick yes if this is a purely nominal role and they have had no active input or interest in falls*	
☐Yes ☐No	**YES** It is recommended that a member of the non-executive board has a specific responsibility for falls. **Your trust /health board is commended for providing this.** **NO** It is recommended that a member of the non-executive board has a specific responsibility for falls. Your trust / health board should review who holds responsibility for inpatient falls prevention and management.	[The 'How to' Guide for reducing harm from falls](#)
2.03	**Does your trust or health board have a current multi-disciplinary working group or steering group or sub-group specifically for falls prevention which meets at least four times a year? As a minimum, this group must contain a nurse, doctor, AHP and manager as part of its membership.** *Tick **No** if falls are discussed only within a multi-purpose group (e.g. clinical governance or patient safety).* *Tick **No** if the group only covers one part of your service (e.g. Medicine but not Surgery).*	

		*Multi-organisation network groups covering a locality or region count as **No** unless they are actively creating falls policy for all the participating trusts / health boards.*	
	☐Yes ☐No [If no go to question 2.04]	**YES** Regular governance meetings to review falls at an organisation-level are recommended. Your trust / health board is commended for doing this. **NO** Regular governance meetings to review falls at an organisation-level are recommended. It is recommended your trust / health board implements this practice.	
2.03a	**Is information on the reported incidence of falls in your organisation routinely presented and discussed at most or all meetings of the falls prevention group?**		
	☐Yes ☐No	**YES** Regular review of incidence of falls is recommended. While we suggest organisations do not compare falls rates to other organisations, it is important to monitor these data over time, *within* your organisation. Your trust / health board is commended for doing this. **NO** Regular review of incidence of falls is recommended. While we suggest organisations do not compare falls rates to other organisations, it is important to monitor these over time, *within* your organisation. It is recommended your trust / health board implements this practice.	NAIF encourages only internal comparison and looking at the impact of quality improvement type activities in your trust rather than benchmarking against external organisations.
2.03b	**Is information on falls rates in your organisation (expressed as falls per occupied bed days) routinely presented and discussed at most or all meetings of the falls prevention group?**		
	☐Yes ☐No	**YES** Regular review of incidence of falls **using occupied bed days** is recommended. While we suggest organisations do not compare falls rates to other organisations, it is important to monitor these data over time, *within* your organisation. Your trust / health board is commended for doing this. **NO** Regular review of incidence of falls **using occupied bed days** is recommended. While we suggest organisations do not compare falls rates to other organisations, it is important to monitor these over time, *within* your organisation. It is recommended your trust / health board implements this practice.	NAIF encourages only internal comparison and looking at the impact of quality improvement type activities in your trust rather than benchmarking against external organisations.

2.04	Is information on falls rates *and* trends routinely provided to individual directorates, departments, wards or units at least quarterly?		
	☐Yes ☐No	**YES** Sharing data on falls rates (using occupied bed days) and trends (in the form of run charts) is recommended. This should be done for individual wards or units but could also be combined for departments or directorates / care groups. Your trust / health board is commended for doing this. **NO** Sharing data on falls rates (using occupied bed days) and trends (in the form of run charts) is recommended. This should be done for individual wards or units but could also be combined for departments or directorates / care groups. It is recommended your trust / health board implements this practice.	
2.05	Do you have a policy that all inpatient wards/units have access to walking aids for newly admitted patients (or patients whose mobility needs have changed) 7 days per week?		
	☐Yes ☐No	**YES** It is recommended that trusts / health boards have a mechanism by which newly admitted patients have access to walking aids. Your trust / health board is commended for doing this. **NO** It is recommended that trusts / health boards have a mechanism by which newly admitted patients have access to walking aids. It is recommended your trust / health board implements this practice.	
2.06	Has your trust implemented a PSIRF response framework for inpatient falls (English trusts only) ?		
	☐Yes ☐No	**YES** It is recommended that trusts develop and implement a PSRIF response framework for inpatient falls. See further information for more detail. Your trust / health board is commended for doing this. **NO** It is recommended that your trust develops and implement a PSRIF response framework for inpatient falls. See further information for more details.	Learning Response Tools - NHS Patient Safety - FutureNHS Collaboration Platform See NAIF PSIRF resource.

2.07	Has your trust / health board undertaken any quality improvement projects to address fall prevention or management in the past year?		
	☐Yes ☐No	**YES** The recent NAIF report recommends using quality improvement methods to address audit findings. See further information for more details. Your trust / health board is commended for doing this. **NO** The recent NAIF report recommends using quality improvement methods to address audit findings. Areas of focus might include components of high quality multi-factorial fall risk assessment such as lying/standing blood pressure, assessment and management of delirium, or post-fall management. See further information for more details. It is recommended your trust / health board reviews audit findings to identify potential projects.	Read the NAIF annual report 2025 and use the NAIF healthcare improvement workbook to help support improvement projects. Submit your QI case study here.

Completed by:	
Date:	