**Falls in older people**
**stakeholder workshop breakout group discussions on the scope**
**Date: 8th March Time: 9:00 – 12:00**

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| **3.1 Population:**<br>**Groups that will be covered:**<br>• People 65 years and over<br>• People aged 50 to 64 who may be at higher risk of falling, for example: people with history of a fall, or a condition known to increase the risk of falls<br><br>Specific consideration will be given to the following subgroups:<br><br>• Specific consideration will be given to people in hospitals. | Is the population appropriate?<br><br>○ Are there any specific subgroups that have not been mentioned?<br><br>• Don't think social prescribers have been captured.<br><br>• The group were excited to see the population of adults aged 50 to 64 would be included but felt it was a random figure. It was mentioned that Northeast region looks at adults aged 18 and over.<br><br>• It was highlighted that it would be beneficial. Particularly because of the deconditioning effect of the pandemic and the loss of confidence the pandemic has caused means the younger aged population are unsure where they can go to, to receive more information.<br><br>• Query - might not be necessary to brief some client have not been able to access falls group because of age restriction. What about community service access? Will this put a burden on services who can't cover that wide a population. |

| **3.3 Key areas that will be covered in the update:** | These are the key areas of clinical management that we propose covering in the guideline. Do you think this is appropriate, acknowledging we must prioritise areas for inclusion? |
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| 1. Information and education for people who are at risk of falls and their families or carers | • It was raised that currently there is no centralised place for people to refer to or receive any access for any education on Falls. For example, there is no national falls prevention society which would benefit and educate people. There isn't a central pool of advice such as providing a leaflet to someone who has come into surgery who has previously fallen.<br><br>• There is no mention of tailoring advice to individuals who are isolated and/or live by themselves.<br><br>• It was raised if people can do self-referral as social isolation plays a huge part for older adults who are susceptible to falls. A lot of services are online which can be difficult. Consider inserting the psychological effects of falls and the declining mental wellbeing of patients.<br><br>• There is no information for people who have fallen and how they get up. There is a major issue of length of time to get to people once they fall. Issue of people laying on floor for laying for hours. Is there any chance to extend in this gline for people on the floor, and how get help. If it's beyond scope that's fine but it needs to be highlighted in this discussion. |

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| 2. Methods of identifying people at risk of falls for further assessment<br>o Routine questioning, observation, screening tools, electronic patient records | • There is no mention of self-referral for those who live by themselves or who are socially isolated. |
| 3. Individual risk factor assessment for people identified to be at risk of falls<br>o Risk assessment tools, gait assessment and frailty indices | • Create a toolbox rather than a range of different assessment tools. |
| 4. Interventions to reduce risk of falls including<br>o Multifactorial and multi-component interventions, exercise programmes, strength and balance training, medication review, home hazard and safety interventions, environmental modifications | • How do we ensure quality assurance of interventions.<br>• Sustainability and scalability. There needs to be something added about their places for people or pathways for people to go onto and carry on and maintain those gains. We want areas to think of a system and long term. We want to make sure there's no cliff edge for people once they have been treated or diagnosed and this should be included in guideline.<br>• Follow ups – an area we need to think about long term follow up and gains they've had from initial follow ups.<br>• Accessibility of services, practicality, and social issues. How do we maximise participation and compliance. It's a very broad topic.<br>• Issues of delivering the services such as the 52-hour exercise programme. Need to implement this in an innovative way as currently as there's no resource to implement this and so it's impossible to implemented. There are hidden costs that don't get factored in.<br>• Might be worth looking tracking people after follow-ups but this might not be feasible. |

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| **Key clinical issues that will not be covered:**<br><br>1 Identification and assessment of fragility fracture risk<br>2 Management of complications of falls<br>3 Interventions targeting specific conditions that increase the risk of falls | • Dizziness is a risk factor for falling and needs to be looked at whatever the cost. Are there guidelines if it's BPTV or dizziness to help encapsulate the client group?<br>• We should pick up Adult CP guidelines. Whenever dizziness is picked up, should mention this as there is a gap. |
| **Any comments on guideline committee membership?**<br><br>**Proposed composition of update committee**<br>• Early member: Consultant practitioner (physiotherapy)<br>• Early member: Consultant in Public Health<br>• Early member: Consultant Physician (General Medicine and Geriatric Medicine)<br>• 2 lay Members<br>• Care home representative with experience of falls prevention<br>• General practitioner<br>• Nurse with experience in Falls Prevention<br>• Occupational therapists involved in assessment of people at risk of falls and delivery of falls interventions<br>• Consultant in Old age Psychiatry<br>• Exercise professional with experience in delivering strength and balance programmes e.g., Postural Stability Instructor<br>**Other/Cooptees:**<br>• Pharmacist with interest in care of older people<br>• Consultant Emergency medicine physician/acute care setting | • Paramedic should be included or considered.<br>• Social prescriber who works mainly with older people.<br>• An Audiologist or physiotherapist who specialises in dizziness and balance.<br>• Someone with search expertise in falls prevention.<br>• Nurse with both community and acute hospital experience or possibly two nurses with experience of either setting. |
| **Further Questions:** | |
| 1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care? | |

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| 2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted? |
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| 3. Are there areas of **diverse or unsafe practice** or uncertainty that require address? |
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| 4. Which area of the scope is likely to have the most marked or biggest health implications for patients? |
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| 5. Which practices will have the most marked/**biggest cost** implications for the NHS? |
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| 6. Are there any **new practices** that might **save the NHS money** compared to existing practice? |
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| 7. If you had to delete (or de prioritise) two areas from the Scope what would they be? |

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| 8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be? |
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| 9. What are the top 5 outcomes? |

1. Mortality
2. Quality of life
3. Falls
    - Incidence
    - Frequency of falls per person ( one or more)
    - Number of fallers
    - Fall related injury, fall related fractures
    - Risk of falling
4. Hospital admission
5. Fear of falling, for example: Falls Efficacy scale
6. Deterioration of independence or physical function.

10. Are there any areas that you think should be included for the purposes of the quality standard? Are there any service delivery or service configuration issues that you think are important?

- Long-term behavioural change as a way of preventing further falls. Is there a follow up on this? Patient group think it's part of getting older, it's not something they seek assistance for. How would you capture this? It goes back to the point there is no central point of information for this group. It's not in any NICE guideline anywhere and this is the perfect opportunity to include this.
- How will we measure incidents of falls. So many go unreported. How will we look at this in any meaningful way?

| 11. Other issues raised during subgroup discussion for noting: |
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| • Dizziness/balance/vertigo issues - Dizziness and vertigo is such a risk factor falls. When people feel dizzy they don't feel confident to leave home and they can't participate in outside activities or programmes to help. The amount of screening and prevention that can be done for dizziness is huge to prevent the falls in adults. This population group needs to be captured.<br><br>In the Zoom chat at the end of feedback session:<br><br>• Ensuring links in the scope to NICE head injury guidance which is currently being reviewed I think. HI can be a cause for presenting with falls as well as result of a fall. |