National Institute for Health and Clinical Excellence

Falls (update)
Scope Consultation Table
07 November – 2 December 2011

Type (NB this is for internal purposes – remove before posting on web)

SH = Registered Stakeholders. These comments and responses will be posted on the NICE website after guideline development begins.
GRP = Guidelines Review Panel member. These are added to this table for convenience but will not be posted on the web.
NICE = Comments from NICE. These are added to this table for convenience but will not be posted on the web.
Non Reg = Comments from organisations and people who have not registered as stakeholder. These are added for convenience but will not be posted on the web.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Royal College of Nursing	13.02	3.3.1.a)	Should non-modifiable risk factors be included here too? They still need to be identified, assessed and managed…	We agree. The scope has been changed so that modifiable and non-modifiable risk factors are included.
SH	National Patient Safety Agency	3.01	3.3.2.a) and Table 1 'hospital patients/ identifying people at high risk of falling'	We very much agree with the scope's overall focus on assessment for modifiable risk factors rather than predicting which inpatients are likely to fall. However, we think the methods for identifying inpatients who are at risk of falling should not be explicitly excluded from the scope as there is a brilliant opportunity to not only encourage evidence based practice (acting on the modifiable risks) but also to discourage currently widespread non-evidence based practice (extensive use of prediction scores which are either unvalidated or show poor reliability). We think this is also essential in terms of which patient groups interventions should be applied to; for example, in the paragraph above you refer to training needs of staff involved in the care of *'patients who are at risk of falling'* – but if you avoid stating what patients are at risk of falling in the CG, it	Thank you. The scope has been changed so that modifiable and non-modifiable risk factors are included, and to make it clearer that all inpatients aged 65 and over will be eligible for a falls risk assessment, and inpatients aged 50-64 are eligible if they have been identified at higher risk of falling by a clinician.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				becomes unclear what those training needs might be, etc. Despite the very poor evidence base for the risk scores, there will be evidence based approaches the CG could rely on e.g. considering inpatients with a history of falling as at risk of falls, considering inpatients with poor mobility as at risk of falls. Or, as you imply in 4.1.2 (a), you may actually require assessment and intervention for modifiable risk factors for all inpatients aged over 65 years. We would suggest 3.3.2 (a) is either dropped altogether (with the distinction of what assessment/screening/targeting is appropriate clarified as part of the CG itself) or, if not dropped, instead worded *'methods of predicting inpatients most likely to fall, except where relevant to targeting specific falls prevention interventions'.* In table 1 we suggest Table 1 'hospital patients/identifying people at high risk of falling' is altered from no to yes under 'for guideline' for the reasons above, for consistency with the community section of the CG, and because it appears the norm for NICE CGs to not only recommend interventions but to also recommend who should receive interventions.	
SH	Royal College of Nursing	13.03	3.3.1.c)	Will recommendations also be included here for the capture of patient (user) views on services? This will be helpful.	We are unable to predict what recommendations will be made during the development of the guideline.
SH	Royal National Institute of Blind People	16.04	3.5.b)	**Review question B:** *What interventions reduce the risk and/or the severity of a fall in hospital, compared with usual care? Which interventions are the most effective?*	Thank you. Whilst your suggestions are useful they cannot directly be used to address the research question. A comprehensive review of the evidence base must first be conducted before

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				Does the intervention vary by underlying pathology? We believe that a standardised visual acuity assessment - using LogMAR acuity - should be a compulsory part of the hospital-based falls risk factor assessment. This will help identify patients with sight loss and ensure that appropriate interventions are implemented to reduce their risk of falls. For older patients with sight loss, there are a number of interventions which will help reduce falls in the hospital setting including: • Training hospital staff about the needs of blind and partially sighted people. For example, sight loss patients would benefit from a description of their environment and clear, verbal instructions about any hazards in the ward. • Ensuring patients with refractive error are given their glasses to wear, which does not always happen. • Providing large, clear signs to help patients navigate safely around the unfamiliar hospital environment. Patients have reported that signs can be too small to read.	the evidence is presented to the Guideline Development Group for consideration.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				• Making sure there is good lighting and contrast in colours (where possible) to help sight loss patients interpret their environment. • Training hospital staff to guide people with visual impairment around the hospital (if required by the patients). Although there are no hard and fast rules, the RNIB has produced some guidance on this issue which can be access at: http://www.rnib.org.uk/livingwithsightloss/helpingpeople/meetgreet/Pages/howtoguide.aspx • Using Eye Clinic Liaison Officers (ECLOs) to provide advice and information on falls prevention in hospital to people with sight loss. An RNIB report - *Innovation and Quality in Sight Loss and Blindness Services* (2011) - provides more information on the value of ECLOs and this document can be viewed at: http://www.rnib.org.uk/aboutus/Research/reports/earlyreach/Pages/ECLO_innovations.aspx	
SH	Chartered Society of Physiotherapy	7.02	3.1.1.c)	Will this apply to privately run care homes too, or just NHS/Social Services owned care homes? Also, suggest you clarify retirement complexes. In some areas there are sheltered complexes that are owned (and rented to residents) by housing associations, and there are a lot of private purchase retirement flats, whereby residents pay for the flat/bungalow outright and pay a service charge to cover warden costs and maintenance, etc.	The text in the scope has been changed to make it clearer that the guideline applies to people who receive NHS funded care, wherever they reside.
SH	Royal College of Physicians	15.01	General	Overall, our experts are reasonably happy with the	The scope has been clarified to make it clearer

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				draft scope. We found the distinction between 'identifying' and 'assessing' confusing in places. Table 1 does not include 'identifying' but does includes 'assessing'. Surely you have to identify the high risk patient to focus assessment. Identifying modifiable risk factors - it is important to also understand non modifiable in terms of risk assessment	that all inpatients aged 65 and over will be eligible for an inpatient falls risk assessment, and those aged 50-64 will be eligible if they have been identified as at higher risk of falling by a clinician.
SH	British Geriatrics Society	6.02	3.3.1.a) 3.3.2.a) & 3.5.a)	There should be a clearer distinction between falls risk screening and falls risk factor assessment	Thank you. The scope does not make reference to falls risk screening. The term 'identify' is used to refer to the process used to discriminate between people who would and would not benefit from a falls risk factor assessment. The term 'risk factor assessment' is used to refer to the process of appraising risk factors to be targeted by a care plan to reduce the risk of falls and further injury.
SH	National Osteoporosis Society	17.02	3.1.1.c)	Older people is not defined. Is it intended to mean 65 or older?	The guideline has been changed to clarify that the population being referred to is that of the existing guideline (people aged 65 and older).
SH	British Pain Society	20.02	4.1.2	We are puzzled by the decision to omit Identifying hospital inpatients aged 50-64 who are at risk of falling	Evidence shows that people aged 65 and older have the highest risk of inpatient falls, thus this group of patients are automatically included in the guideline for a falls risk factor assessment. Whilst the risk of falls is somewhat lower for people aged 50-64, we acknowledge that there are a multitude of factors which may increase the risk of falling amongst small subgroups of these patients, for example those with Parkinson's disease or sensory/cognitive impairments. It is beyond the scope of this guideline to list these

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					factors which may or may not interact with each other. It is therefore expected that for this subset of patients that clinicians will consider their patient's risk on an individual basis and use their clinical judgement to decide whether their patient would benefit from this guidance or not. The text in the scope text has been changed to make this clearer
SH	National Patient Safety Agency	3.05	3.4.e) & 3.4.f)	We think quality of life and activities of daily living are important secondary outcomes but you need to take care not to include them as sole outcome when searching the literature, as this will give you many rehabilitation studies without clear benefit to falls prevention. Also it is conceivable interventions could make patients more active but increase their falls – removing fear of falling without addressing risk of falling could lead older people to be exposed to greater risks, or encouraging more activity and independence could in some circumstances increase falls (some care home studies suggest falls increased in frail groups encouraged to exercise more without their underlying risk factors addressed). Perhaps overall in this section, a-d are primary outcomes and d-h secondary outcomes.	The outcomes listed in 3.4 are to identify relevant literature for inclusion in the development of the guideline. When all of the relevant papers are identified they are reviewed by the committee who use their expertise to interpret the findings in a clinical context, thus it is not possible to change the scope as suggested.
SH	Chartered Society of Physiotherapy	7.07	3.4.a) & 3.4.b)	As well as looking at in-patient falls rates (important to mention that it must be rates per 1000 bed days rather than pure numbers of fallers) more clarity is needed when looking at 'severity' of falls. The NPSA would advocate monitoring the harm suffered from falls.	Thank you for your comment. We would not usually specify a particular unit for rate data, although we agree that this is an example of the kind of data we will seek. The scope has been changed and 'severity' has been replaced with 'impact'.
SH	Cambridge University Hospitals NHS Foundation	14.07	3.5	There should be a review question about what training do staff need to reduce the risk of falls	Staff training is not a primary review question at this stage, as it is anticipated that this issue will be

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Trust				covered in review question 4 which relates to the coordination of the care pathway and how barriers can be overcome. If the results of this question suggest that staff training is a priority that needs to be addressed, then recommendations about staff skills and competencies may be made.
SH	British Pain Society	20.03	3.1.1	Analgesics are a very common cause of falls and vague 'dizziness' in primary care. Encourage GPs to carry out an analgesic review as a potential cause for all falls.	Recommendations for primary care are already provided in the current guideline for the assessment and prevention of falls in older people (CG21). Primary care will not be covered in this update, except in the context of service delivery and the associated quality standard.
SH	College of Occupational Therapists	19.01	General	The outcomes are good and the quality standard will help, but how do we measure these outcomes? For example, some older people find the FES-I or ConfBal notoriously difficult to understand, and they are very subjective.	The outcomes listed in 3.4 of the scope are the outcomes of papers to be included in the evidence review, not the expected outcomes of the guidance.
SH	College of Occupational Therapists	19.02	General	Training of professionals is there in the first guidance but how is the quality of this measured and does it change clinical practice? This is vital to the successful identification of those at risk and meaningful action being taken. Falls are everybody's business, and this needs to be stressed.	Thank you. Your comment relates to the current guideline (CG21) and as such is outside the scope. However, this update will cover service delivery to identify how barriers to implementation can be overcome.
SH	College of Occupational Therapists	19.05	2.1.a) & 2.1.b)	The ages appear arbitrary: people aged under 50 with underlying conditions and pathology can fall and some of the principles are the same so should it just be older people or should there be a cut off point between older people and over 18s?	The remit of the guideline which was provided by the department of health was to specifically focus on older adults. Older adults are defined as those aged 50 and over.
SH	Nottinghamshire Healthcare NHS Trust	18.01	2.1.d)	Research does indicate that people with LD are at a higher risk of falling, than the normal population who may have the same conditions as the people with LD – would be good if this was acknowledged with the Guideline.	People with learning disabilities are not included in section 2.1. (d) as the list relates to people with newly acquired risk factors in hospital. People with learning disabilities are included in the scope in section 3.1.1. (b) 'who have been identified as being at higher risk of falling', and if evidence is

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				Eg Studies have shown a high prevalence of a wide range of health problems amongst people with learning disabilities, and this appears to be irrespective of whether they live in residential care or in the community (Kapell et al, 2000; Maaskant & Haverman, 1990; Minihan, 1990; Nelson & Crocker, 1978; Turner & Moss, 1996; Wilson & Haire, 1990). Older people with learning disabilities present with the same range of medical disorders as in the general population including impaired mobility, respiratory problems, hypertension, urinary incontinence, arthritis and cardiovascular disease, however the incidence of these conditions is greater in older people with learning disabilities (Cooper, 1998; Evenhuis, 1997; Janicki et al, 2002; Van Schrojenstein Lantman-de Valk et al, 1997). *People with learning disabilities have a higher incidence of visual and hearing impairments than are present in the general population (Evenhuis et al, 2001). The presence of a visual and/or hearing impairment have been identified as risk factors that may contribute to a fall in an older/infirm person (NICE, 2004), this means that people with learning disabilities may actually be at a greater risk of falling than there counterparts in the general population.* (References are attached as separate document if you do need them)	found for this specific subgroup, explicit reference will be made in the guideline.
SH	Cambridge University	14.00	2.1.d)	It is not always possible to prevent patients from falling in hospital if they have a pre-existing history of falls in	Thank you, we agree. It is not the intention of the guideline to prevent all falls as this would be

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Hospitals NHS Foundation Trust			the community	impossible to achieve.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.00	2.1.d)	Newly acquired risk factors to falls should also include syncope as 10% of falls in older people are caused by syncope. (Campbell A, et al. *Age and Ageing*. 1981;10:264-270).	This has been added.
SH	Cambridge University Hospitals NHS Foundation Trust	14.04	2.1.d)	Dementia is unlikely to be a newly acquired risk factor in hospital.	This has been removed
SH	Cambridge University Hospitals NHS Foundation Trust	14.05	2.1.e)	Should include mortality also.	This has been added.
SH	Association of British Neurologists	10.00	2.2	It is unrealistic to suggest that all older people who have fallen should be "identified, risk assessed, and considered for an individualised multifactorial intervention". Those who have fallen once are in any event, unless injured, most unlikely to present to medical attention. Indeed, a person may have several falls before bothering a doctor. Some sense of proportion is required. But we agree that in patient falls are a very important issue to be addressed.	The sentence that you quote is taken from the current guideline for the assessment and prevention of falls in older people (CG21), and was included in the scope to provide context and background information on current practice.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.01	2.2.c)	Yes we agree with this point and support a review of the guidance to cover inpatient services.	Thank you.
SH	Cambridge University Hospitals NHS Foundation Trust	14.01	2.2.c)	As there is no joint electronic patient record system it is often difficult to gain information regarding patients who are admitted to hospital with a history of falls in the community. The falls services in the community are organised differently in many areas and are not always easy to access from a hospital setting	Thank you. One of the aims of this guideline is to improve the delivery of falls services across the patient pathway.
SH	Nottinghamshire Healthcare NHS Trust	18.00	2.3.a) & 2.3.b)	*The NSF for Older People (DoH, 2001) acknowledges that many older people with learning disabilities begin the ageing process at an earlier age than the general population. This is*	People with learning disabilities are included in the scope in section 3.1.1. (b) 'who have been identified as being at higher risk of falling', and if evidence is found for this specific subgroup,

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				often as a result of the conditions/syndromes that are also responsible for the learning disability, however to ensure that people with learning disabilities are not discriminated against because of the early onset of their age related symptoms falls services need to be available to them at an earlier age. As demonstrated in the quote above re aging process and people with LD – acknowledged that this Guideline and Quality standard is inclusive of people aged 50-64 who have underlying pathologies or conditions – would people with LD be included in such a statement?	explicit reference will be made in the guideline.
SH	Cambridge University Hospitals NHS Foundation Trust	14.06	3.1	Delirium should be included as a key issue to be covered also	This has been added.
SH	Parkinson's UK	8.00	3.1.1	Parkinson's UK are delighted to see that the review of the guideline is taking into account all hospital inpatient setting and will cover people from 50 years of age who have an underlying condition, such as disturbances of gait, which of course covers people living with Parkinson's.	Thank you.
SH	British Pain Society	20.04	3.1.1	The older population have a higher incidence of chronic pain, and their numbers are increasing. Polypharmacy of analgesic and non analgesic drugs in this group has added risks of ADEs (adverse drug events). The STOPP (Screening Tool of Older Person's potentially inappropriate Prescriptions) criteria were associated with ADEs in older people that contributed to urgent hospitalisation. A prospective 4 month survey of 600 elderly (> 65 years) patients	Thank you.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				revealed that the incidence of ADEs was 26%, of which two thirds were the reason for the hospitalisation. Nearly 70% of ADEs responsible for admission were potentially avoidable, and could be identified by using the STOPP criteria. Potentially Inappropriate Medications (PIMs) concerning analgesics are; long term opioids and neuroleptic drugs in patients with a history of syncope or falls (1 in last 3 months), and the combination of tricyclics and benzodiazepines. 1. Hamilton H, Gallagher P, Ryan C, Byrne S, O'Mahony D. Less in More. Potentially Inappropriate Medications defined by STOPP criteria and the risk of adverse drug events in older hospitalised patients. Arch Intern Med 2011; 171 (11): 1013-1019.	
SH	British Pain Society	20.01	3.1.1	We propose that medication especially pain medication is a prominent cause of unsteadiness and falls in the hospital inpatients group and wonder whether this will be considered.	The guideline does not aim to outline all causes of falls, but will aim to make specific recommendations for preventing inpatient falls where evidence exists.
SH	Chartered Society of Physiotherapy	7.01	3.1.1.b)	Agree that it is useful to extend the scope of the guideline to include this age group with pathologies that increase the risk of falls.	Thank you.
SH	National Osteoporosis Society	17.01	3.1.1.b)	The addition of this population in the review produces an inequality in the guidance given in the inpatient, community setting and those that present at hospital as a result of a fall. For example a 50 year old, with underlying conditions, who falls or is at risk of falling in the community would be excluded from the original guidance; a 50 year old, with underlying conditions, who falls or is at risk of falling in hospital will be included in the extension.	The differing age between the two guidelines is justifiable given the evidence that shows that people admitted to hospital are at an increased risk of falling than people who reside in the community due to a range of factors such as unfamiliar surroundings and acute illness. The recent review of CG21 in 2011 found no evidence for extending the age range in the community setting.
SH	Cambridge University Hospitals NHS Foundation	14.02	3.1.1.b)	A number of hospital falls are related to neurological diagnosis and this often effects patients younger than	The remit of the guideline which was provided by the department of health was to specifically focus

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Trust			50. Many of these patients will continue to have an increased risk of falls	on older adults. Older adults are defined as those aged 50 and over.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.02	3.1.1.b)	An example of an underlying condition which puts patients at higher risk of falls between the ages of 50-64 could include people who have been admitted with blackouts/syncope.	This has been added.
SH	Royal National Institute of Blind People	16.02	3.1.1.b)	**Groups that will be covered:** As highlighted above there is a significant risk of falls among people with sight loss. We believe that section 3.1.1 b in the scope - groups that will be covered - should make specific reference to people with sensory impairments. We request that the wording is amended to read: *Hospital inpatients aged 50 to 64 who have underlying conditions or pathologies that put them at high risk of falling (for example, people admitted to hospital with a fall, those with sensory impairments, stroke or disturbances of gait).*	This has been added.
SH	British Geriatrics Society	6.01	3.1.1.b) & 4.1.2.a)	There appears to be inconsistencies between these statements	The scope has been clarified to make it clearer that all inpatients aged 65 and over will be included in the guideline automatically, and those aged 50-64 will be identified on an individual basis using clinical judgement.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.03	3.1.1.c)	Yes we agree that older people who fall in the community (retirement home etc) should be included in this NICE scope.	Thank you.
SH	Parkinson's UK	8.01	3.2	Parkinson's UK are delighted to see that the following settings will also be covered i.e. person's home, retirement complex and residential/nursing care.	Thank you.
SH	Chartered Society of	7.03	3.2	All relevant settings and service should be covered, as without this there is a risk that people will miss out on	The guideline applies to older people receiving NHS funded care within hospital or community

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Physiotherapy			interventions because their setting is not included in the guidance.	settings, as listed in 3.2. .
SH	National Patient Safety Agency	3.02	3.2.2.d)	This exclusion needs to be worded carefully to avoid the risk of it excluding secondary prevention of falls after the first fall – we would suggest *'management and rehabilitation after a fall, except where this relates to prevention of further falls'*	Thank you. This has been changed in line with your suggestion.
SH	Chartered Society of Physiotherapy	7.04	3.3.1	Suggest a cross reference to existing NICE guideline could be inserted here; otherwise the decision to exclude management of people following a fall is surprising. Suggest some clarification for terminology: In 3.3.1 it states that interventions to prevent inpatient falls will be covered in the guidance, but then in 3.3.2 it states that management and rehabilitation following a fall will not be covered. Surely management / rehab of a patient following a fall are potentially part of an ongoing intervention? Presume there will be a need to look wider than interventions which are just immediate 'wins' such as call bells in reach.	Section 3.3.1 has been changed to make it clearer that treatment, management and rehabilitation will be excluded except where this in the context of falls prevention.
SH	Parkinson's UK	8.02	3.3.1	Parkinson's UK concur that education and information on falls prevention is a key input and hope that condition specific information i.e. high risk of falls in Parkinson's will be covered. It is also imperative that the patient pathway is looked at as a whole across all settings, so we where delighted to see that this was being addressed.	Thank you.
SH	National Osteoporosis Society	17.03	3.3.1.a) & 3.3.1.b)	It is not clear from the scope whether "modifiable risk factors" and "interventions" are intended to cover both personal (eg vision, polypharmacy) and environmental (eg trip hazards). Both are important to prevent impatient falls.	The guideline will cover both personal and environmental risk factors and will make explicit reference to them if there is evidence to support this.
SH	Chartered Society of	7.06	3.3.1.a)	In 3.3.1 and 3.3.2 the attempt to differentiate	The scope has been amended to make it clearer

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
	Physiotherapy		3.3.2.a) & Table 1	between processes/structures to assess modifiable risk factors and methods of identifying those at risk of falling, seems very much the same. In the Table it is proposed not to provide guidance on identifying those at high risk but then want to provide guidance on how to assess them. I think this needs a bit more clarity. Who are we supposed to assess if we can't identify them properly in the first place?	that all inpatients aged 65 and over will be included in the guideline automatically, and those aged 50-64 will be identified on an individual basis using clinical judgement.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.04	3.3.1.c)	Education and information about falls prevention should be appropriately provided for patients and healthcare providers. For example, Dementia should be understood as an obstacle to educating patients.	Thank you.
SH	Tees, Esk and Wear Valleys NHS Trust	11.05	3.3.1.d)	The only way to ensure joint working and prevent silo's is to mandate that acute, community and secondary care must work together to produce a single falls pathway and strategy which encompasses NICE guidance	Thank you.
SH	Association of British Neurologists	10.01	3.3.2	Here it is stated that preventing falls in community settings will not be covered, while in 3.2.b the opposite is suggested. We think that prevention of falls in nursing homes and other care settings is important and should be considered, as indeed is the implication in 4.1.1 b, c etc.	The clinical review will not cover preventing falls in community settings as it is already included in the existing guideline for the assessment and prevention of falls in older people (CG21). However a quality standard is being developed alongside CG21 and will cover the whole patient pathway, and so community settings will be included for the development of the quality standard only as stated in section 3.2. (a) & (b) Please note section 4.1.1. refers to the development of the quality standard, not the clinical guideline.
SH	Chartered Society of Physiotherapy	7.05	3.3.2	We are unclear why methods of identifying patients at risk of a fall not being covered?	The scope has been amended to make it clearer that all inpatients age 65 and over will be included in the guideline. Patients aged 50-64 will need to

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				Good that assessment of modifiable risk factors is included, but many hospitals and services are looking for guidance for identification. If it is felt that the research may not support identification of patients then surely the guidelines need to look into this and give a definitive rationale as to why this sort of identification should not be undertaken in a hospital inpatient setting. I think it would be useful to consider how to identify those at high risk of falling in in-patients (a very controversial topic!). It would be useful to have consensus guidance on how to identify potential fallers.	be identified on an individual basis using clinical judgement.
SH	Parkinson's UK	8.03	3.3.2	Parkinson's UK are concerned that the methodology of identifying risk and management post fall will not be covered and would like to see that this is covered in some way as this would provide a 360 degree approach to prevention, risk and management of people at risk of falling.	The scope has been amended to make it clearer that all inpatients age 65 and over will be included in the guideline. Patients aged 50-64 will need to be identified on an individual basis using clinical judgement.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.05	3.3.2.a)	If methods of identifying inpatients who are at risk of falling have not been covered in the NICE Clinical guidelines 21, then it should be addressed in this scope.	The scope has been amended to make it clearer that all inpatients age 65 and over will be included in the guideline. Patients aged 50-64 will need to be identified on an individual basis using clinical judgement.
SH	National Osteoporosis Society	17.04	3.3.2.a)	We are concerned that "methods of identifying inpatients who are at risk of falling" will not be covered by the extension. If this is because multifactorial falls risk assessment is covered by the original guidance this needs to be referred to. Excluding identification of inpatients at risk could present a barrier to implementing the guidance.	The scope has been amended to make it clearer that all inpatients age 65 and over will be included in the guideline. Patients aged 50-64 will need to be identified on an individual basis using clinical judgement.
SH	Tees, Esk and Wear Valleys NHS Trust	11.02	3.3.2.b)	Although the consultation stipulates that the management and rehabilitation after a fall will not	Section 3.3.1 has been changed to make it clearer that treatment, management and rehabilitation will

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				be covered in this consultation period there is strong concern that it should be. This is especially relevant considering the publication of the NPSA Rapid response Report (NPSA/2011/RRR001), "Essential care after an inpatient fall" (13th January 2011). Patients are dying in the inpatient setting due to poor assessment following a fall. Surely this must be added to the guidance to save lives? Tees Esk and Wear Valley's (TEWV) NHS Foundation Trust has developed a post falls proforma (RAG rated) which we are very happy to share, especially with other mental health, learning disabilities and substance misuse trusts. We also have a substantial training package linked to this.	be excluded except where this in the context of falls prevention.
SH	National Patient Safety Agency	3.03	3.3.2.c)	This point is problematic as currently worded as the bulk of falls prevention is about identifying, treating and managing causative conditions like delirium and dementia – need to be careful not to exclude these by mistake. Additionally in terms of service delivery you will have some evidence that falls prevention and bone health are more effective when 'joined up' rather than separate processes. You currently have excluded preventing hip fractures – which really is a part of any falls prevention (except perhaps hip protectors – but note those were within the scope of the original CG and included as 'insufficient evidence to recommend') We would suggest instead: • *'Preventing, treating and managing osteoporosis, except where relevant to integrated service delivery of falls and fracture prevention*	Thank you. Section 3.3.2. has been amended.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				• *Treating and managing injuries sustained in falls* • *Treating and managing healthcare conditions associated with falls, except in the context of falls prevention'*	
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.06	3.4	Quality and continuity of care for inpatients returning to community care.	The outcomes listed in 3.4. are those used for identifying relevant literature for the evidence review, not the outcomes that the guideline is hoping to achieve or measure.
SH	National Patient Safety Agency	3.04	3.4.a)	We think you mean 'rate of falls and rate (or proportion) of fallers' – current wording of rate with rate and number in brackets is confusing.	Thank you. This has been changed.
SH	Chartered Society of Physiotherapy	7.08	3.4.e)	Could we add self efficacy as a measure, please?	The outcomes listed in 3.4. are those used for identifying relevant literature for the evidence review, not the outcomes that the guideline is hoping to achieve or measure.
SH	Royal College of Physicians	15.02	3.4.f)	We are not certain what will be measured here	The outcomes listed in 3.4. are those used for identifying relevant literature for the evidence review, not the outcomes that the guideline is hoping to achieve or measure.
SH	Royal College of Physicians	15.03	3.4.g)	How will this be measured?	The outcomes listed in 3.4. are those used for identifying relevant literature for the evidence review, not the outcomes that the guideline is hoping to achieve or measure.
SH	Royal College of Physicians	15.04	3.4.h)	There will be coding issues in terms of Length of stay. The concept of an intervention for a 'single pathology' is interesting as these patients will have complex pathologies.	The outcomes listed in 3.4. are those used for identifying relevant literature for the evidence review, not the outcomes that the guideline is hoping to achieve or measure.
SH	Tees, Esk and Wear Valleys NHS Trust	11.03	3.5.a)	Whether patients are identified as a risk of falls through a validated tool, or all patients admitted are considered to be a risk of falls, or their falls history determines their falls risk, MDT should be proactive rather than reactive. The following	Thank you.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				assessments should be completed to prevent a fall occurring; ▪ Full falls history ▪ Full physical assessment ▪ Full investigations i.e. FBC, U&E's, LFT's, CRP, EGFR, bone profile, therapeutic drug level, glucose, B12 and Folate ▪ Medication review/reconciliation ▪ Balance, gait and muscle strength ▪ Transfers and walking ▪ Continence ▪ Fear, agitation, confusion and behaviours that challenge ▪ Pain ▪ Dizziness, and postural hypotension ▪ Alcohol and drugs ▪ Visiual and perceptual abilities ▪ Hearing loss ▪ Footwear and foot care ▪ Osteoporosis risk (including FRAX) ▪ Environmental (including ward and home environment) If any of the sections above are not completed it should state why this is to ensure an equitable level of falls assessment.	
SH	Cambridge University Hospitals NHS Foundation Trust	14.03	3.5.a)	Modifiable risk factors are very dependent on the patient and their underlying pathology. Patients do not always wish to make changes or accept that they are at risk.	Thank you.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Royal National Institute of Blind People	16.03	3.5.a)	**Review question A:** *What assessment tools or processes should be used to identify modifiable risk factors for falling while in hospital? Does this vary by underlying pathology?* Risk factors for falling while in hospital do vary by underlying pathology. For example, in patients with sight loss, risk factors include not being able to interpret their environment and see hazards which could lead to falls. Consultation with Eye Clinic Liaison Officers and feedback from blind and partially sighted inpatients would be a useful way of identifying modifiable risk factors in each individual hospital setting.	Thank you. Whilst your suggestions are useful they cannot directly be used to address the research question. A comprehensive review of the evidence base must first be conducted before the evidence is presented to the Guideline Development Group for consideration.
SH	Tees, Esk and Wear Valleys NHS Trust	11.04	3.5.b)	As above but it must be noted that certain underlying pathologies (e.g. dementia, learning disabilities) will require further assessment and interventions. TEWV NHS Foundation Trust has recognised this in their falls strategy. The strategy is person centre and is used in conjunction with their falls pathway. The strategy includes **Falls pathway and Governance**:- Falls Clinical Pathway Electronic visual display board (eVDB) Paris (electronic recording in relation to falls) documentation	Thank you.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				Additional strategies to support person centred care SBARRD tool Environmental assessment tools (FEAT tool) HSE mapping tool Storytelling Life history and meaningful occupation Dementia care mapping Holistic falls formulation Productive ward Intervention plans Advanced directives **Positive risk taking** 1:1 enhanced observation Hip protection/specialist clothing Assistive technology and telecare CCTV surveillance analysis **Implications for physical care** Polypharmacy Nutrition and hydration Physical exercise and strengthening Incontinence Physical Care **Patient outcome measures** DATIX system	

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				Professional values Professional roles and responsibilities Training **Appendices/toolkit** 1. Benchmarking against national drivers 2. Immediate post falls checklist 3. Falls crib sheet 4. SBARRD tool 5. Falls environmental tool 6. Holistic falls formulation 7. Productive ward 8. Guide to intervention plans 9. Standard process description to formulating intervention plans 10. Standard process description to evaluating/reviewing intervention plans 11. Standard process description for documentation of the intervention review/evaluation on PARIS 12. Hip protector decision support tool 13. Polypharmacy 14. Professional roles and responsibilities 15. Staff compact 16. Falls learning and development proforma 17. Implementation plan 18. Strategy evaluation using PDSA	
SH	National Patient Safety Agency	3.06	3.5.c) & 4.1.1.d)	We would suggest that the phrase 'their carers' be reworded to explicitly include both hospital staff of all types and informal carers (family and friends)	NICE use the term carer to explicitly refer to informal carers such as family and friends, and this is who we are referring to in 3.5. (c) and 4.1.1

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
					(d).
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.07	3.5.c)	The education and information of hospital inpatients and their carers needs to be clear and appropriate. It should be communicated and monitored by trained staff. For example, if an inpatient is at risk of falls due to low blood pressure, they need to be given and encouraged to drink sufficient clear fluids.	Thank you.
SH	Royal National Institute of Blind People	16.05	3.5.c)	**Review question C:** *What are the education and information needs of hospital inpatients and their carers after a hospital-based falls risk factor assessment in hospital?* (a) Education and support: Following a falls risk factor assessment, inpatients newly diagnosed with sight loss will need education and advice to help them cope with their condition. This includes information on: • reducing their risk of a fall in hospital • correction/treatment for their eye condition • details of aids and adaptations • emotional support • referral to voluntary and statutory services • mobility training ECLOs could be used to provide this information and support. (b) Information needs:	Thank you. Whilst your suggestions are useful they cannot directly be used to address the research question. A comprehensive review of the evidence base must first be conducted before the evidence is presented to the Guideline Development Group for consideration.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				The Equality Act 2010 expressly includes a duty to provide accessible information as part of the reasonable adjustment duty. Many blind and partially sighted people want to be able to read their own health information so they can manage their personal health care. Hospital staff must identify each patient's requirements, record their reading needs and ensure that accessible information is provided. This includes offering information in large print or Braille.	
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.08	3.5.d)	Barriers for implementing falls prevention strategies: 1. Continuity of care between hospital and community/residential and primary care. 2. Dementia	Thank you. Whilst your suggestions are useful they cannot directly be used to address the research question. A comprehensive review of the evidence base must first be conducted before the evidence is presented to the Guideline Development Group for consideration.
SH	Royal National Institute of Blind People	16.07	3.5.d)	**Review question D:** *How should the care pathway be coordinated? What are the barriers to implementing falls prevention strategies, and how can they be overcome?* We welcome the fact that the updated guideline will include inpatient settings and service delivery in both hospitals and the community. This should facilitate the coordination of care across a wider range of settings. We would like reference made to the importance of integrating health and social services, as care for older people with sight loss often extends beyond traditional healthcare settings.	Thank you. Whilst your suggestions are useful they cannot directly be used to address the research question. A comprehensive review of the evidence base must first be conducted before the evidence is presented to the Guideline Development Group for consideration.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Tees, Esk and Wear Valleys NHS Trust	11.06	3.6	Our interventions outline above have shown to work as we have seen a 66.6% reduction in fractured neck of femur rate and a 50% reduction in falls	Thank you.
SH	Chartered Society of Physiotherapy	7.09	4 & General	Welcome the development of a quality standard for Falls. Will the quality standards cover the whole guidance, or just the updated bits?	Thank you. The quality standard will cover the whole guideline (existing guideline and the update)
SH	Royal National Institute of Blind People	16.08	4.1	**Quality Standard on Falls:** Section 4.1 outlines the areas of care that will be used to inform the development of quality statements for falls assessment and prevention in older people. In light of the significant link between falls and sight loss, we believe that an area of care / quality standard statement must be dedicated to patients with sensory impairment. Suggested wording follows: *"Identification and interventions to prevent older people with sensory impairments falling in community and inpatient settings"* We are aware that implementation of the original falls guideline (NICE clinical guideline 21) has been poor and this has been attributed to the lack of a consistent service delivery model. Therefore, we would welcome action from NICE to increase compliance with its Quality Standards and	Thank you. There are many different factors that can increase an individual's risk of a fall, . Therefore it is not possible to amend the existing wording.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				guidance.	
SH	Chartered Society of Physiotherapy	7.10	4.1.1	As above (Comment 7.03) Unclear as to why Interventions will be covered but rehabilitation and management will not. I'm not clear as to the difference or where the dividing line is between a physiotherapy-led intervention, that is already in the current guidelines such as strength and balance training, and 'rehabilitation'	Sections 3.3.1 and 4.1.2 have been changed to make it clearer that treatment, management and rehabilitation will be excluded except where this in the context of falls prevention.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.09	4.1.1.d)	This is crucial and we fully support the provision of resources about falls prevention to those at risk and their carers.	Thank you.
SH	College of Occupational Therapists	19.06	4.1.2.b)	It is not clear why a decision has been made to not include management and rehabilitation after a fall in the guidance. Whilst some falls may make it clinically inappropriate most would still need the input as confidence, balance and so on would have been impacted	Sections 3.3.1 and 4.1.2 havebeen changed to make it clearer that treatment, management and rehabilitation will be excluded except where this in the context of falls prevention.
SH	Syncope Trust And Reflex anoxic Seizures (STARS)	12.10	4.1.2.b) & 4.1.2.c)	We feel strongly that these should be considered within the quality standard. Treating and managing the cause of a fall within the hospital setting will reduce re-admission and bed days as well as improve quality of life for the patient/carer. For example, the impact of the associated risk of syncope as a cause of falls is high: 1-6% of hospital admissions are caused by syncope and the average length of stay: 6.1 days (Kapoor W. *Medicine*. 1990;69:160-175 , Hospital Episode Statistics, Dept. of Health, Eng. 2002-2003) If the prevention, treatment and management of falls within hospital are not considered within this inpatient scope, we will not achieve an accurate assessment of the cost effectiveness of the new quality standard.	Section 3.3.1 and 4.1.2 have been changed to make it clearer that treatment, management and rehabilitation will be excluded except where this in the context of falls prevention.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Department of Health	1.00	Assessing patients at risk of falling on hospitals or nursing hoimes	There is so much interest in both hospitals and nursing homes in using risk assessment tools which purport to identify people at risk of falling and which often have poor predictive validity and give false reassurance, that in my view as an experienced researcher in this area, it is critical that the review DOES include risk assessment/falls prediction tools so we can give a definitive statement on the evidence for the use of these tools	Risk factor assessment tools are included in the scope in sections 3.3.1 (a) and 3.5 (a)
SH	Royal College of Nursing	13.01	General	The scope needs to include the risk of falls for people with dementia. Good design and environmental layout need to be considered to assist people with cognitive problems.	Issues such as cognitive impairment and dementia will be considered during the guideline development process, and where evidence exists, explicit recommendations for these subgroups will be made.
SH	Tees, Esk and Wear Valleys NHS Trust	11.00	General	You can not separate the cause of a fall and a person's mental health (i.e. dementia). The two are inextricably linked. Cognitive impairment and delirium must be assessed in order to identify the risk of falling in individuals with dementia. This is especially so when the evidence suggests that most of those patients who fall in acute hospitals have some level of mental health problems i.e. dementia.	Neither the scope nor the guideline intends to separate the cause of falls and people's mental health. Issues such as cognitive impairment and delirium will be considered during the guideline development process and where evidence exists, explicit recommendations for these subgroups will be made.
SH	Royal National Institute of Blind People	16.06	General	**Equalities Act 2010:** In a related point, we believe that all NICE work should reflect the duties of public bodies under the Equalities Act 2010, not just in relation to communication and accessible information, but in relation to non-discriminatory treatment. We would expect NICE to take steps to meet their	NICE and the work that NICE produces endeavours to comply with the Equalities act. The scope of this guideline includes older people and those with conditions and comorbidities that increase the risk of falls.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				legal obligations. This not only requires public bodies to have due regard for the need to promote disability equality in everything they do - including the provision of information to the public - but also requires such bodies to make reasonable adjustments for individual disabled people where existing arrangements place them at a substantial disadvantage.	
SH	Tees, Esk and Wear Valleys NHS Trust	11.01	General	Interventions to prevent people from falling with dementia are different to those put in place with individuals without dementia. Trying to combine the two raises concerns regarding quality of assessment and treatment interventions.	Other conditions and comorbidities such as dementia will be considered during the guideline development process and where evidence exists, explicit recommendations for these subgroups will be made.
SH	College of Occupational Therapists	19.03	General	Some trusts are struggling to achieve good communication between secondary and primary care regarding falls assessments, so that what has already been assessed either gets reassessed or assumed completed when not done. Could the guidelines include this area?	Service delivery will be addressed in the evidence review.
SH	Milton Keynes NHS Foundation Trust	2.00	General	Please note your draft scope was discussed at our Trust Patient Falls Committee yesterday & there was consensus agreement in relation to the scope & details of your clinical guideline	Thank you
SH	National Patient Safety Agency	3.00	General	Overall we very much welcome the draft scope which clearly conveys a complex piece of work covering different aspects of the Clinical Guideline and Quality Standard. We support all content except were explicitly described below.	Thank you.
SH	UK Clinical Pharmacy Association	4.00	General	We have no comments to make on this draft scope.	Thank you.
SH	NHS Direct	5.00	General	NHS Direct welcome the guideline update and have no comments on the content of the scope.	Thank you.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	British Geriatrics Society	6.00	General	Agree with the proposed consultation	Thank you.
SH	Chartered Society of Physiotherapy	7.00	General	Welcome the update of the Guidelines and development of a Quality standard, This will be invaluable in improving the service offered to people who fall whatever the setting. Pleased to see that new guidance will include in-patient fallers as it needs to be highlighted. However, as far as I am aware current evidence for what works is pretty patchy. The RCP have a large trial underway at the moment that might provide some more definite conclusions. I agree that inclusion/consideration of inpatient settings is very much needed.	Thank you.
SH	Society and College of Radiographers	9.00	General	We have read the draft scope and would consider its aims commendable.	Thank you.
SH	Society and College of Radiographers	9.01	General	We recognise that x-ray departments/radiotherapy departments probably do contribute significantly to the falls rate in hospital care due to a multitude of factors and we are not sure how the proposed standards as described will impact on our ability to provide a responsive service. Issues are generally related to patient transport, mobility and manual handling assistance required, for which there is already a supposed system in place of risk assessment and standard paperwork for staff to be alerted to risk. Our concern is another risk assessment which is not seen by the 'ad hoc' carers (i.e. non ward staff). A consideration of the 'ad hoc' departments dealing	Thank you.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				with in-patients would be helpful so that a tool that is fit for all is used.	
SH	Royal College of Nursing	13.00	General	The Royal College of Nursing welcomes proposals to update this guideline and develop quality standards.	Thank you.
SH	Royal College of Physicians	15.00	General	The RCP is grateful for the opportunity to comment on this draft scope. We have had sight of, and would like to endorse, the responses of the British Geriatric Society and the Association of British Neurologists. We would also like to make the following comments.	Thank you.
SH	Royal National Institute of Blind People	16.00	General	We are pleased to have the opportunity to comment on this guideline update. General views are outlined below followed by comments on the specific review questions.	Thank you.
SH	Royal National Institute of Blind People	16.01	General	**Link between falls and sight loss:** Falls lead to significant morbidity and mortality and have sizable psychological effects on the sufferer. There is a substantial link between sight loss and falls and two RNIB reports highlight this important association: (a) Falls - costs, numbers and links with visual impairment (2011) http://www.rnib.org.uk/aboutus/Research/reports/complexneeds/Pages/falls_costs.aspx This report examined the evidence concerning the number and cost of falls attributed to partial sightedness and blindness. Key findings show: • Visual impairment is directly attributable to	Thank you.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				47% of the cost of falls in the population with sight loss and 10% of the cost of all falls in the UK • Sensory deficits such as vision or proprioception impairment are related to the recurrence of falls • 5% of all falls lead to a fracture and almost all hip factures (92%) are a result of a fall (b) Care Homes: literature review (2011) http://www.rnib.org.uk/aboutus/Research/reports/complexneeds/Pages/falls_project.aspx We commissioned ARUP to conduct desk research on falls management in care homes for the elderly, looking at the specific needs of those who are blind or partially sighted. Findings show that changes in visual components, such as visual field, acuity contrast sensitivity and depth perception, have been identified as key risk factors in falling.	
SH	Royal National Institute of Blind People	16.09	General	**Concluding comments:** As the number of falls increases with the ageing population, it is important that hospital staff understand the significant link between visual impairment and falls. We call for visual assessment to be a compulsory part of the hospital-based falls risk factor assessment; and that plans to correct/treat sight	Thank you. As part of the guideline process the committee will consider the best available evidence on what should be part of the in hospital assessment and what interventions should be put in place to prevent falls within the hospital setting.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				loss should be part of the patient's care pathway (where appropriate).	
SH	National Osteoporosis Society	17.00	General	We welcome the extension to the guideline to include inpatient settings and service delivery.	Thank you.
SH	College of Occupational Therapists	19.00	General	There still appears to be too much room for local interpretation which will not address the variation in implementation; what is required is clearer guidance for hospitals and inpatients so that they can be measured against each other	Thank you. One of the aims of this guideline is provide clear service delivery guidance, which will hopefully help to address variations in practice.
SH	College of Occupational Therapists	19.04	General	Coding or noting falls in A&E can also be an issue, with the result that the injury is coded or noted and therefore falls are not identified as an issue and consequently not followed up	Thank you. Falls within the hospital setting have been noted as an issue that needs to be addressed. The purpose of this guideline is provide guidance to the NHS on falls within the hospital setting and how best to implement falls prevention within the hospital and community settings.
SH	British Pain Society	20.00	General	We note that the previous guidance has been poorly implemented so we hope that thought will be given to making the update more relevant and user friendly. The proposed scope of the guideline seems to be appropriate.	Thank you.
NICE	CCP Technical Lead	21.00	General	Thanks for opportunity to comment. I will keep this very brief. The scope looks a little unwieldy for time and resources for SCGs at the moment, but hopefully there will be an opportunity to discuss this at the next internal scope meeting in a little more detail.	Thank you.
SH	Royal College of Nursing	13.04	General	We understand the need to move away from numerical and hierarchical risk scores and other more global identification strategies towards a more person–centred care and therefore individual assessment of risk, but many organisations remain very focussed on them.	The guideline aims to make explicit recommendations about promoting positive actions and reducing actions that have limited value or may potentially cause harm. Statements in relation to the use of risk scoring tools may be made if the evidence review and GDG consensus support such statements.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
				Will there be mention of this in the guideline and standards, strategies to encourage organisations to reconsider? Even though the guideline will not be formally covering this?	
SH	Department of Health	1.01	Interventions to Prevent Falls (all settings)	We need to make explicit reference to the use of telecare/telehealth and assistive technology when we examine interventions	Thank you.
SH	Department of Health	1.06	Interventions to prevent falls in community	There is a lot of interest in the role of ambulance trusts in identifyiung assessing and referring people they are called out to see with falls especially the non conveyed. Some ambulance trusts e.g. Tyneside or Notts have made significant impact on call outs using these approaches and we should incorporate some of this work.	Thank you.
SH	Department of Health	1.02	Interventions to prevent falls in the community	There is so much interest in public health and prevention, that we do need to look at whole population approaches around education, safer streets and housing, access to exercise, etc so that local government and public health have an evidence base on which to make commissioning and provision decisions.	Thank you.
SH	Department of Health	1.04	Interventions to prevent falls in the community	We should set out the evidence (if any) for falls prevention being able to prevent fracture	Thank you.
SH	Department of Health	1.03	Interventions to prevent falls in	In view of Gates and Lamb SDO review on falls clinics, we do need to look at the evidence for single interventions versus multifaceted and whether falls assessments and interventions are best delivered in a	This will be addressed in the evidence review.

Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
			the commun ity	community setting, in primary care, in specialist falls clinics etc	
SH	Department of Health	1.05	Interven tions to prevent falls in the commun ity and in care settings	We need explicitly to look at the evidence for fall prevention in people with dementia and cognitive impairment. They are at especially high risk but sometimes excluded from services	People with dementia and cognitive impairments are included within the scope of this work, and explicit reference to such groups will be made if the evidence review supports it.

These organisations were approached but did not respond:

Abbott GmbH & Co KG
Age UK
Airedale NHS Trust
Apetito Ltd
All Wales Senior Nurses Advisory Group
Alzheimer's Society
Amgen UK
Anglian Community Enterprise
Arrhythmia Alliance
Arrowe Park Hospital
Association for Continence Advice
Association of British Healthcare Industries
Association of Directors of Adult Social Services
Association of the British Pharmaceutical Industry
Barchester Healthcare
Barnet Primary Care Trust
Barnsley Hospital NHS Foundation Trust

Basildon and Thurrock University Hospitals NHS Foundation Trust
Bedford Hospital NHS Trust
British Cardiovascular Society
British Dental Association
British Dietetic Association
British Geriatrics Society-Special Interest Group in Diabetes
British Healthcare Trades Association
British Medical Association
British Medical Journal
British Menopause Society
British National Formulary
British Orthopaedic Association
British Psychological Society
British Society of Rehabilitation Medicine
Buckinghamshire Primary Care Trust
BUPA Foundation
Calderdale and Huddersfield NHS Trust
Camden and Islington NHS Foundation Trust
Camden Link
Camden Provider Services
Care Quality Commission (CQC)
Central & North West London NHS Foundation Trust
Cephalon UK Ltd
Cochrane Bone, Joint and Muscle Trauma Group
Colchester Hospitals University NHS Foundation Trust
College of Emergency Medicine
College of Optometrists
Community District Nurses Association
Community Practitioners' & Health Visitors Association
Confidential Enquiry into Maternal and Child Health
Co-operative Pharmacy Association
Council for Involuntary Tranquilliser Addiction
County Durham Primary Care Trust
Croydon Primary Care Trust
Cumbria Partnership NHS Trust

Cwm Taf Health Board
Department of Health, Social Services and Public Safety - Northern Ireland
dk Medik Ltd
Eli Lilly and Company
Equalities National Council
Faculty of Public Health
Ferring Pharmaceuitcals
General Medical Council
George Eliot Hospital NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Gloucestershire LINk
Great Western Hospitals NHS Foundation Trust
Greater Manchester and Cheshire Cardiac and Stroke Network
Greater Manchester West Mental Health NHS Foundation Trust
Greenwich Teaching Primary Care Trust
Guide Dogs for the Blind Association
Guy's and St Thomas' NHS Foundation Trust
Health Quality Improvement Partnership
Healthcare Improvement Scotland
Hertfordshire Partnership NHS Trust
Humber NHS Foundation Trust
Institute of Sport and Recreation Management
Intensive Care Society
Ipswich Hospital NHS Trust
Lancashire Care NHS Foundation Trust
Limbless Association
Lundbeck UK
Luton and Dunstable Hospital NHS Trust
Medicines and Healthcare products Regulatory Agency
Ministry of Defence
National Care Forum
National Council for Palliative Care
National Institute for Health Research Health Technology Assessment Programme
National Public Health Service for Wales
National Treatment Agency for Substance Misuse

Nester Healthcare Group Plc
NHS Connecting for Health
NHS Cornwall and Isles Of Scilly
NHS Herefordshire
NHS Manchester
NHS Norfolk
NHS Norfolk Primary Care Trust
NHS North West
NHS Nottinghamshire County
NHS Plus
Niger Delta University
North Essex Mental Health Partnership Trust
North London Hospice
North Yorkshire & York Primary Care Trust
Nottingham City Hospital
Nottinghamshire Acute Trust
Novartis Pharmaceuticals
Nutricia Clinical Care
Outer North East London Community Services
Patient Assembly
Pembrokeshire NHS Trust
PERIGON Healthcare Ltd
Pfizer
Pilgrims Hospices in East Kent
POhWER
Poole Hospital NHS Trust
Princess Alexandra Hospital NHS Trust
Relatives and Residents Association
Rotherham NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists

Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Radiologists
Royal College of Surgeons of England
Royal Free Hampstead NHS Trust
Royal Pharmaceutical Society
Royal Society of Medicine
Sanctuary Care
Scottish Intercollegiate Guidelines Network
Sheffield Teaching Hospitals NHS Foundation Trust
Shire Pharmaceuticals Ltd
Social Care Institute for Excellence
Society of Chiropodists & Podiatrists
Society of Teachers of the Alexander Technique
South East Coast Ambulance Service
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
South West London Elective Orthopaedic Centre
St Nicholas Hospice
Strakan Limited
Sue Ryder Care
Sure Start Ashfield
Sutton1in4 Network
Teenagers and Young Adults with Cancer
Trinity Pharmaceuticals Limited
UK Pain Society
University Hospital Birmingham NHS Foundation Trust
Vifor Pharma UK Ltd
Welsh Government
Welsh Scientific Advisory Committee
Wigan Council
Wound Care Alliance UK
Wye Valley NHS Trust

York Hospitals NHS Foundation Trust