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

3.1 Population: **Groups that will be covered:** • People 65 years and over • 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 Specific consideration will be given to the following subgroups: • Specific consideration will be given to people in hospitals.	Is the population appropriate? o Are there any specific subgroups that have not been mentioned? **is the age limit needed**? Falls can occur at any age and attendees reported caring for people in their settings who have falls at younger ages. It can be a problem to ensure people think about falls in younger age groups if they are specifically excluded from NICE guidance. The group discussed how to decide which risk factors are important: Is limiting to this age range for risk factors too limiting. Some alternative options were discussed - Could this be all adults or all adults with some known risk factor such as history of a fall, specific groups e.g., Oncology, renal, gastro, withdrawal addiction, stroke ,. Participants reported aiming to do falls assessment for every patient, even younger population; preference would be for every patient admitted to acute hospital to complete falls assessment. Some services - history of fall is the significant part that they ask everyone , However, some participants noted that specific topics have guidance for all age groups that can tie in to falls in that population (Osteo, rehab etc) . 50 itself is an arbitrary age, is that a reasonable age to start from? It was noted that ideally need to have evidence to support national recommendations. The average age in Cochrane reviews is in 70's and 80's. There may not be evidence for people in lower age groups and that can make inclusion in a NICE guideline more difficult. The previous guideline used consensus to develop recommendations – this is still possible, but recommendations are not as strong An option is to leave the risk factors open and allow the GC to define this as part

	of the process. An important point is the difference between population screening and individual assessment. Does this topic need more than one guideline. This is Falls in older people update; is a separate guideline required for younger at-risk groups? Are interventions different?
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?
1. Information and education for people who are at risk of falls and their families or carers	No objections to this key area
2. Methods of identifying people at risk of falls for further assessment o Routine questioning, observation, screening tools, electronic patient records	There are different aspects to this, and it is important to be clear: there is a population screening part e.g., identifying people on a database or electronic records who are at risk of falling; and separately an individual 'screen' for people as they come in contract with services. Group reported that evidence is not good for predictive tools This needs to be simple in community settings; can use simple questions; questions used often adopted from Falls risk assessment tool; different

	services use slightly different questions adopted from different tools. Problem that tools geared to people who have a history of a fall and need to remember want to prevent first falls. Potential to consider other measures such as EFI (electronic frailty index); not designed to identify risk of fall but can identify older people who are frail and may fall; proxy measures should not be excluded. Potential to use AI on databases to help identify people e.g., coming to hospital, seen in A/E.
3. Individual risk factor assessment for people identified to be at risk of falls ○ Risk assessment tools, gait assessment and frailty indices	The current guidance tells people not to use individual assessment tools, national audit tells people not to use them. Another review could be useful to further emphasise the misuse of these tools as people do use them inappropriately. Also need to be open to any new evidence on these although the group did not think there was new evidence to change the current view. What is the barrier to professionals using tools appropriately? Is this an issue that needs addressing? There is a care home guide to action tool which lists things to consider; this can be useful in some settings. There is again a need to be clear about who this is for, which setting and the aim of the assessment. Of note hospitals tend to add risks to patients, removing alcohol, sedation, amputation, not moving for ages – all increased risk of falls

	There is a massive difference of falls assessment depending on patient setting, at admission, but needed again post chemo or surgery for example. MDT contribute to the assessment in some settings. Falls assessment is not a once off- needs review. Gait assessment can provide useful data for assessing risk of falls. Assessments often correlate with fear of falling and frailty. Looking at using the assessment in care home setting. Gait assessment is objective factual assessment of walking ability. Royal Society on Prevention of accidents (RoSPA) have work on falls. Timed get up and go is a useful assessment There is work on minimum data sets - strength and balance – more an outcome measure. Also 'timed up and go'. Using SPB?
4. Interventions to reduce risk of falls including o Multifactorial and multi-component interventions, exercise programmes, strength and balance training, medication review, home hazard and safety interventions, environmental modifications	Important note for group: screening and assessment are of no news unless actions are taken. There was agreement that there is good evidence for what works There is uncertainty about evidence for costs, real life implementation, measuring prevention is difficult. The previous guideline did some significant work, but it was not widely circulated enough.

Key clinical issues that will not be covered: 1 Identification and assessment of fragility fracture risk 2 Management of complications of falls 3 Interventions targeting specific conditions that increase the risk of falls	
Any comments on guideline committee membership? **Proposed composition of update committee** • Early member: Consultant practitioner (physiotherapy) • Early member: Consultant in Public Health • Early member: Consultant Physician (General Medicine and Geriatric Medicine) • 2 lay Members • Care home representative with experience of falls prevention • General practitioner • Nurse with experience in Falls Prevention • Occupational therapists involved in assessment of people at risk of falls and delivery of falls interventions • Consultant in Old age Psychiatry • Exercise professional with experience in delivering strength and balance programmes e.g., Postural Stability Instructor **Other/Cooptees:** • Pharmacist with interest in care of older people • Consultant Emergency medicine physician/acute care setting	There is a need to ensure different settings are represented. This is not clear from current list. Nurses may work in different settings and have different perspectives so more than one may be required. It may be more about role of person than their professional background. It would be useful to have people who have experience of implementation. People may have multiple hats.
Further Questions:	

1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?
2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?
3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?
4. Which area of the scope is likely to have the most marked or biggest health implications for patients?
5. Which practices will have the most marked/**biggest cost** implications for the NHS?
6. Are there any **new practices** that might **save the NHS money** compared to existing practice?

7. If you had to delete (or de prioritise) two areas from the Scope what would they be?
8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?
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?

11. Other issues raised during subgroup discussion for noting:
Who is the guideline for - Does this list need to be more specific?