Age UK East London Fall Prevention Research: Testing of three communications methods and campaigns messaging to prevent the first fall in the ageing population

March 2020

Acknowledgements

We want to acknowledge co-authors Dr Darren Sharpe and Natasha Wehner-Hewson from the Institute of Health and Human Development based at the University of East London and Sophie Ibotson from Age UK East London and Kikelomo Abidakun, a social worker student volunteer.

A big thank you to Friends of Woodberry Down, MRS Independent Living and the Turkish Cypriot Cultural Association, that helped us facilitate these focus groups, despite their limited time and resources. We also want to thank the Chinese Community Centre for wanting to help but not being able to due to the outbreak of the coronavirus.

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1. Executive summary

This report has been produced by Age UK East London (AUKEL) on the falls prevention messaging which involved consultations with non-fallers among ageing BAME women living in Hackney, London. The overarching aim of the consultation was to help inform the Healthier Hackney Strategy on how best to message residents to prevent and/or mitigate falls, which are shown to negatively impact on confidence and independence. In this consultation, no one messaging method or content is shown to be overwhelmingly privileged. However, the central findings suggest that the messaging content needed most by participants should emphasise a strength-based approach and avoid homogenising and representing older people as all being vulnerable due to their age group. Instead, a messaging campaign should provide a range of points of identification for older people to better connect with the message. It is particularly important to represent individuals who do not see themselves as potential fallers. This should be done by **promoting independence**, reflected in the tone of the message and images used in the campaign. Participants suggested to **avoid patronising** the target audience with simplified illustrations. Once you have a honed message with a clear key headline, the advice is to repeat, repeat and repeat to reinforce the message. What is required are more personalised messages that are carefully tailored to different audiences' commonly addressed **strengths and risks**. The underlying message should be to **preserve older people's dignity**, recognise their **different points of identification**, and **empower** them to retain **autonomy**. These features should be skilfully packaged to amplify the key message of enhancing **health benefits** in adopting a fall prevention strategy.

The consultation findings suggest that the most effective form of messaging is through a **presentation** – in practice, a discussion-conversation. However, participants highlighted the advantages of a **blended approach** using a combination of presentations, leaflets and videos to reinforce the message. Participants found each message method useful for different reasons, and they suggested that the presentation provided the most **personalised way of building awareness about information**. This was largely based on the interactive nature of receiving the information and being able to ask questions. This message method was followed by leaflets and posters, which could serve to reinforce the key message, and video footage to delve deeper into specific concerns highlighted through the presentation discussion-conversation. What is clear is that the participants consulted adopted a pragmatic view of life: they **required solutions** to existing problems and would not usually go out of their way to find information about fall prevention. Therefore, the messaging platforms need to come to them directly, or else be made easily available

in their daily worlds. For this to work, the message needs to be personalised, stress the health benefits (such as enhancing strength and balance), and go out using blended in-person and virtual approaches.

The use of **humour** was highly privileged as a way to capture people's attention, along with **a balance of words and images** on each of the platforms. The messaging platform should avoid being too wordy or childish. However, the channels of messaging should be easily accessible in older people's life worlds, and information should not be concentrated in the hands of health and social care professionals, but positioned and available at multiple social sites. This would reinforce the key message and would be graduated to attract the young-old, middle-aged old, older-old and their carers. The latter categories are not mutually exclusive and carers might themselves be in any of the three previous categories. This report unpacks the evidence that lies behind most, if not all, of these insights, reported behavioural patterns and attitudes held by the consulted participants.

2. Introduction

This document reports on the evaluation of the communications activities and campaigns to prevent and mitigate the risk of the first fall in elderly people living in Hackney. The aim of the study was to test out different communication channels (videos, leaflets and care plans) and messaging techniques amongst a wide range of elderly people to help determine what type of messaging works, why and for whom.

This study has been undertaken by AUKEL. AUKEL has a collective 90 years' experience of service design and delivering health projects. Over 300 people attend exercise and healthy eating sessions at our community centre; 72% felt their health improved. Last year we helped 1,453 people discharge safely from hospital, including installing falls prevention measures in their homes. We deliver information and advice services across Newham, Tower Hamlets and Hackney, and have supported countless people. We run services in Royal London Hospital, Newham Hospital, Homerton Hospital and Whipps Cross Hospital.

In Hackney, we are a key partner for older people services. We have a position on the Adult Safeguarding Board and Dementia Friendly Hackney. Furthermore, we coordinate the largest older people user-led group in City and Hackney, the Older People's Reference Group, with nearly 600 registered members.

2.1 Background

This section provides the policy and social context for the fall prevention messaging consultation exercise. The consultation is focused on one of the four key priority health issues identified by Hackney Council that affect residents. This study focuses on the Hackney Council Public Health priority of identifying people at risk of falls, which forms a vital part of the emerging Hackney Ageing Well Strategy. Research highlights that epistemic health inequalities for elderly people living in Hackney heighten the risk and/or recovery period from the first fall, especially among disadvantaged and vulnerable resident groups.

With older fallers costing the NHS £2.3 billion per year, this project looks to the future. The population aged over 65 is the fastest growing demographic, and the next 20 years will see 39% growth in people aged 65–84 and 106% growth in the over 85s. This older population is at greater risk of falls, and the costs to the NHS will only rise as the population continues to age.

The 2011 Census estimated Hackney's population at 246,300 (increasing to 275,929 in 2019). People aged over 55 make up only 15% of the population. Life expectancy is increasing for men and women, and is now 78.8 years for men and 82.9 years for women. However, life expectancy in Hackney is below the London average, especially for men. Recent gains in life expectancy mean that more people are living to the age of 85 and beyond. In the future, more of the population, who are now just entering old

age, will live to be 85 or older; 45% of men aged 65 will live to be 85, with the comparable figure for women being 58%, if mortality rates continue at current levels.

Hackney was the eleventh most deprived local authority overall in England in the 2015 Index of Multiple Deprivation, whilst in 2010 it was ranked second. In 2015, 17% of its Lower Super Output Areas were in the top ten per cent most deprived, compared with 42% in 2010.

The Index of Deprivation Affecting Older People (IDAOPI) had a value of 42 in 2015, which means that 42% of those aged 60 and over are either in receipt of Pension Credit, out of work benefits or had an income of less than 60% of the national median, excluding housing benefits but before housing costs. In 2015, Hackney ranked second for all local authorities in England for this indicator. Again, this level of socio-economic hardship for residents aged 60–69 supports the case in disproportionate spend in protecting vulnerable older people.

The UK population is multi-ethnic (Office for National Statistics, 2012), with approximately 14% of people from Black, Asian and Minority Ethnic (BAME) groups. Fall rates, activities of daily living (ADL), and attitudes to exercise all vary widely between different cultures, which is the cornerstone of most fall prevention programmes (Horne et al., 2009; Song et al., 2007; Castaneda-Gameros et al., 2018; King et al., 2000).

The ageing population is now apparent worldwide (World Health Organization, 2015), which means that people tend to be living for a considerable period in declining health and with a poorer quality of life, due to a set of health problems associated with the ageing process. If all ageing was simply the result of biological factors, then we would not expect to find any significant differences between different ethnic groups (Löckenhoff et al., 2015). In fact, differences can be found in the prevalence of falls between different ethnic groups.

Different countries also show differences in fall prevalence. For instance, China and Japan have noticeably lower reported fall rates than seen in Western countries. A systematic review by Kwan et al. (2011) reported a median fall prevalence of 18% in Chinese people from a sample of 21 studies, while Aoyagi et al. (1998) reported an average fall prevalence of 14.2% among Japanese people. However, there have been very few studies looking at fall rates in pluri-cultural populations. Of those studies that are available, the majority were carried out in the USA, with differences in the risk of falling identified between ethnic groups, even after adjusting for confounding factors such as age, sociodemographic factors and health (Nicklett and Taylor, 2014; Geng et al., 2017). Interestingly, lower fall prevalence was observed for African-Americans when compared to Caucasians, despite having generally poorer health and living conditions (OR 0.65: 95% CI 0.53,0.80) (Geng et al., 2017). This suggests that this area is worthy of more study, particularly in the UK, where there is a multi-ethnic population, and no current evidence on differences in fall prevalence.

The premise of any fall prevention intervention is to identify all fall risk factors that are present, and where possible remove or modify these, thus reducing the risk of the person falling. The most commonly used intervention is exercise, which has been shown to significantly reduce falls (Gillespie et al., 2012). Physical activity helps to maintain balance, strength, flexibility and reflexes, all of which are important in maintaining postural stability in the face of a perturbation (Myers et al., 1996). However, the issue of acceptability and adherence to the exercise components of a fall prevention programme also needs to be looked at from an ethnic perspective. While some studies in the UK have shown that facilitators and barriers to interventions are often similar for all older adults, there have been some differences reported for South East Asians, particularly related to language barriers, problems due to religious beliefs and cultural practices, and a generally more fatalistic attitude to falling in older age (see Johnson, 2000; Horne et al., 2009; Horne et al., 2013).

Most current interventions have been developed in the USA or Europe, and they are thus oriented towards a Western cultural norm. However, for the UK with its BAME cultures, an intervention may not always be culturally appropriate for each group.

More recently, AUKEL completed a large-scale piece of research, consulting 150 older members of the BAME communities about how integrated they feel in Newham. The results were presented to the Mayor of London. Also, as part of the Connect Hackney Ageing Well programme, we worked with the Tavistock Institute to survey 150 older people participating in Connect Hackney activities to evaluate the impact of the activities on loneliness and isolation. Finally, Healthwatch Newham commissioned us to research how people aged 50 and over feel about using online GP services. We surveyed 100 people and presented findings to the Mayor of Newham.

We are the premier older people's organisation in Hackney and can draw on a national network for insight and learning on falls prevention messaging – what has worked, what has not, and why.

3. The consultation

This section outlines the fall prevention consultation timing, aims and scope. The research and evaluation methodology for this project was designed by the Institute for Health and Human Development (IHHD), University of East London. IHHD was established in 2006 with a remit to develop an interdisciplinary research cluster in health and wellbeing working across the university. IHHD's focus is on social, economic and cultural factors that influence health and wellbeing. IHHD's work is organised within four thematic areas ('Starting well', 'Ageing well', 'Well communities' and 'Mental health and wellbeing'). The central questions of the consultation are:

1. Which message/s around preventative falls action are most attractive to older women in Hackney who have yet to fall but may be at risk?
2. How effective are different channels at delivering the message/s?

The research process had three distinct stages:

1. Desk research identifying promising falls prevention messaging from the 153-strong local Age UK network (See Appendix 1).
2. Focus groups with approximately 20 people[1] to test individually three different message methods.
3. Focus groups with approximately 20 people to test three combined message methods.

We measured the effectiveness of each focus group meeting with a survey, assessing how participants interpreted the message, and how they recalled its immediate impact on the return visit.

3.1 Evaluation and dissemination

We received research ethical approval for our project by Hackney Council Research Ethics Board in August 2019. The research is low risk; issues around data protection, confidentiality and anonymity are our main considerations. AUKEL is GDPR compliant, with the necessary updated data protection and safeguarding policies in place. The project was co-produced with the target group, and it was led and delivered by a core team member with the support of volunteers.[2] As stated, an independent researcher from IHHD designed the research methodology and evaluation. A member of the AUKEL team undertook desk research to identify a selection of falls prevention messages to then test in depth, and took the role of lead moderator in each of the focus group meetings.

3.2 Method

In each focus group meeting, the AUKEL moderator used a scripted series of questions (see Appendix 10, 11 and 12) to lead a discussion among a group of older people. These focus group meetings took place at community-based locations where participants would routinely meet to experience an activity. The focus group meetings usually lasted one to one-and-a-half hours, and it took two rounds of at least five groups to get balanced results. The first round of focus group meetings (n=3) comprised one messaging method, and the second round of focus group meetings (n=2) combined each of the methods of communication. These consultation exercises have involved engaging with and talking with a wide range of ageing people living in Hackney who have or have not experienced their first fall.

Our concept is a research test and learn approach, examining which messages and delivery methods on preventable falls are impactful for older women (and men) who have not yet had a fall, but who may be at risk of falling. The dimensions to falling covered in this consultation looked both at the participants' private life and public life.

[1] The sampling plan was to recruit participants from local partners within Hackney that represent under-represented BAME and faith voices. We aimed to recruit: 10 participants from the Turkish community (Derman); 10 participants from the Chinese community (Hackney Chinese Association); 10 participants from mixed ethnic groups; and 10 participants from the Black African and Black Caribbean community.

[2] Participants involved in co-designing the study included: committee members and volunteers, volunteers delivering projects, and paid and unpaid staff connected to AUKEL.

3.3 Sample

The project tested the effectiveness of different fall prevention messages and methods on women (and men[3]) aged 50–70 and from BAME groups. Research suggests that women account for the greatest number of fallers and fracture injuries.

This sampling framework was not intended to produce a representative sample of older people living in Hackney but focused on capturing a non-probability quota sample to reflect the needs of the worst-affected communities living in Hackney. We tested different methods for delivering fall prevention message/s to the target groups. As a result, we cannot make statistical inferences or claim representativeness from this study, but we are able to share rich insights of intersubjective meaning and understanding co-created by a discrete section of the local population.

In this study, we aimed to learn more about how fall prevention message/s and delivery methods can be made more attractive and relevant to women living in the target area, and how they can be best delivered. We have extracted learning on the different ways women (and men) from different ethnic backgrounds and ages view fall prevention messages and what methods are currently available. Our findings will be of value to stakeholders including GPs, MRS Independent Living, the local voluntary sector via HCVS, the Age UK Network, CCG and Local Authority.

3.4 Consultation topics

We adopted a quasi-experimental study approach and ran the focus group meetings over two distinct stages (Stages Two and Three) to consider participants' views on how best to construct and deliver messages individually and then together. The participating community-based groups were randomly allocated one controlled messaging method: intervention leaflet, presentation or video. Participants from each community-based group were then given the opportunity in a second focus group meeting to review *all* the messaging methods and were asked to compare the tools for their content and accessibility (detailed later).

3.5 Stage One

This first stage consisted of desk research to collate and assess what research has been undertaken on falls prevention and what resources have been produced to help inform the strategies for Stages Two and Three of the consultation exercises. Stage One ensured that decisions have been evidence-based and draw on best practice examples and materials to shape and inform our consultation approach.

3.6 Stage Two

We wanted to learn from participants if they would pick up published materials if they saw them in a GP waiting room, and if the information was clear.

[3] We only had three male participants. The first participated very little and made no vocal contributions to the focus group, the second was recorded in the focus group and contributed (mostly speaking about the pictures needing to be photographs so that more information could be garnered from them), and the third assisted another female participant with the translation in the Turkish Cypriot group.

Research shows that the information available on falls prevention for healthcare workers and recipients is vast. However, research into the messaging surrounding falls prevention and how it is and should be delivered is more limited. The material which does exist suggests that the tone of the messages produced is very important. Research into falls prevention messaging often found that older people were resistant to taking the advice and considered it to be something that other (e.g. frailer, older, 'senile') people should follow. The Age UK (2012) report *Don't Mention the F Word: Advice to practitioners about fall prevention messages to older people* argues that it is more important to focus on the benefits of strength and balance, rather than the hazard reduction aspects of falls prevention. Yardley et al (2008) research into older people's views on advice about falls prevention agrees with these recommendations. For instance, many of the participants felt that the advice was useful, but they did not want to define themselves as 'fallers'.

Age UK England have created a lot of materials on falls prevention and the messages surrounding it, and there are falls prevention teams in many of the Age UK branches. Information available from local Age UK branches is informed by national papers, but often the information they make available focuses on signposting interested residents to local activities and programmes, rather than on the production of materials which are publicly available.[4] So other resources have been used in part to supplement these approaches to messaging. From the desk research, three key approaches emerged on falls prevention messaging.

The **first approach** is information presented in paper form, in a handout or leaflet (see Appendix 16). There are several examples of useful information booklets, which include visual tools for easy consumption.[5] Together they present an overview of falls messaging, with an emphasis on physical activity (strength and balance training). Only one of these handouts includes messages on hazard reduction, which was often viewed as 'common sense' and dismissed by older people, as found by Yardley et al.

The **second approach** is the use of digital tools (e.g. videos on falls prevention). There was one video produced by Age UK England on falls prevention available, and we judged the presentation to not comply with recommendations surrounding tone. The information was overly simplistic, and the cartoon style made the video childlike in its messaging. This was relevant for many of the video tools that we found, such as *Falls Prevention Fuel Tank.* This video attempts to educate people that falls prevention is something that should be done consistently and pre-emptively, but it fulfilled a lot of concerns older people have surrounding messaging and the implications behind it. We

[4] For example, Age UK Croydon (https://www.ageuk.org.uk/croydon/our-services/personal-safety-and-falls-prevention/) and Age UK Trafford (https://www.ageuk.org.uk/trafford/our-services/falls-prevention/) both have falls prevention teams, but the information focuses on the services available.

[5] *Staying Steady: Keep active and reduce your risk of falling* (Age UK England, 2014) e.g. pages 24 and 25; *Best Foot Forward: Falls awareness week 2013, healthy feet supplement* (Age UK England, 2013); *Raising the Bar on Strength and Balances: The importance of community-based provision* (Centre for Ageing Better, 2019); *Get Up and Go: A guide to staying steady, 2015.* (Saga and Charted Society of Physiotherapists) (https://www.csp.org.uk/publications/get-go-guide-staying-steady)

have included a list of tools which should be drawn on (including the *Falls Prevention Fuel Tank*).[6] (Appendix 4).

The **third approach** is to attempt to provide a more personalised and interactive presentation of falls prevention messages. Using the Age UK England's 2019 document *It's Never Too Late to be Active*, we presented the findings of a recent study on attitudes of older people who are physically inactive (e.g. 'Many Age UK resources can be drawn upon to present a workshop to a group – such as resources produced by Age UK Bolton and Age UK Enfield).

3.7 Stage Three

Stage three was undertaken with participants who had been exposed to one of the three communication methods, and who were asked to consider all three methods as a blended communication approach. We went to lengths to capture the participants' personal characteristics (e.g. name, race, age, gender, fall history) to allow for comparison in the analyses (see Appendix 14 and 15).

3.8 Mechanics

The section below discusses how recruitment and engagement were approached in practice to constitute each of the focus group meetings in Stages Two and Three of the consultation.

In total, we ran three focus groups with the lunch club at **Woodberry Down** and visited the centre on two extra occasions. The three focus groups span Stages Two and Three. We reached out to the coordinator, and she invited us to attend the lunch club to see if anybody was interested. We set up on a separate table and the coordinators gathered participants and assisted where necessary. We had a mixture of new and old participants completing the focus group each time. Another by-product of the focus group was two referrals made to the Good Gym, located in Hackney.

We ran one focus group meeting at **MRS Independent Living** in Stage Two following a scheduled class where three participants stayed to take part in the focus group meeting. The project was keen to help us with our work so that they could use the findings to inform their messaging strategy. They have since been in touch to ask how we are getting on and what information we can share with them. We have also connected the group with the Turkish Cypriot Cultural Centre, having mentioned strength and balance exercises and home amendments.

[6] Falls videos for Age UK England and videos in general were often patronising: Strictly no falls, participant stories: Centre for Ageing Better (https://www.ageuk.org.uk/information-advice/health-wellbeing/exercise/falls-prevention/); *How to Reduce Your Risk of Falling* (Age UK England, 2016) (https://www.youtube.com/watch?v=XnLXiJzYmEQ); *Stay Active at Home: Strength and balance exercises for older adults* (Saga and Charted Society of Physiotherapists, 2017) (https://www.youtube.com/watch?v=n8s-8KtfgFM); *Fall Prevention Fuel Tank* (Cardiff and Vale University Health Board, 2018) (https://www.youtube.com/watch?v=KW49BJ8xmrs&list=PL6CzPPBzXiyLewXfcZMRnmmh3RVrm7wPF&index=8); *Are You at Risk of Falling?* (NHS, 2018) (https://www.nhs.uk/live-well/healthy-body/are-you-at-risk-of-falling/?).

We ran two focus group meetings at the **Turkish Cypriot Cultural Centre**, spanning Stages Two and Three of the consultation. We sat with the first afternoon tea session after the Christmas break and worked through the materials. We had one main translator and two coordinators who helped to translate. The facilitators also moved around the room and helped where they could. A by-product of the meetings were five referrals seeking help with grab rails, emergency cords and moving to a new house (due to being on the third floor and having mobility issues).

4. Findings

This section provides a summary of the key findings that emerged from Stages Two and Three of the consultation processes, which involved five focus group meetings using different messaging methods (leaflet, video and presentation) to better determine their individual and combined effectiveness.

Table 1. The demographics of focus group participants

Focus group	Messaging method	Women	Men
Woodberry Down	Presentation	13	0
MRS Independent Living	Video	2	1
Woodberry Down	Leaflets	5	1
Woodberry Down	Combined	7	0
Turkish & Cypriot	Combined	14	1
Total		**41**	**3**

The total number of participants was 44, and some of the participants attended more than one focus group.

Table 2. Participants' age groups, Stage Two

Focus group	50–60	60–70	70–80	80–90	90+
Woodberry Down	1	5	6	1	0
MRS Independent Living	1	0	2	0	0
Woodberry Down	1	1	1	3	0
Total	**3**	**6**	**9**	**4**	**0**

Participants in the first set of focus group meetings were predominately aged between 60 and 80 years.

4.1 Workshop 1: Leaflets/Posters

The responses came from seven participants and two carers (e.g. to help participants with hearing loss). All the participants were women and mostly from black ethnic groups. Out of the seven participants, one participant was a non-faller, one was a regular faller, and several participants had had a fall but classified themselves as those who would not need information (e.g. because of their age or their environment, because the fall had been one-off, or, in one case, because they had had a near miss). (Appendix 10 and 16).

What worked less well	What worked well
Too many words, information needs to be mostly in images.	Need images, bold words, simple language, very visual – English is a barrier to some people.
The white background is off-putting. The selection would cause someone to switch off.	Should have large print that you can read at a distance.
Some of the information isn't relevant to me (e.g. information on strength and balance exercises, saw it as something from a leisure centre)	Billboards outside and in bus shelters should be implemented.
Booklets and leaflets are too long. They need more visuals.	Information available in accessible places for older people (e.g. bus shelters, common rooms of care homes, hospitals, residential areas, churches).
Use plain English.	Need posters.
We do not access information online. We prefer paper-based information.	Stress the importance of environmental factors (e.g. pavements, potholes, leaves, lack of grips in the street).
The information on shoes is common sense.	Think that it would be useful to have age-specific information.
	Individualist approach would encourage people to respond more, e.g. the lady who had not had a fall said that she would watch a DVD about falls prevention if it was sent to her.

4.2 Summary

Participants identified that the first challenge is to **attract the attention of non-fallers** to fall prevention posters/leaflets because they do not necessarily identify with this vulnerable group. Three participants considered the information conveyed in leaflets/posters to be 'common sense'. Participants argued that information should be designed foremost to be **easily accessible** but should **stimulate new ideas to stay independent.** Therefore, the right **balance of written and visual imagery** (e.g. very visual posters drew their attention) is vital to fulfil the demand of other people. Written information should be easy to process, requiring minimal effort on the part of older people to read (e.g. information should be **short, concise and without too much detail**). The **location/place where information is displayed is also important** (e.g. delivered to your door, GP, bus stop or delivered to your door), and it should be displayed and available where older people live their lives.

Messaging should be **tailored and targeted at different at-risk groups** (e.g. youngest-old, middle-old, and oldest-older people and their carers). Information was

often described as familiar to participants who previously had caring responsibilities (e.g. focus on looking after yourself, so that you can look after others).

Some participants thought that the information presented was only relevant to those who had already had a fall. The importance of **'recognition' and 'telling'** (e.g. one participant falls a lot but has not told her GP that she experiences dizzy episodes) needs to be confronted in messages to capture non-fallers. Participants reported that it is information that they might need in the future but not now. For instance, the participant who was in her early 50s said that she was starting to look at information like that, and although she did not classify herself as old enough, she thought it was applicable. Participants commonly said that they would not pick up a leaflet if they had not had a fall, but that they might do if they were older.

4.3 Workshop 2: Video (and digital)

What worked less well	What worked well
The information in the video is common sense.	Shoes
The videos are talking down to you.	Good for normal day-to-day people and situations, not specialised.
Analogies (Fuel tank analogies).	Makes people aware, but not enough details.
Missing: how to carry things, how to put on clothes.	They have been exposed to videos as part of rehabilitation programmes.
Cartoons: would prefer real people, the cartoons don't give enough information because they're too simplistic.	
Should include services which are available.	
Needs more detail.	
Videos wouldn't be sought out by people.	
Family and/or friends are often unable to step in, and people don't like to ask for help.	

4.4 Summary

Participants remarked that a lot of the footage shown to them contained **common sense information and was a bit simplistic**. Participants saw the presentation of the videos as **talking down to older people** (e.g. cartoons, tone of voice, use of analogies) with a focus on trip hazards, and awareness of your home surroundings and your weaknesses etc. Several participants had a good understanding of their bodily capacity due to their involvement in health and rehabilitation programmes, so a lot of the information was familiar to them or considered simplistic (e.g. because they had more specialised needs). See Appendix 12.

Participants welcomed **information for keeping safe outside the home**. Participants highlighted their concerns in navigating the external environment, and highlighted the

negative impact that uneven pavements etc. have on their confidence and sense of independence.

Participants also said that they did not relate to the videos, partially because they were in cartoon form, and it would have been **beneficial to have an older person who was offering the advice**. Participants also suggested **targeting information for carers** as a good way to raise awareness of fall prevention among younger older people.

As a result, participants felt that the videos were not detailed enough. They need **detailed film footage, but lasting no longer than five to six minutes**. Despite these measures, participants reported that **they would not independently search for film footage online**.

4.5 Workshop 3: Presentation (and care plan)

What worked less well	What worked well
Common sense information.	Handholds in the bath, step stall, shoe advice (backless slippers being a risk).
Information is 'not for me'. Would be good when I am older.	Clutter/things around the house getting in the way.
GPs do not have time to deal with falls prevention.	Walking aids.
The simple plans are too basic, and the suggestions are generally carried out anyway.	Most information given is common sense, but it is helpful to be reminded.
Participants requested information about where safety items can be locally purchased and about best prices.	There seemed to be more positive involvement with this approach.
Participants requested a list of numbers of who to contact for help with various problems (e.g. Age Concern).	Participants were not aware of falls prevention plans/care plans, but they were interested in having one.
It is difficult to get in to see a GP – things are often put off until they're bad.	The shorter fall plans were not liked.
	Don't know where to go to get help.
	They found that there was interest in being signposted to local activities, which would help them overcome their resistance by presenting opportunities.
	There was also a lot of emphasis on the information and advice being tailored to the needs and interests of the individual.

4.6 Summary

Participants were responsive to this method of raising awareness of falls prevention and responded positively to the presentation. However, participants highlighted their **lack of awareness of the very existence of fall plans** – despite living with various health conditions. Participants reported never being offered a fall prevention plan/care plan but were interested in having one made. Participants highlighted different ways a fall plan could help them, but they identified the failing in the local health and social care system in making this service readily available. Participants suggested that information on fall plans should be promoted more widely in the community and that **it**

should be made easier for older people to pick up information inside and outside of GP surgeries. See Appendix 11.

Locally, participants identified that there is an information deficit. They found support hard to find. Participants stressed the importance of having **easy access to local services**.

Participants also said that **they preferred the Age UK Care Plan because of its level of detail**. A few participants would have liked to start using Age Fall Plan, whilst other participants thought that they were not yet ready (e.g. not old enough or frail enough).

This presentation method sparked a high level of interest in participants. **They liked having their questions directly addressed**. For instance, one woman spoke about her hearing loss (which can cause vertigo, resulting in falls) – she did not know what to do or where to go, and she needed advice.

Participants would like **primary care and social care professionals to share information and signpost them to local services using a care plan**. Participants recognised that some older people are living with complex needs and should be viewed holistically by healthcare and social care professionals, who **should not wait for people to fall before providing a falls prevention plan**.

Participants found the practical *elements* of the plans the most beneficial, with extra guidance on the next step (e.g. lights in the corridor, so that if they are getting up in the night, they will not fall, and step ladders with grips).

Participants also suggested that they would like to see the creation of a **local falls prevention champion** who could be relied upon for up-to-date information. Participants re-emphasised the lack of information about external environmental obstacles to prevent falling (e.g. uneven paths and leaves) and highlighted that advice given to them was generally unhelpful. For instance, advice may be to wear shoes that are enclosed at the back, but some people struggle to put those shoes on. Participants discussed in depth the problem with appropriate footwear (e.g. slippers versus socks), particularly since swollen feet can often cause problems with wearing slippers. Hackney Council's draft Ageing Well Strategy explores this issue, and should look at opportunities for providing **more tailored foot care advice** through commissioned provision and in future public health campaigns.

Participants wanted detailed plans. Participants preferred **fall prevention plans/care plans to be undertaken in a one-to-one appointment conducted in the person's own home** to better identify individual risks and offer options.

Participants felt that the best advice offered in the short talk/presentation was the **home checklist** (e.g. information about helpful equipment such as hallway nightlights, bathroom grab rails and steps). Participants requested more information on where safety items can be locally purchased and the best prices.

Participants also felt that the **discussion on decluttering was helpful**. There was also advice that reaching up to change lightbulbs was difficult and unsafe. However,

participants identified that they often had **no choice in doing household maintenance themselves**, and that this is an area where they would welcome assistance from the local council. This messaging method also allowed participants to discuss and debate the nuances on falls, home repairs and outside hazards, such as fallen leaves, at length.

Participants expressed concern about the lack of local options available to them, which was made worse by inaccessible transport that could be time consuming and expensive. For example, participants repeatedly mentioned **the inadequate level of local support services,** and that the onus was always placed on them to make the journey to attend an appointment with a health or social care professional – only to have it cancelled when they arrived.

4.7 Workshops 4 and 5: Combined video, leaflet and presentation

This section provides a summary of the key findings that emerged from using combined methods (leaflet, video and presentation) in the focus groups to better determine which would be the most effective method of communication and how they can best work together. Specifically, we asked participants to consider the best method to learn about falls prevention, and how it can best be delivered. **Participants liked a combination of all approaches, but much preferred the presentation format due to their ability to ask pertinent questions on matters that affect their daily lives**. In each focus group, we moved through the materials slowly to allow for translation to ensure the accuracy of meaning and validity in how participants understood and interpreted the combined messaging methods (Appendix 14 and 15).

The falls prevention surveys were distributed (Appendix 9 and 13), but in one of the two focus groups many participants could not fill them in due to low English literacy levels and time pressures, so the moderators went through each of the questions orally.

We then explored the usefulness of posters/leaflets with participants. Participants felt that the posters presented conveyed interesting information and that they learnt new things (Appendix 17). However, participants could not understand all the information being conveyed. Like the earlier focus groups, participants felt that **the posters' use of images helped; however, certain images were not so helpful**. Some participants could not understand what precise message was being conveyed, but they were able to read the pictures to help build understanding. Some participants would have liked additional information included in posters (e.g. nutrition).

In the presentation section of the focus group, we identified that anybody can have a fall, and provided statistics on how one third of adults have a fall each year. We stressed that for older adults, it can lead to broken bones and bruises. It can cause a loss of confidence and a loss of independence. We emphasised that falls can be due to: problems with vision; heart disease; dementia; low/high blood pressure; hearing loss; unsuitable footwear; rushing/trying to get somewhere quickly/not being careful; slipping on a rug; and falling off a ladder. Participants in Focus Group Four added

fragility (e.g. weak knees) to the list of the main causes of falls. Participants wanted to know **ways to prevent falls**. For instance, they wanted practical information on non-slip mats and getting rid of domestic spills. Participants also wanted information on getting help doing things, such as lifting, and keeping shoes in good condition with support for their ankles.

Participants acknowledged the importance of having **an annual medication review and annual sight test to help mitigate falls.** Participants also discussed **the value of doing strength and balance exercises**.

Some participants discussed **the importance of having a Home Hazard Assessment by the local council, and a home hazard checklist**. Some participants filled out the form, with some handing it back and others keeping it for personal use. Some participants found the checklist difficult to understand and remarked that the information was too wordy to translate. Participants suggested that a translated version in multiple languages should be made available.

There was not enough time to show the video resources, so we had a chat about their key features and messages. Participants identified that **many were digitally connected and that they usually accessed information through a smart phone rather than a PC** in a specific location. Not many participants reported using their smart phone to access health information. Participants without internet access said that they would like help accessing this type of information.

A few participants did not understand the information or **did not pay much attention to the information on the screens at their GP practice**. Participants suggested that this failure results from being bombarded by information at the GP practice, and being focused on listening for their name being called, as well as from translation difficulties.

Participants indicated that following exposure to the combination of messaging methods, they would become more **careful** in their daily lives. In practice, participants wanted to make **physical changes** to their home (e.g. grab rail, pull cord) to make them safer, but they also said that local government has been unresponsive to their requests. A few participants reported that they have waited four to six months for a response, and that they have continued to experience falls in the interim.

Participants highlighted the lack of focus on **peer support** in each of the messaging platforms. Participants pointed to the fact that they remind each other to make sure that they take their mobile phone with them as they move around their home.

Participants also suggested that they will **request a review of their medication** because of exposure to the fall plan. Other participants identified that, as a result of the meeting, they would like to try the **home check list**. For instance, one participant wanted to find a solution to deal with water spilling into the bathroom from the walk-in shower.

The participants also rated the posters. When asked their preference, the Turkish participants rated the posters in the following order: Take Control of Your Health (n=12 votes), Top Five Causes (n=8 votes), Eight Steps to Stay Steady (n=7 votes) and the

East Home modifications to prevent falls (n=6 votes). Woodberry Down participants rated the posters in the following order: Poster Two and Four scored the highest, followed by Poster One; Poster Three was the lowest scored. Participants state that **the more personalised the message contained in the poster, the more likely they would be to pay attention to it**. Generally, information was taken from the materials using visual clues. However, participants recommended translation to increase the readability of posters.

To reinforce the message presented in the posters, the participants communicated that they would like to see **posters positioned at different outdoor locations** to reinforce the message, and that they should also feature a strong strapline to catch their attention. Only a few participants suggested that they read posters located at the GP surgery.

Participants generally agreed that the presentation method covered everything that could be said about falls prevention. Also, participants were shown information online about falls prevention, which they liked. Many of the participants did not have access to a computer at home, and those who did only used the computer to shop and for entertainment. None of the participants said that they searched for health-based information. Participants suggested that **a television show on falls prevention would be better**, and more advertisements at GP centres.

Most of the participants suggested that they would like to **receive information on falls prevention from health and social care professionals** they meet (e.g. physiotherapists and GPs)

Specifically, participants would like **tailored information on key factors that affect their daily lives** (e.g. special footwear; walking carefully; handrails in and around the house or streets; treading carefully on stairs; watching out for wet floors; do not run trying to catch a bus; having proper lighting in the house; having eyesight tested regularly; having a walker or Zimmer frame; not reaching stuff with ladders). For instance, one of the participants said that she had fallen three times in her bathroom due to incorrectly fitted units causing her to hit her head. **Information on being careful in the bathroom is much needed**.

Most of the participants remembered the presentation discussion about bath rails as a measure in the prevention of falling. Most participants identified that **a person-to-person presentation/appointment is preferred alongside a home risk checklist/falls plan, reinforced by a leaflet or poster that they could refer to as a reminder.**

5. Analysis

This consultation exercise has revealed different ways to locally improve falls prevention messaging and the correct methods to use. In this section, we drill down into the co-produced evidence created with men and women aged 50–80 living in Hackney, which has one third of older fallers. Being aged 65+, and half being aged 80+, we targeted our efforts at these at-risk groups yet to have a fall. This group stands

to gain the most from improved messaging about falls prevention offers. Participants were asked to look at the posters/leaflets, videos and presentation to share their preferences in terms of accessibility and coherency in conveying the essential message. This is a solution-focused consultation looking at how the use of messaging can mitigate or prevent the first fall among non-fallers.

Through this project, participants have examined current falls prevention messaging and have told us what works and what does not work so well. They have shared a range of insights into what messaging is most attractive and could encourage older people to take up fall prevention. No one messaging method or content is shown to be overwhelmingly privileged in this consultation. However, participants have shared their insight into what information they need the most, and how the different messaging methods can best work together to deliver these desired messages.

The consultation findings will be of interest to Hackney Council. Commissioners from the Council can benefit from robust research that could inform future campaigns to the target group, for example social marketing.

Most attractive messaging contents should emphasise a **strength-based approach**, **avoid homogenising older people as age-based victims**, and **provide a range of points of identification for older people** to connect with the message. It is particularly important to represent individuals who do not see themselves yet as potential fallers. Yardley et al (2008) observe, one 81-year-old participant defined himself as a non-faller despite having fallen out of bed four times in eight months. This should be done by **promoting independence** in the tone of the language and imagery used in the messaging campaign. The concern to **avoid patronising** the audience, almost always through sharing 'common sense' information, was consistently reported. What is required is advanced-level information that is carefully **tailored to different audiences**. The underlying message should be to **preserve dignity, recognition of different points of identification and the need for autonomy**. This can be skilfully packaged, stressing the health benefits of adopting fall prevention strategies.

The most effective method of messaging is mixed, with no strong preferences between different methods. Participants found each method useful for different reasons, and suggested that the presentation provided the most personalised information based on the interactive nature of receiving the information and asking questions, followed by leaflets and posters which could reinforce key messages, and video footage to delve deeper into specific concerns highlighted through the presentation discussion.

What is clear is that the older people consulted adopt a **pragmatic view of life**, **require solutions to existing problems** and **would not go out of their way to seek out information on fall prevention**. Therefore, the messaging platforms need to come to them, or else be easily accessible in their life worlds, and should not be concentrated in the hands of health and social care professionals. For this to work, the message needs to be personalised, stress health benefits such as enhancing strength and balance, and be communicated through blended virtual and in-person

approaches. The **use of humour** was highly privileged as a way to capture people's attention, along with a **balance of words and images** on any platform. However, the messaging platform should avoid being too wordy or childish. The same **message should be positioned and available at multiple social sites** to reinforce the message aimed at young-old, middle-aged old, older-old people and their carers. These categories are not mutually exclusive since carers might themselves be in any of the three previous categories. The following sections unpack in more detail the evidence behind most, if not all, of these insights, reported behavioural patterns and attitudes of the participants consulted.

5.1 Constructing the right tone and representation

Our findings suggest that older people do not reject falls prevention advice because of ignorance of their risk of falling, but because they see it as **a potential threat to their identity and autonomy** (Yardley et al., p. 508).

Most older people take a pragmatic view of life and know all too well that it cannot be risk free. If the message about risk is delivered too forcefully, that can engender fear and nervousness about potentially risky activities.

Advice about hazard reduction may be regarded as simple common sense, and hence potentially patronising. It may also be regarded as oppressive, if it restricts activity, or even (for some) frightening.

Targeting people in this way is unlikely to be effective, but it is a good idea to tailor the advice you are giving to the situation and to the capabilities of the individual. People are more likely to make use of information and opportunities (for example, to do balance training) if they can **personally choose the advice and activities that will suit their abilities, needs, priorities and lifestyle**. Also, it should be acknowledged that the recipient may have valid reasons for rejecting the advice.

Participants also asserted their independence by suggesting alternative forms of exercise or environmental risk reduction in the home. Sometimes humour seemed to be used to distance participants from the threat to their identity potentially posed by messages which implied that they could be considered at risk because of being old and infirm (Yardley et al., p. 512).

A very common way of qualifying approval of falls prevention advice was to agree that it was **useful – but only for other people who needed it** (Yardley et al., p. 512).

Often participants defined themselves as non-fallers, and hence not a suitable target for this advice, because they attributed their falls to an immediate and circumscribed cause – such as temporary inattention or illness – rather than to a persisting vulnerability (Yardley et al., p. 513).

Part of the objection to some falls-related advice concerned the tone adopted in leaflets. Often advice was viewed as presented in an overly didactic, directive manner. One participant explained that: "The leaflet fails to recognise that you're talking to

people who are individuals and who are individuals who have a lot of experience of life, are people who appreciate your advice [general laughter among focus group members] but let's have it in a polite way and recognise that". Most of the people in our study were only too aware of their likelihood of falling, but nevertheless refused to accept that they should be defined as, or behave as, potential 'fallers' (Yardley et al., p. 515).

Older people often have an overly positive perception of their state of health in general, and of their risk of falls. In fact, they will actively disassociate themselves from the 'old' label and the associated ageist stereotype (Hughes et al., 2008, p. 351).

Falls often have negative connotations for older people. Associated with physical injury, functional impairment, psychological trauma, loss of independence, and death, falls are commonly viewed as a symbol of ageing and an issue for frail older persons or the 'oldest old'. Whereas a service provider may consider falls in terms of physical risk management, **older people are often more concerned about the risk to their personal and social identities**. Similarly, although seniors fear functional limitations that result from a fall, they are also concerned about social embarrassment, indignity and damage to their confidence. These negative perceptions have been recognised as major factors in older people's reluctance to admit both susceptibilities to falls and the need for preventive behaviours (Hughes et al. 2008. , p. 351).

Quantitative interviews and focus groups, and small questionnaire-based surveys of older community members, have indicated that health promotion messages related to the prevention of falls may be negatively perceived (Hughes., 2008. et al.).

In our study, the traditional fall prevention message was viewed as 'detrimental' by some, who indicated that such messages may exacerbate fear. Fear of falling is a disabling symptom that affects approximately 34% of older women, including those without a history of falls (Hughes et al., p. 356).

Reinforcement of a positive ageing stereotype has resulted in significant increases in walking speed, improved gait, and functional independence among older people – all factors associated with the reduction of falls and fall-related injuries. (Hughes et al., p. 356).

5.2 Communicating the right level of information

Sometimes a mixed attitude reflected participants' acceptance of certain components of the advice as appropriate for themselves, but rejection of other components of the advice as unsuitable in their case, because of their personal circumstances or references (Yardley et al., p. 512).

One of the most frequent comments from all participants was that **some or all the advice on falls prevention was essentially just common sense**, and therefore not necessary. The steps that should be taken to minimise hazards were viewed as widely known or obvious, while awareness of falling risk was regarded as an inevitable

consequence of experiencing decline in physical capabilities. In this context, falls prevention advice could appear patronising, and even unintentionally insulting: one male participant aged 71 years complained that: 'It can make you feel – somebody producing the leaflets here – that these people here are senile and they just don't have any common sense and they need to be told everything' (Yardley et al., p. 513).

Others have noted that, although elders understand the importance of fall-related risk factors, they do not recognise their self-risk; the **lack of perceived risk of falling is an important barrier** to senior participation in fall prevention programmes, which suggests that, if seniors do not recognise their fall risk, they may be less likely to have a discussion with their physicians about how to reduce falls (Laing et al.,2011. p. 6).

5.3 Strength versus deficit approach

Overall, participants expressed positive attitudes towards provision of advice on the topic of falls prevention and felt that there was currently insufficient information about it. Messages explaining the positive benefits of exercise for balance and mobility were mainly welcomed. Participants related this advice to their own lives, concurred with the benefits, gave examples of the relevant activities they already undertook, and often spontaneously considered whether they could undertake more of these activities (Yardley et al., 2008. p. 511).

Advice to ask for assistance rather than undertake risky activities was seen by some participants as an unacceptable loss of independence and self-confidence. (Yardley et al., 2008, p. 514).

Many older people are receptive to messages about the **positive benefits of exercises that improve balance and mobility**, including health, strength, confidence and enjoyment. They are likely to welcome support and encouragement to help them make this kind of exercise an enjoyable, habitual part of daily life, especially if they are given explanations for the advice offered

They explicitly rejected several unwelcome connotations of the concept of 'falls prevention advice': that they needed to be given advice about how to manage their own lives; that they should constantly dwell on and anticipate the limitations of their physical capabilities; and that they should prioritise safety over other values such as personal dignity, identity and autonomy. Almost all our participants were previously unaware of the benefits of strength and balance training exercises, a method of falls prevention that they welcomed because of the health benefits enabling them to stay independent (Yardley et al., 2008, P.515).

Almost half of the participants (44.6%) **favoured the 'stay independent' message** (i.e. 'If you are more active, you will stay independent for longer'). Independence was associated with feelings of pride and making one's own decisions. People spoke of not wanting to rely on others and the importance of being able to 'live on their own' and maintain daily tasks. Losing one's independence was described quite negatively (Hughes et al., p. 354).

Results from the focus groups supported the argument that a fall prevention message is not necessarily seen as personally relevant to older people. When presented with three different messages – highlighting falls, health or independence – most participants preferred an emphasis on independence. A focus on health was also favoured by several participants, but no one nominated a fall prevention message (Hughes et al., p. 356).

'Independence' has been identified as a highly valued asset for older people, making it a likely focus for public health messages that target this age group. In our study, independence was linked to emotive issues such as staying in one's own home, feelings of pride, and not wanting to be a liability to others (Hughes et al., p. 359).

Rather than focusing on the risk of falls – the very mention of which can be anathema to older people – and the possible consequences, it is always better to start by stressing the benefits of improving strength and balance. **Strength and balance training are a key intervention to reduce the risk of falling**. Training can be given for this at home, in the community or in hospital. Activity carried out to improve balance is likely to be socially acceptable and relevant to a wide range of older people, whereas hazard reduction, which many older people interpret as restricting activity, is not (Age UK, *2012).*

5.4 Limitations

The consultation on the best approach to message fall prevention took place during unprecedented times, which impacted the uptake by groups of participants. The coronavirus impacted access to the Chinese Community Centre, for instance. We had a focus group with the group arranged for 14th February, which was cancelled on the 11th due to the recent outbreak of Covid-19 and fear for the elderly residents at the centre. They cited the importance of keeping participant numbers low, and focusing on internal workshops and talks raising awareness of the coronavirus to members, and the cancellation of all talks/events from outside. This fluid public health crisis also prevents the planned interviews with approximately ten people to gain more in-depth discussion and insight.

Participants expressed degrees of **cynicism** about the progress of their feedback and the effect of the session. The **video focus group** was small, so we hoped to re-run the meeting with a specialised digital connection group, however interest levels were low. The consenting procedure also took longer than expected, which reduced the time for the focus group (Appendix 7 and 8). A more tailored and easily accessible consent form combined with more time added to the front of the focus group would have improved the overall experience and richness of the evidence.

Accessing groups of older people pre-virus was an unexpected challenge. We did not work with Newham New Deal partnership: @nline club because they were coming up to their new cohort and had several things to deliver outside of the normal sessions. When these had passed, they enquired of the attendees whether they would want to

participate after an online session, and many said that they had busy schedules and would not be able to commit. The sessions are full, and a timetable of activities needs to be delivered, and so the group could not offer any time during the session.

We also contacted Ground Works Silver Connections as a means of connecting to their digital participants. Their project had finished last year, and they were awaiting confirmation for future sessions. They also expressed concerns about the short nature of the course (six weeks) and we would need to use a sign-up sheet/flier, rather than tapping directly into the group.

We also tried to encourage participants to get in touch with us directly. We placed leaflets in AUKEL's Dalston Lane office, where people attend the drop-in Information and Advice service (Appendix 5 and 6). We have a lot of information available and so they may have been quite swamped; however, clients are often waiting for a couple of hours in this space, due to demand. These leaflets were also made available to the attendees at the City and Hackney Older People's Reference Group meetings. We did not receive any interest using this route, which is why we relied on working with community groups.

We contacted gatekeepers such as Derman (advocacy and advice centre for Turkish and Cypriot people in Hackney) to see if they would help facilitate a focus group with the Turkish community in Hackney. The chief executive officer explained that they were unable to find a large enough number of participants who fitted our category to participate but referred us to the Turkish Cypriot Cultural Centre, who were able to assist us.

Finally, we also attempted to access older people who regularly use Hackney Lunch Clubs. The coordinator at HCVS sent out an enquiry email on our behalf to see who would be willing to get involved. He received no responses. I separately got in touch with Holly Street lunch club, and they spoke to their members, and none of them wanted to participate. However, we were able to coordinate focus groups with Woodberry Down using this route.

6. Conclusions and next steps

This section expands on what the consultation has found, and what have been the results of exposure to the three different messaging methods and to combined platforms. The findings have been inconclusive about which platform works the most effectively and what content is needed. There are plenty of commonalities and exceptions in the responses elicited. There are three key three findings. Firstly, it is important to strike the right balance in tone in recognition of older people's maturity and ensure that the language used is accessible whether or not English is someone's first language, supported with images. Secondly, information contained in the message should go beyond common-sense information and should be personalised to a group (and perhaps localised as well – local information about local services,

location of information distributed locally to groups) where possible. Thirdly, the underlying message should adopt a strength-based approach.

No one messaging method or type of content is shown to be overwhelmingly privileged in this consultation. Identification of people at risk of falls increased confidence to access falls prevention services for those who have not yet experienced a fall.

Key recommendations:

- The draft Hackney Council Ageing Well Strategy explores foot care advice to prevent falls and should look at opportunities for providing more tailored foot care advice through commissioned provision and in future public health campaigns.
- The importance of 'recognition' and 'telling' who the faller is and where to go for help.
- Avoid patronising older people, and do not forget the skills and knowledge they have acquired throughout their lifetime.
- Time needs to be made at GP surgeries to address fall prevention. Given the time constraints for doctors, perhaps group sessions led by nurses could be arranged, with a care plan to take away. The benefits would be social connections among participants (realising that they are not the only person experiencing these problems), respected quality of information, a local option, and potential for individual concerns to be addressed.
- A detailed booklet could be produced that can double up as a care plan, slightly more detailed and 'permanent' than a throw-away leaflet, which could be kept as a resource at home.
- A local falls prevention champion(s) could be created, who could be relied upon for up-to-date information. This new duty should be part of the named safeguarding officer working out of smaller community groups in Hackney, in the HCVS, and Public Institutes.
- Participants highlighted barriers to accessing local fall prevention programmes due to unclear criteria and threshold. Services need to make courses clear if they are targeted to resident has a preventative measure to their first fall or must wait until they have first fallen.
- If information is given with advice about fall prevention (e.g. exercise), then local options need to be available for people to join.[7] There is no point in educating someone on the need to stay active and strong, if there are no opportunities for this to happen.

[7] AUKEL are trialling a programme called Sparko which is a television channel which acts as a user-friendly portal to the internet. This can be used to access videos on chair-based exercises.

- People in the focus groups mostly appeared to be interested in reducing their risk of falls, but the solutions need to be local, cheap and ongoing.
- Increase access and availability by local government to help elderly people to make their homes safer (e.g. at the moment, someone trying to get a handrail fitted may wait four months).
- Make the streets and physical environment in Hackney age friendly (e.g. conscientious construction and considerate buses/public transport).
- More effort should be put into producing videos which comply with the recommendations of our research and others.
- Specific information on being careful in the bathroom is much needed.

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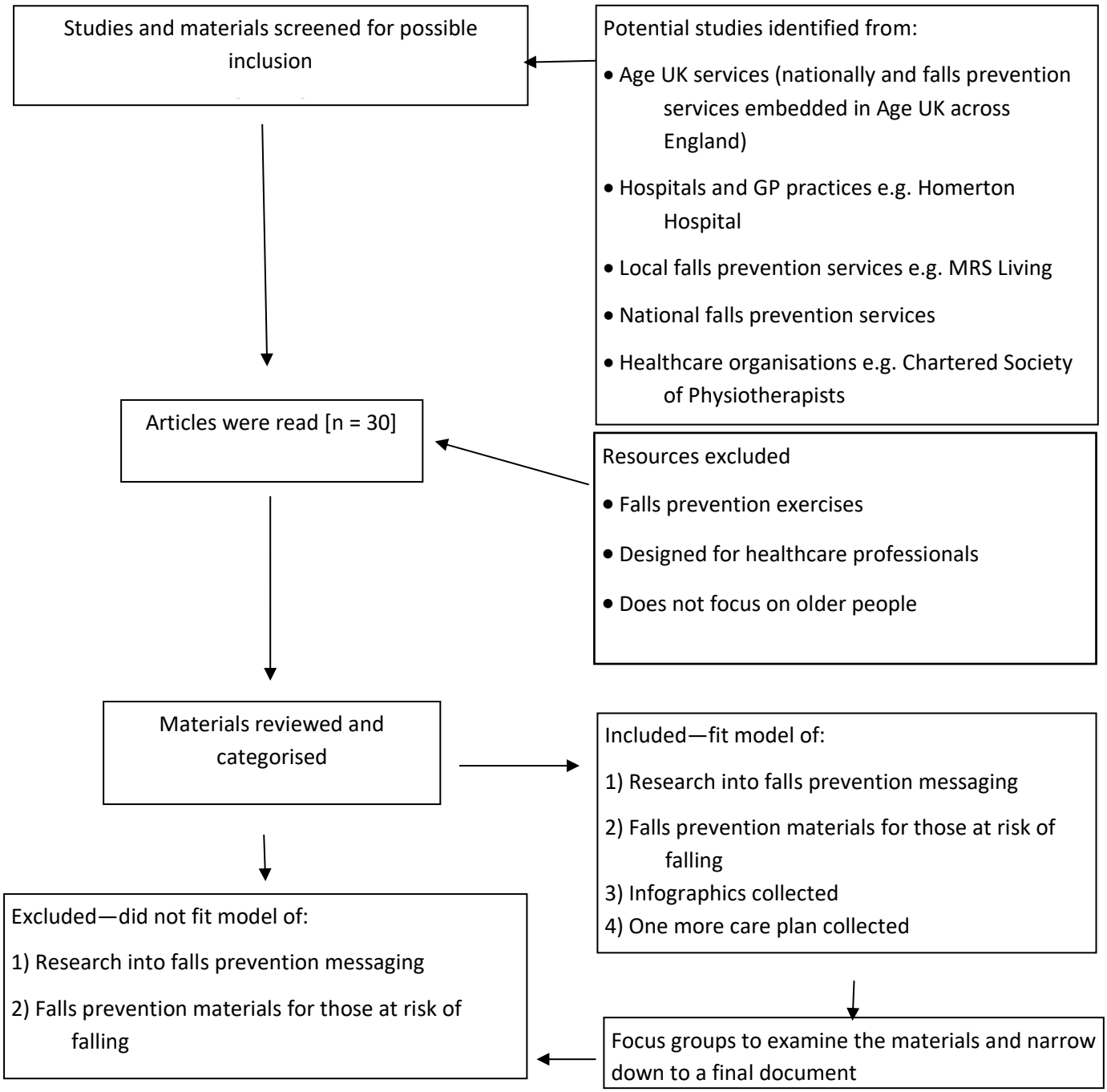
7.1 Appendix 1: Flowchart for the process of study selection



7.2 Appendix 2: Search Strategy

Search Strategy:

- Searches of similar terms were combined such as ‘falls prevention messaging’ and ‘falls prevention programmes’.
- AUKEL national were contacted to provide materials gathered from Falls Week and various falls prevention campaigns.
- GP surgeries, hospitals and falls prevention services were contacted for materials used in local programmes.

Studies selected for inclusion were based on the following criteria:

- Publication date: 2000 to present.
- Studies relating to falls prevention: the population was inclusive of men and women.
- Target age: 60+

Materials which were used to inform those at risk of falling:

- Academic research into falls prevention messaging.
- General research on the effectiveness of messaging.

Studies selected for exclusion were:

- Non-English language and published pre-1997.
- The citation does not describe a study focused on older people.
- Falls prevention exercise programmes.
- Materials which were aimed at those delivering falls prevention (healthcare professionals, carers).

7.3 Appendix 3: Consultation Process

Aug/Sept 19	**DESK BASED RESEARCH:** AUKEL to conduct desk research on approaches to messaging falls prevention. **OUTREACH:** AUKEL to engage BAME community groups.
Early October 19	**REVIEW 1:** Meeting with Darren to review results of research, consider how we present these and which questions needs asking.
Mid- Oct/Nov 19	**ENGAGEMENT PHASE 1:** AUKEL deliver 'single channel' engagement sessions and gather data.
Dec 19	**REVIEW 2:** Meeting with Darren to review results of engagement sessions and determine approach to 'multi-channel' phase.
Jan 20	**ENGAGEMENT PHASE 2:** AUKEL to deliver 'multi-channel phase' and gather data.
Feb- Mar 20	**EVALUATION:** Darren to review all data and write final evaluation.

7.4 Appendix 4: Falls Prevention Resources

Title	Date	Source	Audience	Type of resource	Description
Advice to help stop you from falling	2017 (review date Jan 2019)	NHS, Homerton Hospital	Patients	A4 Handout	Basic messaging, focus on patients
Staying Steady: Keep Active and Reduce your risk of falling	2014	Age UK England	Older People	Booklet	Emphasis on physical activity (strength and balance training)
Get Up and Go: A Guide to Staying Steady	2015	Saga (Chartered Society of Physiotherapists and Public Health England)	Older People	Booklet	Overview of falls prevention techniques
Best Foot Forward: Falls Awareness Week 2013, healthy feet supplement	2013	Age UK England	Older People	Booklet	Focus on foot care in falls prevention
Preventing Falls: strength and balance exercises for better ageing	Unknown	Age UK England et al	Older People	Booklet	Exercises
Raising the Bar on Strength and Balance	Feb 2019	Centre for Ageing Better	Healthcare, older people organisations and charities	Booklet	Overview
Patient Falls Prevention Checklist	2017	Royal College of Physicians	Older People	A4 Handout	Checklist
Postural Stability: strength and balance	2018	Later Life Training ltd. (Used by Age UK Trafford)	Older people	Booklet	Home exercise programme
Stay Stronger for Longer: take the strength and balance challenge	2018	Cambridgeshire and Peterborough Public Health Team	Older People	A4 Handout	Strength and balance programmes
Get up, stand up and don't fall down	2018	MRS: Independent Living (Adult Community Rehabilitation Team and the CCG)	Older People	A4 Handout	Exercises
Strictly No Falls Programme: Participants stories	(Uploaded) Jan 2019	Centre for Ageing	Older people	Video	Testimonials of attendee in falls prevention programme

How to Reduce Your Risk of Falling	(Uploaded) 2016	Age UK England	Older People	Video	An imagined person and their fears – and the steps she takes to prevent herself from falling
Falls Prevention Exercises: Older People's Day	(Uploaded) 2017	Charted Society of Physiotherapists	Older People	Video	Falls prevention exercises and why they are important
Falls Prevention Fuel Tank	(Uploaded) 2018	Cardiff and Vale University Health Board	Older People	Video	Why falls prevention should be done before the first fall and a number of things to consider
Are You at Risk of Falling?	2018 (review due in 2021)	NHS	Older People	Webpage and accompanying video	Interactive self-assessment online
Falls Prevention	2018 (review due in 2021)	NHS	Older People	Website	Website with a number of links for further information
Falls Prevention	Jan 2019	Trafford CCG	Older People	Website	Online resource, falls prevention information (STEADY)
Hackney – a good place to live	Unknown	MRS: Independent Living	Older People	Video	Distributed by MRS
Falls Prevention	Unknown	Age UK Enfield			Directed at healthcare professionals
A practical Guide to healthy Ageing	2015	Age UK national and NHS England	Older People	Handbook	Overview of health information for older people and space for a checklist
Falls Prevention	Unknown	Falls Prevention Bolton	Older People	Website	Overview of falls prevention and signposting to Age UK Bolton falls prevention team
Falls Prevention and Post Falls Care Plan	2016	NHS Royal Berkshire	Older people and healthcare professional	Care Plan	Checklist
Physical Inactivity in Later Life	Unknown	Age UK (It's never Too Late to be Active Conference, 2019)	Healthcare professionals, those delivering		Important findings on personalised information, signposting,

			activity programmes		combating fears that physical activity is risky/ hazardous
Your Falls Free Plan	Unknown	Age UK England	Older people	Booklet	Self-Referral sheet, interactive and informative
City and Hackney Falls Pathway	2018	Homerton Hospital and CH CCG	Healthcare professionals	PowerPoint presentation	Aimed at healthcare professionals
Don't Mention the F Word	2012	Age UK England	Healthcare professionals	Handout	Advice to practitioners about fall prevention messages to older people
Older People's View on Advice About Falls Prevention: A Qualitative Study	2006	Yardley et al.	Academic paper (those in the study- Older people: 61-94)	Study: focus group and interviews	Study on perceptions in older people of falls prevention
'We got more than we expected' Older people's experiences of falls-prevention exercise interventions and implications for practice; a qualitative study	2018	Lafond et al.	Academic paper (those in the study- Older people: 70-95)	Study: face to face interviews	A study into older people and physical activity/uptake
Falls Prevention Knowledge, Attitude, and Practices of Community Stakeholders and Older Adults	2011	Laing et al	Academic paper (those in the study: employees of senior-serving organizations and participants of FP practices by at-risk elders)	Study: Interviews	Perceptions of falls prevention in older people and community stakeholders
Older Persons' Perception of Risk of Falling: Implications for Fall-Prevention Campaigns	2008	Hughes et al.	Academic study (60 years and older)	Study: computer-assisted telephone surveys	Understanding risk of falls

Falls: applying All Our Health	July 2019	Public Health England	Healthcare professionals	Website	Ages of fallers and cost of falls estimated at £4.4 billion to the NHS
Overview: falls	2018	NHS	Healthcare professional, older people	Website	Older women most at risk of falls
Falls in later life: a huge concern for older people	May 2019	Age UK England	Healthcare professional, older people	Website and study	Women account for two thirds of hip fractures
Demographics : future trends	2011	KingsFund	Numerous	Website with a collection of research resources	Population growth figures
Easy Home Modifications to Prevent Falls	2018	Harvard Health (US)	Older People	Infographic	Advice for home modifications
Take Control of Your Health: 6 Steps to Prevent a Fall	2017	National Council on Ageing	Older People	Infographic	Overview of advice regarding falls prevention
Top 5 Causes of Falls	2013	Bright Star (Home Health Care Provider)	Older People	Infographic	Overview of advice regarding falls prevention
Falls Prevention Checklist	Unknown	Independent Age	Older People	Care Plan	Home focused checklist
Memorial Hospital's Matter of Balance	2016	National Council on Ageing	Older People, family members	Testimonial, video	Testimonial of somebody taking part in a strength and balance class
Patient Story	2013	National Quality and Safety Commission New Zealand	Healthcare professionals	Testimonial, video	Case study of an individual's falls and the failing to monitor their environment
Falls Prevention: Doctor's 4 Quick Tips to Prevent Falls	2019	University of Virginia Trauma Centre's Injury Prevention Programme	Older People, families, healthcare professionals	Video	Overview of falls prevention
Top tips to stop falling and prevent falls	2017	Sussex Community NHS oundation Trust	Older People	Video	Overview of falls prevention

7.5 Appendix 5: Recruitment Flyer

7.6 Appendix 6: Recruitment Leaflet

Would you like to improve health care information?

ARE YOU INTERESTED IN...

- Shaping health care policy
- Getting involved in community based research
- Voicing your valuable opinion

AGE UK EAST LONDON

Please get in touch with Sophie
020 8981 7124
07384 511701 or
Sophie.ibotson@ageukeastlondon.org.uk

WOULD YOU LIKE TO IMPROVE HEALTH CARE INFORMATION?

GET INVOLVED

WOULD YOU LIKE TO IMPROVE HEALTH CARE INFORMATION?

WHAT WE ARE DOING

Age UK East London are carrying out a study into the information on falls prevention. We are targeting our research at older women.

By participating, you will get a **£10 gift voucher** and help shape public health information in Hackney.

HOW TO GET INVOLVED

We need participants to take part in the study, which will take place in one afternoon. In order to get involved you need to be:

- Female, 60+ years old
- Preferably, have *not* had a fall

AGE UK EAST LONDON

To get involved, or to find out more information, please get in touch with Sophie
020 8981 7124
07384 511701 or Sophie.ibotson @ageukeastlondon.org.uk

To get involved, or to find out more information, please get in touch with Sophie at Age UK East London at 020 8981 7124 or 07384 511701 or Sophie.ibotson @ageukeastlondon.org.uk

7.7. Appendix 7: Consent form

Consent Form

In order for us to work with you, we need to record your contribution to this research. To comply with the Data Protection Act (1998) we must tell you how we use this data and ask for your permission. By ticking the boxes and signing this form you are providing your permission for us to process your data for the purposes below.

	Please Tick:
1. I give consent for Age UK East London to contact me through for further involvement in the research project, let me know of their findings and outcomes that might interest to me.	☐
2. I give consent for Age UK East London to share anonymised information about me and my case with our funders to help show the impact of the service and help ensure it continues.	☐
3. I give consent for Age UK East London to share information recorded in this focus group with the University of East London, who are assisting us with the research.	☐
4. I give consent for audio equipment to be used and notes to be taken to capture the contributions made—this information will be securely held	☐

Name of Client: _____ **Date:** _____ **Signature:** _____

Name of Representative: _____ **Date:** _____ **Signature:** _____

7.8

Appendix 8: Consent Form: Participant Information Form

Useful Information about

Privacy and Consent

Client Copy

What is personal and sensitive data?

Personal data is data which can be used to identify you. This may include your name, date of birth, address, telephone number etc. Sensitive data is information related to any of the following: racial or ethnic origin, political opinions, religious beliefs, trade union membership, health, sexuality or sex life, offences and/or convictions.

The kind of information we record and use

It is up to you to decide what you share with us. Some information is personal, it could be used to identify you. This includes your name, date of birth, address, or phone number. Some may be sensitive information related to your racial or ethnic origin, political opinions, religious beliefs, trade union membership, health, sexuality or sex life, offences or convictions.

How we'll store your information

We'll store the record of your case in a secure case management system, which is only accessed by the Age UK East London staff and volunteers who helped you. Paper copies of your information may also be stored securely and accessed by staff and volunteers of Age UK East London.

Giving consent without using your real name

You can consent without using your real name, but we can't support you unless we create an unnamed record of your case, which we need for quality assurance purposes. Other personal information might be recorded if you choose to give it to us. Choosing not to use your real name will not affect the level of service or support you receive, and we'll never try and identify you if you have chosen to be an unnamed client. If you choose to be an unnamed client we will give you a reference number for your case instead.

How we might share your personal information

We won't share your personal information without your permission, unless we're required to do so by law, for example in safeguarding situations. We might ask another part of the organisation to contact you, so we can find out if you were satisfied with the service you received and the impact of the help you received from us.

We will share anonymised (unnamed) information about you, how you contacted us, what type of help you needed, what level of support you received, and the impact of that help with our funders.

How long will you keep my information?

We will keep a copy of your information on our computer, database or paper files for 6 years after our last contact with you. If we do not hear from you for 6 years we will remove your information and destroy any paper records we are holding.

Complaints handling procedure

If you're unhappy with how we record and use your information please contact us at info@ageukeastlondon.org.uk or visit our website www.ageuk.org.uk/eastlondon/about-age-uk-east-london and follow the feedback tab to leave your comments.

Appendix 9: Focus Group Survey: Workshop 4 and 5

Falls Prevention

Opening Questions

What is your gender? (Please circle)

Male / Female /Other

How old are you? (Please circle)

50-60 60-70 70-80 80-90 90+

Fall history (Please circle)

Never had a fall / Had a few falls / Fall occasionally / Fall a lot

What ethnicity are you (Please circle)

White

Asian/Asian British

Black / African / Caribbean / Black British

Mixed

Other Ethnic Group

Falls Prevention

Opening Questions

What would be the best way to learn about falls prevention?

What could you do to help prevent a fall?

7.10 Appendix 10: Poster/Leaflet Focus Group Questions: Workshop 1

We are here today to talk about how to prevent and help older people from having their first fall. AUKEL is trying to produce promotional messages for older people to prevent and/or recover from their first fall, so they do not loss their confidence and start to loss connections and friendships outside of the home.

I would like to audio record the discussion, so please speak loudly and one at a time to ensure that we capture everyone's voice and insights.

Q1. Please tell me circumstances of your first fall in later life? (10 minutes)
Probe: Where, how and why did it happen?

Q2. How did it affect your confidence? (10 minutes)

Probe: Did it stop you from doing normal outdoor activities?

Probe: Did you tell anyone?

Probe: What advice and support was you given?

Q3. What type of written advice would have been helpful before/after? (15 minutes)

Probe: What is the best tone to use?

Probe: What is the range or type of language?

Probe: What is the most effective type of imagery?

Q4. What information should it contain? (15 minutes)

Probe: common sense or additional

Probe: strength vs deficit approach

Q5. What would stop you from picking this leaflet? (10 minutes)

Probe: would you pick this up if you saw it e.g. in a GP waiting room?

Probe: Is the information clear?

Q6. Closing discussion (5 minutes)

Probe: Thinking about all that we have talked about today I want to ask some final questions.

Probe: What single thing would most improve the prevention of falls in your community?

Probe: What single thing would improve the messaging?

AFTER the focus group interview procedure

- Make sure to ask if people have any final thoughts to share.
- Explain what will happen next (e.g., data will be analysed, findings will be presented).
- Thank people for coming.
- Immediately record any observations or reflections after the participants have left the session. For example, were there any surprises during the session? Were there some questions participants were hesitant to answer?

- Store notes, consent forms, audio-tapes, etc. in a secure location. Make sure everything is labelled with the date and time of the focus group interview meeting and be certain that notes/transcripts do not contain any identifying information.

7.11 Appendix 11: Presentation/Care Plan Focus Group Questions: Workshop 3

We are here today to talk about how to prevent and help older people from having their first fall. AUKEL is trying to produce promotional messages for older people to prevent and/or recover from their first fall, so they do not loss their confidence and start to loss connections and friendships outside of the home.

I would like to audio record the discussion, so please speak loudly and one at a time to ensure that we capture everyone's voice and insights. This discussion is focused on a presentation and care plan.

Q1. Please tell me circumstances of your first fall in later life? (10 minutes)
Probe: Where, how and why did it happen?

Q2. How did it affect your confidence? (10 minutes)
Probe: Did it stop you from doing normal outdoor activities?
Probe: Did you tell anyone?
Probe: What advice and support was you given?

Q3. What type of support and advice would have been helpful before/after? (15 minutes)
Probe: Personalised/specific vs overview
Probe: common sense or additional
Probe: strength vs deficit approach

Q5. What do you think to the about the layout of the care plan? (10 minutes)
Probe: Brief or more detail?
Probe: Is the information clear?

Q4. Would you fill out a care plan independently? (15 minutes)
Probe: Would you fill one of these out without prompt?

Q6. Closing discussion (5 minutes)
Probe: Thinking about all that we have talked about today I want to ask some final questions.
Probe: What single thing would most improve the prevention of falls in your community?
Probe: What single thing would improve the messaging?

AFTER the focus group interview procedure

7.12 Appendix 12: Video Focus Group Schedule: Workshop 2

We are here today to talk about how to prevent and help older people from having their first fall. AUKEL is trying to produce promotional messages for older people to prevent and/or recover from

their first fall, so they do not loss their confidence and start to loss connections and friendships outside of the home.

I would like to audio record the discussion, so please speak loudly and one at a time to ensure that we capture everyone's voice and insights. This discussion is focused on a video.

Q1. Please tell me circumstances of your first fall in later life? (10 minutes)
Probe: Where, how and why did it happen?

Q2. How did it affect your confidence? (10 minutes)
Probe: Did it stop you from doing normal outdoor activities?
Probe: Did you tell anyone?
Probe: What advice and support was you given?

Q3. What type of advice would have been helpful before/after? (15 minutes)
Probe: What is the best tone to use?
Probe: What is the range or type of language?
Probe: What is the most effective type of imagery? Real people vs cartoons

Q4. What information should it contain? (15 minutes)
Probe: common sense or additional
Probe: strength vs deficit approach

Q5. In what situation would watch/look at online material? (10 minutes)
Probe: would you watch this if it came up e.g. in a GP waiting room?
Probe: Is the information clear?

Q6. Closing discussion (5 minutes)
Probe: Thinking about all that we have talked about today I want to ask some final questions.
Probe: What single thing would most improve the prevention of falls in your community?
Probe: What single thing would improve the messaging?

AFTER the focus group interview procedure

7.13 Appendix 13: Focus Group Surveys: Workshop 4 and 5, Reflection Sheet

Falls Prevention

Reflection Questions

Please consider these questions as a representative of a cohort of older people

Which was the most useful form of communication?

(Please circle)

Poster / Online / Presentation

Why is that useful for older people?

What will you change to prevent a fall?

Falls Prevention

Reflection Questions

Please consider these questions as a representative of a cohort of older people

Which was the most effective medium? (Please circle)

Poster / Video / Presentation

Why did you select that medium?

What will you change to stop yourself from falling?

7.14 Appendix 14: Focus Group 4 and 5 Schedule A.

Returning Focus Group Jan-Mar 2020		
First survey		Characteristics: name, race, age, gender, fall history Questions 1) What do you remember most about the initial meetings? 2) What changes have you made personally since that meeting? 3) What was missing?
Warm up		What do you remember most about the initial materials? Which is the most effective medium?
Vote on order		
Approach One: Posters	10m	Have posters hung up around the room before participants arrive. Ask them to place a sticker on the posters that they do or don't like How long does it take for you to ignore a poster that you see regularly?
Approach Two: Videos	10m	Show them two videos and ask them to vote on which one they prefer using the paddles
Approach Three: Presentation	10m	Presentation on falls prevention • Would a presentation be best delivered by somebody you know (e.g. outreach worker, somebody leading a community group) or a healthcare worker?
Second survey (on small postcards)		• Which was the most effective medium (poster/video/presentation) • Why did you select that medium? • What will you change to stop yourself from falling?
Materials		• Paddles (green and red) • Stickers (and a chart with the sticker colours and corresponding meaning) • Two surveys • Recording sheet (with questions asking and paddle options) for assistant
Focus		• Messaging • What's changed? • Narrowing the focus, moving away from the personal stories, towards the critical views as a member of a cohort • Pull out the criteria for best practice, what components make effective messaging • Finding a consensus Coproduce -> co-design -> disseminate

7.15 Appendix 15: Focus Group 4 and 5 Schedule B

New Cohort (Chinese Centre, Turkish Cypriot)		
Warm Up		Pink Sheet What has been your experience of falling?
Posters		
Approach One: Posters	10m	Ask them to place a sticker on the posters that they do or don't like How long does it take for you to ignore a poster that you see regularly? Stickers: All colours: Good Red: Bad *Annotate where possible*
Videos/electronic		
Approach Two: Online	10m	Who uses the internet? Who uses it for health information? Who would like to use it for health information? Would it be useful to help people access those resources? Who watches the videos in the GP practice? Do you pay attention to them?
Presentation		
Approach Three: Presentation and falls prevention survey	10m	Presentation on falls prevention • Would a presentation be best delivered by somebody you know (e.g. outreach worker, somebody leading a community group) or a healthcare worker? Hand out falls prevention checklist • Would it be useful to have help to go through a checklist or care plan like this?
Survey		
Survey (on small postcards)		• Which was the most effective form of communication (poster/online/presentation) • Why did you select that method? • What will you change to stop yourself from falling?

7.16 Appendix 16: Leaflets: Workshop 1

East London age UK

M·R·S· Independent Living

NHS Homerton University Hospital NHS Foundation Trust

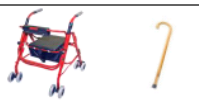
Get up, stand up and don't fall down

A self help guide to reduce your risk of falling

Staying Steady – Community Falls Prevention in Hackney
A project of MRS Independent Living

NHS Homerton University Hospital NHS Foundation Trust

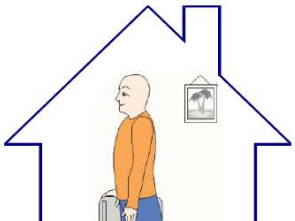
Advice to help stop you from falling

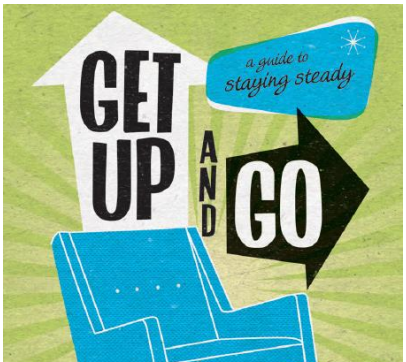
	The hospital wants to help to stop you falling
	Please wear sensible shoes or slippers that fit you
	Make sure you wear your glasses and hearing aid
	Remember to use your walking frame or stick when moving about
	Please tell the nurse if you are worried about walking or falling

Incorporating hospital and community health services, teaching and research

POSTURAL STABILITY
STRENGTH & BALANCE

Home Exercise Programme

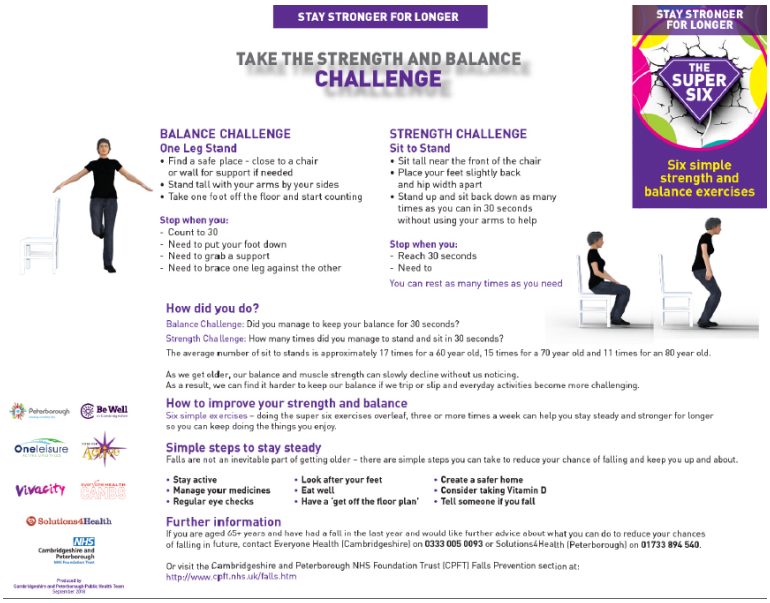




age UK
Improving later life

Best foot forward

Falls Awareness Week 2013
– healthy feet supplement



STAY STRONGER FOR LONGER

TAKE THE STRENGTH AND BALANCE CHALLENGE

STAY STRONGER FOR LONGER
THE SUPER SIX
Six simple strength and balance exercises

BALANCE CHALLENGE
One Leg Stand
- Find a safe place - close to a chair or wall for support if needed
- Stand tall with your arms by your sides
- Take one foot off the floor and start counting

Stop when you:
- Count to 30
- Need to put your foot down
- Need to grab a support
- Need to brace one leg against the other

STRENGTH CHALLENGE
Sit to Stand
- Sit tall near the front of the chair
- Place your feet slightly back and hip width apart
- Stand up and sit back down as many times as you can in 30 seconds without using your arms to help

Stop when you:
- Reach 30 seconds
- Need to

You can rest as many times as you need

How did you do?

Balance Challenge: Did you manage to keep your balance for 30 seconds?

Strength Challenge: How many times did you manage to stand and sit in 30 seconds?

The average number of sit to stands is approximately 17 times for a 60 year old, 15 times for a 70 year old and 11 times for an 80 year old.

As we get older, our balance and muscle strength can slowly decline without us noticing. As a result, we can find it harder to keep our balance if we trip or slip and everyday activities become more challenging.

How to improve your strength and balance

Six simple exercises – doing the super six exercises overleaf, three or more times a week can help you stay steady and stronger for longer so you can keep doing the things you enjoy.

Simple steps to stay steady

Falls are not an inevitable part of getting older - there are simple steps you can take to reduce your chance of falling and keep you up and about.

- Stay active
- Manage your medicines
- Regular eye checks
- Look after your feet
- Eat well
- Have a 'get off the floor plan'
- Create a safer home
- Consider taking Vitamin D
- Tell someone if you fall

Further information

If you are aged 65+ years and have had a fall in the last year and would like further advice about what you can do to reduce your chances of falling in future, contact Everyone Health (Cambridgeshire) on **0333 005 0093** or Solutions4Health (Peterborough) on **01733 894 540**.

Or visit the Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Falls Prevention section at: http://www.cpft.nhs.uk/falls.htm

Produced by Cambridgeshire and Peterborough Public Health Team September 2016

What can I do?

The following twelve-point checklist can be used by patients and their carers and families.

Tell the nurse or doctor looking after you if you have fallen in the last year, are worried about falling, or have a history of falls.

Use your call bell if you need help to move, in particular, if you need help going to the toilet.

Make sure glasses are clean and used as prescribed. Ask for help if you are having trouble seeing.

Use your usual walking aid, keep it close by and check for wear and tear on the rubber feet. Never lean on hospital furniture as it's often on wheels.

When getting up:

- sit upright for a few moments on the edge of your bed before standing
- get up slowly and making sure you feel steady before walking.

7.17 Appendix 17: Infographics: Workshop 4 and 5