

Positive Action on Falls:  
A Peer Education Approach

**Evaluation Report**

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It is rare in any practice intervention for an evaluator to be appointed at the very beginning and to be able to remain so closely involved throughout the process. It has been a privilege to be in this position and to be a member of such an active project steering group.

The steering group membership was:

Lindsay Longfield (LL) – Falls Prevention Co-ordinator (who initiated the Project)

Susan Bartlett (SB) – Health Visitor, Airedale Primary Care Trust

Joan Dally – Senior Physiotherapist, Bradford Hospital NHS Trust

Joan Robertshaw – Service Development Manager,

Zeenat Hussain (ZH) – Health Development Specialist (BME), Bradford District Health Development Service

Terry Allen (TA) – Evaluator, University of Bradford

I am especially indebted to the peer mentors themselves for their painstaking commitment to the evaluation and to the many group participants for the information provided. My thanks are also due to my colleagues Fahmida Ashraf (FA) and Cheryl Shackleton (CS) - both of the University of Bradford - who carried out the focus groups on my behalf.

## Executive Summary

(Figure in brackets refer to sections of the full report)

1. The Positive Action on Falls programme was an imaginative and ambitious initiative which reached over 2,000 people using just a few volunteer presenters.
2. There was evidence from the evaluation that people had responded directly to the programme to make one or two changes which might reduce the likelihood of a fall (5.1.6).
3. The project challenged the myth that older people were resistant to exercise to improve strength and balance, and that falls, and injury, are therefore inevitable (6.1).
4. In order to be successful, support groups for peer mentors are essential (5.2.4), as is effective and well organised management and co-ordination (5.2.2). The demands on the co-ordinator of such schemes should not be underestimated and the responsibility for promotion and publicity can be onerous.
5. The peer mentor model is a cheap, effective and enjoyable way to present information of this sort and is valued by participants (5.1.2/3). It relies on a strongly committed body of mentors who are motivated by a belief in what they are doing (5.2.4).
6. It is also an 'empowering' approach whereby people are given information within a secure group setting and accompanied by some basic practical advice. Participants are encouraged to assess the risks themselves in their home environment and decide either to continue to take them or ameliorate them.
7. 'Retaining control' in this way appears to be an important issue (6.3.5) and has lessons for how health professionals respond. The finding that over

ninety per cent of people who have a fall not requiring medical treatment do not confide in a health professional requires urgent exploration as there were indications that one reason may be concern about how intrusive the response might be. It also means that they therefore receive no help or advice on what measures they might take themselves to prevent another fall (6.2.4).

8. Secrecy about falls seems common and the evaluation gained empirical evidence for the long held assumption that the 'true' falls rate is likely to be very high indeed (5.1.5).
9. Although the programme was effective as a 'one-off presentation' (which was its principal aim), reflection has suggested the desirability of follow up sessions by peer mentors as 'refreshers' and of specific exercise input (5.3.2). Demonstrations of what safety aids are available (5.3.3.2) could be incorporated in a broader falls prevention programme and relevant agencies – housing and social services for example – could be also engaged in the process. The focus groups revealed the benefits to learning and sharing of group discussion around such sensitive topics and this facility too could be built in for those who want to take part.
10. Clearly health professionals have a significant role in falls prevention by providing comprehensive assessments where appropriate – especially for people who have already had a fall - and in giving expert advice and training. In the preventative public health arena however, where this programme is located, there is considerable scope for a more complementary role within the broad 'educational and facilitative' approach outlined above which can utilise the peer mentoring contribution because of its relevance and acceptance by older people.

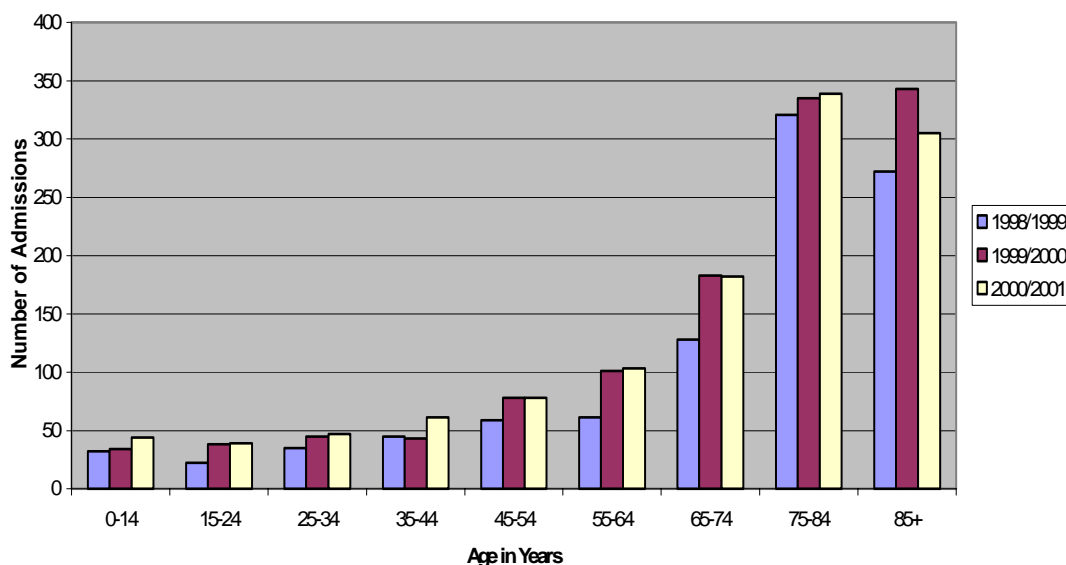
## Chapter One – Introduction

### 1.1 'Falls' as a Health Problem

There is general consensus, based on epidemiological studies, that between 30 and 40% of people over 65, and living in the community, fall each year (Stalenhoef *et al*, 1997, Kenny *et al*, 2001); almost three quarters sustain arm, leg or shoulder injuries as a result. The number is higher in institutions and increases with advancing age. Apart from the likelihood of physical injury, falls often result in a loss of confidence and a deterioration in the person's ability to live independently (HEA, 1999). The personal and economic consequences are therefore substantial and falls among older people represent a major public health problem.

**Figure 1**

#### Hospital Stay of Four Days or More due to Falls Related Accidental Injury, Bradford District



In the Bradford District, in the year 1999/2000, 678 people over the age of 75 were admitted to hospital for four days or more due to an accidental fall; this number appears to be increasing annually (Figure 1). Programmes aimed at their reduction form Standard 6 in the National Service Framework (NSF), with the aim of establishing an Integrated Falls Service by 2005.

Positive Action on Falls represented a novel approach to providing practical information to groups of older people using volunteer tutors - 'peer mentors' – delivering a set programme focussing on risk factors and simple exercise techniques. By September 2003 137 groups had been involved, representing around 2,200 people aged from 60 – 94 years.

### *1.2 Structure of this report*

In Chapter Two I review some of the literature around falls prevention in older people and consider policy issues which underpin current practice and the general lack of originality in approach.

Chapter Three looks at the genesis of the Positive Action on Falls initiative, the philosophy underlying it, how it was planned to operate and what actually happened in practice.

Chapter Four considers the problems in evaluation – from as 'simple' a premise as asking 'what is a fall?' – to the complexities of a design which looks at both the outcomes for participants and the usefulness of the peer mentoring approach in this sort of context. I also tried to address important issues around assessing 'learning' and the extent of behavioural change. Inevitably, given its ambitious nature, the evaluation was not without both methodological and practical problems.

Chapter Five reviews the findings, using data from questionnaires, focus group interviews and the peer mentors themselves.

In Chapter Six, I discuss the learning gained, the value of the model, and implications for future practice in this.

## Chapter Two – A Brief Review of Relevant Literature

### *2.1 Understanding the Issues*

As in any project designed to address a major problem, there is an array of research and information literature to draw on. I concentrated on two broad headings: policy - what might inform current thinking and strategy - and practice – what interventions have been tried and which seemed to have been most effective?

I was struck by the dominance of ‘the professional’ in all areas of assessment and intervention with that conveniently homogeneous group ‘the elderly’ – the term used in most of the health literature and one which may refer to anyone from their mid-fifties to eighty plus and beyond, although actual ages are often not specified at all. Accident prevention work is always problematic because you are trying to persuade someone to take precautions against an occurrence which their experience shows is very unlikely to happen.

### *2.2 Falls Prediction and Assessment*

Prediction of risk, and therefore targeting of intervention, is inherently difficult. Ruchinkas (2003) calls for a recognition of this and a realistic attitude towards anyone’s abilities to forecast infrequent events. In their study, Nikoletti and Myers (2003) found that although the falls assessment tools used showed good test/retest reliability, accuracy was limited and that neither these nor clinical judgement was sufficient to predict falls risk with any confidence. Meyer (2003) found that a balance test added only marginal information, although poor ‘gait’ was seen as a contributory factor (Stalenhoef *et al*, 1997; Cesari *et al*, 2002). Ruchinkas (*op cit*) came to a similar conclusion about the unreliability of clinical judgement and concluded that the major predictors of a propensity to fall were the presence of a neurological condition (e.g. depression) and a previous history of falls.

In spite of the uncertain nature of assessment, and how useful and reliable it is, Gillespie *et al* (1999, 2002) in an extensive literature review, found that the

emphasis was invariably on the importance of the “trained health professional” and hazard assessments that are “professionally prescribed” (Gillespie *et al*, 2002: abstract). Intervention viewed in this way appeared therefore to be seen as something that was ‘done to people’. I was concerned, firstly, about the ageist implications here and was aware that Stevens and Crouch (1995), for example, remarked on negative stereotyping within nursing, and Koch and Webb (1996: 954) referred to “inflexible routines within health care practice”. Secondly, policy also seems to focus strongly on an individualist medical model – the impact of the health professional’s expertise on the person. There was less acknowledgement of the aggregate – public health – dimension of falls prevention; i.e. that knowledge about ‘safe practice’, recognising hazards etc., might be available to all and the individual then could decide how or whether to respond. An individualist approach relies strongly on the power of the health professional as the expert whose intervention may involve radical changes to the home and garden environment, and the introduction of exercise regimes etc. Simpson *et al* (2003) found that

home visits tended to be regarded as intrusive. Inadequate negotiation about adaptations was widespread and led to resentment and unwillingness to co-operate

Simpson *et al*, 2003:152

Hence the role of the expert as the sole instrument in falls prevention remains a problematic matter in the face of concerns about acceptability of intervention and questionable assessment and prediction capacities.

While there are public health initiatives around falls prevention they tend to rely on the place of exercise in preventing falls through improving strength, balance and addressing gait problems (see above) and for its more general perceived beneficial effects. This ‘commonsense’ rationale however still lacks convincing evidence of its impact on the likelihood of a fall. In a substantial study by Cornillon *et al* (2002) 300 ‘elderly’ participants (mean age 71), divided equally into control and intervention groups, experienced 10 sessions of physical activity. Although there were significant increases in balance,

muscular activity and co-ordination there was no significant reduction in falls incidence ( $p = 0.32$  – a very poor correlation).

Virtually all commentators call for a greater awareness of the risk of falls as an essential health concern for older people but I found scant evidence of the part that ‘self-help’ might play in responding to this need. Indeed at a falls prevention conference in Bradford, those attending still largely saw the ‘lessons’ as requiring more from professionals with virtually no recognition of the part persons themselves could play (Longfield, 2001).

Yet at a senior policy level it is recognised that older people should not be seen as inevitably deficient and that “An effective strategy can ...influence how organisations work and encourage the consultation and engagement of older people themselves” (HEA, 1999:14).

### *2.3 Practice in Falls Prevention*

As with many health promotion initiatives the field is characterised by piecemeal interventions, poorly evaluated and reliant upon intuitive notions of what ‘needs to be done’, inevitably derived in the main from the policy influences remarked upon above and resulting in professionally dominated programmes. Yet it is of concern that there remain few trials which are of proven efficacy. The Cochrane Review excluded any study that was not designed as a Random Controlled Trial (RCT) as well as those which were RCTs but did not look at the actual incidence of falls as an outcome, referring instead to what the reviewers called “intermediate or surrogate outcomes such as balance, gait and muscle strength” (Gillespie *et al*, 1999: 12); the aforementioned study by Cornillon *et al* (2002) is an exception, but failed to show any correlation between these factors and a reduction in falls.

Nevertheless there remained the consensus (Gillespie *et al*, 1999 and 2002) that the most successful interventions were likely to be those that targeted multiple, identified, risk factors in individual patients and focussed on behavioural methods – views reiterated by Kenny *et al* (2001) and Runge (2002) in their comprehensive reviews of knowledge around falls risk factors

and mechanisms. Anecdotally I knew of several programmes where older people visited homes and made safety assessments – essentially acting as ‘substitute professionals’ - but there were few references to the sort of programme which ‘Positive Action on Falls’ was promoting, that based on the participation of the risk group itself and one which seemed to offer both a novel practice route and one which was in tune with current policy with its emphasis on service user participation.

Engagement of peers in developing ‘safer living’ is more than a vague rhetorical aspiration as there is a popular view (Finch, 1997) that intervention and advice is more readily accepted from those who are similar in age and appearance to the recipients. There was also an expressed need locally since organisers of older people’s groups frequently enquired if there was ‘someone’ who could provide a session on ‘falls prevention’ as many of their members had experienced a fall. Requests were currently met in an *ad hoc* way if there was a member of the professional health team with an interest in falls prevention.

## Chapter Three - The Intervention Programme

### 3.1 Structure

The pro-active 'Positive Action on Falls' programme was set up to benefit people of 65 years and over and living within the City of Bradford Metropolitan District Council's boundary. The Falls Prevention Co-ordinator (LL) initiated the project and obtained DTI funding for it. Its aims and rationale were specifically to raise awareness through a 'one-off' presentation giving information and some instruction in simple exercises (Box 1). The programme used material from the DTI leaflet 'Slips, Trips and Broken Hips' and also reflected the general consensus emerging from some of the literature reviewed earlier on the importance of maintaining balance and strength, as well as reviewing medication and possible environmental changes (Kenny *et al*, 2001; Runge, 2002).

#### **Box 1 –The 'Positive Action on Falls' Programme**

- Older people will be trained as 'peer mentors' to deliver falls prevention information and education sessions to their peers - dispelling myths and promoting a positive message of maintaining and regaining independence.
- Older people who have experienced a fall and are now maintaining their independence will be involved in the session as 'positive role models'.
- 'Peer mentors' will act as change agents helping older people to help themselves by identifying:
  - simple falls risk factors, which can be addressed by, for example, a visit to the optician.
  - specialist services for more complex risk factors e.g. physiotherapy, medicine review by GP.

The 'peer mentors' and 'positive role models' were to receive training in falls prevention and be required to provide a concise but comprehensive session to groups of older people following a strict protocol (Appendix I). Presenters were not to be 'substitute professionals' and would not give health advice.

'Peer mentors' were to be paid £15 per session and 'positive role models' £10 per session in addition to travelling expenses where requested.

The training spread over 2 sessions and is broadly detailed in Box 2:

### **Box 2 – Training Objectives**

Gaining knowledge of risk factors associated with falls

Which service to access if a risk factor is identified

Gaining local knowledge of exercise activities

Very basic demonstration of 'sit to stand' and 'side step' for strength and balance

Peer mentor programme delivery techniques

Protocols and systems for delivering, monitoring and evaluating the 'Positive Action on Falls' Programme.

The training programme itself was developed by LL and SB and based on work by Bob Lavanture of Loughborough University.

Initially Bradford District's extensive voluntary and statutory sector network of older people's groups were to receive the Programme and this report deals primarily with the evaluation of that stage.

## *3.2 Programme Experience*

### *3.2.1 Management and Promotion*

The Steering Group included representation from the Bradford and District Falls Task Group which is multi-disciplinary in nature, comprising a physiotherapist, a Social Services development manager and health visitor, as well as the District Falls Prevention Co-ordinator and myself as evaluator.

In practice the programme broadly operated in line with the plan but with some notable departures as the project progressed - some disappointing but others enlightening, progressive and unexpected. Like many innovative schemes launched on the euphoria of its proponents, expectations about its

irresistible appeal proved optimistic (Allen, 2003). The programme was promoted by sending out leaflets to social services departments and older people's organisations, as well as through the activities of steering group members.

### *3.2.2 Peer Mentors*

Recruiting peer mentors was done in a similar way but the most effective route was through personal contact – talks etc – by members of the steering group. An initial target of around 50 throughout the span of the programme was radically revised in favour of focusing on a smaller number who could be well supported and given a wide range of practice experience. In the event actually linking with groups also proved to be problematic and was a particular headache for the project (see later). However, of the fourteen peer mentors originally recruited, ten remain and two of the four to drop out did so through ill health. All ten are female and aged from 69-89. That so many have continued working with the project is a testament to their own sense of group identity and the attraction which the project holds for them.

If peer mentors were difficult to recruit then 'positive role models' proved impossible. Clearly I cannot say what difference they would have made to the way the programme was presented and received but in practice the peer mentors, many of whom had experienced a fall, filled the role themselves. There may have been an issue of 'status' here since the peer mentor was clearly the more attractive role. In that context, one of the peer mentors who had dropped out did so through failing eyesight and had also had two falls as a result; she was invited to be a 'positive role model' but declined saying that *"no one would want to listen to me"*.

### *3.2.3 Response by Agencies*

In spite of the apparent demand for 'falls input' which had preceded setting up the project (2.3), identifying, and getting a response from, appropriate groups proved more difficult. Steering group members used their personal contacts initially but it then needed quite a sustained campaign of continuing to publicise, remind and cajole agencies. Much depended on the preferences

and enthusiasm of whoever organised or facilitated the groups and in retrospect the programme seriously underestimated what would be needed here.

#### *3.2.4 Project Worker*

The project suffered throughout its operation from the lack of a dedicated worker specifically to promote and manage the programme – at 25 hours a week this was an important post. Unfortunately, the beginning of the project coincided with the abolition of District Health Authorities and the project had been set up under the aegis of Bradford HA. Hence there was much confusion over which of the PCTs actually held the budget and would then be responsible for recruitment and financial management. This took months to resolve which further held up an appointment. The lack of a worker meant that the peer mentors also experienced a lack of direction, once the training was completed, and although there were vital support groups throughout the programme there was an absence of a single reference point. Effective administration was shared between two workers - the Falls Prevention Co-ordinator (LL) and a steering group member (SB) - each of whom had other responsibilities. This could never compensate for the absence of a 25 hours per week worker to assist with recruiting, training and supporting the peer mentors, as well as general administration and organising materials – all of which still had to be done. The difficulty of finding administrative staff for very short-term projects is a familiar feature - which is ironic because such initiatives require the tightest control and firmest direction as there is no time to get it wrong.

#### *3.2.5 Ethnic Minority Groups*

There was however an unexpected bonus. It had been anticipated that given the way the project was set up to focus on people in their late 60s onwards, the participants and peer mentors would be principally white residents in Bradford because this older population is predominantly white. Data for December 2002 from the four Primary Care Trusts in Bradford showed that 6.0 % of the South Asian population were aged 65 and over, whereas for the non-South Asian, this figure was much higher, at 17.5%. While it had been

planned that learning from this project would be ultimately transferred across ethnic communities it actually happened much sooner than anticipated when, by August 2002, part of the budget for the project worker was released and used to recruit peer mentors from the South Asian community. The focus was particularly on Urdu and Punjabi speakers, and a worker (ZH) from the Bradford District Health Development Service (BDHDS) co-ordinated this aspect very effectively. Fifteen peer mentors were recruited, predominantly women but including four men, and had run 80 sessions by the end of September.

The mode of delivery and the way the groups were set up was different although the programme remained the same. Because of problematic literacy amongst participants, there was an emphasis on oral as well as performative presentation. The 'script' was translated into several Southeast Asian languages (Gujerati, Urdu, Punjabi, Bengali and Hindi) and recorded on to cassette. The sort of groups accessed were also different, with peer mentors able to tap into the very wide network of extended family, community and social gatherings, all of whom were appropriate subjects. Although the BDHDS worker attended most steering groups, and the administrative process remained the same, peer mentor groups met separately. In many ways it felt as though they operated, in practical terms, as separate projects but there were plans for the peer mentors to meet together and it is likely that closer co-ordination would have come about had it not been for the worker being involved in a serious road accident in September 2003. Detailed data about these groups are limited and evaluation was confined to running some focus groups – see later.

Because there were some small differences in the way the programme was presented to ethnic minority groups, I have, at various places in the report, needed to differentiate between them. As one set started later than the other, I refer to the original, and predominantly white, groups and the peer mentors associated with them, as Phase 1 and the ethnic minority groups as Phase 2.

## Chapter 4 - Evaluation

Evaluation was built into the model from the design stage. Such early involvement of the evaluator (TA) helped to identify features which were 'evaluatable' and those which were more problematic. The resultant design nevertheless was fairly ambitious. *Please bear in mind that this chapter refers principally to design issues and implementation carried out with the **Phase 1 groups**. Phase 2 arose when the project was well under way (3.2.5) and its evaluation was confined to using focus groups, as I explain in section 4.5.1.3.*

### 4.1 Methodology

In addition to assessing the efficacy of the intervention I also wanted to look at the appropriateness of the delivery model and, in more depth, at some of the assumptions about older people which were identified in the policy discourses alluded to in 2.2.

#### Box 3 – Falls and Their Aftermath

What is a 'fall'?

Does a fall only count if there is an injury?

If so, how serious does the injury have to be?

Must it be one which requires medical attention?

When, why and how might you report a fall?

Why report it?

To whom?

What happens as a result?

Will the person having had the fall know what will happen before reporting?

How far does he/she remain in 'control' of events after reporting?

[Subtext: May there therefore be denial of a 'fall' ("I can manage OK, I don't want someone telling me what to do")? What may be the effect on independence and autonomy?]

As an example of the challenges for the programme and its evaluation, there were, even at the apparently simple level of 'reporting a fall', contentious and problematic dimensions (Box 3):

#### *4.2 Strategic Issues*

The programme's aim was to broaden knowledge and alter behaviour but how do you measure knowledge – short of a test - and what evidence is there that increased knowledge necessarily results in changed behaviour? For example few people can be unaware of the dangers of smoking yet the habit persists; more relevant to the current project is that in accident prevention among children (Allen and Fawcett, 1999) there was little evidence that parents were unaware of the hazards or how they might be reduced (Kendrick, 1994) but, for various reasons, this did not necessarily translate into any action. Given that the desired outcome from the programme is that people undertake their own analysis of risk accompanied, where appropriate, by change in their behaviour or immediate environment, one can see the accomplishment of such tasks as a 'proxy' for learning. This would be a simple and informal process whereby a participant may, following the peer mentor's presentation, relocate an item of furniture, get their eyesight checked out, query the side effects of medication etc. and, if followed through, be said to have gained in a practical sense from the input.

Clearly I needed a fairly complicated evaluation design to access such complex issues or at least create a suitable 'climate' in which such features could be discussed. The primary aim – assessing how far the programme impacted on knowledge and behaviour - was approached using the model by Kirkpatrick (1979) and usefully developed by Boverie *et al* (1994):

Reaction

Learning

Behaviour

Results

In operational terms, I translated this outline as:

**Box 4**

Reaction – what impression did the presentation make; how was it received?

Learning – did it prompt an association with some of your own ‘living practice’ that might be looked at, such as risky behaviour, medication that affects your balance, hazardous furniture/garden layout and so on; i.e. did the intellectual response to the message connect with something ‘real’ in your life?

Behaviour – might you decide to take some action on the above?

Results – were you able to follow this through, did it make a difference?

There are methodologically tricky areas here. There may be risky behaviour that people do not want to publicly own up to but might decide, privately, to change. For the evaluation we needed a way of getting at this. The design outcome was therefore a complex mix of questionnaires, discussion, observation and sample focus groups.

### *4.3 Ethical Issues*

*4.3.1. Questionnaires* formed the principal data gathering tool for Phase 1. These were anonymous and contained both an explanation of the purpose of the study and emphasised that completion of all or part of the questionnaire was entirely a matter for the participant. They were distributed by the peer mentor at the end of the presentation when time was pressing (4.5.2.2) and hence opportunity may actually have been problematic. Although this process may have been less rigorously applied in the early stages, as far as I know confidentiality was preserved by each questionnaire being placed, by the participant, in a large envelope which was then sealed and sent to me. The one letter of complaint which the project received did however refer to the opportunity for the presenter to read the questionnaires although there was no evidence that this happened.

Follow up questionnaires were far fewer and here the same process should have been adopted, this time by the group leader/organiser. Again the measures for ensuring confidentiality are clearly laid out on each questionnaire so the participants should all have been aware of them.

*4.3.2 Focus groups* for Phases 1 and 2 were all carried out by professional staff from the University of Bradford experienced in research interviews who conducted the focus groups adhering to conventional ethical safeguards:

Transcriptions of the interviews would be anonymised, stored in accordance with the Data Protection Act 1998 and only used for the purposes of this evaluation.

Nobody but the interviewers and myself as evaluator would have access to the data.

Participants were also reminded that personal issues discussed within the group should not be talked about outside it to third parties – although there is, of course, no way of knowing how far this was adhered to given that participants generally knew each other and met regularly.

*4.3.3 Dissemination.* In addition to access to the full report if desired, all groups would be provided with sufficient copies of the ‘executive summary’ setting out the principal findings.

#### *4.4 Planned Evaluation Process (Phase 1)*

##### Inputs

1. Short evaluation questionnaires for each participant immediately after presentation to identify (a) reactions (b) impact. The questionnaire also collected data on participants’ circumstances, demography and on any fall they may have had over the preceding 12 months (Appendix II).

This is all self-reported of course but I was optimistic that, given the confidential nature of this part of the evaluation, unreported falls may be

disclosed and overall I would get a more accurate picture than relying only on reported falls. It was hoped this outcome might be of particular importance in identifying impediments to reporting and how practice may be influenced and related to issues identified in Box 3.

2. A 'key activity' to be undertaken as a result of the programme – the proxy measure referred to in 4.2.
3. Ten sample observations of the programme delivery - subsequently not proceeded with (4.5.1.1).
4. From the participant groups a sample of ten focus groups with an emphasis on issues about the nature of a fall (for example, 'risk taking as personal choice' etc.) (Appendix III)
5. Group interviews with peer mentors

#### Outcomes (Several months on<sup>1</sup>)

6. Follow up questionnaires to all participants (administered via the organisers of their group) to identify 'relevant' falls during intervening period and whether key activity accomplished (Appendix IV).
7. Follow up focus groups with sample as in (4) (Subsequently not proceeded with (4.5.1.2)).
8. Comparison of falls rate of programme participants with predicted rate for comparable group (Subsequently not seen as realistic given the small numbers).

#### Dissemination

9. Formal report (rooted in appropriate literature) involving discussion of impact of programme and significance of mentor model.
10. Feedback reports/presentations to participants
11. Seminar/conference with local/national agencies

<sup>1</sup> This is another research problem when evaluating time limited projects. A late start pushes everything forward and the need to do follow up, say three months on, means that initial data collected towards the end of the project have less value. Moreover the necessarily arbitrary interval period may be too short for 'real' change to be assessed.

#### *4.5 Evaluation in Practice – What Happened*

##### *4.5.1 Methodological Issues*

I deal with specific aspects of the methodology below but it is important to emphasise at the outset that choice of design can be a pragmatic exercise taking into account the kind of knowledge sought, how best to obtain it, the importance of confidentiality, access issues and population size. In the latter respect we were anticipating that the project would reach around 4,000 people in Phase 1. We could have sampled but I felt there were enough variables already and it would be feasible to reach everyone through a questionnaire. In practice the number was far fewer (3.2) and group interviews may have been possible. Indeed, several peer mentors raised the question of whether questionnaires were an appropriate method for this age group and whether interviews would not have been better. There was a series of focus groups of course which, given the lower numbers, actually reached a higher proportion of participants than had been planned. My view was, and experience has not altered it unduly, that the confidential nature of questionnaires meant that for some issues – particularly in reporting falls - we were likely to get information which was not obtainable in a group setting.

There were two significant modifications to the evaluation design as the work progressed:

##### *4.5.1.1 Observation.*

Observation of programme delivery in this sort of setting is always problematic because of the effect on the act itself. Moreover it was subsequently planned that programme leaders would themselves carry out observations and hence this was dropped from the design.

##### *4.5.1.2 Focus Groups*

The detailed design of the focus group question schedule (Appendix III) was carried out once the project was under way when the issues became clearer. The actual interviews were carried out by two colleagues (CS - with Phase 1

participants and FA with Phase 2) who were experienced in focus group practice and working with older people. FA was also a fluent Urdu and Punjabi speaker.

Originally it had been planned that the focus groups for the Phase 1 project would be carried out at the end of the presentation. Once it became apparent that there were unforeseen time limitations at all venues (see section 5.2.1) it was decided that the focus groups would run as a separate 'event' afterwards – ideally no more than a week later. Problems in making links with group facilitators, who were often unresponsive - coupled with a slow rate of 'business' by the time the groups were being planned (in the early summer) - meant that by the time focus groups were taking place, several weeks, if not months, had passed. Nevertheless a great deal of valuable, and often unexpected, information was gained but it meant that follow-up focus groups (as planned in item 7 of the evaluation design) were dropped because they would not be seen by the participants as relevant nor, given the time slippage over the whole of the project, practical.

#### *4.5.1.3 Ethnic minority groups.*

This dimension to the programme had not been envisaged at the outset and hence had to be incorporated into the design while it was already under way (see 3.2.5). The literacy issues which necessitated a different form of presentation (3.2.5) also rendered the use of self-completed questionnaires problematic and so there is not the detailed demographic and falls history data which were gained from the Phase 1 groups. The evaluation of this part of the programme (Phase 2) relied solely on a set of focus groups (conducted in Urdu by colleague FA) but using essentially the same question schedule as for the other participants.

#### *4.5.1.4 Questionnaires*

The peer mentors felt that two of the questions were confusing. In 1(c) (see Appendix II) – something can be hard to follow but you can still learn from it – and in 1(f) – agreement may not be criticism but could be read as such. In retrospect I might well have worded these differently although the

questionnaires were circulated pretty widely before they were actually distributed.

#### *4.5.2 Practical Issues*

##### *4.5.2.1 Lack of Co-ordination*

There were several quite serious practical problems in operating the evaluation which have implications both for the findings and for conducting evaluative research in this way.

The major difficulty for Phase 1, particularly affecting the administration of questionnaires and organising focus groups, was (as I indicated in 3.2.4) the lack of a project worker who would have tried to establish a working relationship with the group leaders/organisers to facilitate programme delivery and to ensure that they were engaged in the evaluation process. This was important at the stage of the presentation, and for the initial questionnaire, but essential for the follow up because the design relied upon them to administer and manage the distribution. It would not happen effectively unless there was a level of involvement in, and commitment to, the programme by the group leaders. While some responded positively, this was the exception and the evaluation suffered accordingly. Several peer mentors had a close affinity to some of the groups and did facilitate this follow up stage but this was fortuitous (albeit welcome) and beyond what one could reasonably expect. Establishing a working relationship with group leaders is important not just for the evaluation which, in any event, is a transitory process, but for keeping 'falls' on the agenda for older people as part of health improvement programmes (see also 5.2.1 and 6.2.4).

##### *4.5.2.2 Time Limitations*

A factor that also impacted adversely on the use of questionnaires was the very tight time schedule operated by many groups -something that none of us foresaw. The day's programme is usually very clearly defined with specific times for arrival and departure, tea and lunch breaks and favourite activities. It usually meant that the falls presentation had to fit into a narrow 'window' of often no more than an hour. This made it a very concentrated event and filling

in a questionnaire could be tedious especially as the presentation itself also involved another questionnaire! The peer mentors deserve great credit for the way they managed this whole process and for their diligence in getting information back to me. This is particularly so bearing in mind a level of scepticism on the part of some about the appropriateness of using questionnaires with this age group and the format of some of the questions.

The above comments only apply to Phase 1; Phase 2 groups were, in the main, recruited through a network of existing community and social networks (3.2.5) and the organisation was less problematic.

## Chapter Five - Findings from the Evaluation

Data on Phase 1 will be considered from a variety of sources – questionnaires, focus groups, discussions with peer mentors and issues arising from the steering group meetings – and relevant literature linkages will be introduced. On Phase 2 of course I only have evaluation data from focus groups. Although I shall begin by looking at information emanating from each method in turn there will clearly be common themes and these will be drawn together in the discussion.

### *5.1 Questionnaires (Phase 1 only)*

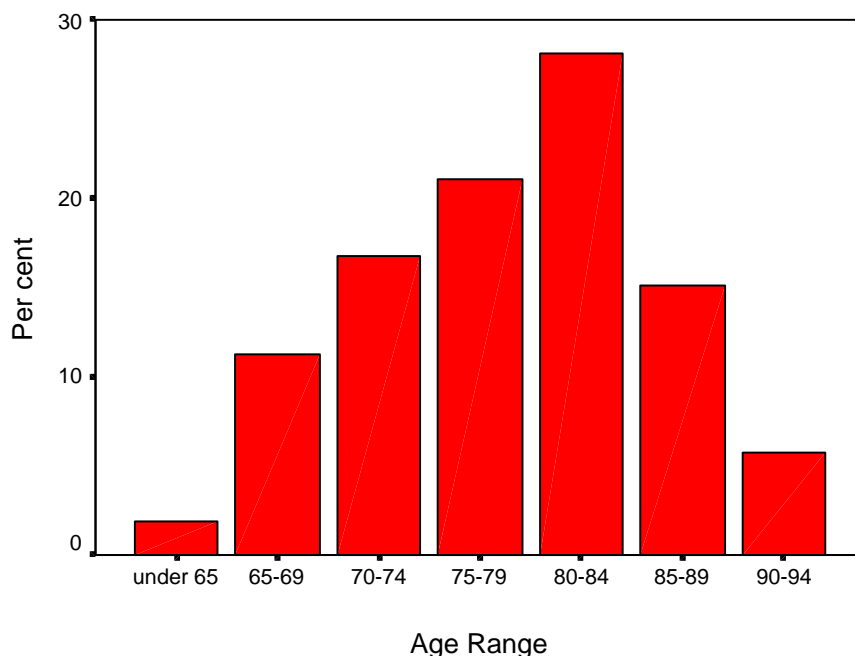
#### *5.1.1 Demography and Household Circumstances*

Data were collected over a period of just under 12 months – from mid-October 2002 until the end of September 2003. A total of 521 questionnaires (Appendix II) were received from a Phase 1 population of more than 1,000 distributed across 57 groups . This represents a response rate of over 50%. By no means every questionnaire was complete in every detail since, as part of the consent process, respondents were invited to disregard any question they did not wish to answer. Hence, in the following presentation I give, for each topic, the actual number of responses (n) upon which the analysis is based.

The age range is shown in Figure Two. This distribution is a function of the chosen venues within which the programme operated, a range of day centres, social groups and luncheon clubs catering for many people whose social contact might be expected to be limited. Indeed, 72% (n=428) lived alone and there was a large preponderance of women over men – 86% (n=469) being female. Data from the 2001 Census indicate that 62% of people over 65 live alone and that 63% of the over-65 population are women. Although the age distribution of those who took part in the project was broadly in line with the national picture, the programme was not otherwise reaching a representative section of the population. It is not important in the context of what it set out to

do but needs to be borne in mind when looking at some of the other data, particularly around falls rate which I shall come to later.

Figure 2 - Age of Participants (n=470)



Even if one postulates a level of social isolation however, virtually all (95% where n=457) said they would find it easy to get hold of someone if they had an accident or were taken ill. Although not specifically asked there were references in the open sections of the questionnaire, and in discussion during the presentation, to Careline<sup>2</sup> and several respondents were already living in sheltered housing.

I was surprised at the number who said they could keep their home warm enough (96% where n=463). This is a very high proportion given that the 2001 English House Condition Survey (ODPM, 2003) concluded that 22% of single householders over 60 were likely to be in 'fuel poverty'; i.e. spending more than 10% of their disposable income on heating, with the corollary that their homes were probably not warm enough. Hence it is not safe to draw any particular conclusion without more information. Cold homes have a direct

<sup>2</sup> Careline is a call centre, usually operated by local authority social services departments, which is contactable by the resident via an emergency pull cord or, more commonly, an alarm 'pendant' worn by the resident. It is a 24 hour service and provides initial advice and alerts a named relative/friends and emergency services. There is a charge for this service

impact upon health (Allen, 2003) and could therefore be a possible factor in falls incidence; this would need further investigation.

A potential hazard for around half the respondents was having to use stairs or steps either in the home - 48% (n=460) or outside 55% (n=451) with 34% (n=451) experiencing both.

#### *5.1.2 Reaction to Presentation (Table 1)*

The seven aspects of Question 1 (Appendix II) proved to be more problematic than had been anticipated and suggests that I should have piloted more widely (see also comments under section 4.5.1). I did wonder whether the use of a Likert scale may have confused respondents by perhaps being unfamiliar and maybe shades of agreement/disagreement were not necessary for every question where a straight 'yes' or 'no' may have sufficed. However responses were not polarised - 'strongly agree v.v. strongly disagree'- which suggests that people welcomed the range offered. Nevertheless it is difficult to reconcile responses to (a) where 95% agreed, or strongly agreed, that they 'now knew more about the risks of falling' (n=463), with the 64% who agreed that (f) the presentation 'didn't tell me anything I didn't already know' (n=353). It may be that the learning taking place was more about risks – an interpretation – rather than 'factual' information which they already may have possessed. However, as is always the case with questionnaires, we shall never know! The lower response rate to this question suggests that many did not know what to make of it. Scepticism could also be voiced about the overwhelming approval of the way the talk was given on the grounds that the presenters were also issuing the questionnaires. Nevertheless, provided the protocol had been followed (4.3.1) and I have no cause to think it was not, the responses should have remained confidential.

**Table 1 - Reaction to the Presentation**

<b>Question 1</b>	<b>Strongly agree %</b>	<b>Agree %</b>	<b>Not sure %</b>	<b>Disagree %</b>	<b>Strongly disagree %</b>
a. I now know more about the risks of falling (n=463)	43	52	2	2	1
b. I think I'm being as careful as I can be (n=466)	43	52	4	1	0
c. It was hard to follow so I don't think I learned very much (n=358)	13	23	7	35	22
d. I can think of one or two things I could change (n=345)	15	44	21	17	4
e. I have more idea what to do if I have a fall (n=422)	37	55	5	4	0
f. It didn't tell me anything I didn't already know (n=353)	20	44	9	23	5
g. I enjoyed the way the talk was given (n=460)	57	40	1	1	0

Of more direct relevance to the programme was (e) the strongly expressed view (92%, n=422) that people 'had more idea what to do in the event of a fall' although alongside this was the conviction (b) that respondents were already being as careful as they could be (95%). The response to this latter question was the highest of all (n=466) and might have been self-fulfilling – no one likes to be thought wilfully careless. However this apparently normative interpretation needs to be seen in the context of the resistance to behaviour change after an accident (see 5.1.5).

A major thrust of the programme, and its evaluation, was about change and hence (d) was arguably the most important question in this section. Nearly 60% could think of something to change (comparing interestingly with 'already being as careful as I can') with around 20% each either being not sure or disagreeing. However this question elicited the lowest response (n=345) and it is arguable that the 100 or so who declined to contribute (compared with responses to other sections of this question) are more likely not to have thought of something than the reverse bringing the propensity to change, over the whole group, down to around 45%.

#### *5.1.3 Open Question 11 – 'Other comments'*

There were 70 responses to this question with 60% commending the quality of the presentation and the useful information provided.

13% referred to their 'fear of falling' and 'taking more care'.

The remainder made comments about their particular situation, e.g. living in sheltered accommodation, or offered suggestions to increase awareness of risk and its management, for example by more publicity, wider availability of Careline 'alarm pendants' and so on.

#### *5.1.4 Falls, slips and trips*

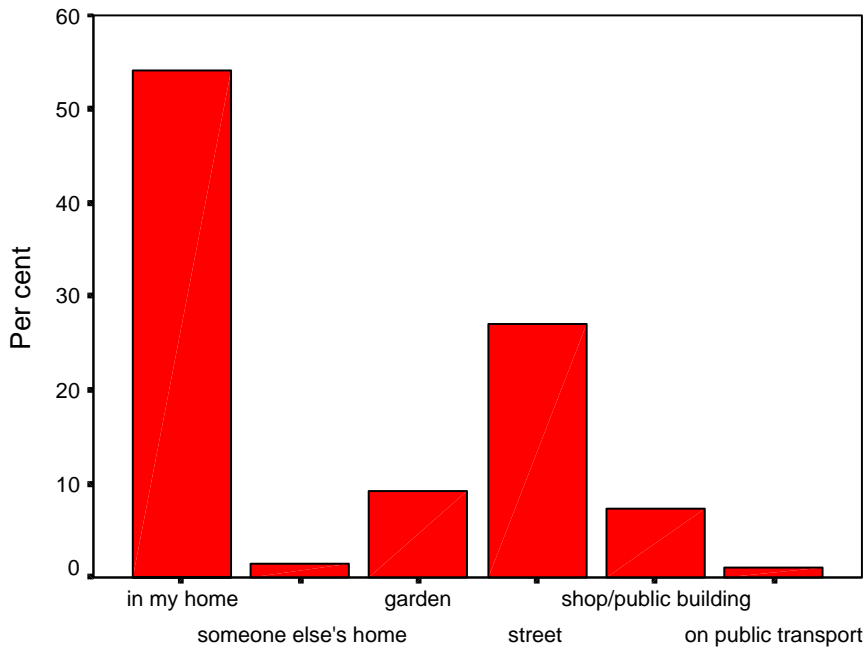
There was a methodological issue here over terminology which could only be tested out during the evaluation – did people interpret 'falls' differently from 'slips and trips'? The DTI leaflet, upon which the programme is based, seemed to conflate meaning. To me however one could 'slip or trip' without necessarily falling and hence the outcome would be different. This was

addressed in the questionnaire by using two questions (2 and 3) – the first referring to a ‘fall’ and the second to a ‘slip or trip’. To test my hypothesis - i.e. did an injury usually follow a slip and was it therefore synonymous with falling - I selected those cases where the respondent had indicated ‘yes’ to a slip or trip and ‘no’ to a fall, yielding 42 cases (with no details given on 11 of them). Of the 31 on whom data were available 36% required medical treatment, a smaller number than in the full sample (49% - see later) but, given the small number, not significantly different from those requiring medical treatment having admitted a ‘fall’. This contradicts my hypothesis and indicates that while I may see a difference between a ‘fall’ and a ‘slip or trip’, it was not shared by those participating.

256 respondents out of 521 (49%) had fallen, slipped or tripped in the past year although not all gave details and the number responding to each part of the accident questionnaire (n) is again given. Note also that for simplicity I shall refer to ‘falls’ but this must be taken to include ‘slips and trips’.

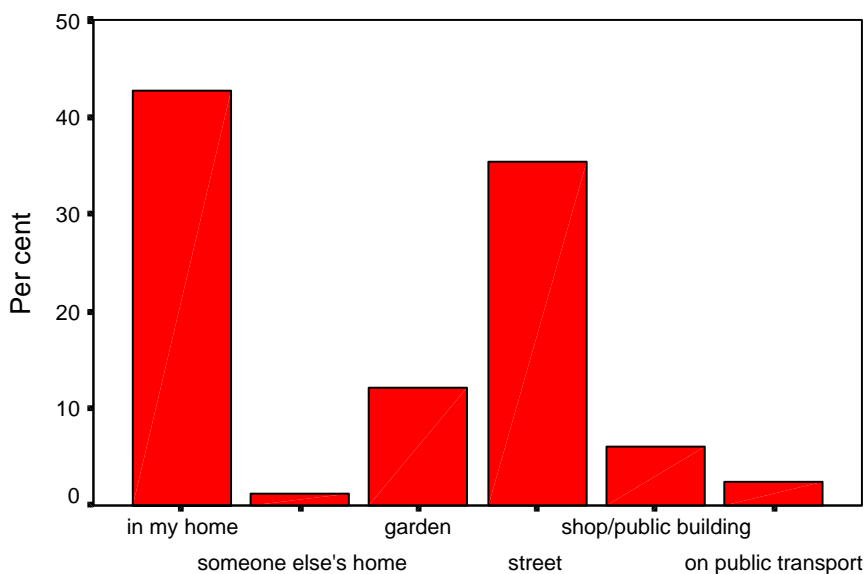
Over half the falls occurred in the home but with a significant number (27%) occurring in the street – a surprising finding and with clear implications for public services (see Figure 3). The cause of fall was not asked and there were no indications in the open Q11 that pointed to any particular factor. Nevertheless it is tempting to speculate that uneven pavements, parked cars on footpaths etc are possible causes and further investigation is needed.

Figure 3 - Accident Location (n=209)



To see if having stairs in the home implied more danger I selected houses with steps or stairs and analysed them similarly – Figure 4. In fact the proportion of accidents in the home is *lower* with this group, suggesting that the presence of stairs is not a factor.

Figure 4 - Accident Location - Residents with Steps or Stairs in their Home (n=82)



Of the 209 who gave details of their fall, 94 (45%) required medical treatment (Table 2):

**Table 2 – Treatment Following Fall**

<b>As in-patient</b>	<b>By A &amp; E</b>	<b>By Doctor</b>
39 (42% )	37 (39%)	18 (19%)

...and of these 94, 84 gave details of their injury (Table 3)

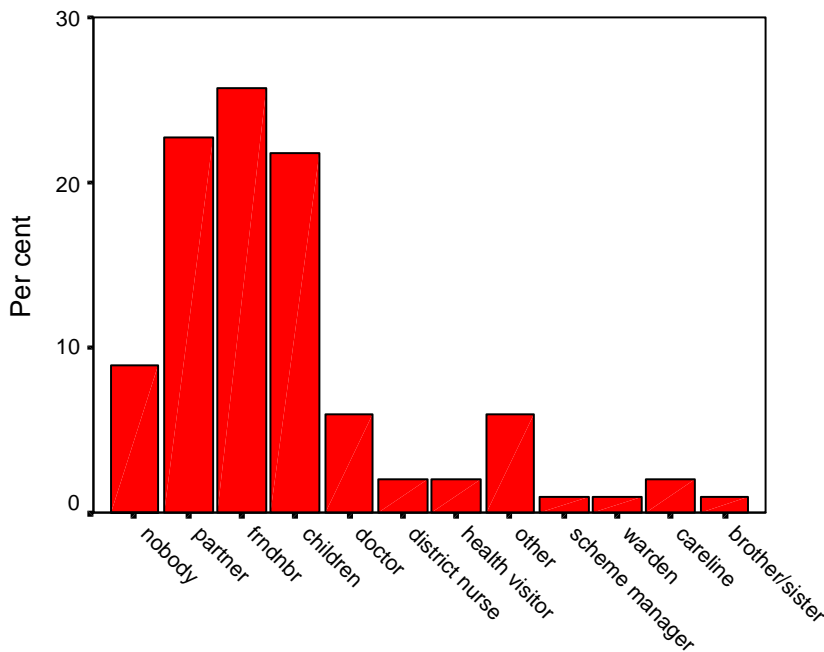
**Table 3 – Injury Sustained**

<b>Injury</b>	<b>sustained by %</b>
Fracture	51
Bruising	31
Cuts and grazes	12
Not much to show	6

While fracture is clearly serious, bruising resulting in medical treatment can also be both traumatic and visibly distressing to both sufferer and concerned friends and relatives.

I turn now to those who experienced a fall but did not require medical treatment. They were asked whom, if anyone, they told about their fall (Figure 5).

Figure 5 - Whom did you tell about your fall? (n=101)



Seventy one per cent told friends, relatives or neighbours, with only 9% telling a health professional and a similar percentage not telling anyone. This is a much lower figure than that reported by Stoddart *et al* (2002). They give 41% of those who had fallen subsequently discussing the fall with a health professional. This was from a random postal questionnaire but included, however, those in residential settings where contact with a health professional would have been more likely. It was not clear from the brief report whether the survey was confidential or not and this may have implications for reporting as I discuss later on. Returning to the data from my questionnaire, even if we include wardens, Careline etc in the group of professionals we find only 14% of these falls 'officially' reported. If there was a recording system in place then it is possible that all these incidents would actually form part of any 'recorded falls' statistics in addition to those needing medical treatment, yet, as I demonstrate below this would still be a significant underestimate of the extent of the problem.

#### 5.1.5 Reported and Unreported Falls

Although the literature cited at the beginning of this report (1.1) rather blithely refers to falls rates of around 'a third' there is a large element of uncertainty.

This figure is quoted by the HEA and drawn from Stalenhoef *et al* (1997) who in turn drew *their* conclusions from an analysis of published research over a 13 year period - although they acknowledge “relevant differences between studies” so data were not pooled. Tinetti *et al* (1988), whose work is drawn on by many other authors, found falls rates of 32% in a population of 336 aged 75 years and over (1988) and 47% (35% if receiving intervention) in a population aged 70 and over (Tinetti *et al*, 1994). In the latter study, however, the participants were chosen because they were already suffering from known ‘falls risk’ factors. While there is no doubt, therefore, that the incidence of falls is high, quantifying it is problematic and evidence less than coherent..

It is a surprise that there seems no system in place for recording those people who actually received medical treatment as the result of a fall. I realise that there are diagnostic and organisational problems here but it is difficult to see how, in the absence of some sort of baseline (however flawed), a reduction in falls rate across the population could ever be demonstrated outside intensive studies like the above. However, putting that discussion to one side, it is evident from the data collected here that even if such a system were in place there would be a very high level of ‘unrecorded’ falls, simply because many people keep it to themselves. Although self reported, the Project evaluation enables us to begin to quantify this – at least for the group involved here – see Table 4.

The falls rate of 26%<sup>3</sup> is substantially lower than the figure of ‘a third’ found by Stalenhoef *et al* (1997) for this age range. Applying a similar calculation to the 230 participants aged 80 and over gives a rate of only 30% whereas the above source refers to 50%. Indeed, given that the female population in the group was proportionately higher than average, and that women are more likely to experience a fall, we would expect the falls rate to have been skewed even more in the upper direction. It is therefore arguable that the group involved was quite a low risk one yet the ‘true’ rate of falls was very high, at

<sup>3</sup> This figure was unchanged by omitting the 9 respondents who were under 65 (3 of whom needed medical treatment) in order to compare it with the statistic given for over 65s.

49% (51% for those aged 80 and over). Overall, therefore we have empirical evidence to suggest that the falls rate figures may be even higher than currently accepted because of a large number of unreported falls which do not require medical treatment and are therefore effectively unknown.

**Table 4 – Calculated ‘True’ Falls Rate**

		<b>n</b>	<b>%</b>
<i>Number of respondents experiencing a fall</i>	A	256	
<i>Number of (A) giving details of fall outcome</i>	B	209	
<i>Number needing medical treatment (45% of B – see Table 2)</i>	C	94	
<i>Number who fell but did not give details (A – B)</i>	D	47	
<i>Deduced number of D who needed medical treatment (45% of D)</i>	E	20	
<i>Total of those experiencing a fall who needed medical treatment (C + E)</i>	F	114	
<i>Number who did not need treatment (A – F)</i>	G	142	
<i>Number not needing treatment but who reported fall to a professional (14% of G – see 5.1.4)</i>	H	20	
<i>Total number of falls probably reported (F + H)</i>	J	134	
<i>Hence maximum ‘known’ falls rate (J ÷ 521)</i>			26
<i>Number who did not require treatment and who did not report the fall to a professional (G – H)</i>	K	122	
<i>Hence ‘true’ falls rate ( [J + K] ÷ 521)</i>			49

This is an important finding both for health promotion strategy and also because it raises questions about why falls are not reported to health professionals. How far might admission of an accident like this be seen as evidence of ‘not coping’ with all the implications this has for older people in a climate of ageism and discrimination?

There was a further question – ac 5 – for those who had falls (see Table 5).

**Table 5 – Do you think you might change things or (if it happened at home) alter the layout of your furniture as a result of this accident?  
(n=159)**

Yes	No	No response
28% (including 2% who had already made a change)	48%	24%

The response rate is also very low – 159 out of the 209 who had generally given details about their accident - and it is reasonable to assume that people who did not respond to this question had not made any changes. The problem with questionnaires of course is that you do not know how people interpreted the question. Looking at it now I can see that the normative response would clearly be ‘yes’ if falls are constructed as a preventable result of inappropriate behaviour or lack of forethought in how furniture, carpeting etc. is laid out. On the other hand it is not an appropriate response if the fall was ‘an accident’; i.e. an unpredictable event that is not likely to recur and hence does not need to be guarded against. This clearly runs counter to the public health falls message which, in spite of disclaimers, is essentially about not taking risks and that most falls are preventable – an undisputed ‘given’.

#### *5.1.6 Follow-up Questionnaire*

Notions of what constitutes a fall, risk taking and what happens if you tell anyone – issues emerging very clearly in the above discussion – were expected to be prominent in the focus group sessions and were explored with varying degrees of success. However before I turn to examine those outcomes I wish to look at the response to, and issues arising from, the follow up questionnaire.

Methodologically this was important in acting as a proxy for ‘learning’; i.e. how far had the programme stimulated some behavioural or environmental change

(section 4.2). I have already referred to the practical difficulties in administering the questionnaire generally and the particular ones in relation to the follow-up (section 4.5.2.1). Not surprisingly therefore the response rate was very disappointing at a mere 50. While in no way representative of the overall impact, some interesting pointers do arise.

Thirty per cent of respondents come up with something they could change – principally in the way they did things - but also altering the layout of furniture. It is tempting to relate this to the 60% who, in response to the initial questionnaire, said they could think of something to change. Expressions of intent are not reliable being influenced often by normative expectations, so the 30% outcome seems reasonable.

Of those who did not decide to make any changes (n=31, as 4 gave no details) 16% either did not want to bother their doctor or were prepared to live with a level of identifiable risk. Over 50% could not think of anything but the majority of these (74%) also thought their home was as safe as they could make it.

Thirty two per cent had had an accident since they completed the last questionnaire between February and April. This represents a very high rate, given the short time period (around 6 months) but there is no way of knowing of course how 'typical' this is. As before, the given location was predominantly in the home (64%, n= 14) and around a third needed medical treatment. Of those who did not, only two told a 'professional' about their fall.

### *5.2 Feedback from Peer Mentors (Phase 1 only)*

I was unable to meet with the ethnic minority peer mentors' group (Phase 2) in time for this report. Arrangements had been made but the BDHDS co-ordinator was involved in a serious road accident and at the time of writing is still absent.

I met five times with the Phase 1 peer mentors' support group in private. I shall consider feedback under separate headings dealing with their

observations on the presentation sessions, the structure and management of the programme, issues around the evaluation, and personal development and learning for the mentors themselves.

### 5.2.1 Presentations

The guidance from the training was very specific – to deliver a set programme, using a ‘flip-over’ pack of visual aids and to demonstrate some simple exercises. The materials used – A4 and A3 size – were said by the peer mentors to be adequate for the task although one of the steering group, observing a presentation, commented that as a member of the audience they were too small to be much use and the pictures added little to the presentation. It seems that they were however helpful to give a structure to the presentation and as an *aide memoire* for the presenters. Certainly anything larger by way of posters or full scale flip charts would have been too bulky and impractical and since the DTI leaflets (from which the text of the programme derives) are also given out (DTI, 2002), they may represent a reasonable and practical compromise.

Although it was expected that the group organisers would be involved in what went on – and this had been an assumption in the evaluation design – it was by no means always the case (3.2.3). The peer mentors felt that the active co-operation of the organisers was well nigh essential for the programme to work smoothly and several referred to the wisdom of making a personal contact beforehand – ideally with a visit to the venue if practical. Sometimes the mentors were presented with very large groups and, if they were aware in advance, often went in pairs. The absence of a ‘positive role model’ seemed to be no disadvantage and, as I have indicated earlier, they often fulfilled this function themselves (3.2.2). There was a case study of an older person who had had a fall included in the presentation material but the peer mentors often relied on something they considered more ‘real’ in the shape of what had happened to them when they had fallen, as had been the case for many.

An important feature of the programme was demonstrating simple exercises aimed at improving strength and balance. Some peer mentors thought it was

'the best bit' as it broke up the lecture style 'flow'. It was emphasised that people were not expected to try this themselves there and then, and some peer mentors were anxious that should this happen, and participants fell, then there would be liability. Nevertheless it was recognised that actually performing the exercise would be a valuable feature and this too has implications for how the falls prevention programme might proceed; for example through a programme of follow up exercises run by a physiotherapist.

One of my concerns at the outset was that as they used their personality and experience to engage with the audience, the insistence that they adhere to a script and, most importantly, were not seen to be giving health advice, might be a difficult tension for them. This seems not to have been the case. Many commented that as they become more familiar with doing the presentation, they were able to use their personal life as exemplars so brought their own perspective into play in that way – *"we enlarged on the script"*.

Using life experiences seems one of the strengths of the model and capitalised on the *similarity* of experience in many cases. They brought sensitivity to the topic as well:

*Sometimes people were upset by the content - one participant had been so seriously hurt in a fall that she could not walk.*

A further factor was that with such a structured presentation there would be little opportunity for dialogue. This proved to be the case and while some peer mentors would have welcomed the opportunity for discussion, most felt that in order to manage the presentation at all they needed to be in control of what went on, given the short time often allowed, so that formality was an advantage. I comment further on this in section 6.2.2

As I indicated in 4.5.2.2, time constraints were a big problem and on several occasions peer mentors were not told in advance what facilities were available to them. In addition proximity to lunch time or transport home was always a

stress factor. There was a feeling that the presentation was sometimes seen as part of a centre's programme to keep the participants occupied rather than being seen as an important health intervention.

### *5.2.2 Programme Management and Organisation*

The biggest problem that arises, when having recruited an enthusiastic and able group of volunteers, is keeping them occupied and lack of work was a concern for some time, together with uncertainty over who actually dealt with day to day issues (see also 3.2.4). It was partially resolved following the appointment of the part time co-ordinator but as this is only for 8 hours and the original plan was for 25 it is not surprising that she has been very hard pressed. Nevertheless several new groups have been identified and there is now a recognisable management structure which the peer mentors appreciate. In spite of some of the problems, the volunteers have remained with the project - "*because it is a wonderful idea*" - and this reflects the open relationship with the steering group, and the Falls Prevention Co-ordinator (LL) in particular, wherein contentious issues can be discussed. The mentors are recognised as the lynch pin of the project whose contribution is crucial and valued. I saw this at work particularly in the programme review where concerns were talked through and amendments made where necessary.

### *5.2.3 Evaluation*

I have referred at several points to some of the concerns the Phase 1 peer mentors had about the conduct of the evaluation, both some possible methodological limitations and, above all, the practical difficulties. The value of the process and its importance in identifying practice and process issues was accepted but it did represent a significant burden for several reasons, notably time constraints (to which I have referred above) and the difficulty of engaging the attention and participation of the 'audience' after nearly an hour-long concentrated presentation:

*Nine questionnaires from 18 people present. Chaotic. This was due to the movement of people whilst I was talking.*

They deserve credit for persisting so diligently and for the valuable data which have come out of the evaluation. Because I was meeting regularly with the mentors' groups I was able to respond to their concerns and keep them apprised of what was going on – feeding back an analysis of the findings at the half way stage was, I think, helpful in reinforcing their commitment.

#### *5.2.4 Personal Development and Learning*

I think this group of volunteers was characterised by a commitment to the task rooted in a belief in its value – sometimes because they had experienced falls themselves and were conscious of the notions of risk taking with advancing years – and because, in several cases, they had a background in teaching, nursing and care provision. This being the case, they found a good deal of personal fulfilment and sense of purpose in the project – evidenced by the tenacity with which they stuck to it in spite of the problems which I have alluded to above. The feeling that they were sharing knowledge without being 'superior' or didactic was another feature - that they were reminding people of what they already intuitively knew but in a context of change and innovation:

*Most participants said it did not tell them anything they didn't know but it was a reminder.*

One of the peer mentors had retained contact with two of the groups to whom she gave presentations and was reminded of the more subtle effects of accident prevention when a participant said:

*We may not really have changed anything but sometimes, when we are doing something, 'things come to mind' and we remember what you said.*

An active support group, in which information is exchanged and contentious issues openly discussed, is a crucial ingredient in this and the project was strong in this respect. One member openly admitted that *"without the support group I would have dropped out"*. As I have already noted, it is particularly

important when the 'work' available fluctuates, seen at the time as "*a big problem*", as it enables all to retain the focus and group identity.

### *5.3 Feedback from focus groups (Phases 1 and 2)*

Ten focus groups were carried out with Phase 1 and six with Phase 2. More had been planned with the latter group (as well as meetings between myself as evaluator and their peer mentors) but the accident which befell the co-ordinator (ZH) meant that these could not be organised in time to be included in this report. Although the mode of delivery differed between Phases 1 and 2, I have aggregated responses because (a) the interview schedules were the same and (b) similar issues were identified and opinions expressed. Where there has been significant differences this has been indicated in the text.

#### *5.3.1 Accidents and prevention*

There was an overall feeling that infirmity and illness were the inevitable consequences of ageing:

*old age itself is a major cause as older people are less active and more prone to illnesses and disease*

*my mind is willing but the flesh is weak*

*[but] I still want to do the things I used to do*

Loss or erosion of faculties - particularly eyesight - was mentioned and the need to be aware of side effects from medicine affecting balance or causing dizziness, for example. Factors which were said to help offset these problems included a healthy diet, exercise and whether there was family support. Indeed all the groups referred to 'family' as being the principal source of help and to whom they would turn in an emergency.

The research literature reviewed (2.1) indicated that a previous fall was the most significant indicator of the likelihood of falling again and it may be that this loss of confidence is itself an important factor, with some people even

deciding that they could no longer live on their own. This is a complex area to understand since we also know from the questionnaires that the majority of those who had fallen did not plan to do anything differently, so there are issues about the nature of accidents and whether people believe them to be avoidable at all – clearly topics for further study but the data are helpful here in highlighting the question.

In considering prevention the basic ‘safety messages’ seem to have been assimilated – perhaps reinforcing what was already known, as groups emphasised environmental factors such as loose carpeting or trailing wires, aids such as handrails and adequate lighting. ‘*Slowing down*’ seemed to be the predominant reaction.

### 5.3.2 Responses to the Presentation

For many participants it was the first time they had received advice or information about falls prevention although they had talked amongst themselves and with friends:

*...it was a good experience and we have learned several tips on how to prevent accidents that we never thought about before*

*made me think about things I have never thought of before*

*...removed a rug at the top of my stairs...*

As the peer mentors noted (5.2.4) the presentation rarely told them anything specifically about falls risk that they did not already know – perhaps intuitively, so the idea of practical responses was appreciated:

*Even though it was common sense...[it] made me think about things that I have never thought of doing*

The exercises seemed to be welcomed although how far they have been carried out is unclear. Exercise was particularly valued by younger

participants often in the context of helping to safeguard older family members, although some older people themselves were sceptical about doing exercise because of existing infirmity. Advice on 'what to do if you have an accident' was also welcomed – again by younger participants.

It seems that the topic was not clearly brought out in the Phase 2 groups, but all the Phase 1 groups agreed that:

*they would prefer to have an 'outsider' to give them advice and somebody who 'is not young'*

Anecdotally it was also evident that some participants had forgotten quite a lot of the presentation so follow up 'refresher' sessions by the peer mentors may be beneficial particularly in the context of the more general approach I refer to in Chapter 6.

### *5.3.3 Sources of Help*

The groups were asked to look at what services were available, who might most appropriately provide them and their experiences of using them.

Responses varied greatly suggesting a range of different professional practices - indeed some participants had not hitherto been aware of sources of help. I am presenting responses from Phase 1 and 2 groups separately in the following paragraphs since although there were commonalities, the ethnic minority groups expressed the views more forcefully in this area.

#### *5.3.3.1 Phase 2 Groups*

Their opinions about health professionals were very mixed with some saying they received a great deal of attention from their family doctors whereas others, a majority of those interviewed, felt that their doctors resisted home visits or being called upon in an emergency. Some practice receptionists were seen as particularly obstructive. There were other observations too which were not directly the concern of this evaluation but which nevertheless suggest a good deal of tension between some patient groups and their health

care providers. This factor is relevant because as a result there remains more of a reliance on family support and herbal remedies for relief of pain and inflammation following a fall. Assessing the falls rate among the ethnic minority population in Bradford may be further complicated if this is common practice since only the most serious incidents would receive medical or hospital attention.

Although there appeared to be an emphasis on the importance of family support, it seems in part to arise from scepticism about the likely responses from health professionals. There is also a risk of ethnic stereotyping here with an assumption that an extended family will 'naturally' fill a caring role; indeed this was a view challenged by one of the groups saying that people's situations varied greatly.

Doubts about the motives of professionals were not confined to health workers. Social services offices were criticised for not having a specific phone number staffed by someone who spoke Urdu or Gujarati. Some were also critical of researchers who asked questions but provide no direct help. For others, although help appeared to be on offer, particularly over adaptations which might help prevent falls, they found themselves disqualified if they were renting from a private landlord who may be unwilling to be involved in any minor structural alterations.

#### *5.3.3.2 Phase 1 Groups*

Opinions were similar in their apprehension about seeking advice etc from health workers. Following an accident for example some respondents said they were told that virtually anything that happened to them was:

*put down to old age...they have that condescending attitude – 'Oh she's so old'*

so that their embarrassment at falling at all was compounded rather than sensitively responded to. Issues around embarrassment seemed quite important alongside the view that '*you don't have to tell anyone*'.

In terms of whom you seek advice from (a specific open question), people usually referred to friends and family but no one in these groups – well over 100 people in total - mentioned a health professional, supporting the data from questionnaires (5.1.4). This is highly significant in the context of information about falls and their prevention because, as I emphasised when reviewing the literature (2.2), the health research and guidance puts enormous emphasis on the role of the health professional yet it seems they are not the automatic choice of the older person at all. The principal source of advice, the family, was not unproblematic either with many participants saying that they sometimes felt “*patronised*” by their children as they got older.

Like the Phase 2 groups, actual knowledge about help and sources of help was very limited. Many respondents referred to the use of a walking stick as a stability aid yet this had not been recommended by any professional. Knowledge about simple aids was likewise very scanty; e.g. hand rails and bathseats and they welcomed the suggestion (from the interviewer, CS) that demonstrations of what was available would be very helpful. An interesting point made here was that there had been occasions, in the general context of professionals visiting groups on the periphery of Bradford, that available items were usually distributed preferentially in the City – a feeling that “*people on the outskirts didn’t count*”.

## Chapter Six - Discussion

The Positive Action on Falls programme was an imaginative and ambitious initiative which set itself far reaching goals using a novel approach. Although there have been several problems in realising these aims, without the sense of purpose and belief in the task on the part of the steering group and the peer mentors, the very real lessons learned and the achievements made would not have come about.

Overall the Project has produced a large amount of information and I now propose to examine some of the overarching themes in summary form, reflecting the twin aims of the evaluation and some of the issues pertinent to personal control and ageing:

- to have a direct impact on older persons' understanding of issues around falls and their capacity to avoid them, or cope better with their aftermath.
- to assess the effectiveness of the 'peer mentor' model of information delivery.

### *6.1 What the Project Accomplished*

Through addressing 137 groups, the project reached around 2,200 people using just a few volunteer presenters. The evaluation collected questionnaire data on 521 participants in Phase 1 - a substantial body of information by any standards – and gained insight on the way the programme was presented, the demography and circumstances of the participants in Phase 1 and the falls rate among them, revealing a much higher than reported figure (5.1.5). Focus groups gave a detailed insight into how older people perceived risk and the provision of health care (5.2.1) as well as their ability to cope in the event of a fall and their feelings about how they were treated and from whom they would seek advice and help (5.3.3). An (admittedly limited) follow up questionnaire showed evidence that a number of people had responded directly to the presentation to make one or two changes which might reduce the likelihood of

a fall (5.1.6). While it would have been more persuasive to have a larger body of evidence we can certainly say – from this and from focus group responses (5.3.2) - that a number of people were directly influenced. The difficulty of ever achieving this should not be underestimated; persuading people to take precautions against the occurrence of an event when their experience shows it is unlikely to occur is self-evidently difficult. The project also challenged a myth that older people were resistant to exercise to improve strength and balance, and that falls, and injury, are therefore inevitable. The focus groups (5.3.2) suggested that although this remains a strong and persuasive discourse it is increasingly challenged by the emphasis on the benefits of 'healthy living' and there was a real interest in responding to exercise opportunity.

## *6.2 Issues for Future Practice*

### *6.2.1 The 'Peer Mentor' Approach*

The peer mentor model is a cheap, effective and enjoyable way to present information of this sort and is valued by participants (5.1.2 & 3). It relies on a strongly committed body of mentors who are motivated by a belief in what they are doing (5.2.4). The mutual support systems used were effective and the open dialogue with the steering a group a strong feature.

### *6.2.2 The Programme*

The programme was effective as a 'one-off presentation' which was its principal aim. Reflection has however suggested the desirability of follow up sessions as 'refreshers' and of specific exercise input to improve strength and balance (5.3.2). Demonstrations of what safety aids are available (5.3.3.2) could also be incorporated in a programme and relevant agencies – housing and social services, for example – could be also engaged in the process. The focus groups revealed the benefits to learning and sharing of group discussion around such sensitive topics and this facility too could be built in for those who want to take part. The emphasis then would be on a wider ranging initiative in which the peer mentoring element would be an essential ingredient because of its relevance and acceptance by older people.

### 6.2.3 Co-ordination

The model involves groups of *volunteers* engaging with *voluntary* groups. Professional management of the process is, therefore, essential and in Phase 1 this was not satisfactory at times. It led to problems in promoting the programme most effectively and communication difficulties for the peer mentors (5.2.2). Much of the explanation lay outside the control of the steering group and was due to delays in trying to find a PCT to take financial management responsibility, as well as the very short time scale of the project – one year – which inhibited appropriate recruitment. Demand on the co-ordinator should not be underestimated (3.2.4) and the present post holder – only working 10 instead of the planned 25 hours – has an immense task in engaging with the various meeting groups on whom the project has focussed. The Phase 2 groups now also have a co-ordinator providing 8 hours a week, primarily to support peer mentors. There is less of an organisational problem here as the model differs from Phase 1 in its use of existing family and community networks.

### 6.2.4 Promotion

The extent of the difficulties in promoting the scheme had not really been foreseen at the outset and this too is a common feature of innovative programmes – a fear of being overwhelmed by the demand for such an ‘obviously desirable’ service. In fact a great deal of promotion has proved necessary and, given the settings, this is likely to continue to be the case.

The involvement of the group leaders/facilitators is crucial, capitalising on the prominence given to falls prevention in the national framework and locating the peer mentoring contribution within it. The project experience shows that while some are keen and actively involved, others were less so (3.2.3; 5.2.1).

Feedback from the focus groups in particular suggest that health professionals have a good deal of work to do in gaining the confidence of some older people given the apparent reluctance to tell them about a fall or seek advice (5.3.3). Opinions about their ability to intervene sensitively are mixed. The findings from the first questionnaire - that over 80% of people who

have a fall not requiring medical treatment keep quiet about it or only tell friends and family (5.1.4) suggest two things - (a) they are not sure quite how a professional will respond and/or (b) they want to still manage things themselves; i.e. to retain some control. Although I only had data from the focus groups for Phase 2 the same issues arose and there is a similar message for health professionals here.

#### *6.2.5 Personal Control*

'Retaining control' appears to be an important dimension in this evaluation. A fall itself can be seen as a loss of control and may, for a variety of reasons, be kept secret – a significant feature of this evaluation. Sometimes people put it to one side as 'an accident' and this may explain the very high number of people who, having experienced a fall, plan to make no change to the way they live or in their environment (5.1.5) since, being 'an accident' it is not preventable. Moreover, they may argue, there is no point in telling anyone. There are others who, having fallen, are very frightened of a repeat event (5.3.1) and may keep that fear to themselves, thereby receiving no help or advice on what preventative measures they might take. There is another, larger, group who, if they tell anyone, keep it within the family - perhaps through apprehension about the consequences and thereby reflecting some of the issues discussed above. The strength of the peer mentor approach is evident here. It is an 'empowering' model whereby people are given information (most of which they already intuitively 'know') within a secure group setting and accompanied by some basic practical advice. Moreover this comes from peers who may well have experienced a fall themselves – and there was the clear preference for a 'presenter' who was "*not young*" (5.3.2). Participants are encouraged to assess the risks themselves in their home environment and decide either to continue to take them or ameliorate them. They were able to be open with each other in focus groups – and confidential through questionnaires – in ways which stimulated learning and the confidence which comes from knowing others are in the same situation and may have similar feelings. This is a simple statement of what is, as we have seen, a complex way of working but one which may enable the individual to remain in control of events.

Clearly health professionals have a significant role in falls prevention by providing comprehensive assessments where appropriate – especially for people who have already had a fall. In the preventative public health arena however, where this programme is located, the focus is more likely to be complementary and involve specialist input – exercise, for example - and helping to make people aware of what aids and adaptations are available (and how to obtain and pay for them). This would all be in the context of a broad 'educational and facilitative' programme involving various methods of delivery, one of which may be utilising this peer mentoring approach because of its relevance and acceptance by older people.

In conclusion, and in spite of the complexities of the management and evaluation of this programme, it has produced an innovative model and some very important information which is of direct relevance to how a variety of services may be provided in the most acceptable and effective way.

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# APPENDIX I

## Positive Action on Falls

### Protocol for delivering a Falls Prevention Education Session

In order to ensure that the Falls Prevention Education Session is presented in a consistent way, the following points should be adhered to at all times.

- 1 **No independent health advice should be given during a session.**
- 2 The Positive Action on Falls resources should not be changed unless agreed by the Positive Action on Falls Team.
- 3 The evaluation of the project is very important. You therefore agree to take part in the evaluation as and when required.
- 4 The session will be delivered exactly as shown during the training sessions.
- 5 Any problems or concerns raised in a session should be reported to the Positive Action on Falls Team as soon as possible.
- 6 To keep in contact with the Positive Action on Falls Team on a regular basis, at least once a month.
- 7 To provide information as requested by the Positive Action on Falls Team as and when required.
- 8 To attend both half-day training sessions before delivering a Falls Prevention Education Session and attend updates as required.
- 9 To be aware of confidential information and to maintain confidential information as required.
- 10 To keep to the protocol at all times.

Signed: ..... Peer Mentor/Positive Role Model

..... Positive Action on Falls Team

## **APPENDIX II**

### **Positive Action on Falls**

The attached questionnaire has been compiled by Dr Terry Allen, a researcher at Bradford University who is finding out how helpful this sort of programme is to you. It is entirely up to you whether or not you fill in this questionnaire but, if you agree, I need some idea of your circumstances – if you have to cope with stairs for example, or whether you may already have had a fall – as well as asking for your impressions of the talk you have just been given. Only I will see the answers you give to these questions and I will not know who you are - so you can put what you like knowing that whatever you say will be entirely confidential. Please tick a box which corresponds most closely to the answer you want to give. I will get the clearest picture if you are able to respond to all the questions but please feel free to ignore any which you don't want to answer.

Thank you for your help. Please put the completed questionnaire in the envelope provided, seal it and hand it to the people who gave the talk and they will send it on to me.

Dr Terry Allen  
Department of Applied Social Sciences  
University of Bradford BD7 1DP  
01274 – 233195  
August 2002

## Positive Action on Falls

1. Do you agree or disagree with the following comments to do with the talk you have just been given:

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
d. I now know more about the risks of falling	1	2	3	4	5
e. I think I'm being as careful as I can be	1	2	3	4	5
f. It was hard to follow so I don't think I learned very much	1	2	3	4	5
h. I can think of one or two things I could change	1	2	3	4	5
i. I have more idea what to do if I have a fall	1	2	3	4	5
j. It didn't tell me anything I didn't already know	1	2	3	4	5
k. I enjoyed the way the talk was given	1	2	3	4	5

2. Have you had a slip or trip in the past year?

Yes	1	No	2
-----	---	----	---

3. Have you had a fall in the past year?

Yes	1	No	2
-----	---	----	---

*If you answered 'yes' to either of these questions, please complete the attached green form*

4. Do you live on your own?

Yes	1	No	2

5. Is there someone you can easily get hold of if you have an accident or are taken ill?

Yes	1	No	2
-----	---	----	---

6. Do you have to go up and down stairs in your home?

Yes	1	No	2
-----	---	----	---

7. Do you have to go up and down steps to get in and out of your home?

Yes	1	No	2
-----	---	----	---

8. Are you able to keep your home warm enough?

Yes	1	No	2
-----	---	----	---

If you can't keep it warm, is this because:

The heating is inadequate?	1
It is too expensive to run?	2

9. Lastly, so I can get a picture of the variety of people who are involved in this programme, could you say whether you are:

Male	1	Female	2
------	---	--------	---

10. And aged:

65-69	1
70-74	2
75-79	3
80-84	4
85-89	5
90-94	6

11. If there are any other comments you would like to make, please do so in the space below.

.....

.....

.....

**Thank you again for your help. Through this group, I would like to contact you again in a few months to see how you have been getting on. When I have collected together all the responses I will be letting you know the sort of things people were saying.**

**PART TWO - Please only fill this part in if you have had a fall, slip or trip in the past year...**

**1. Where did it happen?**

In my home	1
In someone else's home	2
In the garden	3
In the street	4
In a public building/shop	5

**2. Did it require medical treatment?**

Yes	1	No	2
-----	---	----	---

If no, please go to question 4 If yes, please continue with question 3

**3. Did the medical treatment involve:**

Hospital in-patient treatment	1
Outpatient Treatment – Casualty or A&E	2
The doctor/nurse was able to deal with it	3

**How serious was it:**

Fractured arm/leg	1
Fractured skull	2
Bruising	3
Cuts and grazes	4
Nothing much to show!	5

**4. If you didn't need medical treatment who did you tell about your fall?**

Nobody	1
Wife/husband	2
Friend or neighbour	3
Children	4
Doctor	5
District nurse	6
Health visitor	7
Anyone else (please say who)	8

**5. Do you think you might change the way you do things or (if it happened at home) alter the layout of your furniture as a result of this accident?**

Yes	1	No	2
-----	---	----	---

## APPENDIX III

### Positive Action on Falls

#### Focus Group Schedule

##### *General context*

*Do you think you're more at risk of accidents as you get older?*

[Why, what sort of accident, effects..]

*Is there anything you can do about it?* (May lead into discussion on notions of risk taking)

[Aids, adaptations..]

##### **Intervention**

*What were your impressions of the talk given last week (or whenever)?*

[Learning, style of presentation, 'peers as educators']

*Apart from last week (?), have you been given any advice/help about accident prevention?*

[From whom, professionals, family, friends/peers] (threat to independence?)

[ If advised, what did it amount to, any use, did you take any notice?]

##### **Exploration**

*Who are you most likely to take advice from?*

[GP, other health professionals, family, peers, friends]

*Have you had a fall?* (For Phase 1 this was covered in questionnaire so try to focus on outcome etc as below rather than on graphic detail!)

*What happened?/who did you tell?/outcome?/how dealt with it?*

[Independence threat, risk taking]

##### **Conclusion/Generalisation**

*What would most help you to avoid accidents in your home and remain independent?*

##### **NB**

Italics = opening question

(xxxxxx) = remember context

[xxxxxx] = probes

TA/CS

14.5.03

## APPENDIX IV

### Positive Action on Falls

A few months ago, you kindly filled in a questionnaire telling me something about your circumstances, whether you had had a fall, and giving your opinion on the talk you had just heard. You also had the chance to think about a change you personally might make - either in your surroundings or how you do things - which may reduce the likelihood of a fall. The purpose in contacting you again is to see how things have gone for you. As before, it is entirely up to you whether or not you fill in this questionnaire. Only I will see the answers you give to these questions and I will not know who you are - so you can put what you like knowing that whatever you say will be entirely confidential.

#### 1. Were you able to come up with something you would like to change?

Yes	1	No	2
-----	---	----	---

**If no, please go to question 3**

**If yes, what did you decide?**

(please tick as many boxes as you wish)

I decided to change the way I do something	1
I decided to make a change in the layout of my furniture	2
I decided to add a safety feature inside the house	3
I decided to add a safety feature outside the house	4
I decided to discuss possible changes with my doctor or one of the other health workers I see	5
I decided to discuss possible changes with my family to see what they thought	6
Other changes (please say what they were)	7

#### 2. Did you actually make the change?

Yes	1	No	2
-----	---	----	---

**If no, why do you think this was?** (please tick as many boxes as you wish)

The change I had planned was not really practical	1
I changed my mind afterwards	2
My family didn't think much of the idea	3
I couldn't be bothered	4
It was going to be too expensive	5
Other reason (please say what it was)	6

**3. If you answered no to question 1 - deciding not to make any changes - was this because:** (please tick as many boxes as you wish)

I can't think of anything in the way I do things which needs changing	1
My home is as safe as I can make it	2
I'm well aware of the risks we heard about but it's my choice and I'm prepared to take some risks to live in the way I want to	3
I didn't want to bother my doctor or health workers	4
Other reason (please say what)	5

**4. Have you had a fall, slip or trip since you did the last questionnaire?**

Yes	1	No	2
-----	---	----	---

*If yes, please complete Part Two*

**Thank you very much for taking part in this programme which we hope will contribute towards understanding how people feel about the risk of falls and how it can be reduced and managed.**

**PART TWO - Please only fill this part in if you have had a fall, slip or trip since you completed the last questionnaire...**

**5. Where did it happen?**

In my home	1
In someone else's home	2
In the garden	3
In the street	4
In a public building/shop	5

**6. Did it require medical treatment?**

Yes	1	No	2
-----	---	----	---

If no, please go to question 4 If yes, please continue with question 3

**7. Did the medical treatment involve:**

Hospital in-patient treatment	1
Outpatient Treatment – Casualty or A&E	2
The doctor/nurse was able to deal with it	3

**How serious was it:**

Fractured arm/leg	1
Fractured skull	2
Bruising	3
Cuts and grazes	4
Nothing much to show!	5

**8. If you didn't need medical treatment who did you tell about your fall?**

Nobody	1
Wife/husband or partner	2
Friend or neighbour	3
Children	4
Doctor	5
District nurse	6
Health visitor	7
Careline	8
Warden/Scheme manager	9
Anyone else (please say who)	10