Patient and Public Involvement

Older People’s Experiences of Falls and Bone Health Services (England)

Commissioned by:
The Healthcare Commission
Healthcare Quality Improvement Partnership (HQIP)
Help the Aged

Conducted by:
The Clinical Effectiveness and Evaluation Unit,
Royal College of Physicians, Clinical Standards Department

Advised and approved by:
The Falls and Bone Health Audit Steering Group

Report - 1st September 2008
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Report approved by the National Falls and Bone Health Steering Group

*The Healthcare Commission initially funded this project have been replaced by Healthcare Quality Improvement Partnership (HQIP) who took over funding responsibility for this and other national audits from 1st April 2008.*
Introduction

Getting services “right” for older people who have fallen or who are at risk of falling is a challenge. Since falls services are fairly new, there is limited experience on how best to provide them: thus feedback from service users, the patients, is needed to help understand how local services best develop to not only “treat the fall” effectively but also successfully help patients reduce their risk of a subsequent fall. This approach is based on the conviction that involving patients in decisions about their own healthcare will improve the services they receive and the benefit they derive from them.

This report presents the findings of a study to investigate the experiences and thoughts of patients’ who have used falls services in NHS trusts around England. The participants were patients who were currently or had recently been attending a falls service. Most such patients have had a recent fall: others had been referred because they were considered to be at particular risk of falling. This study complements the findings from the recent set of national audits investigating the organisation of falls services (2005/6) and the clinical care received by a sample of patients who had fallen and sustained fractures (2006/7).

Using set focus group questions, participants were asked about how they accessed the falls service, their experience of components of the falls services and how effective they felt the interventions to have been. These aspects were chosen as they reflect the relevant statements in the guidance on which the audits were based. These were the National Service Framework for Older People (NSF, 2001), and the National Institute for Health and Clinical Excellence (NICE) clinical guidelines on prevention of falls (CG21, 2004) and secondary treatment of osteoporosis (TAG 87, 2005).

We encourage you to consider the key messages obtained from older people who have used falls services and the recommendations derived from their messages within this report.

The information provided by this project will be used for three further pieces of work, a falls prevention experience audit tool; a best practice focus group toolkit and a patient-centred information/advice leaflet focusing on the aspects of falls and bone health services important to enable patients to become partners in their treatment and falls prevention plans.

We would especially like to thank the older people who spoke about their experiences and participated in the focus groups, all the staff that helped contact participants and those at the focus group venues. Finally we would like to thank everyone who helped in the design, performance and analysis of this project.

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Dr Finbarr Martin
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Dr Jonathan Potter
Director, CEEU
Executive Summary

Background
A major component of preserving the well-being and independence of older people is to promote healthy life choices and physical activity. For falls and fracture prevention, the National Service Framework (NSF) for Older People (2001) requires that NHS services provide information and advice as part of a jointly agreed intervention plan for patients who attend falls services. Since services are fairly new, there is limited experience of how best to do these things: thus patient feedback is required to help local services develop a partnership approach to reduce the risk of a fall or fracture.

Aim
The aim was to gather patient’s views and experiences and produce recommendations so that falls service providers could develop the best services possible.

Methods and Findings
This project was funded by the Healthcare Commission and Help the Aged. It was conducted by the Clinical Effectiveness and Evaluation Unit (CEEU) of the Royal College of Physicians, and overseen by a multi-disciplinary advisory sub-group to ensure clinical governance and ethical standards. Men and women attending or who had recently attended one of the participating falls services were included. They were drawn from 11 acute and seven primary care trusts covering ten areas of England. Patients with significant cognitive impairment were excluded. A literature review identified relevant topic areas. The focus group topic guide included questions on access to falls services, patients’ treatment plans and information received.

Nine focus groups involving 40 participants were conducted from November 2007 to March 2008. Focus group discussions were transcribed verbatim using standard transcription standards. A thematic analysis was performed using data management software (MaxQDA2). Four themes resulted from the analyses concerning falls services: (a) access, (b) assessment and interventions, (c) interpretations of falls, and (d) perceived benefits and critiques. Within each theme key messages were identified, implications considered and recommendations for the NHS formulated.

Key messages
- Participants were often unaware of what falls services were available, how referral took place and how they related to other primary and community services.
- Participants often thought that their GPs were probably not aware of these services.
- Some participants felt that the name ‘falls clinic’ was odd and off putting and open to misinterpretation.
- Most participants reported having experienced a thorough assessment but some were not aware of the outcomes or conclusions or of their right to ask for the results.
- On the whole, participants reported their attendance at falls clinics to have been a positive experience, highlighting both physical and psychosocial benefits.
- They considered their thorough health assessment or ‘MOT’ to be an added benefit, but it was generally unclear to them how the assessment outcomes were used to develop individualised management plans, or how interventions might reduce their own falls risk.
- The range of interventions experienced by participants reflects many of those recommended in the NICE 2004 guidelines e.g. strength and balance training, home hazard and safety intervention, medication review, dietary advice and where patients can seek further advice.
- Some participants found the experience of falling very frightening with fear of a recurrence affecting their confidence and they appreciated the chance to reflect on this as part of the focus group discussion.
- Once participants had accessed falls services few had any negative comments on the treatment provided except some issues with regard to the lack of reliable transport and the wish for longer-term follow-up in group settings.
Conclusions

This project provides information on patients’ perspectives of current falls services. It has revealed some important limitations of current practice and identified barriers to effective patient involvement, highlighting that there is sometimes inadequate discussion between patients and healthcare professionals about the results of assessments and treatment plans. This may lead to reduced adherence of patients to their individual intervention plans. We present recommendations derived from these perspectives, for the purpose of supporting the development of better services for falls and bone health in older people.

Recommendations

1. Letters of invitation to patients to attend falls clinics/services should reflect GPs’ support and include details explaining why this is happening and describe what benefits patients may get from attending the service.

2. Information about falls services for service users and the general public should be easily accessible and available in libraries, council offices/buildings as well as healthcare settings. The style and content of the information should be written in plain English, with adequate sized text and contain easily digestible information and useful contact details.

3. Local referral pathways and the criteria for recommending specific components of the falls service, such as exercise programmes should be easily accessible to healthcare professionals, and include contact details.

4. Providers should consider renaming falls services to emphasise the priorities of potential service users, which are usually the preservation of mobility and functional independence.

5. Patients should be involved in agreeing their individualised management plan, based on clarification through discussion of how specific risks can be reduced. Management plans should be based on a discussion of risk assessment results, patients own priorities for outcomes and the drawbacks as well as the potential safety benefits of activity modification or limitation. Once a management plan has been agreed, everyone involved in its delivery should work towards these agreed goals.

6. A friendly environment which promotes individual and group discussion and sharing of experiences between attendees is likely to favourably impact on uptake and adherence and therefore the effectiveness of falls and bone health prevention programmes.

7. Healthcare professionals should also explore the psychological impact of the fall (including the fear of falling) and incorporate this in individual treatment plans.

8. Follow-up should include exploring patients’ experience of the service, highlighting any unmet needs and facilitating patients’ to participate in long term exercise interventions.

9. Service providers should ensure reliable transport arrangements are in place to enable older and less mobile people to attend services.

Next Steps

The information provided by this project will be used to:

- Develop a pilot falls prevention experience audit tool, designed for local or national use.

- Produce a best practice toolkit to support local services obtain patients’ views through focus groups.

- Develop and pilot a patient-centred information/advice leaflet focusing on the aspects of falls and bone health services important to enable patients to become partners in their treatment and falls prevention plans.
Background

The importance of falls and fracture services

In the United Kingdom (UK), 28–33% of the population over 65 years, and 32–42% of the population over 75 years will fall each year (Masud and Morris, 2002). The associated mortality and morbidity from a fall is high. This includes physiological and psychological stress as well as physical injury, threatening functional independence and resulting in reduced health-related quality of life. The commonest serious injury from a fall is hip fracture, which affects approximately 60,000 people per year in the UK, and costs the National Health Service (NHS) approximately £1.7 billion and results in up to 14,000 deaths. In 2001 the National Service Framework for Older People (NSFOP) set out a model for service provision for falls and bone health. The NSFOP required all local health and social services to have an integrated falls service in place by April 2005.

Appropriate attention to primary and secondary prevention, including treatment to improve bone health can reduce the incidence of falls and associated morbidity and help maintain independence (NICE, CG21, 2004). In a recent review of progress - A Recipe for Care-Not a Single Ingredient (Department of Health (DH) 2007), the DH national clinical director for older people, Professor Ian Philp, commenting on patchy progress made to date, emphasised that putting in place fully integrated falls prevention services could prevent up to 400 hip fractures annually in each strategic health authority.

Mobility problems which can result in falls, and osteoporosis which increases the chance of a fracture, are long term conditions affecting many older people, some of whom have a range of other health problems. A major component of preserving well-being and independence is to promote healthy life choices and physical activity by older people. The key actions to address this are incorporated in the NSFOP standards, specifically the provision of advice, and the agreement with the patient of a treatment plan, including where appropriate the invitation to participate in an exercise programme. Since falls services are fairly new, there is limited experience of how best to do these things: thus patient feedback is required to help local services develop effectively. This approach is based on the conviction that involving patients in decisions about their own healthcare will improve the services they receive and the benefit they derive from them. The need for patient feedback is specifically highlighted in the NSFOP and other relevant health policies.

The series of audits

This project, which focuses on patient information and involvement and key concerns of patients as users of current falls services, is part of an ongoing series of audits of services for falls and bone health in older people. The audits are being conducted by the Clinical Effectiveness and Evaluation Unit (CEEU) within the Clinical Standards Department of the Royal College of Physicians (RCP) of London and have been commissioned by the Healthcare Commission.

The first audit, in 2005, was the national audit of the organisation of the services (RCP 2006), based on the NSFOP standards and the National Institute for Health and Clinical Excellence (NICE) Guidelines on Falls (NICE, CG 21, 2004). The audit covered commissioning and service provision, whether hospital based or in the community, such as organisational structures, people and processes (care pathways and protocols, assessments and referral systems) for the care of all older people who had fallen. The audit included questions about whether the services had arrangements for the provision of oral and written information and advice to service users about lifestyle, medication and environmental issues, in appropriate languages. It also included questions on treatment planning including the availability of a range of therapeutic exercise options. Audit information was returned from 90% of acute trusts, 74% of which stated they had an integrated falls and bone health service, 93% stating that treatment plans were discussed and agreed with individual patients, and 80% that there was provision to give a range of lifestyle advice, although the audit did not get detail on how
this advice was provided. Only 50% of services had arrangements to obtain user feedback on their service provision.

The second audit (RCP 2007) investigated the clinical care received by individual patients. This time the focus was on the clinical management and secondary prevention received by a sample of patients who had attended a hospital between October 2006 and January 2007 having sustained a fragility fracture, twenty of the hip and forty of other bones. For all 60 patients, this included auditing the details of subsequent assessment and interventions designed to prevent future falls and fractures. The audit standards were based strictly on the NSFOP, NICE guidance on falls (NICE, CG21, 2004) and NICE Technology Appraisal Guidance on Bisphosphonates (alendronate, etidronate, risedronate), selective oestrogen receptor modulators (raloxifene) and parathyroid hormone (teriparatide) for the secondary prevention of osteoporotic fragility fractures in post menopausal women, (NICE, TAG 87, 2005). Against these standards, this 2007 audit showed an unacceptable degree of variation across the NHS, with an inadequate level of service received by patients in many local health services in hospital care and by most patients regarding subsequent preventive services.

Why seek older peoples’ views?

In the introduction to the Department of Health’s white paper on further development of community based healthcare services, “Our health, our care, our say”, (2006) it was emphasised that changes in the way services are provided needed to be informed by the findings of the Citizens’ Summit in Spring of 2007. This was summarised as follows:

- People will be helped in their goal to remain healthy and independent.
- People will have real choices and greater access to both health and social care.
- Far more services will be delivered, safely and effectively, in the community or at home.
- Services will be integrated, built round the needs of individuals and not service providers, promoting independence and choice.
- Long-standing inequalities in access and care will be tackled.

Older people need to be supported to be able to play their full part as partners in the management of common long term conditions, such as reduced mobility, falls and osteoporosis. Health behavioural change theory suggests that provision of information is important but on its own is not sufficient to alter health-related behaviours. Individuals need support to appreciate the relevance of the information to them, be motivated to alter their future health and be able to identify and overcome obstacles to the intended change in lifestyle. This requires a patient centred approach to information provision and to treatment planning. NICE CG 21 includes guidance that individuals at risk of falling, and their carers, should be offered information orally and in writing about what measures they can take to prevent further falls. The second clinical audit showed that clinical notes rarely recorded any evidence of this happening in practice (overall: 10% verbal, 6% written) (RCP 2007). This might represent under-recording of good practice, but documentation of targeted (individualised) intervention plans being agreed with patients was also low (9% overall).

Since the audit consisted of retrospective notes review, it could not elicit patients’ views. Hence the development of this project to gather patient’s experiences and opinions of the services they received, and their attitudes and beliefs about what seemed important.

This project was jointly funded by the Healthcare Commission and Help the Aged. Help the Aged have a longstanding commitment to promoting healthy active ageing and to involving older people as advocates in service development. The work benefited from the findings of previous studies funded by Help the Aged about older peoples’ perceptions about mobility and falls.
Aims and Objectives

Aims
The aim of this project was to elicit information about the views and experiences of patients to help develop recommendations to support falls service providers nationally on how best to work with patients as partners in their treatment. The scope was to include:

- optimising uptake and adherence to exercise programmes, (using the evidence base)
- provision of information
- gathering feedback about services

Project objectives
There were 5 key project objectives; the first two were to be met by reporting on the information from the focus groups participants whilst the other three would involve future work to follow on from the report.

1. Explore the aspects of falls services current patients consider most important for providing feedback about and how this can be most effectively achieved.
2. Provide a list of recommendations for service providers on how this and related aspects of services can be improved.

Then, using insights and information obtained from participants to develop:

3. A patient falls rehabilitation experience tool with audit questions on these aspects of practice, suitable for use locally or in a subsequent national audit, and based on patients’ rather than providers’ perspectives.
4. A patient-centred information and advice leaflet focusing on the aspects of falls and bone health services important to enable patients to become partners in their treatment and falls prevention plans so as to improve uptake and adherence of the relevant interventions.
5. Produce a best practice toolkit to support local services obtain patients’ views through focus groups.

This report forms the first key deliverable of the study. It outlines patients’ perspectives of current falls services, written with indications of how services can improve to reflect these perspectives. This information will now be used to achieve the remaining objectives.

Measurement of the project’s success

Process
- 65% of invited patients attend the focus groups (participation).
- Project stages and deliverables are delivered within timescale, and on budget.

Outcomes
- Discussion at the focus groups provides sufficient information to identify consistent themes likely to be transferable to falls services nationally.
- The discussions and analysis provide insight into the way successful services are organised /provided, which have the desired impact for older people.
- The key concerns/opinions of patients can be translated into a form which enables design of audit questions.
- The key deliverables above are completed.
Methods

Study Design
Patients’ knowledge and opinions on current falls services were investigated by carrying out a series of focus group discussions employing a grounded generative approach and undertaking a thematic analysis of the transcribed discussions. The intention was to hold 4 to 8 focus groups with 10 to 15 participants attending each group, thus aiming for an overall sample of between 40 and 120 participants.

Focus groups was the method chosen as there was insufficient information available on the important perceptions, opinions and concerns of patients who have attended falls and bone health services, and therefore closed questioning approaches such as could be achieved with postal questionnaires were unsuitable. The use of focus groups meant access to a smaller number of patients who had been service users but the ability to gather information rich in depth reflecting in detail a range of concerns and perspectives.

Governance and Ethics Approval
The audit was managed by the CEEU, Royal College of Physicians (RCP), London, and its conduct was accountable to the Healthcare Commission. A multi-disciplinary advisory sub-group was established, which included two members of the public involvement group at the RCP (Appendix 1). This sub-group reported to the national falls and bone health audit steering group. The associate director of the national falls and bone health audit provided clinical leadership. A project officer was employed to facilitate the focus groups and undertake the thematic analysis.

The information governance advisor at the Healthcare Commission was contacted to ensure that the method of patient recruitment met their requirements and would not need approval from the Patient Information Advisory Group (PIAG)\(^1\). The advice was that NHS trusts hold patient data on falls patients and could legitimately contact them about assisting the development of such services. Having done so, patients could then decide without duress, and if they wanted to participate they could reply, supplying their contact details, directly to the CEEU via a prepaid envelope. This meant that the CEEU did not have access to personal details until the patient had supplied them by agreeing to be contacted.

The project proposal was sent to the chair of a local research and ethics committee for their opinion on whether the project required ethical approval. This was returned with the statement that under NHS research governance this project did not require ethical approval but it was advised that the local clinical governance offices of participating sites should be contacted to discuss what local arrangements or advice applies to this type of project (Appendix 2).

Site Recruitment
The aim was to recruit patients to the study who represented a wide geographical spread. Initially 6 areas within England were identified, and then later expanded to 10. In each area acute NHS trusts were invited to participate by letters to their chief executive, the previous 2007 falls audit leads, and the clinical audit or effectiveness manager. The selected acute hospital trusts represented a range of performance, based on the 2005 organisational audit scores. The trusts were asked to provide contact details of a lead if they chose to participate in the recruitment. In a number of areas some aspects of the local falls service (especially the exercise groups) were managed by a primary care trust (PCT). In these cases invitation letters were also written to PCT chief executives and their clinical audit / effectiveness managers.

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\(^1\) The PIAG was established by the Department of Health to provide advice on issues of national significance involving the use of patient information and to oversee arrangements created under Section 60 of the Health and Social Care Act 2001. Its membership is drawn from patient groups, healthcare professionals and regulatory bodies.
Study Population
The study population was comprised of a sample of male and female participants aged 65 years of age or greater who had fallen and as a result were attending or had attended one of the participating falls services chosen from services which had participated in the previous round of national audits - 91% of trusts. Local leads for those audits were contacted for discussion on how and when to identify patients. Each site identified and invited a sample of 10 to 20 attendees or recent attendees within the falls service, restricting this to patients without significant cognitive impairment as this would compromise the patient’s ability to recall their treatment and be able to take part in a focus group. Therefore selection was up to the local site based on their knowledge of their patients based on these criteria.

Local clinical governance departments, specifically the patient and public involvement leads, were contacted to discuss the project.

In the first instance it was hoped to use only patients aged 65 years and above who met the same criteria used for inclusion in the 2007 national clinical audit (i.e. fallen and sustained a fragility fracture) but early during the recruitment process it became clear that this restriction would result in difficulty achieving the target numbers of participants for the focus groups. So, inclusion was broadened to include other falls service attendees, so they are more typical of falls services attendees generally. It was also decided to seek from among those expressing agreement to participate, a purposive sample representative of attendees generally in terms of gender, ethnicity, and age. Due to low participant numbers, it was not possible to achieve this.

Focus Group Recruitment
A staff information sheet which gave detailed information on the project was sent to each service provider which had expressed a wish to be involved in the study (Appendix 3). This information had been agreed with the project advisory sub-group (Appendix 1). The information was personalised to include relevant local detail, so that it was clear that the project had senior management support locally.

In addition an invite letter to participants (Appendix 4), a reply letter (Appendix 5) and a participants’ information sheet (Appendix 6), which outlined the details of the project and what it would involve if people took part, were drafted, reviewed and finalised by the project advisory sub-group. These were sent to participating sites as hard copies or pdf documents (whatever the site preferred) so that they would be available to give to the patients either directly or in the post with the invite letter. Pre-paid envelopes were also provided.

Local trust staff sent invite letters on their headed note paper to the selected patients, along with information about the project. If the patients wanted to take part, they were requested to send the reply letter directly to the CEEU in the pre-paid envelope. Patients were made aware that carers could also attend the focus group with the patient if needed.

Difficulties and solutions
Recruitment of local sites and the focus group participants was slow compared to the initial project timeframe and required a revision of recruitment methods. At the advisory sub-group meeting in December 2007, the following changes to the recruitment method were agreed and subsequently approved by the project executive meeting in January 2008.

Under the revised recruitment procedure sites were asked to give (rather than send) invite letters and the project information to current attendees at their falls prevention exercise classes. The incentive of a gift voucher was also added. Patients’ replies were to be returned direct to the local service. Once 5 or more patients had agreed to participate, the focus group was held at a local site, usually after the exercise class. None of the local staff attended the focus group, enabling participants to talk freely amongst themselves and to the focus group facilitator.
Organisation of Focus Groups

Venues

The project officer provided information about arrangements and potential venues for focus groups. A focus group check list was drawn up from this information (Appendix 7). Once sites had agreed to participate and were recruiting participants, neutral but well known venues in the local area such as community halls, libraries and town halls were contacted about availability of rooms. The venues thought to provide the most suitable arrangements for the patient group were chosen and advice was also sought from the local lead in making these arrangements.

Despite the venue checklist and clarifying access by car, disabled access and availability of toilets, it became apparent after holding a couple of focus groups that these facilities were not always appropriate for older people who had fallen. Lifts were available but these were often designed for wheelchair users. Older people using sticks or frames found the lifts unsatisfactory and were reluctant to use them. Ground level rooms were sometimes a long way from the front entrance and often toilets were too far away from the focus group room for people who could not walk quickly. Disabled access could also mean a long graduated slope to the front or side entrance which was not liked for people with sticks or walking frames. Thus the venue checklist was altered (Appendix 8). However, even with the new checklist problems were still encountered, for example, chairs often had no arms so that the people had difficulty in getting up from sitting.

How focus groups were arranged

All the focus group arrangements were confirmed by letter and then by phone one or two days before: still several participants were unable to attend, often cancelling at the last minute. Due to the timing of receiving the necessary funding, the focus groups took place during the winter months and some of the cancellations were due to inclement weather. As a result some of the focus groups had to be postponed and rescheduled (Table 1).

Table 1: List of Focus Groups held

<table>
<thead>
<tr>
<th>Number</th>
<th>Focus group venue</th>
<th>Postponed</th>
<th>Date Held</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Isleworth PILOT but data included in analyses</td>
<td>No</td>
<td>26th November 2007</td>
</tr>
<tr>
<td></td>
<td>Birmingham</td>
<td>Yes on 11th December Not rescheduled</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Derby</td>
<td>No</td>
<td>12th December 2007</td>
</tr>
<tr>
<td>3</td>
<td>Stockport</td>
<td>Yes, once 28th November</td>
<td>14th December 2007</td>
</tr>
<tr>
<td>4</td>
<td>Cambridge</td>
<td>Yes, once 30th November</td>
<td>10th January 2008</td>
</tr>
<tr>
<td>5</td>
<td>Streatham</td>
<td>No</td>
<td>18th February 2008</td>
</tr>
<tr>
<td>6</td>
<td>Poole</td>
<td>No</td>
<td>19th February 2008</td>
</tr>
<tr>
<td>7</td>
<td>Margate</td>
<td>No</td>
<td>4th March 2008</td>
</tr>
<tr>
<td>8</td>
<td>Grimsby</td>
<td>Yes, twice on 5th December and 7th January</td>
<td>7th March 2008</td>
</tr>
<tr>
<td>9</td>
<td>Bath</td>
<td>No</td>
<td>26th March 2008</td>
</tr>
<tr>
<td>Total</td>
<td>9 Focus groups</td>
<td>5 postponed, 1 not rescheduled</td>
<td></td>
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Focus Group Topic Guide
A literature review was undertaken to review guidance regarding the content for the questions to be used in the focus group topic guide. From this, and the information within the NSF and NICE guidelines, questions were devised with input from the project advisory sub-group members (Appendix 9). These questions were used as a pilot in the first focus group. Topics covered in the guide included access to falls services, what discussions they had had with staff, what treatment plans were put together for them, how they were put together, what information they were given, how useful it was and their general experiences of the falls services.

How focus groups were run (facilitated)
A minimum of two people helped run each focus group. One was the facilitator, usually the project officer and the other person was usually a member of the project sub-group or someone within the CEEU. Before the focus group commenced, all participants were informed that the discussion would be recorded but that they would not be individually identified in any of the focus group outputs. In this report they are given pseudonyms, often chosen by the participants themselves. Each participant was asked to speak clearly (to optimise transcription), to respect one another’s point of view and to allow all to speak their piece.

The topic guide was used to initiate and facilitate discussions but additional relevant areas for discussion were encouraged if they arose. After the session had been completed participants were helped to their transport to get them home. Taxis and travel were paid for by the CEEU. Sometimes participants needed to be collected and taken home by a member of the CEEU team. Once the focus group had been held the local falls lead was contacted to let them know that it had been completed, with confirmation that each site and each participant would be sent a summary of the focus group themes.

Thematic analysis
The audit recordings of the focus groups were transcribed verbatim, utilising standard transcription conventions. Both the audio file and the transcript were sent to the project officer. The transcripts were then checked for accuracy, requiring checking of transcripts against the audio-recorded files, resulting in differentiation between speakers and in addition amending any discrepancies noted. A thematic analysis was then performed, involving repeated reading of the transcripts, and identification of progressively more abstract categories (Joffe and Yardley 2004). The initial coding was completed by the project officer using the data management software MaxQDA2, resulting in the identification of seven initial codes (Appendix 10).

Once the data had been coded utilising this initial framework, the codes along with the coded transcript excerpts were examined in further detail. Additional notes were taken to outline and describe the coding framework and, as a result, several of the codes were merged and later further refined based on additional analysis. The themes which emerged in the second round of analysis (i.e. identification of initial themes), followed by a second iteration of the themes are identified in Appendix 10. These emerging themes were described and illustrated in a draft report, and further illustrated with data from the focus groups. Further interpretation by a researcher (CB) incorporating feedback from the project advisory group resulted in a fourth iteration of the themes, presented within this report (Appendix 10).

The resulting themes were:

I: Access to falls services

II: Falls services: assessment, intervention, evaluation and follow-up

III: Interpretations of falls: causes, consequences and impact

IV: Perceived benefits and critiques of falls services
Findings

Patient Characteristics
Nine focus group discussions took place between November 2007 and March 2008, including 40 participants and 2 carers from a combination of 11 acute and 7 primary care trusts. Participating trusts are outlined in Appendix 11. The participants covered 10 geographical areas in England. Focus group numbers ranged from 1 to 7 (Table 2). Three-quarters of the participants were female and just over 80 per cent (27 out of 33) were 75 years or older (using provided age only). 95% (38) were white British.

Forty out of 47 (85%) people who agreed to attend an identified focus group (had knowledge of date, time and venue) actually did so. Of the 7 who did not attend, two did not like the venue, one had an appointment which could not be cancelled, one had an unscheduled utilities visit, one was unwell, and two identified no reason. It was not possible to estimate the overall number of people who were actually invited to take part as sites were asked to identify and invite 10 to 20 people (dependent on whether there was one or more hospital trust involved) to participate in the focus groups and when the response rate from this sample was not high enough, further patients were identified and invited.

Table 2: Focus Group Characteristics

<table>
<thead>
<tr>
<th>Date held</th>
<th>Numbers attended</th>
<th>Sex and age groups of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td></td>
<td>Under 75</td>
<td>75 or over</td>
</tr>
<tr>
<td>2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26th November</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>12th December</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>14th December</td>
<td>1 (NB: 2 cancelled on the day, 1 night before)</td>
<td>0</td>
</tr>
<tr>
<td>2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10th January</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>18th February</td>
<td>7</td>
<td>NB: 5 age unrecorded</td>
</tr>
<tr>
<td>19th February</td>
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</tr>
<tr>
<td>4th March</td>
<td>7 NB: 2 age unrecorded</td>
<td>2</td>
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<td>7th March</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>26th March</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>40</td>
<td>2</td>
</tr>
</tbody>
</table>

One man’s age was unknown
For six women, the age was unknown
Thematic Analysis

Each theme is presented in turn, and initially described, in order to identify the theme’s focus and parameters. Each theme is then systematically explored and key messages are highlighted, with each message being supported with excerpts from the focus groups (with use of pseudonyms and identification of focus group by a capital letter) and further explanation if required. Bulleted subheadings do not identify sub themes or codes but are used only to ease the reading of the complex narrative. The importance of the theme was not quantified by the frequency with which it arose in discussion. Words such as ‘sometimes’ or ‘often’ are general impressions from the transcripts. Potential implications for the involvement of patients in the evaluation of falls services are then highlighted and a set of recommendations given.

I: Access to falls services

This theme addresses the means by which the focus group participants learnt about and accessed their local falls service. It includes participants’ and other health care professionals’ perceptions about falls services, both prior to, and following referral, and also the multiple ways in which people came to attend falls services.

- Participants were often unaware of falls services available.
  Participants and their friends were often unfamiliar with falls services and their first acquaintance with them was when they were invited to attend for the first time:

  Doreen: ‘I mean I didn’t even know there was a falls clinic in D.
  Rosemary: No, it’s the first time I’d heard about it.
  Edna: I had to explain to my friends, ’It’s the falls clinic, not the fool’s clinic!’ (D)

Other participants suggested that they only knew about the existence of such services through previous contact with hospital and rehabilitation services:

  Rusty: ‘Well I’ve known this place since 1988 because I used to come here and do physio.
  Facilitator: Okay, okay.
  Rusty: Yeah.
  Facilitator: And so did you ask to come back or did they refer you back?
  Rusty: I think I did mention here because I thought there would be something that they’d wanted us to exercise or something and I mentioned this place.’ (E)

- Participants sometimes thought that their GPs were unaware of the availability of falls services.
  Perhaps more worrying were the belief of some focus group participants that their GPs, who are one of the main sources of referrals to falls services, were also unaware of the services available in their local area:

  Susan: ‘It is new, very new. Well I presume it is because most people I’ve spoken to, they’re ‘What do you mean, falls clinic?’ and I’ve had to spell it in case they get the wrong one (laughs). Yeah, so I automatically spell it now because as I say I had these funny looks coming at me which I then realised well if I spell it (laughs)...but as I say I don’t know whether all the GPs have got that sort of information because my actual GP has never mentioned it. As I say it was this locum which I was very grateful for.’ (A)
• Participants were either given no information on falls services or too much. Some participants commented that knowledge about services would influence people’s behaviour in relation to seeking help, and suggested that sheer volume of information can militate against action:

Audrey (participant’s wife and carer): ‘Well, in the stroke unit there was a stand with an enormous number of different leaflets and also, I’m afraid I don’t remember the titles of these people, but we were given a folder in the hospital and it was added to when we left and I must admit I haven’t read it all completely through but the help is there, it’s just knowing where to … now and again, this falling down, in that area but people don’t know how to start looking for help. We were lucky.’ (H)

• Route of referral to falls services was varied with some participants being unaware of how they got referred and it was unclear whether the referring healthcare professional had discussed the potential benefits of the service with them.

Focus group participants suggested that referral to falls services were made by a number of different healthcare professionals, with some participants uncertain as to who had referred them. With such different routes of referral it was unclear from the focus group discussion whether the benefits of attending a falls clinic had been discussed with the patient at the point when the referral was made. Some participants suggested that GPs were one source of referral, as a result of one of their regular visits. Several participants also mentioned accessing services via locums, seconded GPs, hospitals, physiotherapists, rehabilitation services or as a result of an emergency home visit:

Gladys: ‘It was on a Sunday and we had the emergency doctor out and he said … I was telling him about the falls and he said ‘Have you ever been to the falls clinic?’ I said ‘I’ve never heard of it’, so he said ‘You’ve had a lot of falls and they should have sent you’. He said ‘You’ll be assessed by a lot of different people. So’, he said ‘I’ll get in touch with your doctor’, which he did and then I went to the clinic and it’s gone on from there.’ (B)

Facilitator: ‘Right so was it your GP that recommended you go to the falls clinic or was it the hospital?

Audrey (invited participant Harry’s wife): No I think it was through the stroke clinic.’ (H)

Perhaps of more concern were those who were not aware how referral took place:

Facilitator: ‘OK, so how did you come to be involved at (the falls clinic)?
Julia: I’m not sure.
Facilitator: You’re not sure?
Julia: I think the doctor …
Facilitator: OK and this is your GP?
Julia: ‘Yeah.’ (A)

Desmond: ‘Well, I didn’t, I didn’t know, you know, I thought if I’d, I assumed the (the hospital) had referred me. Well, (name of physiotherapist) who is one of the physios here,
he said that a chap called (name) had referred me here. But I mentioned that to the neurologist who’s been treating me and he said he didn’t know the name so I don’t know.’ (E). And later: ‘By accident, I think. I was in (hospital) being treated with a human immunoglobulin for my (condition) and I think I must have come to the attention of the physios there because I don’t get around very easily and someone recommended me here because I go … when I got home from the hospital, I got a letter asking me to come here.’ (E)

- Referral was sometimes perceived as a chance event rather than a predictable event which had occurred as a direct result of either experiencing a fall or being at increased risk of falling. Participants appeared to be referred to the service at different points along the patient journey. In some cases, participants were referred before falling, as a preventative measure, whilst others attended the fall clinic after one or more falls of varying severity. Some participants felt that their referral to a falls clinic was more often by chance and considered themselves lucky if they got access to the right services:

  Roseanna: ‘Well I found a lovely young GP, but she was only there on a six month secondment just out of hospital, that was this time last year and she sent me to the falls clinic at the local hospital and she was the only one really interested in my falls.’ (C)

- Referral to a falls clinic after a participant had suffered a fall was sometimes delayed. Some participants felt that it took too long to get referred to the right services:

  Edna: ‘… I’m on other medication for the pain but not for that, but I felt that there was a gap in the net there, somehow, that I did the bone density but then nothing, nothing happened for several months, and then, eventually, eventually (the physiotherapist-name) came and then she couldn’t do them because I was in pain, so I’ve lost six months, I expect, of when I could have been doing some exercises and I’m gradually going down.’ (D)

  Doreen: ‘Well I got referred by my GP because he was fed up looking at me black and blue.’ (D)

  Reg: ‘… they said that they would get me into the falls clinic because with my walking I’m a bit like that, but they forgot all about it until six months ago when I broke my wrist, and I came up here and they said ‘Oh dear, we should have had you up here about three years ago.’ (G)

  Edna: ‘Well, as I said, I fell through the gap somehow or other because my last contact was when I broke my wrist in the hospital and as I say, I don’t know whether it was Help the Aged or whether it was Age Concern, this lady came along, after that they said that you have to go to the falls clinic but nothing happened….’, ‘it’s ten months since I fell, when I went to see Dr (name) it was ten months, but I did get referred to Dr (name), at least I got that, but there is nothing much they can do for me except eventually (the physiotherapist)
came to see me through my GP and she said, ‘You really should’, and I thought, I said, ‘Well, yes but nothing’s happened’, so she said, ‘Oh well I’ll write urgently for them to come’, and (physiotherapist) did come and see me.’

• Some participants were confused over the name of “falls clinic” and felt that the name was not recognised well by patients. Several focus group members appeared confused about the name of the service:

  Facilitator: ‘… Oh, that’s interesting. What about you?
  Ruby: Well no this is my query, on this letter, what is the falls clinic?
  Facilitator: Did you …?
  Ruby: I mean I’ve broken my wrist twice as you can see but what do you mean by falls clinic?
  Facilitator: Did you go to see Dr (name), at (name of hospital)? You didn’t?
  Ruby: ‘No.’

Others appeared confused by the different titles given to the various services, and perhaps were unclear about their function:

  Norma: ‘… and then I went to rehab for six weeks. After that, I got notification, not straight away, from the falls clinic to go and visit. And I went along. Now it’s interesting to me that you have been offered a falls prevention course, I was never offered that.’

• Some participants felt that the name “falls clinic” was odd and off putting. Many of the participants suggested that the name – falls clinic – sounded odd and was misinterpreted:

  Joan: ‘Lots of people, when I’ve said that I’ve been to the falls clinic, they said ‘The what fools clinic? I said ‘No’. 
  Norma: I got that.
  Joan: Yes, so it’s about knowing that the service is out there as well.’

• Participants were concerned about not wanting to be a nuisance by asking for access to falls services. Participants were cautious of being too persistent about enquiring after such services as several perceived themselves to be a nuisance or wasting GP time. However some suggested that perhaps one way of getting access was by being more proactive, asking about the availability of falls services and perhaps taking someone with you for support:

  Susan: ‘I’d say ‘Well, go to your GP and ask’, because this falls clinic isn’t very well known, I’ve never heard of it until … and it wasn’t my actual GP, it was a locum who [put me onto it].’

  Roseanna: ‘What would I tell them to do? I’d tell them to take a daughter with you or a bossy niece (laughs).’
I: Access to falls services

Messages

- Participants were often unaware of falls services available.
- Participants sometimes thought that their GPs were not aware of falls services.
- Accessing timely and appropriate information about falls prevention services was sometimes difficult.
- Route of referral to falls services was varied with some participants being unaware of how they got referred, and it was unclear whether the referring healthcare professional had discussed the benefits of the service with them.
- Referral was sometimes perceived as a chance event rather than a predictable event which had occurred as a direct result of either experiencing a fall or being at increased risk of falling.
- Timely referral to a falls clinic after a participant had suffered a fall was a problem for some.
- Some participants were confused over the name of “falls clinic” and felt that the name was not recognised well by patients.
- Some participants felt that the name “falls clinic” was odd and off putting.
- Participants were concerned about not wanting to be a nuisance by asking for access to falls services.

Implications

- If patients do not have a clear understanding of why they were referred to a falls service and how they were likely to benefit, and if they do not feel that they were involved in the discussion or judgement about the referral, then their autonomy and/or commitment and/or adherence to treatment may be undermined.
- If they did not perceive their GP to be involved and supportive of their attendance at the falls service, this may reduce their commitment. Advice from GPs remains a powerful lever for patients’ behaviour.
- Delays between the index event (fall) and attendance at a falls service reduces face validity of their subsequent experience of the service and may undermine uptake and adherence, thereby reducing effectiveness.
- Falls services don’t seem clearly positioned in patients’ perceptions of the NHS structure of primary care and hospital services.
- The term “falls clinic” may be off-putting or confusing, reducing uptake or adherence.

Recommendations

1. Falls services should consider renaming to emphasise the mobility and functional independence aspects of the service.
2. Invitation letters to patients to attend clinics/services should have reference to GP’s support and include details as to why the referral is happening and what benefits patients are likely to get from the service.
3. Clear customer focused information about falls services should be provided to patients either directly such as the NICE ‘Information for the public’ leaflets or where they can access this information locally.
4. Local referral pathways and criteria to access falls service components including contact details should be displayed and easily accessible to all healthcare professionals.
5. Public awareness of falls prevention services should be enhanced through publicly available information.
II: Falls services: assessment, intervention, evaluation and follow-up

This theme focuses on the services which people received, detailing information about assessment, the content and components of the falls services which participants made use of, and also their subjective evaluation of these services, although the specific benefits of the falls services received are addressed in another theme. This section also addresses some concerns with transport to the services, and considers longer term follow-up, once the time limited programmes have been completed.

- Most participants, once referred to a falls clinic, received a thorough assessment. Participants reported having a range of assessments which were described as trying to identify the cause(s) of falls and/or to ensure fitness level and ability in order to participate in the falls prevention programmes. Health check-ups referred to sometimes by participants as an 'MOT' were described as very thorough:

  Facilitator: ‘Yeah, so what sort of test, you said a MOT but what… like can you tell me a bit more about that?
  Dolly: Well I had blood pressure, everything, you know ECG, sugar test, blood pressure, weight, waterworks, everything, the lot.
  Facilitator: Yeah, did anybody else have a similar experience or…?
  Connie: I had blood pressure.
  Facilitator: Yeah? Did you have any tests when you came? (G)

  Marianne: ‘We had blood pressure tests and we had a photograph taken (laughs) didn’t we?
  Joanne: What at the falls?
  Marianne: The falls clinic.
  Joanne: Oh yeah, yes, a right good MOT.
  Facilitator: So you said an MOT, so what exactly did they do?
  Joanne: Everything.
  Facilitator: Like… can you give me an example?
  Joanne: Oh goodness knows, your blood pressure for a start, they even ask you about your waterworks and everything like that. What else? You have an ECG; I had a chest x-ray because I said I’d got a bit of a cough.’ (B)

Other participants reported not having had any sort of initial assessment or further testing:

  DD: Not really, I was just told to do the exercises. I mean I’ve had the pain for a long time so mine is just… well it’s osteoporosis I’ve got in my arms and there’s not much they can do, exercise helps a bit …’ (G)
Participants were not always aware of the outcome of assessments or that they had the right to ask for results and it was unclear if healthcare professionals discussed risk assessments with patients and then used them to develop an individualised management plan. Although most participants had a thorough assessment, it was unclear whether the outcome of these assessments in terms of relevance to falls were reviewed and discussed with them and then used to develop an individualised management plan. One participant suggested that they had not discussed the outcome of their risk assessment and that they didn’t know they had a right to ask for the information:

Ruby: ‘… as I say, I would like to know the degree of the osteoporosis I have, but probably they can’t tell you that, anyway. I don’t know that’s something I don’t know. Do you know?
Facilitator: ‘You’ve had the scans so they should have the results of the scans available’
Ruby: ‘Could I ask to see those?’ (H)

The range of interventions experienced by participants reflects many of those recommended in the NICE 2004 guidelines e.g. strength and balance training, home hazard and safety intervention, medication review, dietary advice and where patients can seek further advice. The most frequently discussed intervention component of the falls programmes was exercises for strength and balance, with those who participated in such exercises being very eager to explain and discuss the various routines and the types of exercises in which they participated during their weekly or bi-weekly sessions:

Facilitator: ‘What sort of exercises do you do? Can you give me a description of what you do?
Marianne: Well we work with the Thera-Band, you know the elastic band and… (Over talking)… and it’s mostly pulling against yourself.
Joanne: Up to your chin, yeah, then we have breathing exercises, you know in and out, yeah.
Marianne: Yeah she puts us through a nice little routine doesn’t she?
Joanne: Yes she does, yes.’ (B)

Facilitator: ‘So what do you do at your exercise class?
May: Well we start by sitting on our chairs and you just do things like wriggling our toes and our hands and then you go onto doing exercises with your arms and throwing your legs one way and another and then of course the testing time comes when they say put the chairs back (laughs) and I have… for quite a long time I couldn’t let go of the back of the chair when I was doing that and I still can’t do a lot of the exercises where we stand up. Anything which involves very quick movements on the legs, I can’t cope with, I feel as if I’m falling over if I try them and that’s when I have to sit off for the time.’ (H)

Exercises were described as occurring within both groups and individually.
One participant with severe and complex health needs reported exercising in one-to-one physiotherapy/exercise sessions, rather than group sessions. They were also given information on how to complete the exercises on their own, outside of the programme:

Francis: ‘Yes. I had exercise as well. The nurse from… I had some exercise from here (F), I have treatment, lie on the bed, do some exercise, and they come in every day.’ (F)

Harry: ‘Yeah at the moment the exercises are taking place on my bed, that’s as far as we get and it’s much the sort of thing that you have, the starting off with the nice simple exercises, getting onto the leg swinging, getting on and off the bed and whatever…At the moment it’s one to one, we haven’t had any group exercise, I haven’t been involved in group exercises.’ (H)

Other components of interventions offered within the context of falls services included provision of assistive technology to help with daily activities. Participants noted that these additional pieces of equipment helped them to do things for themselves and to maintain some level of independence. One participant reported that additional equipment would help her ‘to stay in my own home and live to be 98, like my granny’. Other examples are included below:

Lewis: ‘Well I just said that the staff are proactive, they invite you in terms of ‘Would you like a walking frame?’ They’ve given me this thing on the bottom of that walking stick which has made a tremendous difference for me.’ (E)

Reg: ‘I’ve had another rail put up, up the stairs. I’ve had to have my chairs lifted up a couple of inches and arms on them, so I’ve had to have new chairs with arms on them. I’ve got a battery operated RC and I’ve had to have an orthopaedic bed for me neck and I have to sleep with three pillows, it’s bloody awkward in the morning, you slip right down.’ (G)

Facilitator: ‘Okay and this was somebody from the falls services that came out?
Marianne: This came through the falls clinic, yeah.
Facilitator: Okay so they do come out and do home assessment?
Joanne: Yes, she’s coming to my house too, about the bath.
Facilitator: Okay. Have you had anybody come to your home Gladys to sort of help you get some sort of aids or…?
Gladys: When I had my broken bones they did bring me a trolley to carry…’ (B)
Julia: ‘I’ve had handrails outside and inside and rails on the stairs, in the bathroom which I’m quite happy for…’ (A)

Other services provided within the context of falls services included dietary information, assistance with medications and information on accessing other potentially useful services, such as meal deliveries:
Facilitator: ‘Okay, good. So what sort of treatment then did you receive? You got exercises, what other treatment did you get?

Molly: Dietician one week.

Facilitator: Okay, and what did the dietician do?

Molly: Emphasising that you should be having five fruit or vegetables a day, for your health. We were weighed, we were told what our body mass was and whether it was within normal limits or not. Which is all interesting.

Joan: Yes, it was the same sort of thing as well. Yes. They were very, very good. They took an interest personally, I had that feeling, you know.

Molly: Well they had to begin with. They did come to your house, and they took me to where I had fallen down the stairs, and they wanted me to go down. (laughs) I wouldn’t go.

Facilitator: So the fall service did that for you, they came in and checked?

Molly: They did, so that they had seen my circumstances and seen exactly where the incident occurred.’ (F)

One participant described an event held by her local falls collaborative, involving active participation by older people:

Louise: ‘…they’ve just had a big day two weeks ago that we went to and all these stalls were there, it’s all to do with falls and they check the walking sticks, they check everything’

Facilitator: ‘Oh yes that sounds interesting’

Louise: ‘Yeah, and everybody got new slippers, if you took your old slippers in, you got a new pair of slippers as well.’ (H)

- Participants identified a small number of needs that were not currently met by the falls services and for which they had to seek alternative help. Some participants needed help with daily tasks such as gardening and cleaning that were not covered by any local services. Other participants also suggested they were no longer able to use public transport and alternative methods of transport had to be considered:

Rosanna: ‘…for getting help in the house, just a little bit of help like because I’m still getting dizzy when I climb and like my light fitting needs cleaning you know and things like that and in the ordinary days, two years ago I just climbed a ladder and cleaned it myself, take the shades off and brought them down and washed them and put them back up and changed the bulbs or cleaned them but I can’t do it now…So I got in to see young Dr… I’m trying to think of his name and I said to him ‘Doctor is there any chance you could get me some help?’ I said ‘I’m trying to get help with my cleaning…’(C)

Emily: ‘I don’t like getting on buses because I’ve had two near misses. They don’t let you sit down before they start off again and as they swing round to go to the traffic I’ve nearly fallen twice. So I’m not very happy about that, I’m still trying to get ‘Dial a Ride’.‘ (E)
Participant’s experiences of falls services were generally very positive, with social aspects and the role staff play predominating within accounts of their experiences. Participants enjoyed meeting individuals with similar health issues and similar levels of functional capacity in what was often described as a friendly and social setting. Individuals receiving visits from a physiotherapist reported having their therapist’s undivided attention and feeling well looked after:

Lewis: ‘But I’ve found that the first time I arrived, I think the group will confirm, that we were assessed very subtly and very efficiently and very professionally and at each subsequent visit we did that same set where we climbed the stairs and we walked between two cones here and then we have a separate room which was jolly good because I got used to that routine you see and then I was assessed, we were all assessed again, this well this was last week I think, we’d do the same set and so it’s very well organised and it’s well planned all through for the benefit of the patients…’ (E)

Joan: ‘… I suppose because we’re all in the same boat, and you can share your problems and worries. And the physiotherapist and occupational therapists that run it are very, they’re very helpful, and they say ‘Oh good, you’ve done it well!’ which strangely enough helps. So I must say that F have really… they’ve done me very proudly.’ (F)

George: ‘When I come along here and had… in 19, no, 2001 when I came along here I think on the first falls clinic, and seen Dr (name) and that, and I was surprised how well… you know, although you’re down, like when I was down on the floor, I had no chance in hell of getting up, but I managed to get to somewhere without hurting myself to get some help. And that is I think a very good thing, to be able to do that…’ (I)

Molly: ‘… If you were likely to wiggle about and look as if you were falling, there was always somebody near you. You weren’t left. And what impressed me mostly was that we were picked up by ambulance and taken up to (name) and on arrival everybody was smiling and happy, and they welcomed us in, even the office workers, you know, said hello. And we sat down round a table and had a cup of coffee to start with. And I thought, you know, it puts you at ease.

Joan: That’s what happened to me, too. They’re very good there. And of course, you’re not likely to fall then because there are all these bars and things. Most of the exercises are done so that you’re within reach of a bar or something, if you see what I mean. But I found it very good. I used to look forward to going there. (F)

May: ‘No on the whole I was quite pleased with my treatment. I was certainly well looked after at the (name) Clinic and I’ve very much appreciated the help at the exercise group’ (H)
Complaints regarding falls services included dissatisfaction with gaining access to certain services. Some individuals had specific complaints relating to the way in which needs for services are assessed, the basis on which services were provided and the explanations given to service users:

Rosanna: ‘Well, that’s what I went to my GP for because then Social Services ... Health and Social Welfare now as it is in (Name), said to me ‘Oh, you’ll have to get your doctor to write’, and that’s what I got out of my doctor. ‘It’s nothing to do with us, go back to them’, and they don’t want to know, they say ‘Well we come to see you and your house is always spotless’, so you know, do I have to live in a muck up before I get any help? But it shouldn’t be so.’

And later,

Rosanna: ‘I think the Health and Social Services as they call themselves now should be more expansive, I think that they should look at somebody who’s trying to live decently, who doesn’t want to sit in bingo all day .... But you know, that’s what I, I feel there’s that about it, that they should be more expansive, and that they are too expensive ...’ 

May: ‘The thing is, though, the times I have been taken to hospital when I’ve had one of these falls, either hit my knees or cut my head open or whatever, they never tell you anything when they’ve seen you. I’m not saying they’re not good to you while you’re in there, but they just say ‘Oh, you can go home, now’. There’s no explanations, no nothing.’

Participants regretted the end of their falls prevention programme and suggested that they needed longer-term follow-up to encourage them to continue prevention measures. Some participants reported some opportunity to keep ‘topped up’ by re-visiting the programme, however, most participants saw the end of their falls prevention programme as the end of their falls service experience:

Vera: ‘I think it’s a shame that there’s no follow-up. You get eight weeks here and then…
Rusty: It’s dead!
Vera: Suddenly you’re discharged and you’ve got nowhere to go, no exercises. I think it’s a shame that there isn’t a follow-up.’

Facilitator: ‘Yes, so have you just finished your group? Have you just finished your sessions?
Phillip: No, finished in December.
Facilitator: And have you had any follow up since then?
Phillip: Erm, no. I think we had one phone call saying they’d be in touch with us later on, or something of the sort, but no more.’
Barbara: ‘Well, I could have gone on a bit longer, quite honestly, yes. It would have been nice. But then, because as I say, you can’t be greedy, because they’ve got waiting lists, haven’t they?’

Facilitator: Why was that, you wanted to go on longer? Was it for the social thing?

Barbara: Yes, and because you did the exercises, you see, didn’t you? And people tend not to do them when they’re …. Like all these things, isn’t it? It’s like diets, isn’t it; you tend (to) just drift off. I am persevering and trying, but some days I think ‘Oh, I haven’t done my exercises.’ (I)

Participants reinforced the benefits of having continuous support, and some hinted at how the benefits of the falls service intervention which they had received might be sustained:

Susan: ‘And now we’re both carrying on to, but separate, to our physio which has been a great help really, to be able to carry straight on, because you haven’t sort of lapsed in between, you’ve carried on doing your exercises.’ (A)

Joanne: ‘What are we going to do after ten weeks?!
Marianne: I don’t know! (Laughs)
Joanne: We’ll have to meet up again.
Marianne: Yeah. We’ll have to join a gym, won’t we?’ (B)
II: Falls services: assessment, intervention, evaluation and follow-up

Messages

- Most participants who attended a falls clinic reported having received a thorough assessment.
- Participants were not always aware of the outcome of the assessments, particularly in terms of risk of future falls.
- Participants were not always aware they had the right to ask for results of the assessments.
- It was unclear if the outcome of the assessment was consistently discussed and used to develop an individualised management plan.
- The range of interventions experienced by participants reflects many of those recommended in the NICE 2004 guidelines e.g. strength and balance training, home hazard and safety intervention, medication review, dietary advice and where patients can seek further advice.
- Participants identified a small number of needs that were not currently met by the falls services for which they had to seek alternative help.
- Participants' experience of falls services were generally very positive, with social aspects and the role staff play predominating in their accounts.
- Complaints regarding falls services included dissatisfaction with gaining access to certain services.
- Participants regretted the end of their falls prevention programme and suggested that they needed longer-term follow-up to encourage them to continue prevention measures.

Implications

- Without an agreed management plan discussed with the patient based on the outcomes of a multi-factorial risk assessment, patient's sense of control and subsequent uptake and adherence with interventions could be compromised.
- Inability to access services could result in dissatisfaction or poor adherence to interventions.
- Lack of longer-term follow-up of prevention programmes is likely to impact negatively on long term effectiveness.

Recommendations

1. Patients should always be involved in agreeing an individualised management plan, based on discussion of risk assessment results and patients own priorities for outcomes (i.e. their own balance of concern regarding risks and independence).
2. Patients require that these management plans be written with explanation of why and how risks can be reduced.
3. Follow-up should include exploring patients’ desire to continue exercise interventions over the long-term and facilitating this where possible.
4. Attention should be paid to ensuring easy access to falls prevention services.
III: Interpretations of falls - causes, consequences and impact

This theme addresses the subjective interpretations and understanding about falls recounted by the focus group participants. It includes participants’ articulation about the causes of falling in older people, some of the perceived consequences of falling, and highlights potential implications of these representations for treatment or intervention.

- Most participants had a view on what they thought had caused their fall and whether this could be prevented.

Most of the participants had experienced a fall, with a large number having experienced multiple falls. Participants’ explanations about how and why falls happen appeared important in making sense of individual experiences of falling. Although all focus group members had participated in falls services, their accounts interestingly reflected different perspectives about the degree to which falls could be predicted or prevented:

Walter: ‘…I had two little dizzy periods before the fall where I sort of went to fall and realised I was going and managed to grab onto something twice and then the third time I went over backwards and as I say it’s lucky the bed was behind me, I ended up on the bed with my legs up above my head and didn’t know how I’d got there.’ (A)

Ava: ‘I think they can diagnose you as being liable to fall but they cannot prevent you from falling unless you build up your muscle strength, that’s the only way they can guarantee any stability.’ (D)

- Participants suggested a number of reasons for their falls including physiological, physical, environmental, behavioural and cognitive factors.

An example of how an environmental factor played a part in a fall:

Ruby: ‘…when I fell in the garden the second time and broke my wrist going down to hang the washing out, it took me a long while before I could go down the garden again, you have to make yourself don’t you?
Facilitator: You do, it’s a bit like falling off a bike…
Ruby: Yes and I’m very aware now when I’m walking, because footpaths are so dangerous…’ (H)

Many people spoke about a loss of concentration, or a distraction as being a precursor to a fall. The next two examples identify cognitive factors as creating potential risks. The first example illustrates how a loss of attention can cause relatively minor problems to have disastrous consequences:

Doreen: ‘…with this nerve which is going right down to my toes that has caused my right foot not to be picked up properly and so if there’s a slight discrepancy at the level, unless you keep on the ball, if you’re talking to somebody or allow yourself to drift you can hit it and feel yourself go, and fortunately I haven’t but I noticed it even yesterday getting out of the car, our drive slightly rises to one side, I nearly went and I thought, ‘Oh God, think, think, think’, you know?’ (D)
Ava: ‘Do you find if you’ve got to keep your mind on the ball…'

Doreen: ‘I have to keep my mind. The only time I did fall I was in a terrible rush and I wasn’t thinking, I wasn’t looking and down I went.’

Edna: ‘Yes, I find that too.

Ava: ‘You can’t drift off, you’ve got to concentrate.’ (D)

The next example illustrates how behavioural facts are perceived as a risk of falling. Several participants describe doing something ‘silly’ or ‘naughty’ immediately prior to their fall, having either acted against advice they had been given, or their error having been pointed out subsequently to them, for example by partner or family:

George: ‘If you’re going to do something silly, you say to yourself ‘Well, what a fool I am’, I mean, I’ve actually fallen down from being a fool, and I’ll admit that.’ (I)

Some participants were unable to identify a reason for their fall, or viewed falling as inevitable, often as a consequence of ageing:

Reg: ‘Well it’s only because your balances go, has just gone, you know there’s nothing you can do about it. They told me when I came back from (name) to G…’ (G)

Participants suggested that doctors did not discuss any medical reasons why they might be more at risk of falling even after risk assessments had been completed. All focus group participants had experienced one or more assessments in relation to their fall, and the vast majority had participated in interventions designed to reduce their falls risk, such as exercises or home visits. It seems that, contrary to expectations, their individual risk assessment was not discussed with them and therefore there is likely to be a disconnection between the accounts of older participants and the causal explanation for their fall, and the activities in which they were subsequently asked to participate in order to reduce their personal falls risk:


Facilitator: So did anybody have their falls explained? Did anybody say this is why you’re falling, at the clinic? Anybody?

Norma: Nobody seems to know.

Molly: No. Everybody seems to be in the dark completely about how it happens, and why. I thought it was just an age thing you see …’ (F)

Some participants found the experience of falling a very frightening one. One of the most compelling aspects of the focus groups was the alarming and frightening nature of people’s own falls, and the subsequent fear or anxiety experienced:

Louise: ‘… early hours Saturday morning going down for a drink and I didn’t put the light on as I entered the kitchen and just went and hit my face on the work surface and then hit my leg on something else and I couldn’t get up, I had to scream and scream for my husband and he didn’t hear me so in the end I had to wait until I got up and I ended up with a black eye and bruises all over my legs.’ (H)
Participants appreciated the chance to reflect on their experience or fear of falling as part of a group discussion; however it was unclear whether this had occurred with healthcare professionals. Participants were able to recount the circumstances of their falls in vivid detail. There was a sense in which the opportunity to talk about one's fall facilitated a connection with others in the group. Participants were able to share their ideas and concerns and provide support for one another. It was unclear however, how much of a chance participants had had to talk about their experience with falls service healthcare professionals.

Both the physical and emotional trauma of falls and falling were discussed in a great amount of detail. One participant, for example, described ‘terrible flashbacks’ of her falls. Falls were also described as making one ‘feels one’s age’. This anxiety or fear about falling was not just restricted to those who had experienced a fall:

Rosemary: ‘I think this is one of the worries that I’m frightened all the time, you see I haven’t had a fall and I’m frightened…

Edna: That you’re going to …

Rosemary: …and I’m thinking about it nearly all the time and this is one of the things I would be glad of help with, you know, how can you get rid of this fear that you have…’ (D)

One participant highlighted not only her emotional response to the falls she has experienced, but also her reliance on her husband to help right herself, highlighting the potential burden of falls for partners, spouses and carers:

Julia: ‘Well first, I always cry when I fall. I don’t know why but I always cry, my husband’s there to pick me up and I fell down the stairs last Sunday week so I’ve had quite a few falls but my husband’s there to pick me up.’ (A)

Participants had their own ways of managing when they had fallen and tried to prevent subsequent falls through behavioural change or removing home hazards. A variety of strategies for both managing a fall and preventing subsequent falls were mentioned, with some participants highlighting the importance of ‘common sense’:

Bill: ‘I think it’s more common sense myself. I think its common sense. You can only do what you can do under the circumstances at the time, and if you’ve got nothing to catch hold of and you’ve got to get up, sit still for a start, couple of minutes to see if you’ve broken anything. If you haven’t got anything, then just holler. Make a noise. Do anything. It’s good to have a little whistle around.’ (I)

Connie: They give all these … not to use slip mats and things like that.

Joan: Well you wouldn’t, would you, if you’ve got any sense but there you are, not many older people would probably have slip mats.

Reg: But they were the thing years ago weren’t they?

Joan: Yeah.

Facilitator: What was sorry?
Reg: Slip mats outside every door because you went upstairs, there was eight slip mats outside every door.

Joan: That's right yeah, they're the easiest thing in the world isn't they to…

Reg: Yeah. And they're a thing of the past.’ (G)

Other participants described modifying their behaviour in response to a fall, sometimes avoiding the circumstances in which the original fall occurred:

Gladys: But I’ve realised, and I think it is important, as soon as you feel tired, sit down for ten minutes or more, put your feet up and I’ve brought my little stool and as soon as I begin to feel tired now I don’t push myself, I just sit down and put my feet up and as soon as I feel steady again I get up and start and I do that time and time in the day but I can keep on longer that way, otherwise I’ve had it, you know, for the rest of the day if I push myself too far, I’ve just had it for the rest of the day.’ (B)

• Participant’s confidence was affected as a result of a fall and for some it becomes a constant battle to try and retain their independence. Some participants described their determination to continue with previous activities, mindful of the potential for loss of independence if they succumbed to fear:

Norma: ‘It’s a fact, almost every day. Almost every day I still fight for confidence to do things.

Facilitator: And what helps you get that confidence?

Norma: The feeling that you have to get out there or else you’re stuck in your flat, which is totally unacceptable for me, and so I have to grit my teeth and do things. But it’s not easy, and as I say, no one understands until they’ve been through the experience.’ (F)

This apparent distinction between relevant and appropriate changes in behaviour to accommodate such factors as fatigue, and undesirable changes resulting from activity avoidance due to anxiety was also raised by other participants:

Molly: ‘It really… you know I thought, well what can I do about this?

Norma: It’s time with trauma.

Molly: Yes.

Norma: And allowing yourself the time. And not pushing yourself in that particular way, but to push yourself to get better again.

Molly: Yes.’ (F)
III: Interpretations of falls - causes, consequences and impact

Messages

- Most participants had a view on what they thought had caused their fall and whether this could be prevented.
- Participants proposed a number of explanations for their falls including physiological, physical, environmental, behavioural and cognitive factors.
- Participants’ accounts suggested that doctors did not discuss with them the medical reasons for their fall or future risk of falling, even after the assessments had been completed.
- All participants found the experience of falling a very frightening one.
- Participants appreciated the chance to reflect on their experience or fear of falling as part of a group discussion: however it was unclear if this had occurred with healthcare professionals.
- Participants had their own ways of managing when they had fallen and tried to prevent subsequent falls through behavioural change or removing home hazards.
- Participants’ confidence was affected as a result of a fall and some described their ongoing ‘battle’ to retain their mobility confidence and independence.

Implications

- Fear of falling, if unexplored and unmanaged either within a group of people with similar experiences or with healthcare professionals, may predominate over any potential benefits of the physical interventions provided by the falls service.
- If patients’ own methods of self-managing risk are not explored and if necessary modified or enhanced by healthcare professionals and incorporated into management plans, then maladaptive responses to risk such as activity limitation may persist.
- Lack of information in the form of discussion between patients and healthcare professionals about any medical reasons for their fall could result in patients making inappropriate assumptions about why they are at increased risk of falling, such as ‘it’s just my age’ and subsequently adopt inappropriate self-management strategies, e.g. restrict activities. It may reduce uptake and adherence to prescribed interventions.

Recommendations

1. Healthcare professionals should also explore the psychological impact of the fall and include ways of managing this impact in individualised plans.
2. Group based discussion should be considered as an option to improve post event recovery.
3. Goal centred planning should incorporate discussion of the drawbacks as well as the potential safety benefits of activity modification/limitation.
4. Once a management plan has been agreed, the whole health and social care team should know and work towards these agreed goals.
IV: Perceived benefits and critiques of falls services

This theme addresses the perceived benefits of attending the falls services, including physical improvements, potential for screening and psychosocial advantages. Focus group members' feedback of their evaluation of services was also included within this theme. Although in general participants were very satisfied with the services they received, some specific critiques have been included within this theme.

- Participants on the whole found attendance at falls clinics to be a positive experience highlighting the physical and psychosocial benefits. Physical benefits such as increased muscle strength, better balance and improved coordination were highlighted. A number of participants identified how gains in these components of physical fitness also resulted in concurrent improvement in confidence:

  Desmond: ‘Yeah, my balance has definitely improved because instead of you know, for instance when I get out of bed I have to creep around and sometimes you know, stumble, fall over but now I stand up straight and I don’t look down, you know I look ahead and I find that, you know my balance is much improved.’ (E)

  Molly: ‘Erm, well, because you gain confidence if you’ve got something that can help you. For instance, I used my walking stick today because I’m not doing any walking around to speak of, but if I’m going out anywhere, for instance shopping, I’ve got a shopping trolley that’s got four wheels, which acts the same way as my walker you see. And I’ve got a great deal more confidence now. I wouldn’t go out without it because I do definitely sway from side to side, you know.’ (F)

  Julia: ‘How did I get the confidence? Facilitator: Yeah, yeah. Julia: Well only by going to (name) Hospital. Facilitator: And can you tell me why you’re glad you went and why it’s been helpful? Marianne: Because I can feel it’s helping me. Facilitator: Yeah so you see the results? Marianne: Yes and people, my family say that I look better as well. I seem to have a reason for living now, you know I’d lost the reason and there didn’t seem anything worth bothering about.’ (B)

Many participants also noted the social benefits of meeting on a regular basis:

  Marianne: ‘I’m glad I went. Facilitator: Yeah, you’re glad you went? Joanne: It’s been very helpful. Facilitator: And can you tell me why you’re glad you went and why it’s been helpful? Marianne: Because I can feel it’s helping me. Facilitator: Yeah so you see the results? Marianne: Yes and people, my family say that I look better as well. I seem to have a reason for living now, you know I’d lost the reason and there didn’t seem anything worth bothering about.’
Participants considered the thorough assessment of their health or ‘MOT’ an added benefit of attending a falls clinic. As described earlier, some focus group members appreciated the opportunity to have a thorough health screen, within the context of the falls service. Participants discussed the benefits of the overall health check that their service provided and some suggested that they helped to rule out other ailments or flag up an existing, but hidden condition:

Rosanna: ‘Yes if anybody was having falls and there was another falls clinic I’d say ‘Well you go’ because they may have found out that there was something wrong with my brain or they may have found out there was something or other wrong with me, you know something like that why I was falling, apart from the harassment of neighbours and the nervous strain of that. They may have found out like the girl that I saw, the woman I saw walking, shuffling through, they found her out, not recently but some time ago. I thought there was no after… at least I know that there’s nothing wrong with my brain.’ (C)

Walter: ‘Well we’re sort of going back a bit from what you were saying earlier, I mean the one bonus… one of the bonuses that’s come out of this is that as a result of all this testing, scans, x-rays I’ve had, they’ve found I’ve got a slight dysfunction in the liver enzyme or whatever it is so that’s being followed up which may not have been found, they don’t really know but they suspect it’s a result of the Statin I’ve been taking…’ (A)

Some participants felt that falls services made them more aware of potential hazards. Some participants noted how attendance at falls services improved their awareness about potential risks:

Lewis: ‘It makes me use my head, I think a lot more now when I’m faced with a flight of stairs… …and I sort of plan the ascent or descent, I look for secure points and I think very carefully about it. So it’s raised my awareness, awareness of my vulnerability.’ (E)

Although the clinical effectiveness of attendance at falls clinics would be a reduction in the incidence of falls, few participants mentioned this as one of their noted benefits of the service. Interestingly, few people mentioned a decrease in the number of falls they were experiencing as a consequence of attending the services. There was one notable exception:

Gladys: No it’s… I’ve not fallen since I’ve been going to the clinic, no I’ve staggered but I’ve been able to save myself but before I just went but I always seem to go round, you know as if I was trying to save myself. But no I certainly… but I do keep sticks around, I’ve got one in each room so that if anyone comes to the door I don’t get up quickly before and go without a stick, so I pick the stick up to go and if any of the family are there, as soon as I start to get up, they get the stick and give it me (laughs).’ (B)
Participants felt that the social environment of the falls services and the friendly professionalism of the staff impacted positively on their motivation to attend. The majority of participants commented on the friendly environment within their falls services which helped to establish relationships within the group and, more widely, within local communities. Participants praised the facilitators of local Falls Clinic, and one described their ability to communicate as ‘absolutely first class’. One participant highlighted the benefits of creating a mutually supportive and enjoyable setting for maximising outcomes for group members:

Lewis: ‘I think (Name) made a very good point actually that, and it comes down from the top, the people that run the classes generate a happy, pleasant atmosphere and in the two groups that I’ve been I’ve got to know individuals and we’ve chatted light-heartedly and of course the point I’m making is if you’ve got that sort of psychological approach then the treatment is better for you. If you’re happy, content and feel secure with the group and then you take part and hopefully the treatment is more effective.’ (E)

Few participants had any negative comments on falls services. Those that did suggested specific concerns including a lack of opportunity to cope with risk, issues around access to additional services or equipment, the gender composition of falls service groups, the lack of permanent staffing, problems with transport to and from the service and the desire for the programme to continue for longer. Whilst feedback about the experience of attending falls services was almost universally positive, specific questions were posed by the focus group facilitators to identify any issues or dissatisfaction which participants had noted. An example from one participant about the lack of opportunity to learn to cope with risk:

Phillip: ‘Well we just had started on the first course, having a demonstration of how to walk in effect, and that we did a little practice and practice with parallel bars and the like, but very much emphasis on not doing anything which might endanger, you’d have a fall then, up there too, for you to fall and patch you up. And I think that sometimes detracted from what they were doing. They were not putting you at any risks; you spent your time relatively inactively, which you could have been struggling on, possibly a little dangerously, in improving things under their watchful eye. But they even said that if you did fall down and hurt yourself, they wouldn’t get you up, they’d send for the ambulance service. And this… in other words, they were not prepared to take any risk with you, and I think overcoming one’s disability is there’s an element of risk taking, is impaired. And they seemed frightened that you would go to take any risk. But whether there’s a thing written where you should attend such a clinic, giving them carte blanche as it were to do what they think is good for you, rather than saying well don’t do this one if you think you’re in any danger of falling.’ (F)
Complaints regarding falls services included dissatisfaction with gaining access to certain services and lack of reliable transport to and from services. One specific area of complaint was the unreliable transport systems on which many relied, in order to attend the falls services:

Gladys: ‘No, no, I think the only problem has been getting there, for me.
Facilitator: Yeah and why has that been a problem, getting there?
Gladys: Well they book… sometimes they book the transport but sometimes they… they were very late one week, wasn’t I in getting there?
Joanne: Um.
Gladys: And before I started the treatment when I was going with the broken bones, they rang up in the morning and said ‘I’m sorry we’ve forgotten to book your transport’ but anyway (laughs) it were quite a while after this, a little ambulance came, it was a little one too and they did pick me up eventually. But I ring the day before now to make sure it’s booked…’ (B)

Comments were noted about the lack of opportunity to use the treadmill within the context of the falls clinic and previous concerns about the unreliability of transport to and from the service have already been noted in section I. One participant raised the issue of needing additional services over and above those already provided:

Facilitator: ‘Good. Okay, so what was difficult about the service? Was there something that you would like to change? What would you like to change about the service? No changes, Francis? No? Anybody?
Joan: Nothing at all.
Norma: I wish that they could have provided someone to come and walk with me more than once a week, because in the end I had to go out on my own, and I wasn’t yet out of trauma really. So I think that service could be improved, but I realise its difficult.’ (F)

As noted in section II several participants expressed a desire for their falls service groups to continue for longer, although appreciated the resource implications of this. Some interesting points were raised about the social relations and composition of the falls service groups, including the facilitators. One participant noted some concern about the gender imbalance:

Desmond: ‘Well for a start they were all very considerate and kind and did their, you know, did their best to involve us all. But my problem is that I was in a group of six and the other five were elderly ladies and they were coping better than I was you see and it was little bit embarrassing, you know I was trying to keep up but I don’t think, well I know very few people understand my [condition], it’ just unknown. My old GP told me that many GP’s go through their entire career and never meet one case.’ (E)
One participant also expressed a concern about the frequent changes of staff:

Desmond: ‘This is, I’m not sure this is a good thing. It’s difficult to build a relationship with the staff although they’re all very helpful and considerate. But when I started here there was a young lady running the class and she got transferred to B and then there was somebody else and then (name of physiotherapist) and he’s away for six weeks I understand and he was replaced by another lady and you sort of don’t, you sort of start afresh each… I mean I was only here for quite a short time but you know, you have someone different each time running it, which I don’t think is to be recommended.’ (E)

Whilst staff transience was a problem for some, others enjoyed staff changes as they were able to demonstrate what they had learned for new staff members:

Vera: ‘Well funnily enough when we first come in, they’re checked first of all and one of the newer ones said ‘well we’ve got to find out what you’ve learnt’. So she was asking all the different questions of what we have to do if we have a fall. And she said ‘oh you’ve got it in the right orders too’. So it was nice really.’ (E)
IV: Perceived benefits and critiques of falls services.

Messages

- Participants on the whole found attendance at falls clinics to be a positive experience highlighting a range of physical and psychosocial benefits.
- Participants considered the thorough assessment of their health or ‘MOT’ an added benefit of attending a falls clinic.
- Participants felt that falls services made them more aware of potential risks.
- Although the clinical effectiveness of attendance at falls clinics would be the reduction in the incidence or risk of falls, few patients mentioned this as one of the benefits they noted from attending the service.
- Participants felt that the social environment of the falls services and the friendly professionalism of the staff impacted positively on their motivation to attend.
- Few participants had any negative comments on falls services: those who did suggested specific concerns including a lack of opportunity to consider coping with risk, issues around access to additional services or equipment, the gender composition of falls service groups, the lack of permanent staffing, problems with transport to and from the service and the desire for programme to continue for longer.

Implications

- Once patients gain access to a falls services programme, their experiences are very positive and perceived by those who use them to be highly beneficial, suggesting substantial effort should be directed at targeting removing access barriers.
- The benefits of the service as perceived by patients (physical and psychosocial) are important considerations in management plan goals.
- Adherence to treatment is more likely to be a function of the social environment of falls services and the nature of staff rather than in solely seeking a reduction in risk or incidence of falls.
- Some patients have specific concerns about their experience with falls services so there should be some way of capturing these concerns and using this feedback to modify services.

Recommendations

1. Creating a welcoming and friendly social environment which enables group interaction and sharing of experiences may increase satisfaction and lead to increased effectiveness of the services.
2. Individual preferences for group or solo exercise programmes should be explored and accommodated if possible, to enhance uptake and adherence.
3. Patients’ perceived needs and outcome goals should be discussed with healthcare professionals and fed into management plans.
4. Follow-up should explore patients’ experience of the service and identify any unmet needs.
5. Service providers should ensure reliable transport arrangements are in place to enable older people to attend falls services.
Discussion

Strengths and limitations of the study
The focus group participants represented a wide selection of patients using NHS falls services in England, but was not a random sample. The detailed qualitative information gathered is indicative of the variety of perceptions and opinions of falls service attendees but does not quantify the prevalence of particular views. The data does however provide important insights into the views, opinions and experience of these participants and has enabled the formulation of recommendations.

Although our intention had been to recruit a purposive sample of 40 to 120 participants across 4 to 8 focus groups, we had to adapt our approach and achieved 40 participants in a greater number of groups. The patient sample included males and females and a mixture of complex and non complex health problems. Although the sample did not include participants with significant cognitive impairment, it did include participants not confident to travel to the focus group venue alone who needed help. Therefore the sample did include participants with physical impairment and long-term health problems, not just the ‘well elderly’. Thirty eight people (95%) who chose to participate were white British (compared to 94% of the full audit participants). As no data was collected on those who were invited but chose not to participate, it is not possible to report any additional differences, such as clinical characteristics of those who attended and those who declined.

Conclusions
This project provides information on patients’ perspectives of current falls services. It has revealed some important limitations of current practice and identified barriers to effective patient involvement, highlighting that there is sometimes inadequate discussion between patients and healthcare professionals about the results of assessments and treatment plans. This may lead to reduced adherence of patients to their individual intervention plans. We present recommendations derived from these perspectives, for the purpose of supporting the development of better services for falls and bone health in older people.

Next Steps
The information provided by this project will be used to:
- Develop a pilot falls prevention experience audit tool, designed for local or national use.
- Produce a best practice toolkit to support local services in obtaining patients’ views through focus groups.
- Develop and pilot a patient-centred information/advice leaflet focusing on the aspects of falls and bone health services important to enable patients to become partners in their treatment and falls prevention plans.
REFERENCES

- Department of Health “Our Health, Our Care, Our Say”, 2006.
- Department of Health “A Recipe for Care-Not a Single Ingredient”. Clinical case for change: Report by Professor Ian Philp, National Director for Older People, 2007
- National Institute for Health and Clinical Excellence, Technology Appraisal (TA) 87, Bisphosphonates (alendronate, etidronate, and risedronate), selective oestrogen receptor modulators (raloxifene) and parathyroid hormone (teriparatide) for the secondary prevention of osteoporotic fragility fractures in post menopausal women. January 2005
- Royal College of Physicians, Clinical Effectiveness and Evaluation Unit, National Audit of the Organisation of Services for Falls and Bone Health in Older People report. February 2006
- Royal College of Physicians, Clinical Effectiveness and Evaluation Unit, National Clinical Audit of Falls and Bone Health in Older People report. November 2007
**Appendix 1**

**Falls patient involvement advisory sub-group**

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<thead>
<tr>
<th>Title</th>
<th>Forename</th>
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<td>Dr</td>
<td>Finbarr</td>
<td>Martin</td>
<td>Associate Director (Chair)</td>
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<td>Ms</td>
<td>Nena</td>
<td>Foster</td>
<td>Project Officer (Associate Lecturer)</td>
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<td>Ms</td>
<td>Pamela</td>
<td>Reeve</td>
<td>Clinical Nurse Specialist</td>
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<td>Prof</td>
<td>Claire</td>
<td>Ballinger</td>
<td>Professor of Occupational Therapy</td>
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<td>Mrs</td>
<td>Sheilah</td>
<td>Rengert</td>
<td>RCP patient and public involvement representative</td>
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<td>Mrs</td>
<td>Jenny</td>
<td>Jefferson</td>
<td>RCP patient and public involvement representative</td>
</tr>
<tr>
<td>Ms</td>
<td>Anil</td>
<td>Seiger</td>
<td>CEEU manager</td>
</tr>
<tr>
<td>Mrs</td>
<td>Janet</td>
<td>Husk</td>
<td>Project Manager</td>
</tr>
<tr>
<td>Ms</td>
<td>Michelle</td>
<td>Spencer-Williams</td>
<td>Project Coordinator</td>
</tr>
</tbody>
</table>
Received 3/8/07

Ms Jan Husk
Project Manager
Falls and Bone Health in Older People Audit
Clinical Effectiveness and Evaluation Unit
Royal College of Physicians
11 St Andrews Place
Regent’s Park
London, NW1 4LE

1 August 2007

Dear Ms Husk,

Full title of project: Older peoples experiences of falls and bone health services

Thank you for seeking the Committee’s advice about the above project.

You provided the following documents for consideration:

- Letter dated 1 August 2007
- Project Proposal dated 26 March 2007

These documents have been considered by the Chair.

The Research Governance Framework (RGF) sets out the responsibilities and standards that apply to work managed within the formal research context. The Chair has advised that the project is considered to be audit, and should not be managed as research. Therefore it does not require ethical review by a NHS Research Ethics Committee or approval from the NHS R&O office. The Chair has also agreed that confidentiality issues are protected.

NHS sites – You must check with the local clinical governance office what other review arrangements or sources of advice apply to projects of this type. You should ensure that the project is not presented as research to the NHS organisation.

This letter should not be interpreted as giving a form of ethical approval to the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

Yours sincerely,

NICK WATTS
Co-ordinator
On behalf of South East REC

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This Research Ethics Committee is an advisory committee to South East Coast Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and the Research Ethics Committees in England.

Older people’s experiences of falls and bone health services report. 1st September 2008 42
Appendix 3

Older people’s experiences of falls and bone health services

Staff Information Sheet

Project background
This project aims to explore information, involvement and the key concerns of patient users of falls and bone health services. This work builds upon the audit of falls and bone health in older people currently underway at the Clinical Effectiveness and Evaluation Unit (CEEU) of the Royal College of Physicians (RCP), London. The first phase of the national audit undertaken in 2005 focused on the organisation of the services, based on the NSFOP standards and NICE Guidelines on Falls and on Osteoporosis. Currently, the CEEU is analysing data from the second phase, the national clinical audit, to ascertain the details of service provision at the individual patient level. This data includes information on specific patient related activities, but does not capture patient’s views of these services. Ascertaining the views of service users requires a patient centred enquiry into the process of information provision and to treatment planning.

Methodology
A project steering group has been established, comprising individuals from the voluntary sector (Help the Aged), expert providers and patient/public representatives, linking to the National Falls and Bone Health Steering Group.

In order to obtain patients’ views up to 8 focus groups will be carried out around the United Kingdom. Data from these focus groups will be analysed thematically, verified and reported back to the service users, providers and the wider falls and bone health community.

The project team have been in contact with your Chief Executive ………………………who has agreed to participate. We will contact your Clinical Governance / Audit Department to ensure that the project follows appropriate information governance requirements. Under NHS research governance this project does not require ethical approval.

Due to ethical constraints, neither the Royal College of Physicians nor Help the Aged can recruit patients directly as this has to be performed by a member of NHS staff involved in patient care or organisation of care. However, once patients have been identified and have agreed to take part (by providing their contact details), coordination of contacting participants and arranging focus groups will be undertaken by RCP project staff.

Potential participants must be approached by an individual (identified locally) involved in the day to day provision of the falls and fracture service (e.g. Specialist nurse for falls, osteoporosis or fracture liaison or a consultant within the falls service). Participants have to have fallen or have fallen and incurred a non-hip fracture (similar to group 1 patients in the clinical audit); have used their current local falls and bone health services and be able to comment on their experiences within a focus group setting. Special assistance (i.e. interpreters) will be provided as necessary and all venues will have wheelchair access. Jan Husk, the project manager, will contact you with more detail on recruitment at your site.

What happens next?
Once you or your trust has signed up
- Jan Husk will contact you to discuss how you are going to contact the patients
• Jan Husk will speak to your local clinical governance department
• Jan Husk will contact you about appropriate venues for the focus group in your area
• You will identify the patients (either current or previous users of falls services)
• You will need to print the invite and reply letters on your headed paper to send or give to patients along with the patient information sheet, Help the Aged leaflet and the reply envelope
• Patient information sheets, Help the Aged (HTA) leaflets and reply envelopes will be sent to you so that you can include them with the invitation letter (you do not have to use the HTA leaflets)
• We will update you on the progress and the outcomes of the focus groups

The focus groups
The potential participants will be invited by letter from the local service provider (you) and given an information sheet, providing more detail about the project. A reply letter and a pre paid return envelope will also be provided to express interest and consent to taking part. Any questions regarding the project should be answered by the member of staff in charge of recruitment or a member of the project team (contact details provided on the information sheet).

Focus groups will be held between November 2007 and January 2008 at a venue convenient for participants. The sessions will last approximately 2 hours. We can organise transport to and fro or the patient can do this themselves and if this is the case we will provide travel claims forms so that travel expenses can be reimbursed. Refreshments will be provided at the focus group. Once a patient has agreed to take part and supplied their details we (RCP) will correspond with them and make all the arrangements for the focus groups. These groups will be facilitated by CEEu (RCP) and the project team. The venues, refreshments and patient travel will be paid for by the RCP.

Safety and Confidentiality
All focus group discussions will be audio-recorded with both a facilitator and assistant present. Data collected will be anonymised and participants can withdraw their participation at any stage of the project with no consequence to them or their care. If participants wish to withdraw from the project they may do so my contacting the project team on 020 7935 1174 ext 347/266 so that we can cancel any existing arrangements such as travel.

Reports and outputs
The focus group material will be reported to participating trusts and nationally. Patients will receive a summary which includes key messages. Chief executives will receive the same summary.

Participants will also be asked to feedback on the report in order to incorporate their ideas into developing questions for a patient experience audit tool as well as the final report. This patient experience audit tool (PEAT) will be available for use locally or nationally to assess services incorporating the patients’ perspective on falls services and potential pilot sites for the use of the patient experience audit tool will be solicited at a later date.

Based on this project we hope to comprise a best practice toolkit suitable for use by individual local services on how to use a focus group to obtain patients feedback specifically on falls service provision (use of scenarios and the questions). Results will be disseminated through meetings/presentations, the CEEu website, Help the Aged, publications and the networks available to the steering group.

Any further questions: Project Manager: Janet Husk, Tel: 020 7935 1174 ext 347/266 Email:
Re: Older people’s experiences of falls and bone health services

We would like to invite you to take part in a patient involvement project run jointly by our hospital trust, the Royal College of Physicians (London) and Help the Aged. It has been funded by Help the Aged, and by the Healthcare Commission, which is a government funded body whose job is to check on the quality of services provided by the NHS.

We are inviting people aged 65 years and over who have fallen and then attended their local falls service. The aim is to obtain older people’s experiences at a focus group to find out what worked for them so that a patient questionnaire can be developed to aid future national and local falls services.

Please read through the attached information and if you wish to take part complete your contact and personal details on the reply letter and return it in the pre paid envelope to the Royal College of Physicians. Once they have your details they will contact you within two weeks of receiving your reply letter regarding information and arrangements for you to attend the focus group which will be held locally.

If you need more information contact < lead name> on phone number………………………… or the project manager on 020 7935 1174 ext 347

If you do not wish to take part, you do not need to do anything and we will not contact you again. It will not affect your treatment if you do decide not to take part or you withdraw after saying “yes”.

We plan to feed back the focus group results to participating trusts and to patients if they wish.

We look forward to hearing from you regarding your participation in the project.

Jan Husk
Project Manager

Dr Finbarr Martin
Associate Director, Falls

Jonathan Potter
Director CEEu
Appendix 5
Copy ONLY (Form to be on local hospital headed paper)

Older people’s experiences of falls and bone health services, 2007

Yes, I would like to take part in a focus group so that I can feedback on my local falls service. I have read the enclosed information and I am aware that I can contact either <local person name > or the project manager to ask further questions.

I understand that my participation is voluntary and that I am free to withdraw at any time. If I decide to withdraw I will phone 020 7935 1174 ext 347/266. I am aware that this will not affect any future treatment.

I would / would not (circle answer) like to receive a summary of the project results

I have supplied my contact details below

Title: ___________________________ Forename: _________________________________
Surname: _____________________________________________________________
Address: ______________________________________________________________
_________________________________________________________________
_________________________________________________________________
Post code: ___________________________ Telephone: _________________________
Email: _________________________________________________________________

In order to ensure we get a good mix of people attending the focus group, please can you let us know by putting a X in the following boxes which tells us whether you are;

Male ☐ Female ☐ 65 to 74 years ☐ 75 years or older ☐ White British ☐

Please can you circle one of the following contact methods below so that we can get in touch with you regarding the date and the venue of the local focus?

- Post
- Telephone
- Email

Once you have completed your details please can you put this letter in the pre paid return envelope and post it. Our partners in this project at the Royal College of Physicians will be in touch within 10 working days of receiving your reply.

________________________________________  ________________  ___________
Print name Date Signature
PARTICIPANT INFORMATION SHEET

What was your experience after you fell?

On behalf of the Royal College of Physicians and Help the Aged, we would like to invite you to take part in a focus group. A focus group is where several people get together to discuss their experiences of a specific topic. In this case it will be about what happened after you fell. Before you make a decision to take part, it is important that you understand why the project is being carried out, by whom and what your participation will involve. Please take time to read the following information carefully and discuss it with others (family, friends) if you wish before making a decision. If anything is not clear, or if you would like more information, we would be happy to discuss this with you. Please contact a member of the project team on 020 7935 1174 ext 347 /266.

Purpose of the project
The purpose of the project is to find out whether patients who have attended falls prevention services after a fall have received helpful information about falls, safety, bone health and available treatments. We are very interested in hearing about your experiences and to get your feedback on the type of information you received. One of the aims of the project is to develop a patient questionnaire about falls services and gathering your feedback and experiences at a focus group will help us to achieve this.

1. Why have you been chosen?
Your views and recent first-hand experience of falls prevention services are important to us and will help to develop services and information for patients. To get a balanced feedback, we need to obtain the comments and opinions of a cross section of people who have been to falls services. If you do decide to take part in the project you need to keep this information sheet, then complete and sign the reply letter. Once completed it needs to be posted to us in the pre-paid envelope. The details in the reply letter will be used to make sure we include a balance of people (men and women, various ethnic origins, younger and older) in the focus groups. Therefore not everyone who does reply will be invited to a focus group, but we would like to thank you in advance for your time. If you take part, all your personal details will be kept confidential and will be destroyed at the end of the project.

2. Do you have to take part?
Absolutely not! Your involvement is entirely voluntary and you may withdraw at any time. We would like to assure you that the standard of care you receive will not be affected at any time if you participate or choose to withdraw.

3. What will happen if you agree to take part?
Contacting you: Members of the project team, at the Royal College of Physicians will contact you by the method you choose (phone, letter or email) on the reply letter. At this time we will let you know if you have been chosen for the group, the location, time and date and how long it will last.
Travel arrangements: We will make the travel arrangements for you so that you can attend. If you prefer to make your own travel arrangements we will reimburse your travel costs so that you can get to the focus group.

Focus group arrangements: All information regarding the focus group will be confirmed in writing the week before it is due to be held. Please expect a phone call or a reminder, one to two days before focus group to confirm the arrangements. At the focus group you and others will be asked to talk about falls and bone health services and your experiences. These sessions will be tape recorded and have members of the project team present.

Thank-you: As a way of saying thank-you for your time and your valuable input we will be sending all the people that attended a focus group a £20 Marks and Spencer voucher in the post along with a letter of thanks.

Results: If you are interested in seeing the results, then please confirm this on the reply letter or let us know at the focus group and we will send you a summary.

Use of your details: We will only hold your details for the duration of the project and to send you the results. After this time your details will be destroyed.

4. What will happen to the results of the project?

- With your input at the focus group we hope to design a patient questionnaire and leaflet to do with falls services which will contribute to improved service provision.
  - We hope to get your feedback on the questionnaire and leaflet either in a focus group, by post or email but we will ask your permission to do this at a later date.
- We plan to summarise the results for the hospitals which took part in the project and for the participants as well.
  - At no time would the hospitals be given any of your personal details or be able to identify you from the summary
- We will also present the results at future meetings and conferences attended by doctors, nurses, physiotherapists, occupational therapists, patient liaison staff and others involved in falls services because your views will be important to them.

5. Who has approved the project?
The project has been approved by the Healthcare Commission which is a government funded body who is role is to ensure the quality of services provided by the NHS.

6. What's next?
If you would like to take part, all you have to do is complete and sign the reply letter and return it in the pre-paid addressed envelope to us at the Royal College of Physicians.

7. Contact for further information
The project lead within your hospital will give you his/her name and their contact number when he/she sends you the invitation letter about the focus group. If you want any further information about this project please contact Janet Husk, the project manager on 020 7935 1174 extension 347
  - Thank-you for taking the time to read and consider this information.
Appendix 7

Check list for booking venues

City………………………Venue………………………………

- Cost of venue for 3 hours- need deposit? How much? Can they invoice us for this? Happy to invoice us for the rest of the payment?

- Dates available and times available

- Room big enough for 15 people with enough chairs

- Disabled access

- Disabled toilets

- Ground floor or lift?

- Tea/coffee making facilities- do they provide it/ can we buy it? How much per person?

- Public transport links

- Distance from city centre

- Taxi firms recommended?
Appendix 8

Check list for booking venues

Complete answers next to questions

City………………………Venue………………………………

What rooms are available? ..........................................................................................

• What is the cost of venue for 2 hours
  • Do they need a deposit?
  • How much?
  • Can they invoice us for this?
  • Are they happy to invoice us for the rest of the payment or is OK to be invoiced for it all?

• What is the length of time to travel from London to venue (for project officer and helper)

• What dates / times are the rooms available in February and March?

• Is the room big enough for 10 people with enough chairs?
  • Do the chairs have arms on so people can get out of them easily?
  • Is there a table to put the tape recorder on?

• Is there disabled access into the building?
  • Can cars (taxis) pull up immediately outside the building?
  • Are there steps into the building?

• How far away is the room from the main building entrance?
  • Are there any steps or obstructions for people walking into the room with a stick or accessing the room in a wheelchair?

• Are there disabled toilets?
  • Are the toilets on the same floor as the meeting room at the venue?

• Is the room on the ground floor
  • If no, is there a lift?

• Tea/coffee making facilities / biscuits
  • Do they provide it?
  • Can we buy it?
  • How much per person?

• What are the Public transport links to the venue?
  • What is the distance from the train station to the venue?

• What is the distance from city centre?

• Are there any taxi firms that could be recommended?
Appendix 9

QUESTIONS AND PROMPTS FOR THE PPI FOCUS GROUPS

Date: 07.11.07

• Introductions
• Information (toilets, drinks, tape recorder etc.)
• Ground rules (anonymity, respecting everyone’s views, not disclosing beyond the group etc)

(NB Numbered points represent the main questions, - comments represent prompts. Points in italics are to be tailored to the individual service venue – *do we know that all the people in one focus group will have experienced the same service?*

Good general prompts include:
- Was this similar for everyone?
- Did anyone have a different experience? Does anyone have a different view?
- Can (or does) anyone want to add to that?
- How did that make you feel?)

1. How did you come to be involved with the clinic or day hospital?

2. How was your fall explained to you by staff?
   - How did this make you feel?

3. How was your treatment planned (designed) for you?
   - In what ways were you involved in the planning?
   - How was the decision made about what your plan would involve?
   - How was the decision about where and when your treatment would take place made?
   - Did you manage to attend the whole course of treatment?

4. Can you tell us a bit about your treatment plan?
   - What were the aims/targets/planned outcomes?
   - What were the different aspects covered within the plan?
   - What activities were you involved with as part of the plan?
   - Did anything prevent you getting treatment?
   - Did you feel that the treatment plan was designed just for you?

5. Can you tell us about any information you were given?
   - Written information? Leaflets?
   - Who gave you this?
   - When did you receive it?
   - How easy was it to read?
   - Was there anything you wanted to ask after reading it, and were you able to do this?
   - if you were given information in hospital after you fell did this help you, reassure you or help you make decisions about your treatment

6. In what ways has this information helped you/been useful, if at all?
7. Would you pass this information on to a friend who has had a fall?
   - Why?
   - What is useful?
   - What is not so useful?

8. What advice would you give a member of staff writing a leaflet for people like yourself?

9. Looking back on the experience, including the treatment, how do you feel about it now?
   - What was difficult about it?
   - What needs to be different and why?
   - What worked well for you?
   - What did you enjoy?

10. What would you tell a friend who had a fall about the service?

11. Are there any other thoughts? Is there anything else that anyone wants to say?
   - Thanks
   - What happens to the data

What people will receive (summary?)
Appendix 10
IDENTIFICATION OF CODES AND THEMES WITHIN THEMATIC ANALYSIS

A) Initial codes identified (NF)
- Unmet needs;
- Experiences and perceptions of falls and falling;
- Continuity of care for older people;
- Accessing falls services;
- Benefits/non-benefits of the service;
- Loss of independence; and
- Not prescribed/additional exercise.

B) Identification of initial themes (NF)
- Accessing service
- Benefits of service
- Continuity
- Perceptions and experiences
- Unmet need

C) Second iteration of themes (NF)
- Barriers and facilitators to access;
- Integrated prevention needs and services;
- Interpretations of falls and falling and the impact on treatment; and
- Clinical and non-clinical benefits of falls services.

D) Third and final iteration of themes (CB)
- Access to falls services
- Falls services: assessment, intervention, evaluation and follow up
- Interpretations of falls: causes, consequences and impact
- Perceived benefits and critiques of falls services
Appendix 11

List of participating Acute NHS and Primary Care Trusts

**Acute Trusts**
- Cambridge University Hospitals NHS Foundation Trust
- Derby Hospitals NHS Foundation Trust
- East Kent Hospitals NHS Trust
- Guys and St Thomas’ NHS Trust
- Kingston Hospital NHS Trust
- Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
- Poole Hospital NHS Trust
- Royal United Bath NHS Trust
- Tameside and Glossop Acute Services NHS Trust
- Trafford Healthcare NHS Trust
- West Middlesex University Hospital NHS Trust

**Primary Care Trusts**
- Bath and North East Somerset PCT
- Cambridgeshire PCT
- East Kent Coastal PCT
- Lambeth PCT (did not recruit)
- Streatham PCT
- Tameside and Glossop PCT
- Wiltshire PCT (did not manage to recruit enough numbers)