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? ○ Are there any specific subgroups that have not been mentioned? The group discussed there should be special consideration for care homes and specialist settings. The group also noted that falls should be captured in care homes for people of all ages because these people are at greater risk of falls compared to the general population The group were pleased we are covering people in hospitals as a subgroup. However, highlighted this sub-group should probably be for everyone over the age of 18. Some people in the group noted the 50 – 64 age group should be used in all settings because this age group are at high risk of falls. However, others agreed this age range should only be for people at higher risk at falls or specific conditions. The group also emphasised special consideration should also be given to people with learning disabilities or mental health problems – this may be a missing subpopulation! The group discussed that Intermediate care settings and Virtual wards (hospital at home settings) should be included in the scope. However, it was noted that these are NHS settings and therefore would likely be included. The group also discussed that fewer falls would likely occur in homes, and it was therefore discussed that this would be useful when looking at interventions.
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	It was noted that language is important, and it is important different means of information (e.g., accessible and jargon free) are available. The group emphasised that lay people, people with disabilities, and people with dementia should have appropriate access to information on falls. It was also noted that training and education of caregivers is really important, and that care should be individualised.
2. Methods of identifying people at risk of falls for further assessment ○ Routine questioning, observation, screening tools, electronic patient records	The group noted that screening is time-consuming but could be useful for all adults who have had a fall. The group also noted that a medicine review could be important for identification risk of falls.
3. Individual risk factor assessment for people identified to be at risk of falls ○ Risk assessment tools, gait assessment and frailty indices	Medicine review could be important for identification risk of falls

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	It was noted a lot of falls occur because people can be impatient. For example, falls occur in a care homes because people do not like waiting for a caregiver to take them to the toilet. It was noted that wait times in care homes can sometimes be down to shortages of staff. The group requested education and training to be considered as an intervention. A large number of sub-group members noted eyesight was also important to consider – bi-focal glasses, the wrong glasses, and not having glasses when needed can significantly increase your risk of a fall.
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	The group were happy that fragility fracture is not included because not all teams have the ability to complete this identification and assessment (e.g., occupational therapists). This should be done by specialists who have the specific knowledge to undertake these assessments.

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<td>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</td>
<td>The group noted the shift towards hospital care in the committee membership compared to the previous guideline. The group thought it would be useful to strengthen the council and exercise element in the guideline committee membership. The group also recommended we include either a social care manager, social care commissioner, social worker, or director of social because social care representatives are missing in current guideline committee membership list. The group also noted a volunteer who helps with reducing the risk of falls may be beneficial committee member.

The group stressed the importance of having a mix of members from community and acute settings. The group noted it would be useful to have two nurses on the committee – one from the community and one hospital-based nurse – to obtain different perspectives

The group also thought a pharmacist should be a main member of the guideline committee.

The group noted an ambulance guideline committee member or cooptee may also be useful because ambulance workers tend to be first responders to falls in the elderly.

It was also noted a valued member or cooptee may be someone who runs or works at minor injury units because lots of people who have falls present here with their initial fall related injury.

An eye health expert would also be useful cooptee member.</td>
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<tr><td colspan="2">Further Questions:</td></tr>
<tr><td colspan="2">1. Are there any critical clinical issues that have been missed from the Scope that will make a difference to patient care?</td></tr>
<tr><td colspan="2">The sub-group did not have any comments.</td></tr>
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2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?
On page 7 it says number of fallers. It was asked if this could be updated to number of people experiencing falls.
3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?
Three-wheel delta frames are very dangerous once you are out of the hospital due to tripping hazards on curbs etc.
4. Which area of the scope is likely to have the most marked or biggest health implications for patients?
Preventative measure for falls could have a large impact. A big impact could also be seen in the community when discharging patients and looking at the best way to do this by minimising future risks.
5. Which practices will have the most marked/**biggest cost** implications for the NHS?
We look at falls in terms of fracture risk but if we take a holistic view of this (e.g., social isolation) this could have a large impact on costs and QoL. Keeping independence is also important and a loss of independence is normally associated with fear of falling. The key with fall prevention is stop people's health deteriorating and ideally this is what we want to capture in economic analyses. Bay watching, cohort nursing, and 1-1 care is very expensive and this could result in a big cost saving if there is little evidence for it being effective. It was noted that a lot of people still have falls with these interventions.
6. Are there any **new practices** that might **save the NHS money** compared to existing practice?

Not discussed	
7. If you had to delete (or de prioritise) two areas from the Scope what would they be?	
Not discussed	
8. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?	
Not discussed	
9. What are the top 5 outcomes?	

1. Mortality
2. Quality of life
3. Falls
  o Incidence
  o Frequency of falls per person (one or more)
  o Number of fallers
  o Fall related injury, fall related fractures
  o Risk of falling
4. Hospital admission
5. Fear of falling, for example: Falls Efficacy scale
6. Deterioration of independence or physical function.
	Ambulance call-outs
	Hospital attendance not just admission (e.g., A&E)
	Urgent community response standard
	Hospital admission to include the length of stay

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?	

Not discussed
11. Other issues raised during subgroup discussion for noting:
Fatigue and muscle weakness from covid could increase the risk of falls. People who get bi-focal glasses or are changing glasses are at greater risk of falls. Eyesight and risk assessment of eyesight could be useful when assessing risk of falls (e.g., when was there last eyesight test etc.)