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? 1. Group mentioned people who may not neatly fall into this category. Particular people who are in their mid-to-late 40s who may not be viewed as at risk of falls.
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	• Group asked that we reconsider the wording of this section. Increasingly people's experiences as they are getting older may be shifting away from the more traditional model, we are seeing more people who may not be surrounded by families or children. This social structure does not always exist. • Important to access people with health and social inequalities.

2. Methods of identifying people at risk of falls for further assessment o Routine questioning, observation, screening tools, electronic patient records	• Several types of risk tools mentioned (including MUST), but group keen to ensure that a more holistic approach is used in identifying people at risk of falls. • The older person's social structure was raised again here. Understanding that for someone living alone, or who only has intermittent care or brief visits from family and friends, changes in their levels of mobility, capacity, cognition and other risk factors for falls may be missed. • Early identification and early assessment is key to supporting patients. So, the timing of asking routine questions would be very important. • Clinical assessment over time – to understand the impact to the person (deterioration). • Importance of assessing people within their homes. • Where is the identification taking place: hospital, home setting? • Which types of screening tools are we referring to? Malutrition Universal Screening Tool (MUST). • Assessments of bone health, vision, hearing, alcohol use • Review of medication
3. Individual risk factor assessment for people identified to be at risk of falls o Risk assessment tools, gait assessment and frailty indices	The following key areas were mentioned: 1. Malnutrition 2. Staff training for people in care homes or emergency services. Not necessarily clinical professionals but people working with older adults need to be trained to identify risk. 3. Hypertension and other conditions which are managed with the use of prescribed drugs that may increase the risk of falls due to the side effects of medications. 4. Enabling and engaging with older people so they feel empowered to participate in their care, increase their own self-management and understand the effects of exercise and increased mobility on reducing their risk of falls. . 5. Understanding the impact of people's Psychological health and social environment on how empowered they may feel to engage with clinical services, seek to improve their own care and proactively address worrying symptoms and circumstances. 6. Environmental factors – risk assessment would be different in hospital and home

<table>
<tr><td>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</td><td>1. Timely referral to health care professionals.
2. Ensuring that older people are aware that falls are not necessarily a natural part of the aging process and can be prevented.
3. The role of vision care in supporting the reduction in risk of falls.
4. Impact of prescribed drugs and related side effects that could lead to risk of falls. –
5. Assessment of prescribed drugs in people with multimorbidities on multiple prescriptions. The group noted that medications are very rarely deprescribed.
6. Group keen to signpost people to self-management programmes – the impact of exercise on balance and coordination.
7. Helping people to understand what constitutes a home hazard.</td></tr>
<tr><td>Key clinical issues that will not be covered:

Identification and assessment of fragility fracture risk
Management of complications of falls
Interventions targeting specific conditions that increase the risk of falls</td><td>1. Complication of falls very relevant and very real, very keen to ensure that this is addressed.
2. GATE pace, and cognition and changes in cognition could lead to falls.
3. Refer to related guidance:
a. CG 32 nutrition support
b. CG 100 alcohol use
c. NG77 cataracts guideline</td></tr>
<tr><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)</td><td>• Cooptee Opthamologist (Eye care professional).
• Dietician with interest in falls.
• Podiatrist
• audiologist
• Physical activity organisation representation.
• Social prescriber/ personalised care representatives
• Charity who works with older people (e.g., Agile, silver voices, old people’s advocacy alliance).</td></tr>
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- 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

Further Questions:

1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?

    1. Postural hypotension.
    2. Identifying areas where the guideline could address inequalities
    3. Engaging people.
    4. Anxiety and poor mental health in older people and the impact this has on the loss of confidence that would increase their risk for falls.
    5. Roles and responsibilities – who does the assessment, so no one is missed.
    6. Signposting older adults to non-clinical groups that can provide support.

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 addressing?
1. Prescribing and the lack of regular medication checks. 2. Capacity of services varies, post code lottery, 3. Good management of some conditions may increase risk of falls due to side effects of drugs. 4. Managing multiple health problems and the direct impact on risk of falls. 5. Different practices of managing falls for hospitals/home.
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?
1. Cost of treatment in malnutrition - early prevention and treatment of malnutrition could result in huge cost savings. 2. More strength and balance exercise could have cost implications as this could reduce risk and reduce incidence of falls. 3. Medication: cost effectiveness of medication reviews
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.	Falls reported may not be a reliable outcome measure as reporting varies across service.
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:	