# Falls: assessment and prevention in older people and people 50 and over at higher risk (update)

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| AGILE: Chartered Physiotherapists working with Older People | Guideline | 004 | 006 | NICE will need to specifiy how they define frailty for the purpose of this guideline as the definition is open to interpretation. Are they defining it as a specific score on the Electronic Frailty Index or Clinical Frailty Scale or some other way? | Thank you for your comment. A link has been added to the section on How to assess frailty in the NICE guideline on multimorbidity. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 005 | 018 | Assessing gait and balance for individuals with a single fall will require further definition as some professionals may lack training / resources to complete this. A recommendation surrounding appropriate simple gait and balance screening tools such as Timed Up and Go should be considered. | Thank you for your comment. The committee noted that an assessment of gait and balance can be done by a simple test such as the Time up and Go test (TUG) which is designed to be done with minimal training. Although this does not predict a person's risk of falling it may help identify people who need a more detailed assessment.<br><br>The recommendation has also been updated to note that this can be carried out in the same service or involve an appropriate referral. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 005 | 019 - 021 | Offering falls prevention exercises and home hazard assessments should be completed by appropriately trained professionals and this needs to be stated. | Thank you for your comment. The recommendations here highlight what is needed. The recommendations in the section 1.3 on interventions to reduce the risk of falls mention who should do the exercise and home hazard assessment interventions. This recommends that exercise programmes are delivered by appropriately trained professionals. |
| AGILE: Chartered Physiotherapis | Guideline | 005 | 024 | The recommendation assumes all professionals have the expertise to provide consistent, evidence-based falls prevention | Thank you for your comment. The recommendations also link to the section on 1.5 |

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| ts working with Older People | | | | advice. The content of advice to be given should be clarified to ensure national consistency. | for extra detail and links will be added to the guideline website. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 006 | 013 | Not all professionals will be trained to conduct comprehensive assessments, risking inaccuracies. Clear referral pathways are needed for cases beyond their scope. The guideline should reflect the fact the Comprehensive assessment should be completed by an appropriately trained professional and that organisations should have clear standard operating procedures outlining who to refer to and how to refer if the assessing clinician does not have some or all of the skills required. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric |

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| | | | | | outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 007 | 018 – 032 | The interventions should be documented in the form of a falls prevention plan that is shared with the patient and is held in a part of the electronic record that is commonly agreed upon at local level. | Thank you for your comment. How to document of interventions and falls prevention plans were not included as part of the scope of this guideline and no recommendations have been made in this area. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 007 | General | The assessment list is comprehensive but impractical for generalist professionals due to the specialist knowledge, skills, and resources required for many components. Clear referral pathways, training, and resources are essential to implement this effectively. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also |

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| | | | | | been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 008 | General | A structured medication review, particularly involving adjustments or withdrawal, must be conducted by a qualified prescriber to ensure clinical safety, legal compliance, and appropriate management of risks. Referral pathways should be in place for non-prescribing practitioners. | Thank you for your comment. The recommendation has been updated to state "plan withdrawal and consider liaising with specialist mental health services as appropriate". The recommendation also refers to the section on medication review in the NICE guideline on medicines optimisation which mentions appropriate healthcare professionals carrying out the reviews. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 009 | 011 | Not all services have access to occupational therapists, but other appropriately trained individuals can complete home hazard assessments. Clear guidance is needed to ensure consistency and address resource limitations in settings without OT availability. | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy |

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| | | | | | assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 009 | 016 - 018 | Investigating cardioinhibitory carotid sinus hypersensitivity and considering cardiac pacing require specialist expertise and access to cardiology services. Clear referral pathways and criteria for patient selection are essential to ensure appropriate and timely care. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added |

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| | | | | | to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist.<br><br>It was not possible to go into the detail of how these interventions would be delivered |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 010 | 001 - 003 | The recommendation lacks specificity regarding the duration, frequency, and type of exercise required to achieve meaningful change. Clear guidance on evidence-based parameters and strategies for promoting adherence to physical activity and reducing sedentary behaviour is needed to ensure effectiveness and sustainability. | Thank you for your comment. Evidence was not available to recommend specific information such as duration and frequency of exercise and the committee agreed it would need to be tailored to the person's specific needs. The committee recommend that programmes focus on functional components related to the person's risk of falls, such as balance, coordination, strength and power.<br><br>The available evidence did not show harm from brisk walking. The committee were aware of old |

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| | | | | | evidence that suggested harm, but because this was not shown in our review, they avoided making any statements on this. Rather they recommended that exercise programmes should focus on functional components related to the person's risk of falls, such as balance, coordination, strength and power. We have added a comment about this into the committee discussion.<br><br>Recommendation 1.3.9 (now 1.3.10) has been updated to state that the exercise programmes should be 'progressive and challenging'. Exercise progression has been defined in the terms used in this guideline section to state that 'Exercise progression can be defined through a tailored (or individualised) increase in one or more factors involving the intensity, frequency, duration and complexity of exercise selection. This will be based on performance over the programme period." |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 010 | 004 - 005 | Cognitive behavioural approaches require specialised training to deliver effectively. Health professionals must be appropriately trained to ensure safe and evidence-based practice. Clear guidance on who should deliver these interventions and referral pathways for untrained professionals is essential. | Thank you for your comment. The committee agreed that for some assessments and interventions that there would need to be an appropriate referral. Recommendation 1.1.3 has been updated to state "Offer a comprehensive falls assessment and comprehensive falls management to people who have fallen in the last year and meet any of the following criteria (this can be carried out in the same service or involve an appropriate referral)". The rationales have also been updated to reflect this. |

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| AGILE: Chartered Physiotherapists working with Older People | Guideline | 011 | 010 - 014 | It is unclear why these three specific interventions (delirium assessment, ward environment, and tailored education) have been prioritised when there are numerous other risk factors associated with falls in an inpatient setting. The lack of connection between these points makes the recommendation seem arbitrary and disconnected, reducing its practical relevance. | Thank you for your comment. Following stakeholder comments the point about delirium has now been moved into recommendation 1.2.2 for comprehensive falls assessment and a cross reference added to the NICE guideline on delirium for assessment and diagnosis. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 012 | 001 - 007 | This section lacks specificity and may be overly simplistic given the complexities of hospital care. An i**ndividualised approach is needed.** Encouraging activity must account for individual patient conditions, mobility levels, and safety concerns, which are not addressed here. | Thank you for your comment. Evidence was not available to provide much detail in the recommendations for hospital inpatients. Therefore, the committee made a recommendation to encourage physical activity. The recommendation has been expanded to suggest the type of exercise or physical activity to encourage. This states 'for people able to exercise, look for opportunities to encourage physical activity that are related to the person's risk of falls, such as balance, coordination, strength and power'. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 012 | 018 | It is unclear why delirium is singled out here. This may divert attention from other critical and modifiable risk factors in care home residents | Thank you for your comment. This recommendation has been reworded. Delirium has been moved into the factors to include in a comprehensive falls assessment and this point has been expanded to any risk factor. It now states 'This can be facilitated done by taking into account whether the risk factors can be resolved, improved or managed'. |

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| AGILE: Chartered Physiotherapists working with Older People | Guideline | 013 | 027 | General exercise and movement classes are not evidence-based for falls prevention. The recommendation should specify the use of evidence-based interventions, such as strength and balance training by appropriately trained individuals, to ensure effectiveness in reducing falls risk in residential care settings. | Thank you for your comment. The recommendation has been updated to state "For people able to exercise, consider the following that should be tailored to the person's abilities and preferences on an individual or group basis: interventions to encourage physical activity that addresses the person's risk of falls, such as balance, coordination, strength and power; an exercise or movement class or programme". Evidence was not available to recommend everyone should be considered for an appropriately tailored evidence based programme. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 014 | 004 - 013 | This recommendation overlooks the resource limitations and expertise required to deliver effective interventions. Many services teach exercises in a supervised session and then allow the patient to practice exercise between the initial session and subsequent reviews. The guideline should make it clear that not ALL sessions have to be supervised by that initial prescription of exercise and review/progression of exercise should occur under direct supervision. Specific guidance on service provision, staff training in behaviour change, and evidence-based strategies for addressing fear of falling are needed to make this feasible. | Thank you for your comment. The committee have written a more detailed definition of supervised exercises following stakeholder comments. "A programme is supervised when a professional or trained non-professional has regular contact to reassess performance, correct technique, suggest progressions or regressions and to motivate and inform participants. Supervised programmes could be delivered one-to-one, in a group, in-person or online and it is not necessary for all exercise to be directly supervised. For example, a supervised programme might include a once weekly instructor-led exercise class with additional home exercise carried out alone, or a home |

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| | | | | | exercise programme with scheduled progress visits or telephone calls from the instructor."<br><br>The committee also agreed that supervised exercises can be carried out in the community by a trained fitness instructor and do not always need NHS staff input.<br><br>Guidance on service provision and training in behaviour change were not included in the scope of this guideline and therefore no recommendations have been made relating to this. |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 014 | 017 | This point contradicts accommodating each person's needs and preferences | Thank you for your comment. This point has been updated to "Where possible, enabling social contact and support." |
| AGILE: Chartered Physiotherapists working with Older People | Guideline | 015 | General | This recommendation overlooks significant practical challenges. It requires setting-specific guidance to account for resource constraints, simplified and phased communication to avoid overwhelming individuals, and clear emphasis on follow-up and evidence-based interventions. Additionally, resources and training are critical for tailoring discussions and materials. Strategies to address psychological barriers, such as fear of falling, should also be included to maximise engagement and outcomes. | Thank you for your comment. Providing information which is recommended in the NICE guideline on patient experience in adult NHS services and it also covers how to deliver information. This particular recommendation is about points to include in that information. Training was not included as part of the scope for this guideline therefore no recommendations have been made relating to this.<br><br>The committee recommend considering cognitive behaviour interventions for people who have concerns about falling when strength and balance exercises do not appear to be working. |

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| | | | | | However, strategies to address fear of falling was not included for any other reviews. The guideline focuses on interventions that prevent falls. |
| Association of Clinical Psychologists UK | Guideline | 004 | General | As set out in the introduction, falls and risk of falls can have a major impact on people's lives, regardless of age. This could be because of the immediate impact and injury, and moreover related to the psychological impact of loss of confidence, fear of a repeated fall, leading to anxiety, depression and loneliness due to a reluctance to mobilise or venture outside familiar surroundings. | Thank you for your comment. |
| Association of Clinical Psychologists UK | Guideline | 006 | General | When looking at prevention, assessing the nature and origin of the falls when people are admitted to hospital is possibly rather late. Falls that might not require hospital admission, or even a visit to the GP, also will benefit from a multi factorial risk assessment and intervention. | Thank you for your comment. The guideline covers falls that happen in a variety of settings including community, hospital inpatients and residential settings. |
| Association of Clinical Psychologists UK | Guideline | 006 – 007 | General | **The multifactorial assessment**<br>ACP-UK comments that the multifactorial assessment refers to a range of factors, and while it refers to history, causes and consequences, it misses out one psychological factor that can be a major contributor. This is the fear of falling and the wider anxieties and behaviours or lack | Thank you for your comment. Concerns about falling is included as part of the assessment. However, the guideline focuses on interventions that prevent falls in people who have had a fall. It does not cover the wider population of people who only have a fear of falling. Interventions to |

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| | | | | thereof (apathy, lack of initiation). Coping strategies related to this, such as self-medication, drugs and alcohol use, will also need to be considered.<br>Obtaining information about the falls' history and characteristics only, will miss out on a fear of falling and the behaviours that a person engages in in order to avoid falls.<br>While an assessment in the community and hospital can assess individual factors, it will also be important to understand home living situations; the type of accommodation, rugs, steps, stairs, obstacles and general level of maintenance. This also need to be considered within the context of how safe the wider environment is. Age friendly and dementia friendly communities will support the creation of a safe community, with no trip hazards in the surrounding pavements and regular places to rest. | address fear of falling were not included as part of the scope of this guideline.<br><br>Home hazard assessments are covered in the recommendations in section 1.3 on interventions to prevent falls. |
| Association of Clinical Psychologists UK | Guideline | 011 | General | 1.1.5 **Exercises**<br>ACP-UK comments that in order to retain engagement and transfer of skills, exercises need to be designed so that they can be carried out as part of daily routines, and where possible incorporated in day-to-day activities, not requiring additional equipment or similar. | Thank you for your comment. The committee anticipate that if a person is assessed as needing exercise intervention in hospital, they will be referred to community services at discharge and the recommendations in the community settings would apply. Recommendation 1.3.10 covers detail on what should be included but evidence was not available to go into more detail other than what is covered in this recommendation. |

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| Association of Clinical Psychologists UK | Guideline | 011 | General | 1.1.7 **Psychotropic medication.**<br>While ACP-UK appreciates that a medication review is required, we would like to see a rephrasing of discontinuation of psychotropic medication to 'an alternative to be considered with specialist input if appropriate'.<br>**Reference**<br>• Echt, M.A., Samelson, E.J., Hannan, M.T. et al. Psychotropic drug initiation or increased dosage and the acute risk of falls: a prospective cohort study of nursing home residents. BMC Geriatr 13, 19 (2013). https://doi.org/10.1186/1471-2318-13-19<br>James, I.A., Moniz-Cook, E., Duffy, F., Lord, N., Ritchie, M. & Reichelt, K. (2024). First line psychosocial alternatives to psychotropic medication for Behaviours that challenge in dementia care: A toolkit for health and social care practitioners. The British Psychological Society: Leicester. | Thank you for your comment. The recommendation has been updated to state "plan withdrawal and consider liaising with specialist mental health services as appropriate". |
| Association of Clinical Psychologists UK | Guideline | 012 | General | 1.1.9 **Falls prevention programmes**<br>ACP-UK comments that the big challenge might be to get people to attend the programmes, if their fear of falling or other psychological conditions hinders them from attending programmes. Individual work at home might be required, including motivational interviewing, in order to facilitate engagement in groups. | Thank you for your comment. Evidence was not available to recommend motivational interviewing or other adherence measures. The recommendation in maximising participation is aimed at improving people's participation in these programmes and interventions in general. It includes statements on encouraging change, addressing potential barriers and ensuring the interventions are flexible enough to |

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| | | | | Adaptations to instructions might need to be considered for people with cognitive changes.<br><br>Other wider interventions/ approaches/ policies are required to be linked to these guidelines: healthy eating, sufficient income to buy and cook food, and to stay warm. | accommodate each person's different individual needs and preferences'. The committee hope this will address some of these concerns.<br><br>The NICE guideline on Decision making and mental health has been cross referenced in this guideline, and this covers recommendations relevant to people with cognitive changes.<br><br>Wider interventions and approaches were not included as part of this guideline scope. |
| Association of Clinical Psychologists UK | Guideline | 013 | General | 1.1.12.2 - **Interventions not supported because of insufficient evidence**<br>*Group exercise (untargeted)*: ACP-UK feels that while there might be limited evidence that exercise helps with falls prevention, the impact on psychological and physical health cannot be underestimated. These might be exactly the groups that are considered more acceptable to access and where possible falls prevention exercises can be incorporated.<br><br>**Reference**<br>• Lafond N, Maula A, Iliffe S, Vedhara K, Audsley S, Kendrick D, Orton E. *'We got more than we expected.'* Older people's experiences of falls-prevention exercise interventions and implications for practice; a qualitative study. Prim Health Care Res Dev. 2019 Jul 1;20:e103. doi: | Thank you for your comment. Evidence was not available to make stronger recommendations for a falls prevention programme. Instead, the committee recommended that tailored interventions are considered to encourage physical activity that are related to the person's risk of falls, such as balance, coordination, strength and power was as far as the committee.<br><br>The impact of exercise on psychological and physical health was not included as part of the guideline and the reference you cite was not included as part of the evidence. |

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| | | | | 10.1017/S1463423619000379. PMID: 32800005; PMCID: PMC6609972. | |
| Association of Clinical Psychologists UK | Guideline | 013 | General | 1.1.12.3 - *CBT interventions*: ACP-UK suggests that while these interventions in and of themselves do not reduce falls risks, they will be an important component of a multifactorial intervention, in order to address the psychological factors that impede and hinder people to engage with falls preventions and that can lead to more serious psychological conditions, contributing to loneliness and isolation. | Thank you for your comment. Cognitive behaviour interventions have only been recommended for the community setting. Evidence was not available to recommend them in residential care settings. |
| Association of Clinical Psychologists UK | Guideline | 014 | General | 1.1.12.6 - *Hip protectors*: ACP-UK comments that these can be particularly troublesome when used with people who lack capacity and for whom best interest decisions need to be made. Open discussions with family and staff will be required to discuss the implications of attempts to reduce the impact of falls on the person's quality of life and what positive risk taking can be tolerated. | Thank you for your comment. Hip protectors were not included in the review because they are not designed to prevent a fall, rather reduce the impact of a fall. |
| Association of Clinical Psychologists UK | Guideline | 018 | General | **2.1 New research recommendations.**<br>It will be worth setting up co-production research projects with older people and older people at risk of falls. This might help to begin to explore the nature of unwitnessed falls. | Thank you for your comment. This guideline just focuses on falls prevention. Replacing drinks with decaffeinated options and meaningful activities was not part of our reviews so no research recommendation has been made in this area. |

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| | | | | There is research that replacing drinks with decaf options reduces the need to urinating and could contribute to less falls.<br><br>Engagement in meaningful activities in care settings and hospitals might contribute to the desire to walk and explore.<br><br>**Reference**<br>• Decaffeination and Falls Prevention – A joint investigation with Stow Healthcare and Care England (2024) https://stowhealthcare.co.uk/decaffeination-and-falls-prevention-a-joint-investigation-with-stow-healthcare-and-care-england/<br>• Improving health outcomes for care home residents Decaffeination and falls prevention. A joint investigation by Care England and Stow Healthcare, in partnership with University Hospitals of Leicester NHS Trust (2024). https://stowhealthcare.co.uk/wp-content/uploads/2024/04/Decaffeination-and-Falls-Prevention_Final_Online.pdf | |
| British Dietetic Association - Older People Specialist Group | Guideline | 005 | 024 | **Offer health and lifestyle information.** Recommend inclusion / signposting to evidence based older adults nutrition Public Resources - British Dietetic Association (BDA) | Thank you for your comment. The guideline only covered the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. This guideline did not cover general health and lifestyle |

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| | | | | | recommendations therefore links to these resources have not been included on the website. |
| British Dietetic Association - Older People Specialist Group | Guideline | 006 | 010 | Recommend inclusion in the evidence review the UK guidance for older adults nutrition within residential care settings Care Home Digest - British Dietetic Association (BDA, 2024) | Thank you for your comment. The guideline only covered the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. This guideline did not cover general health and lifestyle recommendations therefore links to these resources have not been included on the website. |
| British Dietetic Association - Older People Specialist Group | Guideline | 006 - 007 | General | **Comprehensive falls assessment.**<br>As part of a comprehensive falls assessment an apparent omission is a bullet point on **Review of Physical Health**. Anticipate this would include areas not listed i.e assessment for frailty / deconditioning, self-neglect, co-morbidities, etc. | Thank you for your comment. The committee anticipate that a general question on physical health would be asked and there are recommendations in the intervention section on exercise and physical activity for each setting. Specific points related to physical health in the assessment recommendation are covered by other points, for example, frailty would come up as part of the bullet point on gait, balance and mobility, and muscle weakness strength assessment. A bullet point has been added on reviewing long term conditions associated with falls risk.<br><br>Following stakeholder comments people with learning disabilities have been added to the younger age group (50 to 64). This group has been described as 'Factors that could increase the person's risk of falls' rather than just 'conditions that increase a person's risk of falls'. |

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| British Dietetic Association - Older People Specialist Group | Guideline | 007 | 001 | **Comprehensive falls assessment 'muscle weakness assessment'**<br>It would be useful to clarify what form of muscle is being assessed.<br><br>World guidelines for falls prevention and management for older adults: a global initiative lists hand grip strength as a potential measurement instrument and approach for multifactorial falls risk assessment. The Age and Ageing 2022; 51: 1–36 https://doi.org/10.1093/ageing/afac205. | Thank you for your comment. This has been updated to 'muscle strength assessment'. Detail on how to do assessments of specific factors has not been included in this guideline because this would be covered by other guidelines. Where an existing NICE guideline exists with details of how to assess that are relevant to falls prevention we have added a cross link to this. |
| British Dietetic Association - Older People Specialist Group | Guideline | 007 | 013 | **Recommendation: asking about diet, weight loss and** fluid intake:<br>The other listed risk factors recommend assessment or examination but this wording is not reflected in the line relating to nutrition<br><br>• Recommend rewording to include:<br>– Screening for malnutrition using a validated nutritional screening tool e.g. Patients Association Nutrition Checklist, MUST, MNA, MST.<br>– Where malnutrition or nutritional concerns are identified, prescribed ONS should not be prescribed routinely and instead local NHS guidance for malnutrition management should be followed. | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |

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| | | | | **Rationale**<br>• Malnutrition screening should be embedded in the comprehensive falls assessment. Malnutrition, frailty and sarcopenia are interlinked conditions which are prevalent amongst older adults, increasing risk of falls and fractures.<br>• All the other fall risk factors considerations recommend assessment or examination rather than simply "asking about"<br>• There is evidence to demonstrate that there is no clinical superiority of prescribed Oral nutritional supplements (ONS) over food to support individuals with malnutrition – (Weekes and Baldwin 2021,Thomson et al 2022 ).<br><br>**Action Points:**<br>• Individuals identified as malnourished, at risk of malnutrition or poor hydration should receive advice as per local protocols.<br>• Identified concerns regarding poor nutritional or fluid intake should be recorded along with malnutrition screening assessment.<br>• Seek professional guidance from your local Dietetic department on referral | |

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| | | | | pathways, advice resources and menu guidance.<br><br>**Supporting Evidence**:<br>1. World guidelines for falls prevention and management for older adults: a global initiative, *Age and Ageing*, Volume 51, Issue 9, September 2022, Available from: https://doi.org/10.1093/ageing/afac205<br><br>2. NICE Clinical Guideline [CG32). Nutritional support for adults. Last updated August 2017, Available from Recommendations \| Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition \| Guidance \| NICE<br><br>3. Trevisan C, Crippa A, Ek S et al. Nutritional status, body mass index, and the risk of falls in community-dwelling older adults: a systematic review and meta-analysis. J Am Med Dir Assoc 2019; 20: 569–582.e7.<br><br>4. Gingrich A, Volkert D, Kiesswetter E, Thomanek M, Bach S, Sieber CC, et al. Prevalence and overlap of sarcopenia, frailty, cachexia and malnutrition in older medical inpatients. BMC geriatrics. 2019;19(1):1–10. | |

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| | | | | 5. Spotting and treating malnutrition - British Dietetic Association (BDA)<br><br>6. Patients Association Nutrition Checklist<br><br>7. The 'MUST' Toolkit \| BAPEN | |
| British Dietetic Association - Older People Specialist Group | Guideline | 007 | 013 | **Recommendation:** asking about diet, weight loss and **fluid intake:**<br><br>We acknowledge there is no strong evidence connecting hydration to muscle health. There is some evidence which discusses hydration in muscle mass health and draws links to increased protein breakdown in dehydrated individuals but it does not show direct link with sarcopenia prevalence: https://pmc.ncbi.nlm.nih.gov/articles/PMC10674909/ https://pmc.ncbi.nlm.nih.gov/articles/PMC6723611/<br><br>Dehydration impacts negatively on health. Adequate hydration is an important aspect of healthy ageing. Hydration can minimise the symptoms of postural hypotension, light-headedness, dizziness and UTIs, which may lead to falls.<br><br>Evidence: https://www.bda.uk.com/resource/hydration-in-older-adults.html | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |

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| | | | | | |
| British Dietetic Association - Older People Specialist Group | Guideline | 007 | 014 | **Assessment of Alcohol misuse:**<br>Our interpretation of epidemiological literature on alcohol use and fall injuries among older adults remains fairly sparse and inconclusive, however intoxication increases risk of falls and in older population risk of hip fractures.<br>**Alcohol:**<br>Recommendation: In line with current Public Health guidelines, alcohol consumption should not exceed 14 units per week. | Thank you for your comment. This section of the guideline is only on what to assess. Interventions related to alcohol consumption were not covered in the guideline and no recommendations have been made in that area. A cross reference has been made to the NICE guideline on Alcohol-use disorders. |
| British Dietetic Association - Older People Specialist Group | Guideline | 008 | 012 | **Interventions to reduce the risk falls -** There is no mention of Bone health: **Calcium Intake**:<br><br>**Evidence**: Studies cited in the guidelines indicate that increased dairy product intake improves bone density and reduces fall risk. A specific study noted an 11% reduction in falls among care home residents with increased calcium intake.<br>Effect of dietary sources of calcium and protein on hip fractures and falls in older adults in residential care: cluster randomised controlled trial \| The BMJ<br><br>Blain H, Masud T, Dargent-Molina P et al. A comprehensive fracture prevention strategy in older adults: the European Union Geriatric Medicine Society (EUGMS) statement. J Nutr Health Aging 2016; 20: 647–52. | Thank you for your comment. The effect of interventions on the improvement of bone health was not included in this guideline so no recommendations have been made in this area. |

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| | | | | Li N, Hiligsmann M, Boonen A et al. The impact of fracture liaison services on subsequent fractures and mortality: a systematic literature review and meta-analysis. Osteoporosis Int 2021; 32: 1517–30. | |
| British Dietetic Association - Older People Specialist Group | Guideline | 009 | 003 | **Vitamin D Supplements - recommend consideration of the below**<br><br>**Regular Intake Recommendations:**<br>• Vitamin D supplement should be taken regularly during autumn and winter months and year-round by at risk individuals, eg. housebound, those who are 65 years and older, ethnic minority groups with dark skin, people who spend little or no time outside, people who always cover their skin when outside.<br><br>**Rationale:** Vitamin D is essential for musculoskeletal health. It aids calcium absorption, supports bone mineralisation, and protects muscle strength, reducing risks of rickets, osteomalacia, and falls.<br><br>**Barriers and Recommendations:**<br>• Include vitamin D as part of a comprehensive approach to falls prevention, especially for individuals at high risk of deficiency, such as care home residents or homebound older | Thank you for your comment and the cited references. The guideline meta-analysis showed no difference in the rate or number of falls, and therefore committee agreed that the clinical evidence did not support using vitamin D supplementation as an intervention to prevent falls. Instead the committee linked to existing NHS advice on taking vitamin D to maintain bone and muscle health and the NICE guideline on vitamin D: supplement use in specific population groups. The NHS advice also notes that too much vitamin D can weaken bones.<br><br>Of the cited studies, Sanders 2020 was included as evidence in the guideline review. None of the other references met the protocol criteria and therefore were not included as evidence. |

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| | | | | adults. This supports muscle function and bone health, reducing fall risk.<br>• Question: Have NICE any recommendations to support this recommendation as implementation can be challenging in practice particularly in our housebound communities, due to difficulties for those using blister packs and a lack of clarity regarding appropriate dosing?<br>• Overdosing poses risks, such as increasing fall risk. It is advised to avoid once-yearly high-dose vitamin D, which is linked to higher fall rates.<br><br>**Dosage Guidelines:**<br>• Daily intake: a minimum of 400 IU.<br>• SACN recommendations suggest doses >800 IU can reduce fall risks.<br><br>**Action Points:**<br>1. Ensure clear communication on dosing and use validated resources such as the SACN report.<br>2. Seek professional guidance from your local dietetic teams and or Pharmacy teams.<br><br>**Supporting Evidence:** | |

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| | | | | • **World Falls Prevention Guidelines:** Systematic reviews highlighting the role of vitamin D in reducing falls.<br>• **NICE Guideline [PH56]:** Increasing supplement use among at-risk groups.<br>• **SACN vitamin D and health report**<br>• **Royal Osteoporosis Society (2020):** Clinical guidelines on vitamin D and bone health.<br>• **BDA (2024):** Vitamin D and healthy ageing.<br>• **OHID (2022):** Vitamin D call for evidence.<br><br>**References:**<br>– World guidelines for falls prevention and management for older adults: a global initiative, *Age and Ageing*, Volume 51, Issue 9, September 2022, Available from: https://doi.org/10.1093/ageing/afac205<br><br>– NICE Clinical Guideline [PH56]. Vitamin D: increasing supplement use among at-risk groups. Last updated August 2017, Available from https://www.nice.org.uk/guidance/ph56<br><br>– SACN vitamin D and health report - GOV.UK (2016) | |

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| | | | | – Royal Osteoporosis Society. Vitamin D and Bone Health: A Practical Clinical Guideline for Patient Management. Available at https://strwebprdmedia.blob.core.windows.net/media/ef2ideu2/ros-vitamin-d-and-bone-health-in-adults-february-2020.pdf<br><br>– The Association of UK Dietitians (BDA) Nov 2024 Vitamin D - British Dietetic Association (BDA)<br><br>– Eating, drinking and ageing well - British Dietetic Association (BDA)<br><br>– Office for Health Improvement and Disparities (OHID). Vitamin D: call for evidence, April 2022. Available from https://www.gov.uk/government/calls-for-evidence/vitamin-d-call-for-evidence<br><br>– NICE Clinical Knowledge Summaries. Vitamin D deficiency in adults. Last revised in January 2022. Available from https://cks.nice.org.uk/topics/vitamin-d-deficiency-in-adults/<br><br>– Dautzenberg L, Beglinger S, Tsokani S et al. Interventions for preventing falls and fall-related fractures in community | |

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| | | | | dwelling older adults: a systematic review and network metaanalysis. J Am Geriatr Soc 2021; 69: 2973–84<br><br>– Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial<br><br>– Vitamin D supplementation: upper limit for safety revisited?<br><br>– Safety considerations when using Vitamin D (2022)<br><br>– Compston J, Cooper A, Cooper C, et al. UK clinical guideline for the prevention and treatment of osteoporosis. Arch Osteoporos. 2017;12:43. Compston J et al National Osteoporosis Guideline Group (NOGG). UK clinical guideline for the prevention and treatment of osteoporosis 2022<br><br>– Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial Vitamin D supplementation: upper limit for safety revisited? | |

# Falls: assessment and prevention in older people and people 50 and over at higher risk (update)

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| British Dietetic Association - Older People Specialist Group | Guideline | 009 | 003 | **Vitamin D Supplements - recommend consideration of the below**<br><br>It may be appropriate to consider that there is evidence that an increased risk of falls with high dose vitamin D:<br>- Intermittent administration of large doses of vitamin D, e.g. ≥100,000 IU is not advised, based on recent reports of an associated increased risk of fracture and falls Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial Vitamin D supplementation: upper limit for safety revisited?<br>- a meta-analysis, a protective effect of vitamin D on fractures was only seen at daily doses ≥800 IU (20 µg) (Evidence level 1a). This dose of vitamin D may also reduce falls<br>- (Evidence level 1a). It is recommended that in postmenopausal women and men ≥50 years who are at increased risk of fracture, a daily dose of 800 IU of cholecalciferol should be advised (Grade A recommendation). Compston J, Cooper A, Cooper C, et al. UK clinical guideline for the prevention and treatment of osteoporosis. Arch Osteoporos. 2017;12:43. Compston J et al National Osteoporosis Guideline Group (NOGG). UK clinical guideline for | Thank you for your comment and the cited references. The first study was included as evidence in the evidence review. None of the other references met the protocol criteria and therefore were not included.<br><br>The guideline meta-analysis showed no difference in the rate or number of falls, and therefore committee agreed that the clinical evidence did not support using vitamin D supplementation as an intervention to prevent falls. Instead the committee linked to existing NHS advice on taking vitamin D to maintain bone and muscle health and the NICE guideline on vitamin D: supplement use in specific population groups. The NHS advice also notes that too much vitamin D can weaken bones. |

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| | | | | the prevention and treatment of osteoporosis 2022 | |
| British Dietetic Association - Older People Specialist Group | Guideline | 009 | 019 | **Falls prevention exercise programmes**<br>BDA OPSG welcomes the inclusion of promoting physically active aging with a focus on resistance training programmes. We understand the aim of resistance training is to increase muscle strength by making your muscles work against a weight or force. We recognise this is an important determinant in preventing and maintaining daily functioning and impact on physical dependence in later life.<br>We would recommend a specific recommendation highlighting the emerging evidence that regular resistance activity combined with a nutrient rich diet are the ideal combination.<br><br>**Supporting evidence for consideration**<br>1. Muscle health, nutrition and ageing - British Dietetic Association (BDA) 2024<br>2. Leandro dos Santos et al (2016) *Sarcopenia and physical independence in older adults: the independent and synergic role of muscle mass and muscle function*.<br>Freiberger, E, Sieber, C. and Pfeifer, K. (2011) *Physical activity, exercise, and sarcopenia – future challenges*. | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |

# Falls: assessment and prevention in older people and people 50 and over at higher risk (update)

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| British Dietetic Association - Older People Specialist Group | Guideline | 012 - 013 | 009 - 029 | **Residential care settings (including nursing homes) – comprehensive falls management**<br>**This section should include recommendations for food provision in care homes.**<br>• **Improving calcium and protein intakes by using dairy foods is a readily accessible and cost effective intervention shown to reduce falls and fractures in aged care residents.**<br><br>Evidence<br>1. S Iuliano, S Poon, J Robbins, M Bui, X Wang, L De Groot, M Van L A Ghasem Zadeh, T Nguyen, E Seeman. Effect of dietary sources of calcium and protein on hip fractures and falls in older adults in residential care: cluster randomised controlled trial. BMJ 2021;375:n2364<br>**2.** Baek Y, Iuliano S, Robbins J, Poon S, Seeman E, Ademi Z. Reducing hip and non-vertebral fractures in institutionalised older adults by restoring inadequate intakes of protein and calcium is cost-saving. Age Ageing. 2023;52(6):afad114.<br>UK guidance for older adults nutrition within residential care settings Care Home Digest - British Dietetic Association (BDA, 2024) | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |
| British Dietetic Association - Older People | Guideline | General | General | British Dietetic Association (BDA) Older People Specialist Group Committee (BDA OPSG) welcome the opportunity to provide | Thank you for your comment. The guideline only covered the impact of nutrition on falls, or nutrition in combination with other interventions |

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| Specialist Group | | | | professional dietetic comments on NICE Falls consultation draft guideline. We invest considerable expert input into a range of evidence based older adults nutritional resources Public Resources - British Dietetic Association (BDA) | such as exercise and falls. This guideline did not cover general health and lifestyle recommendations therefore links to these resources have not been included on the website. |
| British Dietetic Association - Older People Specialist Group | Guideline | General | General | Good nutrition and hydration are essential for the promotion of healthy ageing and recovery from illness. We are concerned that there is no mention of sarcopenia within the draft guidelines. Frailty is mentioned seven times but there is currently no mention of sarcopenia and malnutrition. These are linked conditions. Whilst some loss of muscle mass and strength are a natural part of ageing, sarcopenia can increase risk of falls (Zhang et al (2019) Falls among older adults with sarcopenia dwelling in nursing home or community: A meta-analysis<br><br>Sarcopenia is linked with malnutrition and frailty (Laur et al (2017) Malnutrition or frailty? Overlap and evidence gaps in the diagnosis and treatment of frailty and malnutrition. Appl. Physiol. Nutr. Metab. 42: 449–458<br><br>Risk of malnutrition, sarcopenia and frailty increase with increasing age. A list of references are summarised in Frailty and the NHS: Highlighting the significant connection with malnutrition | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |

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| | | | | There is minimal content on nutrition included in the draft guidelines. Nutrition in combination with exercise, is important to prevent muscle loss and strength during ageing. Recommend including a signpost to the evidence based Muscle health, nutrition and ageing - British Dietetic Association (BDA) resource. | |
| British Dietetic Association - Older People Specialist Group | Guideline | General | General | The prevalence of sarcopenia and its association with falls varies according to the diagnostic definition used and the population studied. In the longitudinal iLSIRENTE study, the prevalence of sarcopenia was approximately 25% in people aged 80 years and above, and participants with sarcopenia were three times more likely to fall during a follow-up period of 2 years (Landi F, Liperoti R, Russo A et al. Sarcopenia as a risk factor for falls in elderly individuals: results from the ilSIRENTE study Clin Nutr 2012; 31: 652–8.<br><br>A growing number of clinicians and researchers advocate paying more attention to diagnosing and treating sarcopenia in older adults identified as being at a high risk of falls, although further research is required on how this should be conducted and whether applying non-exercise interventions for sarcopenia such as protein supplementation will reduce falls. | |

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| | | | | Recommend there is reference to screen / assessment of sarcopenia on page 5; 4; 1.1.3, 6.<br>Muscle health, nutrition and ageing - British Dietetic Association (BDA, 2024) | |
| British Dietetic Association (BDA) | Guideline | 005 | 024 | **Offer health and lifestyle information.** Recommend inclusion / signposting to evidence based older adults nutrition Public Resources - British Dietetic Association (BDA) | Thank you for your comment. The guideline only covered the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. This guideline did not cover general health and lifestyle recommendations therefore links to these resources have not been included on the website. |
| British Dietetic Association (BDA) | Guideline | 006 | 010 | Recommend inclusion in the evidence review the UK guidance for older adults nutrition within residential care settings Care Home Digest - British Dietetic Association (BDA, 2024) | Thank you for your comment. The guideline only covered the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. This guideline did not cover general health and lifestyle recommendations therefore links to these resources have not been included on the website. |
| British Dietetic Association (BDA) | Guideline | 006 - 007 | 012 | 1.2.1 - **Comprehensive falls assessment.** As part of a comprehensive falls assessment an apparent omission is a bullet point on **Review of Physical Health**. Anticipate this would include areas not listed i.e assessment for frailty / deconditioning, self-neglect, co-morbidities, etc. Evidence of higher risk in learning disabilities. | Thank you for your comment. The committee anticipate that a general question on physical health would be asked and there are recommendations in the intervention section on exercise and physical activity for each setting. Specific points related to physical health in the assessment recommendation are covered by other points, for example, frailty would come up as part of the bullet point on gait, balance and |

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| | | | | | mobility, and muscle weakness strength assessment. A bullet point has been added on reviewing long term conditions associated with falls risk.<br><br>Following stakeholder comments people with learning disabilities have been added to the younger age group (50 to 64). This group has been described as 'Factors that could increase the person's risk of falls' rather than just 'conditions that increase a person's risk of falls'. |
| British Dietetic Association (BDA) | Guideline | 007 | 001 | **Comprehensive falls assessment 'muscle weakness assessment'**<br>It would be useful to clarify what form of muscle is being assessed.<br><br>World guidelines for falls prevention and management for older adults: a global initiative lists hand grip strength as a potential measurement instrument and approach for multifactorial falls risk assessment.<br>Age and Ageing 2022; 51: 1–36<br>https://doi.org/10.1093/ageing/afac205. | Thank you for your comment. This has been updated to 'muscle strength assessment'. Detail on how to do assessments of specific factors has not been included in this guideline because this would be covered by other guidelines. Where an existing NICE guideline exists with details of how to assess that are relevant to falls prevention, we have added a cross link to this. |
| British Dietetic Association (BDA) | Guideline | 007 | 013 | **Recommendation: asking about diet, weight loss and** fluid intake:<br>The other listed risk factors recommend assessment or examination, but this wording is not reflected in the line relating to nutrition<br><br>• Recommend rewording to state: | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on |

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| | | | | – Assessment for malnutrition using a validated nutritional screening tool e.g. Patients Association Nutrition Checklist, MUST, MNA, MST.<br>– Where malnutrition or nutritional concerns are identified, prescribed ONS should not be prescribed routinely and instead local NHS guidance for malnutrition management should be followed.<br><br>**Rationale**<br>• Malnutrition screening should be embedded in the comprehensive falls assessment. Malnutrition, frailty and sarcopenia are interlinked conditions which are prevalent amongst older adults, increasing risk of falls and fractures.<br>• Malnutrition should be proactively screened for in older adults in primary care, and given relevant advice based on the aetiology for the patient (Fisher et al 2023)<br>• All the other falls risk factors considerations recommend assessment or examination rather than simply "asking about".<br>• There is evidence to demonstrate that there is no clinical superiority of | nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |

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| | | | | prescribed oral nutritional supplements (ONS) over food to support individuals with malnutrition – (Weekes and Baldwin 2021,Thomson et al 2022 ).<br>• There is evidence to demonstrate significant inappropriate clinical use of prescribed nutritional supplements (ONS) in the community, with no clinical benefit Cadogan et al 2020<br>• There is evidence to demonstrate that patients do not routinely enjoy these products (Hetherington et al 2024 Thomson et al 2022,) and routinely do not use them as prescribed (Qin et al 2022)<br><br>**Action Points:**<br>• Individuals identified as malnourished, at risk of malnutrition, or poor hydration should receive advice as per local protocols.<br>• Identified concerns regarding poor nutritional or fluid intake should be recorded along with malnutrition screening assessment.<br>• Seek professional guidance from your local dietetic department on referral | |

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| | | | | pathways, advice resources and menu guidance.<br><br>**Supporting Evidence**:<br>8. World guidelines for falls prevention and management for older adults: a global initiative, *Age and Ageing*, Volume 51, Issue 9, September 2022, Available from: https://doi.org/10.1093/ageing/afac205<br><br>9. NICE Clinical Guideline [CG32). Nutritional support for adults. Last updated August 2017, Available from Recommendations \| Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition \| Guidance \| NICE<br><br>10. Trevisan C, Crippa A, Ek S et al. Nutritional status, body mass index, and the risk of falls in community-dwelling older adults: a systematic review and meta-analysis. J Am Med Dir Assoc 2019; 20: 569–582.e7.<br><br>11. Gingrich A, Volkert D, Kiesswetter E, Thomanek M, Bach S, Sieber CC, et al. Prevalence and overlap of sarcopenia, frailty, cachexia and malnutrition in older medical inpatients. BMC geriatrics. 2019;19(1):1–10. | |

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| | | | | 12. Improving the assessment of older adult's nutrition in primary care: recommendations for a proactive, patient-centred and aetiology approach 2023 BMJ Nutrition Prevention & Health 6(2):e000661<br><br>13. Spotting and treating malnutrition - British Dietetic Association (BDA)<br><br>14. Patients Association Nutrition Checklist<br><br>15. The 'MUST' Toolkit \| BAPEN | |
| British Dietetic Association (BDA) | Guideline | 007 | 013 | **Recommendation:** asking about diet, weight loss and **fluid intake:**<br><br>We acknowledge there is no strong evidence connecting hydration to muscle health. There is some evidence which discusses hydration in muscle mass health and draws links to increased protein breakdown in dehydrated individuals but it does not show direct link with sarcopenia prevalence: https://pmc.ncbi.nlm.nih.gov/articles/PMC10674909/ https://pmc.ncbi.nlm.nih.gov/articles/PMC6723611/<br><br>Dehydration impacts negatively on health. Adequate hydration is an important aspect of healthy ageing. Hydration can minimise the | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |

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| | | | | symptoms of postural hypotension, light-headedness, dizziness and UTIs, which may lead to falls.<br><br>Evidence: https://www.bda.uk.com/resource/hydration-in-older-adults.html | |
| British Dietetic Association (BDA) | Guideline | 007 | 014 | **Assessment of Alcohol misuse:** Our interpretation of epidemiological literature on alcohol use and fall injuries among older adults remains fairly sparse and inconclusive, however intoxication increases risk of falls and in older population risk of hip fractures.<br><br>**Alcohol:** Recommendation: In line with current Public Health guidelines, alcohol consumption should not exceed 14 units per week. | Thank you for your comment. This section of the guideline is only on what to assess. Interventions related to alcohol consumption were not covered in the guideline and no recommendations have been made in that area. A cross reference has been made to the NICE guideline on Alcohol-use disorders. |
| British Dietetic Association (BDA) | Guideline | 008 | 012 | **Interventions to reduce the risk falls -** There is no mention of Bone health: **Calcium Intake:**<br><br>**Evidence**: Studies cited in the guidelines indicate that increased dairy product intake improves bone density and reduces fall risk. A specific study noted an 11% reduction in falls among care home residents with increased calcium intake. | Thank you for your comment. The effect of interventions on the improvement of bone health was not included in this guideline so no recommendations have been made in this area.<br><br>We have cross-checked the papers and we have already included Iuliano 2021 in the residential care review; Blain 2016 is a position paper on fracture prevention and Li 2021 is a systematic literature review and meta-analysis of fracture liaison services and not falls |

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| | | | | This does not encourage prescribing of calcium, but a focus on calcium intake within the diet.<br><br>Effect of dietary sources of calcium and protein on hip fractures and falls in older adults in residential care: cluster randomised controlled trial \| The BMJ<br><br>Blain H, Masud T, Dargent-Molina P et al. A comprehensive fracture prevention strategy in older adults: the European Union Geriatric Medicine Society (EUGMS) statement. J Nutr Health Aging 2016; 20: 647–52.<br><br>Li N, Hiligsmann M, Boonen A et al. The impact of fracture liaison services on subsequent fractures and mortality: a systematic literature review and meta-analysis. Osteoporos Int 2021; 32: 1517–30. | prevention. Therefore, these are not included as they did not meet the review protocol criteria. |
| British Dietetic Association (BDA) | Guideline | 008 | 016 | **Medication review**<br>Consideration to include discontinuing prescribed items that are not medications, including borderline substances such as nutrition products and non-licensed food supplements such as some forms of vitamin and mineral prescriptions.<br>All prescribed items should be reviewed in line with local pathways, this should include prescribed nutritional supplements or prescribed over the counter items such as vitamin D where this should be purchased in | Thank you for your comment. Stopping items that are not prescribed medications was not covered in the guideline. The committee anticipate prescribers would be aware of this NHS policy when making any prescriptions including following national guidance on vitamin D prescribing. |

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| | | | | line with NHS advice on self-care of vitamins and minerals. NHS England » Policy guidance: conditions for which over the counter items should not be routinely prescribed in primary care | |
| British Dietetic Association (BDA) | Guideline | 009 | 003 | **Vitamin D Supplements - recommend consideration of the below**<br><br>**Regular Intake Recommendations:**<br>• Vitamin D supplement should be taken regularly during autumn and winter months and year-round by at risk individuals, eg. housebound, those who are 65 years and older, ethnic minority groups with dark skin, people who spend little or no time outside, including those in carehomes, and people who always cover their skin when outside.<br><br>**Rationale:** Vitamin D is essential for musculoskeletal health. It aids calcium absorption, supports bone mineralisation, and protects muscle strength, reducing risks of rickets, osteomalacia, and falls.<br><br>**Barriers and Recommendations:**<br>• Include vitamin D as part of a comprehensive approach to falls prevention, especially for individuals at high risk of deficiency, such as care home residents or homebound older | Thank you for your comment and the cited references. The guideline meta-analysis showed no difference in the rate or number of falls, and therefore committee agreed that the clinical evidence did not support using vitamin D supplementation as an intervention to prevent falls. Instead the committee linked to existing NHS advice on taking vitamin D to maintain bone and muscle health and the NICE guideline on vitamin D: supplement use in specific population groups. The NHS advice also notes that too much vitamin D can weaken bones.<br><br>Of the cited studies, Sanders 2020 was included as evidence in the guideline review. None of the other references met the protocol criteria and therefore were not included as evidence. |

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| | | | | adults. This supports muscle function and bone health, reducing fall risk.<br>• Question: Have NICE any recommendations to support this recommendation as implementation can be challenging in practice particularly in our housebound communities, due to difficulties for those using blister packs and a lack of clarity regarding appropriate dosing?<br>• Overdosing poses risks, such as increasing fall risk. It is advised to avoid once-yearly high-dose vitamin D, which is linked to higher fall rates.<br><br>**Dosage Guidelines:**<br>• Daily intake: a minimum of 400 IU.<br>• SACN recommendations suggest doses >800 IU can reduce fall risks.<br><br>**Action Points:**<br>3. Ensure clear communication on dosing and use validated resources such as the SACN report.<br>4. Seek professional guidance from your local dietetic teams and or pharmacy teams.<br><br>**Supporting Evidence:** | |

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| | | | | • **World Falls Prevention Guidelines:** Systematic reviews highlighting the role of vitamin D in reducing falls.<br>• **NICE Guideline [PH56]:** Increasing supplement use among at-risk groups.<br>• **SACN vitamin D and health report**<br>• **Royal Osteoporosis Society (2020):** Clinical guidelines on vitamin D and bone health.<br>• **BDA (2024):** Vitamin D and healthy ageing.<br>• **OHID (2022):** Vitamin D call for evidence.<br><br>**References:**<br>– World guidelines for falls prevention and management for older adults: a global initiative, *Age and Ageing*, Volume 51, Issue 9, September 2022, Available from: https://doi.org/10.1093/ageing/afac205<br><br>– NICE Clinical Guideline [PH56]. Vitamin D: increasing supplement use among at-risk groups. Last updated August 2017, Available from https://www.nice.org.uk/guidance/ph56<br><br>– SACN vitamin D and health report - GOV.UK (2016) | |

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| | | | | – Royal Osteoporosis Society. Vitamin D and Bone Health: A Practical Clinical Guideline for Patient Management. Available at https://strwebprdmedia.blob.core.windows.net/media/ef2ideu2/ros-vitamin-d-and-bone-health-in-adults-february-2020.pdf<br><br>– The Association of UK Dietitians (BDA) Nov 2024 Vitamin D - British Dietetic Association (BDA)<br><br>– Eating, drinking and ageing well - British Dietetic Association (BDA)<br><br>– Office for Health Improvement and Disparities (OHID). Vitamin D: call for evidence, April 2022. Available from https://www.gov.uk/government/calls-for-evidence/vitamin-d-call-for-evidence<br><br>– NICE Clinical Knowledge Summaries. Vitamin D deficiency in adults. Last revised in January 2022. Available from https://cks.nice.org.uk/topics/vitamin-d-deficiency-in-adults/<br><br>– Dautzenberg L, Beglinger S, Tsokani S et al. Interventions for preventing falls and fall-related fractures in community | |

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| | | | | dwelling older adults: a systematic review and network metaanalysis. J Am Geriatr Soc 2021; 69: 2973–84<br><br>– Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial<br><br>– Vitamin D supplementation: upper limit for safety revisited?<br><br>– Safety considerations when using Vitamin D (2022)<br><br>– Compston J, Cooper A, Cooper C, et al. UK clinical guideline for the prevention and treatment of osteoporosis. Arch Osteoporos. 2017;12:43. Compston J et al National Osteoporosis Guideline Group (NOGG). UK clinical guideline for the prevention and treatment of osteoporosis 2022<br><br>– Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial Vitamin D supplementation: upper limit for safety revisited? | |

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| British Dietetic Association (BDA) | Guideline | 009 | 003 | **Recommend inclusion of reference to NHS guidance on prescribing in additional bullet point:**<br><br>Nutritional supplements or prescribed over the counter items such as vitamin D should be purchased in line with NHS advice on items with limited clinical effectiveness; this includes routine prescribing of vitamins and minerals . NHS England » Policy guidance: conditions for which over the counter items should not be routinely prescribed in primary care | Thank you for your comment. The committee anticipate prescribers would be aware of this NHS policy when making any prescriptions including following national guidance on vitamin D prescribing. |
| British Dietetic Association (BDA) | Guideline | 009 | 003 | **Vitamin D Supplements - recommend consideration of the below**<br><br>It may be appropriate to consider that there is evidence that an increased risk of falls with high dose vitamin D:<br>- Intermittent administration of large doses of vitamin D, e.g. ≥100,000 IU is not advised, based on recent reports of an associated increased risk of fracture and falls Annual high-dose oral vitamin D and falls and fractures in older women: a randomized controlled trial Vitamin D supplementation: upper limit for safety revisited?<br>- a meta-analysis, a protective effect of vitamin D on fractures was only seen at daily doses ≥800 IU (20 µg) (Evidence | Thank you for your comment and the cited references. The first study was included as evidence in the evidence review. None of the other references met the protocol criteria and therefore were not included.<br><br>The guideline meta-analysis showed no difference in the rate or number of falls, and therefore committee agreed that the clinical evidence did not support using vitamin D supplementation as an intervention to prevent falls. Instead the committee linked to existing NHS advice on taking vitamin D to maintain bone and muscle health and the NICE guideline on vitamin D: supplement use in specific population groups. The NHS advice also notes that too much vitamin D can weaken bones. |

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| | | | | level 1a). This dose of vitamin D may also reduce falls<br>- (Evidence level 1a). It is recommended that in postmenopausal women and men ≥50 years who are at increased risk of fracture, a daily dose of 800 IU of cholecalciferol should be advised (Grade A recommendation). Compston J, Cooper A, Cooper C, et al. UK clinical guideline for the prevention and treatment of osteoporosis. Arch Osteoporos. 2017;12:43. Compston J et al National Osteoporosis Guideline Group (NOGG). UK clinical guideline for the prevention and treatment of osteoporosis 2022 | |
| British Dietetic Association (BDA) | Guideline | 009 | 019 | **Falls prevention exercise programmes**<br>BDA ONPSG welcomes the inclusion of promoting physically active aging with a focus on resistance training programmes. We understand the aim of resistance training is to increase muscle strength by making your muscles work against a weight or force. We recognise this is an important determinant in maintaining daily functioning and impact on physical dependence in later life.<br>We would recommend a specific recommendation highlighting the emerging evidence that regular resistance activity combined with a nutrient rich diet are the ideal combination. | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |

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| | | | | This should focus on the importance of eating well and adapting to nutrition requirements with age and **not** encourage the prescription of nutrition products<br><br>**Supporting evidence for consideration**<br>3. Muscle health, nutrition and ageing - British Dietetic Association (BDA) 2024<br>4. Leandro dos Santos et al (2016) *Sarcopenia and physical independence in older adults: the independent and synergic role of muscle mass and muscle function*.<br>Freiberger, E, Sieber, C. and Pfeifer, K. (2011) *Physical activity, exercise, and sarcopenia – future challenges*. | |
| British Dietetic Association (BDA) | Guideline | 011 | 003 | **Recommend inclusion of reference to NHS guidance on prescribing in additional bullet point:**<br><br>Nutritional supplements or prescribed over the counter items such as vitamin D should be purchased in line with NHS advice on items with limited clinical effectiveness; this includes routine prescribing of vitamins and minerals . NHS England » Policy guidance: conditions for which over the counter items should not be routinely prescribed in primary care | Thank you for your comment. Stopping items that are not prescribed medications were not covered in the guideline. The committee anticipate prescribers would be aware of this NHS policy when making any prescriptions including following national guidance on vitamin D prescribing. |

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| British Dietetic Association (BDA) | Guideline | 012 - 013 | 009 - 029 | **Residential care settings (including nursing homes) – comprehensive falls management**<br>**This section should include recommendations for food provision in care homes.**<br>• **Improving calcium and protein intakes by using dairy foods is a readily accessible and cost-effective intervention shown to reduce falls and fractures in aged care residents.**<br><br><u>Evidence</u><br>1. S Iuliano, S Poon, J Robbins, M Bui, X Wang, L De Groot, M Van L A Ghasem Zadeh, T Nguyen, E Seeman. Effect of dietary sources of calcium and protein on hip fractures and falls in older adults in residential care: cluster randomised controlled trial. BMJ 2021;375:n2364<br>Baek Y, Iuliano S, Robbins J, Poon S, Seeman E, Ademi Z. Reducing hip and non-vertebral fractures in institutionalised older adults by restoring inadequate intakes of protein and calcium is cost-saving. Age Ageing. 2023;52(6):afad114. | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and therefore have not been included in the guideline. |
| British Dietetic Association (BDA) | Guideline | General | General | The BDA optimising nutrition prescribing specialist group (ONPSG) are pleased to feedback on this guideline. | Thank you for your comment. Evidence was only looked at if it investigated the impact of nutrition on falls, or nutrition in combination with |

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| | | | | The ONPSG aims to promote the appropriate and cost-effective use of nutritional products on prescription. At present there is significant evidence of overuse and inappropriate use of these products ( up to 50% of patients in a recent systematic review – Cadogan et al 2020).<br>Patients with frailty over the age of 50 have the highest prescription rates of nutrition products. There is significant overlap in the demographic that would be at risk of falls. Therefore, the ONPSG would be keen for the appropriate use of these products to be spelled out in any reference to nutritional assessment or management. | other interventions such as exercise and falls. As no evidence was identified the committee did not make recommendations specific to nutrition and prevention of falls. General advice on nutrition, fluid intake or weight loss has not been included.<br><br>Thank you for the references. They are not specific to falls prevention and were uncontrolled before-and-after studies therefore have not been included in the guideline. |
| British Dietetic Association (BDA) | Guideline | General | General | Good nutrition and hydration are essential for the promotion of healthy ageing and recovery from illness. We are concerned that there is no mention of sarcopenia within the draft guidelines.<br>Frailty is mentioned seven times but there is currently no mention of sarcopenia and malnutrition. These are linked conditions. Whilst some loss of muscle mass and strength are a natural part of ageing, sarcopenia can increase risk of falls (Zhang et al (2019) Falls among older adults with sarcopenia dwelling in nursing home or community: A meta-analysis. Clinical Nutrition https://doi.org/10.1016/j.clnu.2019.01.002) | Duplicate of comment 369. See 369 for response |

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| | | | | Sarcopenia is linked with malnutrition and frailty (Laur et al (2017) Malnutrition or frailty? Overlap and evidence gaps in the diagnosis and treatment of frailty and malnutrition. Appl. Physiol. Nutr. Metab. 42: 449–458 )<br><br>Risk of malnutrition, sarcopenia and frailty increase with increasing age. A list of references are summarised in Frailty and the NHS: Highlighting the significant connection with malnutrition<br><br>There is minimal content on nutrition included in the draft guidelines. Nutrition in combination with exercise, is important to prevent muscle loss and strength during ageing. Recommend including a signpost to the evidence based Muscle health, nutrition and ageing - British Dietetic Association (BDA) resource. | |
| British Dietetic Association (BDA) | Guideline | General | General | The prevalence of sarcopenia and its association with falls varies according to the diagnostic definition used and the population studied. In the longitudinal iLSIRENTE study, the prevalence of sarcopenia was approximately 25% in people aged 80 years and above, and participants with sarcopenia were three times more likely to fall during a follow-up period of 2 years (Landi F, Liperoti R, Russo A et al. Sarcopenia as a risk factor | Duplicate of comment 370. See 370 for response. |

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| | | | | for falls in elderly individuals: results from the iISIRENTE study Clin Nutr 2012; 31: 652–8.<br><br>A growing number of clinicians and researchers advocate paying more attention to diagnosing and treating sarcopenia in older adults identified as being at a high risk of falls, although further research is required on how this should be conducted and whether applying non-exercise interventions for sarcopenia such as protein supplementation will reduce falls.<br><br>Recommend there is reference to screen / assessment of sarcopenia on page 5; 4; 1.1.3, 6.<br>Muscle health, nutrition and ageing - British Dietetic Association (BDA, 2024) | |
| British Geriatrics Society | Guideline | 006 | 018 | Rec 1.2.2 – include assessment of pain, and if indicated appropriate validated pain assessment | Thank you for your comment. No evidence was identified to include pain as part of the comprehensive falls assessment. However, the committee believe health care professionals would ask this anyhow. |
| British Geriatrics Society | Guideline | 007 | 001 | Muscle strength assessment may be a more suitable term than muscle weakness assessment | Thank you for your comment. The recommendation has been updated to 'muscle strength assessment'. |
| British Geriatrics Society | Guideline | 007<br>013<br>General | 4<br>16<br>General | Rec 1.3.4 and 1.3.21 - consider calcium and vitamin D supplements to those who have a high q-fracture / FRAX risk score or to those | Thank you for your comment. No evidence was identified to recommend the use of vitamin D for falls prevention. The NICE guideline on |

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| | | | | whose dietary intake is likely to be insufficient or likely to have insufficient skin sun exposure | osteoporosis which is currently been updated includes reviews on calcium and vitamin D in people with osteoporosis. |
| British Geriatrics Society | Guideline | 007 | 015 | The term dizziness should be changed to rotational vertigo - rationale being that dizziness is a vague term that is opening to misinterpretation | Thank you for your comment. The bullet point related to dizziness has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider performing a Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers recommendations on what to do when dizziness and vertigo are identified. |
| British Geriatrics Society | Guideline | 008 | 012 | Rec 1.3.2 – we would advise a comment on reviewing and discussing concordance with medication | Thank you for your comment. This is covered in the section on reviewing medicines in the NICE guideline on medicines adherence which is linked to within this recommendation. |
| British Geriatrics Society | Guideline | 009 | 020 | Strength and balance exercise programme that is evidence-based to reduce falls risk and rate | Thank you for your comment. The committee did not have evidence to make recommendations on specific programmes. Examples of exercise programmes have been added to the Tools and resources tab of the guideline page. |
| British Geriatrics Society | Guideline | 017 | 014 | This should have neurological and musculoskeletal conditions included | Thank you for your comment. The committee did not want to make the list appear comprehensive because there could be many conditions increase the risk of falling and there would be a risk that some were missed off. The guideline did not include a review of risk factors. Arthritis has been added as an example. |

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| British Geriatrics Society | Guideline | 018 | 008 | could also contain "and / or dynapaenia?" | Thank you for your comment. The review questions focused on falls as an outcome and not muscle strength therefore this has not been included as a research recommendation |
| British Geriatrics Society | Guideline | General | General | Rec Section 1.3.3 and 1.3.20 – we suggest consider involving a psychiatrist or neurologist to support a potential change to psychotropic medication | Thank you for your comment. The recommendation has been updated to state "plan withdrawal and consider liaising with specialist mental health services as appropriate". |
| British Geriatrics Society | Guideline | General | General | The World Falls Guidelines provide a structured algorithm to stratify falls risk and identify suitable interventions for individuals, this feels a reasonable step for incidental and opportunistic case finding and subsequent signposting or action. This could be useful in a community or outpatient setting. | Thank you for your comment. A visual summary has also been produced to aid readers. However, a structured algorithm similar to the World Falls Guideline is beyond the scope of this guideline. |
| British Geriatrics Society | Guideline | General | General | Rec 1.3.4 and 1.3.21 - consider calcium and vitamin D supplements to those who have a high q-fracture / FRAX risk score or to those whose dietary intake is likely to be insufficient or likely to have insufficient skin sun exposure | Thank you for your comment. No evidence was identified to recommend the use of vitamin D for falls prevention. The NICE guideline on osteoporosis which is currently been updated includes reviews on calcium and vitamin D in people with osteoporosis. |
| British Geriatrics Society | Guideline | General | General | Worth acknowledging the World Falls Guidelines, published in 2022 | Thank you for your comment. The World Falls Guidelines has been referenced where appropriate in some of the committee discussions within the reviews (multifactorial interventions and exercise reviews). However, this guideline is narrower in scope in that it focuses on prevention of falls and does not |

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| | | | | | attempt to address fear of, or concerns about falling. |
| British Geriatrics Society | Guideline | General | General | A multifactorial falls assessment should be undertaken by a clinician with training and experience of delivering holistic, patient-centred falls reduction assessments, such as a geriatrician. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric |

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| | | | | | outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| British Psychological Society | Guideline | 024 | 008 - 016 | In producing our response to this guidance, we consulted with our Faculty of the Psychology of Older People. The BPS agree with the committee's conclusion that CBT approaches "could be considered for people who have a fear of falling and do not respond to strength and balance exercises." However, a range of other psychological models and approaches may also be appropriate for more complex presentations where a fall/illness has impacted upon a wide range of quality-of-life factors.<br><br>Therefore, we recommend the inclusion of a line at the end of this paragraph to reflect that: "*Potential referral to psychology services for assessment around loss trauma and adjustment should be considered*." | Thank you for your comment. The review only covered the effectiveness of CBT for prevention of falls. Interventions covering management of the impact of having a fall were not included as part of the scope of the guideline. Therefore, recommendations for referral to psychological services for assessment around loss trauma and adjustment have not been included. |
| British Psychological Society | Guideline | 032 | 007 | The BPS welcome the inclusion of the guidelines committee member list which discloses a comprehensive list of contributors who have helped to shape this guideline document. An opportunity may have been missed to have contributions from Practitioner Psychologists with experience working with older people. These professionals can offer valuable insight into | Thank you for your comment. |

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| | | | | the complex relationship between wider scale trauma, loss and adjustment needs around falls in relation to psychological methods, approaches, and techniques. | |
| British Society of Physical and Rehabilitation Medicine | Guideline | 005 | 001 | Please also include whether they had near falls\ trips | Thank you for your comment. The guideline focuses on interventions to prevent falls rather than addressing fear of falling. The committee did not think that near miss or fear of falling equates to actual falling and did not think that everyone who has a near fall would need an assessment. They also agreed that it was not feasible for practitioners to give a comprehensive assessment to all these people. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 006 | 012 | Offer comprehensive falls assessments to . Please include<br>Living with long term neurological conditions such as stroke, Parkinson's disease, Multiple Sclerosis<br>Living with childhood onset neuro disabilities<br>Musculoskeletal conditions affecting posture and balance<br>Consider undiagnosed dementia or neurological degenerative conditions such as Parkinson's disease | Thank you for your comment. The definition for conditions that could increase the risk of falls has been updated. However, the committee agreed that it would not be possible to list all conditions and restricted it to a few examples. They did not what the list to appear to be comprehensive. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 006 - 007 | 018 | Referral for a review by a rehabilitation medicine specialist in patients with long term neurological and MSK conditions | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been |

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| | | | | | updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 007 | 017 | Assessment of autonomic function (orthostatic intolerance) | Thank you for your comment. The committee agreed this would be covered by the bullet point related to dizziness which has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider |

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| | | | | | performing a Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers recommendations on what to do when dizziness and vertigo are identified. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 009 | 018 | Medical review by a trained specialist: Rehabilitation Medicine specialist in people aged 50-64, Elderly care specialist in people >65 years | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare |

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| | | | | | professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 010 | 005 | Consider providing assistive devices such as walking frame. | Thank you for your comment. Evidence was not identified to be able to recommend assistive devices such as walking frame. Also, this recommendation is only about cognitive behaviour interventions for people who did not respond to exercise. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 011 | 015 | At discharge provide assistive device such as walking frames which may help to prevent falls | Thank you for your comment. Evidence was not identified to be able to recommend assistive devices such as walking frame. Also, this recommendation is only about cognitive behaviour interventions for people who did not respond to exercise. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 012 | 020 | Please include for people taking antihypertensive medications, diuretics and alpha blockers such as Tamsulosin do a lying and standing BP to look for postural hypotension. | Thank you for your comment. All medications would be included at in a structured medication review. Cardiovascular examination (including a lying and standing blood pressure test) are included as factors in the comprehensive falls assessment. |
| British Society of Physical and | Guideline | 013 | 029 | Please include recommendation about hydration with fluid intake of 1.5 litres per day | Thank you for your comment. General recommendations about diet and fluid therapy were not part of the scope of the guideline. |

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| Rehabilitation Medicine | | | | | |
| British Society of Physical and Rehabilitation Medicine | Guideline | 015 | 003 | Consider a referral to Rehabilitation Medicine specialist and for young people in residential care needing a full assessment.<br>Education about adequate hydration with fluid intake of 1.5 litres<br>Advice about ensuring good lighting<br>Bedside control of lights<br>Not to quickly get up from bed. | Thank you for your comment. The initial recommendations on identifying people at risk of falls have been updated to note that an appropriate referral may be needed. Advice on adequate hydration was not included in the scope of the guideline because it is covered in other generic health and lifestyle advice. Evidence was not available to make detailed recommendations on the residential care home environment, so the committee made a general recommendation on providing advice on how to mover around safely and use equipment. |
| British Society of Physical and Rehabilitation Medicine | Guideline | 017 | 013 - 018 | The conditions that could increase the risk of falls: Please include Long term neurological conditions. This will cover conditions such as Stroke, Parkinson's disease, Multiple sclerosis which are associated with high risk of falls<br>Please also include adults living with childhood onset neurological disabilities. This will cover adults with cerebral palsy and inherited neurological conditions.<br>Medications: Please include antihypertensive medications, alpha blockers such as Tamsulosin used for treating prostate problems, diuretics, anti-spasticity medications such as baclofen, Tizanidine and Dantrolene, and anti-seizure medications<br>Polypharmacy is an independent risk for falls. Anyone taking more than 5 drugs should be | Thank you for your comment. The definition of long-term conditions has been updated to 'a health condition that could increase their risk of falls (such as, a long-term condition that affects their daily life, for example, arthritis, dementia, diabetes or Parkinson's disease)'. Not all long-term conditions are included because the list is not meant to be exhaustive. Medications would not be included here and are covered by the recommendations related to medication review. |

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| | | | | assessed for falls. (Ref: Dhalwani et al. Association between polypharmacy and falls in older adults: a longitudinal study from England) | |
| British Society of Physical and Rehabilitation Medicine | Guideline | General | General | Those with Acquired Brain Injury (ABI) are also at risk from Psychotropics | Thank you for your comment. The guideline focuses on those at risk of falls. The committee anticipate the recommendations related to psychotropic medicines would also apply to people with acquired brain injury if they have been identified as at risk of falls. This should be picked up in the neurological assessment that is recommended in the recommendation on what to include in a comprehensive falls assessment. |
| British Society of Physical and Rehabilitation Medicine | Guideline | General | General | Consider those with cognitive disability from any source, not just dementia | Thank you for your comment. Dementia is highlighted in the rationale for interventions for people in residential settings because it is a common occurrence in residents. However, cognitive impairment in general is mentioned and the recommendation for comprehensive falls assessment included cognition as a factor to include. |
| British Society of Physical and Rehabilitation Medicine | Guideline | General | General | Flow of document is not reader friendly, suggest topics are grouped by younger people (50-65 yrs) and older age groups (>65 years) and follow on into inpatient and outpatient pathways | Thank you for your comment. The guideline has been updated to put the populations at the start of each section. This shortens some recommendations. A visual summary has also been produced to aid readers. |
| British Society of Physical and | Guideline | General | General | Consider role of psychology in fear of falling for younger age group as loss of function and mobility is significant | Thank you for your comment. The guideline focuses on interventions to prevent falls rather than addressing fear of falling. The role of psychology was considered but only with regard |

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| Rehabilitation Medicine | | | | | to cognitive behavioural interventions for people who have a fear of falling who do not respond to strength and balance exercises (recommendation 1.3.11). |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Equality impact assessment | Full document | Full document | **Concise Summary of the NICE Equality Impact Assessment on Falls in Older Adults**<br>The **NICE Guideline on Falls in Older Adults** aims to address the needs of diverse populations, particularly focusing on accessibility and inclusivity in falls prevention and management strategies. The guideline's recommendations reflect a commitment to Equality, Diversity, and Inclusion (EDI) principles, with particular attention to the following groups: | Thank you for your support. |
| | | | | **Key EDI Considerations Addressed in the Guidelines**<br>1. **Age:**<br>• Falls prevention programmes are tailored to the specific needs, preferences, and abilities of older adults, particularly in community, residential, and hospital settings.<br>• Emphasis is placed on adapting exercise and movement classes, addressing environmental | |

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| | | | | risk factors in hospitals, and ensuring that interventions are flexible to encourage participation.<br>2. **Disability:**<br>• Recommendations ensure that people with disabilities, including those with cognitive impairments or learning disabilities, receive personalised falls prevention interventions.<br>• Cognitive and mood assessments are recommended to improve adherence to falls prevention strategies.<br>3. **Race and Cultural Factors:**<br>• Addressing cultural and language barriers, the guideline stresses the need for accessible information and communication, including the provision of translated materials and diverse formats.<br>4. **Socio-Economic Factors:**<br>• For individuals from lower socio-economic backgrounds, the guideline highlights the need for home | |

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| | | | | hazard assessments and intervention in cases where financial disadvantage affects access to necessary resources like footwear and eyewear.<br>5. **Other Vulnerable Groups:**<br>• Specific groups, including homeless individuals, asylum seekers, and those with alcohol misuse, are recognised as potentially facing additional barriers to accessing services. Tailored approaches are recommended to engage these populations.<br>**6. Gender Considerations in Falls Risk Assessment**<br>In reviewing the evidence on falls risk assessment, the committee acknowledged the World Health Organisation's 2007 report, which highlights gender-specific differences in falls risk. The report notes that:<br>- **Women with osteoporosis** are at an increased risk of falls and fractures.<br>- **Men** are at a higher risk of fatal falls.<br>The committee recommended that **osteoporosis risk** be included as part of the | |

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| | | | | falls risk assessment. This recommendation aligns with the **comprehensive falls assessment** and ensures that both women and men at risk are properly identified. The committee also agreed that the guideline recommendations do not create any barriers for either gender to be identified as at risk of falls, ensuring an inclusive and equitable approach to falls prevention.<br><br>**Conclusion:**<br>The guideline adopts a comprehensive, inclusive approach to falls prevention, ensuring that all recommendations are flexible and adaptable to meet the varied needs of diverse patient populations, thereby advancing equality in care delivery. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 005 | 004 - 015 | **Recommendation 1.1.3 –** We recommend providing greater clarity on the roles of specialist and community services in delivering comprehensive falls assessments. The guideline should specify that when the cause of a fall is associated with a known condition (e.g., Parkinson's disease, stroke), the responsibility for conducting the comprehensive falls assessment should rest with the relevant specialist service. This approach ensures that the assessment is informed by the appropriate clinical expertise and facilitates the development of tailored interventions. *(Please refer to Comment 51* | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant |

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| | | | | *for further elaboration on this recommendation.)* | expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist.<br><br>In addition, long term conditions have been added as a risk factor to the comprehensive risk assessment recommendation. The committee anticipate healthcare professionals carrying out the assessment would refer to the appropriate person if the condition is identified as the cause of a person's fall. |
| County Durham and Darlington NHS | Guideline | 005 | 004 - 015 | **Review Statement: Clarification on Specialist Services and Community Falls Service Roles in Comprehensive Falls Risk Assessment** | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These |

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| Foundation Trust (CDDFT) | | | | I propose a clarification in the guideline regarding the completion of comprehensive falls risk assessments. The current wording in section 1.1.3 ("Offer comprehensive falls assessment and management for people who have fallen in the past year and...") does not adequately specify that clinical expertise related to the individual's condition should be responsible for conducting the falls assessment.<br>In cases where the cause of the fall is known—such as conditions including Parkinson's disease, stroke, or other neurological or movement disorders—it is imperative that the specialised service managing the underlying condition (e.g., Neurology, Stroke Rehabilitation, or Movement Disorder Services) conducts the comprehensive falls risk assessment and formulates a tailored intervention plan. This approach ensures that assessments are appropriately aligned with the specific risks and needs of the patient, with interventions grounded in the relevant clinical expertise.<br>Without this clarification, there is a risk that the guideline could be misinterpreted as suggesting that all falls risk assessments should be referred to community falls services. However, when the cause of the fall is already established, it is far more efficient and clinically appropriate for specialist | recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist.<br>In addition, long term conditions have been added as a risk factor to the comprehensive risk |

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| | | | | services to take responsibility for both the assessment and intervention.<br>The community falls service is itself a specialised service, designed to investigate the causes of falls when these are not already known. Referrals to the community falls service should be made only when the cause of the fall is unclear or when further specialist advice is required after other services have completed their assessments and interventions. For instance, the community falls service could provide additional guidance when specialist services are unable to determine how to further prevent falls. However, the community falls service should not be approached as a default for all patients who have experienced a fall, particularly when the cause is already established.<br>This clarification is vital to ensure that:<br>1. Falls risk assessments and interventions are carried out by professionals with the most relevant clinical expertise, ensuring more effective, tailored care.<br>2. The roles and responsibilities of specialist services and community falls services are clearly delineated, avoiding unnecessary referrals and ensuring efficient use of resources.<br>3. The community falls service is utilised appropriately, focusing on its | assessment recommendation. The committee anticipate healthcare professionals carrying out the assessment would refer to the appropriate person if the condition is identified as the cause of a person's fall. |

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| | | | | core role of identifying unknown causes of falls and intervening when necessary, rather than being burdened with cases that would be better addressed by other specialist services.<br>By defining these roles more explicitly, the guideline can prevent misinterpretation, streamline referral pathways, and promote better outcomes for patients by ensuring that falls prevention and management strategies are aligned with individual needs and the appropriate level of clinical expertise. | |
| | | | | **Key Points Addressed:**<br>1. **Specialist Services Responsibility**: Specialist healthcare services (e.g., neurology, stroke rehabilitation, Parkinson's disease clinics) should conduct falls risk assessments and develop interventions when the cause of the fall is known. This ensures assessments are tailored to the underlying condition.<br>2. **Community Falls Service Role**: The community falls service should focus on assessing cases where the cause of the fall is unclear. It can also provide advice when other specialist services require further input to prevent future falls. | |

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| | | | | 3. **Clear Role Distinction**: Explicitly defining the roles of specialist and community services will ensure that falls prevention and management are efficient, targeted, and based on clinical expertise, reducing confusion and improving patient outcomes. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 005 | 019 - 023 | **Recommendation 1.1.5** – Offering a falls prevention exercise programme for individuals with gait or balance impairments is highly beneficial. However, further guidance on integrating such programmes with existing community services (e.g., fracture liaison services) would strengthen implementation. For example, in our Trust, we have integrated falls prevention exercise programmes with fracture liaison services to address both bone frailty and fall risks simultaneously. | Thank you for your comment. Specific aspects of service delivery such as fracture liaison services were not included as part of the scope of this guideline. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 005 | 019 - 023 | We suggest including attention under **Recommendation 1.1.5** on monitoring individuals aged 50 to 64 with bone frailty, particularly when the cause of their fall is unclear. Integration with fracture liaison services could help proactively manage this demographic, as demonstrated by our Trust's approach, which facilitates referrals for individuals meeting specific criteria (e.g., recurrent falls without a clear cause). | Thank you for your comment. Bone frailty is covered in the osteoporosis guideline which is currently been updated and therefore has not be included in the falls guideline. |

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| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 005 | 024 - 029 | **Recommendation 1.1.6** to provide lifestyle information is valuable. However, expanding the resources to include digital education materials, such as videos or interactive content, would enhance accessibility and engagement. For example, our Trust developed a video on falls prevention that could serve as a resource: Falls Prevention Video. This could be referenced within the guideline or made available for stakeholders to adapt. | Thank you for your comment. The type and format of information has not been covered in this guideline. Further detail on format and delivery of information is included in the NICE guideline on patient experience in adult NHS services. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 006 & 007 | 018 – 019, 001 - 017 | **Recommendation 1.2.2** – This recommendation includes a comprehensive list of factors for assessment. However, it would benefit from explicit guidance on the sequence of assessments to ensure efficiency, particularly in settings with limited resources. For example, prioritising gait, balance, and mobility assessment could identify immediate fall risks and guide further, more detailed evaluations. | Thank you for your comment. The sequence of assessments was not covered as part of the guideline. The committee noted each person's circumstances would be different. A further explanation has been added to the rationale that states "The complex nature of comprehensive assessment means that clinical judgment would be needed to determine what to assess and when."<br><br>The rationale has also been updated to state that the comprehensive falls assessment could be carried out by a single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may |

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| | | | | | require referral to a specialist. *[Note, if comment 73 or the rationale changes this paragraph may need to change too.* |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 006 & 007 | 018 – 019, 001 - 017 | **Recommendation 1.2.2** – We suggest including a point on assessing bone health for individuals aged 50 to 64 with unclear fall causes, as their risk of fractures could be significant. This aligns with our Trust's integrated approach of linking fracture liaison services with falls assessments to ensure bone health is addressed proactively. | Thank you for your comment. Bone health would be considered as part of osteoporosis risk assessment. A link has been added to the NICE guideline osteoporosis which is currently being updated therefore more detail has not been included in this guideline. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 007 | 018 - 024 | **Recommendation 1.2.3** – This recommendation could be strengthened by specifying mechanisms for coordinating interventions across multidisciplinary teams. For example, establishing a "falls care pathway" that involves primary care, community services, and specialists could ensure that all risk factors identified are promptly addressed without duplication of effort. | Thank you for your comment. An extra point has been added to the recommendation stating his can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to state that the comprehensive falls assessment could be carried out by a single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| County Durham and Darlington NHS | Guideline | 011 | 005 - 014 | **Recommendation 1.3.13** – The focus on tailored education sessions is commendable. However, for patients with limited capacity, this could be expanded to include caregiver education to ensure continuity of care post- | Thank you for your comment. Education for caregiver education was not covered in the guideline. However, there is a cross reference to the NICE guideline on decision making and mental capacity. |

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| Foundation Trust (CDDFT) | | | | discharge. This aligns with the NICE guideline on decision-making and mental capacity but could benefit from a clearer operational suggestion. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 011 | 015 - 017 | **Recommendation 1.3.14** – Referring individuals to community services at discharge is crucial. However, guidance on how to ensure seamless communication and follow-up between hospital and community teams could improve the practical implementation of this recommendation. For instance, creating a standardised discharge summary template focused on falls-related risks and interventions could support this process. | Thank you for your comment. Communications and standard discharge templates between hospital and community care were not covered in the scope of this guideline. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 011 | 019 - 023 | **Recommendation 1.3.15** – The emphasis on structured medication reviews is excellent. However, it could include specific guidance on integrating pharmacist-led reviews, particularly in hospital inpatient settings, to optimise medication adjustments in a timely manner. This approach has been successful in our Trust in reducing polypharmacy-related fall risks. | Thank you for your comment. Detail about what to do as part of a structured medication review in hospital has not been included in this guideline because it is covered in the NICE guideline on medicine optimisation which has been cross referred to in this guideline. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 011 | 025 - 029 | **Recommendation 1.3.16** – While the advice on following NHS recommendations for vitamin D is appropriate, clearer guidance is needed for healthcare providers on assessing vitamin D levels in at-risk individuals during hospital stays. Proactive supplementation for those identified as | Thank you for your comment. Evidence was not available to make more detailed recommendations about vitamin D. |

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| | | | | deficient may prevent long-term risks without directly attributing to falls prevention in the hospital. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 012 | 002 - 013 | **Recommendation 1.3.17** – Encouraging physical activity during hospital stays is vital. Including examples of tailored activities for individuals with limited mobility (e.g., seated exercises) and guidance for staff on safely facilitating these activities would enhance the practical application of this recommendation. | Thank you for your comment. Evidence was not available to provide much detail in the recommendations for hospital inpatients. Therefore, the committee made a recommendation to encourage physical activity. The recommendation has been expanded to suggest the type of exercise or physical activity to encourage. This states 'for people able to exercise, look for opportunities to encourage physical activity that are related to the person's risk of falls, such as balance, coordination, strength and power'. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 012 | 014 - 018 | **Recommendation 1.3.18** – Prompt intervention is essential, but this could be expanded to include routine team reviews in residential care settings to monitor the effectiveness of falls interventions. Regular multidisciplinary reviews could address unresolved or newly identified risk factors. | Thank you for your comment. Team reviews were not covered in the guideline. A link has been added to the NHS England document on Providing proactive care for people living in care homes – Enhanced health in care homes framework which provides more detail. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 012 & 013 | 020 – 022, 001 - 006 | **Recommendation 1.3.19** – Including a specific mention of deprescribing protocols for medications with known fall risks would strengthen this recommendation. Additionally, providing examples of psychotropic medicines with withdrawal plans, as highlighted in Recommendation 1.3.20, would be beneficial for implementation in residential settings. | Thank you for your comment. We have avoided giving more details in this guideline's recommendations because there are links to information from other NICE guidelines: managing medicines in care homes and medicine optimisation. |

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| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 013 | 007 - 014 | **Recommendation 1.3.20** – This is a crucial point for reducing fall risks related to psychotropic medicines. However, the recommendation could clarify strategies for discussing withdrawal plans with individuals who lack capacity, ensuring carers and legal representatives are appropriately involved in decision-making. | Thank you for your comment. We have avoided giving more details in this guideline's recommendations because there are links to information from other NICE guidelines: managing medicines in care homes and medicine optimisation. There are also links at the beginning of the recommendations to two other relevant guidelines: Advocacy services for adults with health and social care needs and Decision making and mental capacity. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 013 | 016 - 020 | **Recommendation 1.3.21** – The recommendation aligns with NHS guidance, but it could include further clarity on whether healthcare providers should actively assess and advise on vitamin D supplementation during routine assessments in residential care. Such clarity would help ensure consistency across services. | Thank you for your comment. Assessing different levels of vitamin D was not included as part of the evidence review therefore no recommendations have been made on this. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 013 | 022 - 026 | **Recommendation 1.3.22** – Encouraging physical activity is essential. However, this recommendation could expand to include examples of staff training modules to facilitate safe mobilisation and promote activities for people with mobility or cognitive limitations in residential settings. | Thank you for your comment. Staff training was not included as part of the guideline scope therefore no recommendations have been made on this. |
| County Durham and Darlington | Guideline | 013 & 014 | 027 – 29, 001 | **Recommendation 1.3.23** – Exercise programmes tailored to individual abilities are highly beneficial. Including specific guidance | Thank you for your comment. Evaluating the effectiveness of exercise programmes was not part of the scope of this guideline. |

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| NHS Foundation Trust (CDDFT) | | | | for evaluating the effectiveness of these programmes over time and criteria for referring to physiotherapists or occupational therapists for customisation would enhance the practical implementation of this recommendation. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 014 | 004 - 013 | **Recommendation 1.4.1** – Including supervised exercises and discussing barriers with patients is commendable. However, adding a recommendation for co-developing intervention plans with multidisciplinary teams, including physiotherapists, could further support patient adherence and personalised care. | Thank you for your comment. The co-development of intervention plans with multidisciplinary teams was not included in the scope of the guideline therefore no recommendations have been made relating to this. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 014 and 15 | 014 – 017, p15: top line | **Recommendation 1.4.2** – The flexibility of programmes is crucial. Additional guidance on using patient feedback to adapt programmes over time and creating community-based group classes to maintain motivation and social interaction could further improve adherence and outcomes. | Thank you for your comment. Using patient feedback to adapt programmes was not included in the scope of the guideline. However, the committee recommend that interventions are flexible enough to accommodate each person's individual needs and preferences |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 015 | 003 - 025 | **Recommendation 1.5.1** – The provision of tailored information is critical. Including more explicit guidance on integrating education into clinical pathways (e.g., during hospital discharge or primary care visits) and offering resources in multiple languages or accessible formats would promote inclusivity and accessibility. | Thank you for your comment. Details on how to provide information is covered in the NICE guidelines on Patient experience in adult NHS services and People's experience in adult social care services: improving the experience of care and support for people using adult social care services which are linked to in the list of general guidelines at the beginning of the recommendations. |

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| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 015 | 003 - 025 | This recommendation (**1.5.1**) could be strengthened by including a specific point about involving carers and families in creating emergency response plans for falls, including instructions for accessing local support services. | Thank you for your comment. Creating an emergency response plan was not included as part of the scope. This is covered in the NICE guideline on home care which is linked to in the list of general guidelines at the beginning of the recommendations. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 016 | 002 - 015 | **Recommendation 1.5.2** – The inclusion of hospital-specific fall prevention education is essential, especially regarding unfamiliar equipment. It may be beneficial to include a recommendation for staff training on how to clearly explain and demonstrate the use of equipment, such as call bells and bed controls, to patients upon admission. This proactive approach may reduce confusion and the risk of falls due to equipment misuse. | Thank you for your comment. Staff training was not included in the scope of this guideline therefore no recommendations have been made relating to this. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 016 | 012 - 013 | The role of family and carers in identifying potential hazards should be clearly defined. An additional suggestion could be to implement a "falls awareness" programme for visitors, highlighting what they can do to help identify and address fall hazards in the hospital environment. This would empower families and friends to assist in falls prevention actively. | Thank you for your comment. Falls awareness for visitors was not included in the scope of this guideline therefore no recommendations have been made relating to this. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 016 | 017 - 026 | **Recommendation 1.5.3** – Discussing the risk of falls and how to move around safely is important. However, there could be more emphasis on the importance of person-centred care plans in residential settings. Ensuring that each resident's unique mobility | Thank you for your comment. Care planning was not included as part of the scope of this guideline. It is covered in the NICE guideline on people's experience in adult social care services which is linked to at the start of the recommendations. |

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| | | | | needs are assessed, and providing tailored recommendations for fall prevention based on their abilities, preferences, and health status would support better outcomes. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 016 | 025 - 026 | For better implementation of this recommendation, it would be helpful to encourage staff to engage residents in regular discussions about their safety concerns and preferred ways to manage their own mobility. This could promote autonomy and reduce the risk of falls due to reluctance to ask for help. | Thank you for your comment. The recommendation has been updated to include a bullet point on how to manage a person's safety concerns, including when and how to seek help if they have a fall. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 016 - 18 | General | **Recommendation 1.1.4** – It would be helpful to include criteria for determining when a gait and balance assessment should be conducted by a specialist clinician (e.g., physiotherapist or neurologist) versus a general healthcare provider. This distinction could improve the accuracy of assessments and subsequent interventions. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added |

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| | | | | | to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 017 | 005 | **Comprehensive Falls Assessment** – It may be useful to include a recommendation for a standardised tool for falls assessments in both community and residential settings to ensure that the assessment is thorough and consistent. Such tools can support the identification of risk factors and make interventions more targeted and effective. | Thank you for your comment. The guideline committee did not think there was enough good evidence to back on of the standardised tools for falls assessments. The rationale has also been updated to state that **the** comprehensive falls assessment could be carried out by a single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood |

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| | | | | | pressure and medication checks), whereas others may require referral to a specialist. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 017 | 006 - 012 | **Comprehensive Falls Management** – The guideline could clarify that this management should also involve regular reviews of the interventions to ensure their continued relevance, particularly as the patient's condition or risk factors change over time. This ongoing evaluation would allow for more dynamic care that responds to changing health statuses and prevent a static approach to fall prevention. | Thank you for your comment. The guideline did not include a question on ongoing reviews of interventions therefore no recommendations have been made relating to this. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 017 | 014 | The mention of long-term health conditions, such as heart disease and dementia, is essential in understanding the multifaceted nature of fall risks. It might be useful to clarify the interplay between these conditions and the specific fall prevention strategies required. For instance, heart disease may require interventions to manage orthostatic hypotension, while dementia could demand more tailored strategies addressing cognitive decline and its impact on mobility. | Thank you for your comment. The committee avoided going into detail here and just gave examples of long-term conditions. Specific recommendations on what to do to manage these conditions would be covered by other guidelines. This guideline focuses on how to prevent falls once a risk factor has been identified. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 017 | 014 | Further elaboration on how these conditions specifically interact with falls risk management strategies would be beneficial. For example, a section focusing on how to tailor fall prevention to individuals with both heart disease and dementia could improve | Thank you for your comment. The committee avoided going into detail here and just gave examples of long-term conditions. Evidence was only available to make general recommendations and not on tailoring interventions for people with more than one risk factor. Specific recommendations on what to do |

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| | | | | care by taking into account the complexities of managing these conditions concurrently. | to manage these conditions would be covered by other guidelines. This guideline focuses on how to prevent falls once a risk factor has been identified. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 017 | 015 - 018 | Psychotropic medications are indeed a significant factor in increasing fall risk, and the guideline could benefit from detailing the specific ways these medications contribute to falls. For example, antipsychotics can cause sedation or dizziness, while antidepressants may impact balance. Recommendations could include more frequent review of psychotropic medications for patients at risk of falling, with a focus on adjusting dosages or considering alternatives where appropriate. | Thank you for your comment. Regular review of medications was not included in the scope of this guideline. The committee anticipated that people would have a medication review on a regular basis. More detail is available in the NICE guideline on medicine optimisation. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 017 | 019 - 022 | **Recommendation 1.5.4** – The importance of supervised exercise is well-acknowledged. To enhance this recommendation, it could be beneficial to specify that exercise sessions should focus on both strength training and balance improvement, as these are key components of fall prevention. Furthermore, evidence supporting the role of virtual or online supervised exercise programs, especially for those who are housebound, could be highlighted. | Thank you for your comment. The recommendations in the sections related to interventions for each setting specify that exercise or physical activity should focus on the components related to the person's risk of falls, such as balance, coordination, strength and power.<br><br>This section defines what the committee meant by supervised exercises. It highlights ways that exercise could be delivered rather than specifying one way. Evidence was not available to specify one method of delivery over another. |
| County Durham and | Guideline | 017 - 018 | 024, 001 - 003 | **Recommendation 1.7.1** – Wearable technologies for falls risk assessment hold | Thank you for your comment. This additional information has been added to the research |

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| Darlington NHS Foundation Trust (CDDFT) | | | | promise but require a thorough evaluation in real-world settings to ensure their effectiveness. The recommendation should emphasise that wearables must be compatible with existing healthcare systems, and healthcare professionals must be trained to interpret the data these devices provide accurately. | protocol table in the appendix of the evidence report. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 018 | 004 - 006 | **Recommendation 1.7.2** – The research into environmental interventions in hospital inpatient settings is crucial. It may also be valuable to explore how changes to hospital design and room layouts can impact falls risk, such as improving lighting, reducing clutter, and ensuring non-slip floors. A recommendation could be added to involve patients and staff in the design and evaluation of these interventions. | Thank you for your comment. We mention lighting and flooring in the research recommendation on environmental interventions in hospital inpatients. Hospital design and room layouts is outside of the scope of this guideline. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 018 | 007 - 009 | **Recommendation 1.7.3** – The research into enhanced supervision in hospital settings is important. A more specific research question could be whether increasing the number of staff available for supervision (e.g., through the use of nurse assistants or volunteers) results in fewer falls, especially for high-risk patients. | Thank you for your comment. This has been added to the research recommendation. |
| County Durham and Darlington NHS | Guideline | 019 | 001 - 004 | **Recommendation 1.7.4** – Research into dementia-related interventions for falls in residential care settings is critical. The guideline could emphasise the need for research into how non-pharmacological | Thank you for your comment. The research recommendation protocol also includes non-pharmacological interventions which address behavioural and psychological symptoms of dementia with the aim of reducing risk of falls. |

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| Foundation Trust (CDDFT) | | | | interventions, such as personalised care plans and environmental modifications, can be integrated to reduce falls risk for residents with dementia. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 019 | 005 – 007 | **Recommendation 1.7.5** – Assistive technologies in community settings have the potential to reduce falls but need more widespread research into their accessibility, affordability, and effectiveness. The guideline could encourage trials of various assistive devices, such as fall alarms or motion-sensor lights, and their integration into care plans. | Thank you for your comment. We have included assistive technologies as a research recommendation 'do assistive technologies in community settings reduce the incidence of falls' so their effectiveness and cost-effectiveness can be investigated. Our review was about effectiveness for falls prevention, and not accessibility so this was not included as part of the research recommendation. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 019 | 008 - 010 | The rationale regarding the limitations of falls risk assessment tools is well-explained. However, there should be a clearer distinction between tools used for initial screening and those used for more in-depth risk evaluation. It may also be useful to recommend the development of new tools that integrate physical assessments with environmental and behavioural factors. | Thank you for your comment. The tools used for the screening review were either physical tests that could be performed in < 5 mins such as the chair test or screening tools such as STRATIFY. The physical tests that were examined for a more in-depth evaluation of balance and gait were in review E and included the BEST test or Berg balance scale etc but evidence could not recommend one over the others. Initial screening tools such as those examined in review C i.e. FRAT did include assessments of behavioural, environmental and physical assessments. |
| County Durham and Darlington NHS | Guideline | 019 | 011 - 012 | It might be beneficial to explore how the results of falls risk assessments can be used more effectively in hospitals. For example, integrating the assessment into a broader care plan could ensure that the information is | Thank you for your comment. Integrating assessment into a broader care plan was not included as part of the scope of this guideline. A research recommendation has been made for wearable technologies. |

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| Foundation Trust (CDDFT) | | | | actively used by healthcare providers to guide interventions. The use of real-time data from wearable technologies, once validated, could improve falls prevention practices. | |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 020 | 003 | The evidence regarding clinical judgment for assessing falls risk, as mentioned, highlights the importance of healthcare professionals' knowledge of the patient. However, it should be noted that this is a subjective process. The guideline could be improved by suggesting clearer protocols for healthcare professionals to follow, ensuring a more systematic and standardised approach to identifying at-risk individuals. | Thank you for your comment. Unfortunately, evidence was not available to provide clearer protocols for health care professionals. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 020 | 009 - 012 | The guideline mentions that healthcare professionals often identify falls risk during health checks, such as when a person presents with unsteady gait or falls history. The recommendation could be enhanced by proposing a more structured falls risk assessment tool for use during these brief consultations. This would help ensure a more consistent approach, particularly in time-limited appointments. Furthermore, while the guideline acknowledges the limited time available for assessment, it could recommend integrating digital tools or mobile health applications that could support professionals in identifying falls risks more efficiently. | Thank you for your comment. The review on risk tools looked at those that could be done within 5 minutes (such as the timed up and go) which would be suitable for brief consultations. However, the committee were not able to make a recommendation for these screening tools due to limited evidence.<br><br>The more structured assessment would be done following this, as part of the comprehensive falls assessment.<br><br>The evidence was not available to recommend integrated apps. Tools would be needed in the first place to be able to develop a mobile application.<br>Evidence review D looks at electronic patient records as a tool to identify people at risk of |

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| | | | | | falls. However, due to limited clinical evidence and the absence of health economic evidence the committee agreed to make no recommendation relating to electronic patient records. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 020 | 013 - 016 | The issue of short consultation times in community settings is a key challenge in accurately assessing falls risk. The recommendation to improve training or expand scope to include more comprehensive falls risk checks within the limited consultation period could be considered. Another possible solution would be to recommend follow-up assessments if a risk is identified, allowing healthcare professionals to conduct a more in-depth evaluation without overloading consultations. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving |

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| | | | | | any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | 020 | 018 - 021 | The recommendation to offer a comprehensive falls assessment and management for individuals reporting a fall in the last year aligns well with best practices. However, the guideline could strengthen the recommendation by suggesting more specific referral pathways. For example, patients with multiple risk factors (e.g., neurological conditions or prior fractures) should be promptly referred to specialist services for further assessment, ensuring a holistic approach to managing falls risk. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an |

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| | | | | | appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| County Durham and Darlington NHS Foundation Trust (CDDFT) | Guideline | General | General | Here are my views on the following questions based on the NICE guideline review and your perspective:<br><br>**1. Would it be challenging to implement any of the draft recommendations? Please say why and for whom. Include suggestions for overcoming challenges (e.g., practical resources or national initiatives).**<br><br>• **Challenges**:<br>The implementation of several recommendations could present challenges, particularly in community and hospital outpatient settings, where short consultation times limit the opportunity to conduct thorough falls risk assessments. The lack of comprehensive tools or structured processes for identifying at-risk | Thank you for your comment.<br><br>**With regard to point 1:**<br>To address the short consultation times, we have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. This recommendations in section 1 are about identification of people for comprehensive falls assessment rather than the actual doing the assessment. These have been updated to make it clearer that comprehensive falls assessment can be carried out in the same service or involve an appropriate referral. The rationale for those recommendations has also been updated to explain that it may not be practical in all settings because not every service would have the expertise or time to carry this out. Outpatient appointments have been given as an example of this where it also noted that any risk factor identified could be added to the letter usually |

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| | | | | individuals during these brief appointments could lead to inconsistent or missed assessments. Additionally, healthcare professionals in community settings may have limited training or access to advanced tools like wearable technologies, which could hinder their ability to assess falls risk effectively.<br>• **Suggestions to Overcome Challenges**:<br>  • **Streamlined Assessment Tools**: The introduction of simple, quick-to-administer risk assessment tools could help overcome time constraints. These could include digital tools, mobile applications, or checklists that allow healthcare professionals to identify risk factors within a short timeframe.<br>  • **Additional Training**: Training for healthcare professionals in community | sent to the GP to update them about the person's appointment.<br><br>Unfortunately, evidence was not available to recommend streamlined assessment tools and training was not part of the scope. The committee have made a research |

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| | | | | and outpatient settings could focus on efficient ways to assess falls risk, using observation, patient history, and structured questions.<br>• **Referral Pathways**: Implementing clearer, formalised referral pathways for individuals identified as at risk of falling could ensure that individuals receive the appropriate level of care without relying solely on in-depth assessment during the initial consultation.<br>• **Technology Integration**: The use of wearable technology and other assistive tools could be encouraged to assist in identifying at-risk individuals. However, wider availability and training on these tools would be required to make this a practical solution. | recommendation for wearable technologies in the hope that this will be funded.<br><br>**With regard to point 2:**<br>The committee have made the recommendations broad enough that should ICBs choose they can adopt your suggested strategies. |

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| | | | | **2. Would implementation of any of the draft recommendations have significant cost implications?**<br><br>**Cost Implications:**<br><br>The implementation of the draft recommendations could indeed have significant cost implications, especially in relation to the following areas:<br><br>• **Tailored Interventions**:<br>  • **Exercise Programmes**: Ensuring that individuals can access tailored exercise programmes may involve costs related to **transportation** for people who are housebound or live in areas with limited public transport. This could increase reliance on community transport services, adding a financial burden.<br>  • **Home Hazard Assessments**: Implementing regular home hazard assessments and adaptations may require funding for **occupational** | |

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| | | | | **therapists** and **home modification services** to improve accessibility for vulnerable individuals, particularly in residential settings or private homes.<br>• **Training Costs**:<br>  • There will be a need for **staff training** to ensure that healthcare professionals can deliver personalised interventions effectively. This training might include upskilling in telehealth technologies, falls prevention methods, and cognitive impairment assessments. These costs may be incurred through time spent away from direct care duties or paying for specialist training.<br>• **Infrastructure Investments**:<br>  • To accommodate individuals with mobility issues, there may be a need to **adapt physical environments** to ensure they are accessible for those at risk of falls. This could include making residential settings safer or enabling access to out- | |

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| | | | | patient services for exercise classes and assessment centres. Infrastructure investments may also be needed to equip local community services to handle increased demand, particularly in remote areas.<br>• **Transport provision** to facilitate access to out-patient services, where individuals may face transport barriers, could be an additional cost for healthcare systems.<br>• **Comprehensive Assessments**:<br>• The cost of conducting **comprehensive assessments** (such as for osteoporosis, cognitive impairments, and other conditions contributing to falls) may be an additional financial burden. This includes both direct costs (e.g., medical examinations, assessments) and indirect costs (e.g., additional consultations or follow-up services). Healthcare systems may also need to | **With regard to point 3:**<br>Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost- |

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| | | | | employ more specialists to conduct these assessments in a timely manner.<br><br>**Strategies to Mitigate Costs:**<br><br>To address these potential cost implications, the following solutions could be considered:<br><br>• **Utilising existing community-based resources** (e.g., local volunteer transport schemes, telehealth services) to reduce the financial impact of transport barriers.<br>• **Leveraging national or regional health initiatives** that fund specific interventions (e.g., NHS programmes on falls prevention or osteoporosis care) to support implementation and minimise financial burden on local services.<br>• **Collaboration with social care services**, NGOs, and local councils to enhance support for individuals with mobility or transport issues, reducing pressure on health services.<br>• **Prioritising preventative care**: The initial costs of these interventions could be offset in the long term by reducing the incidence of falls and | effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to 'consider' the OT doing the home hazard assessment and intervention.<br><br>Integrating home assessments with existing falls prevention services was not included as part of the scope of this guideline. |

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| | | | | fall-related injuries, which can result in significant cost savings in terms of hospital admissions, rehabilitation, and long-term care.<br><br>By balancing these investments with long-term health outcomes, the overall cost impact could be mitigated and potentially lead to a more efficient and effective healthcare system. | |
| | | | | **3. What would be the feasibility and likely impact on the wider health and social care system of fully implementing recommendation 1.3.5 related to offering home hazard assessments carried out by an occupational therapist?**<br><br>Offering home hazard assessments is a valuable recommendation with the potential to significantly reduce falls in the home environment. Implementing this recommendation would require collaboration between healthcare professionals (e.g., Falls Risk Assessor Clinicians—not exclusively Occupational Therapists) and local authorities. While this may initially increase service demand, the long-term benefits, such as preventing falls, reducing hospital | |

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| | | | | admissions, and lowering healthcare costs, could outweigh the initial investment.<br>The feasibility of implementing this recommendation depends largely on the availability of qualified occupational therapists and the capacity of services to accommodate this additional responsibility. In areas with limited staffing, this may present a challenge. A collaborative approach involving falls prevention services and occupational therapy teams could help share the workload, increasing capacity and improving accessibility.<br>• **Feasibility**:<br>  • **Logistical Challenges**: Coordinating home hazard assessments could present logistical challenges, especially in rural or underserved areas where access to occupational therapists is limited. Ensuring equitable access to this service across regions could require additional resources, including funding for transportation or the development of remote assessment models.<br>  • **Interdisciplinary Collaboration**: The success | |

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| | | | | of this recommendation would depend on the integration of various services. Effective communication and collaboration between occupational therapists, GPs, falls prevention teams, and social services would be necessary to ensure that individuals are referred for hazard assessments at the right time and that the recommendations are followed through.<br>• **Impact on Health and Social Care System**:<br>  • **Improved Patient Safety**: By addressing home hazards, the recommendation has the potential to significantly reduce the risk of falls in vulnerable populations. This could improve overall patient safety, particularly for individuals living independently in the community who may not have access to frequent healthcare interventions. | |

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| | | | | • **Reduction in Fall-Related Injuries**: Home hazard assessments could prevent the majority of falls that occur in the home, particularly in the elderly, leading to fewer hospital admissions, fractures, and the need for intensive rehabilitative care. This would ease the pressure on emergency services and hospitals.<br>• **Cost Savings**: Long-term, the reduction in fall-related injuries could save significant resources. For instance, the cost of a hospital stay following a fall could far exceed the cost of providing home hazard assessments. Additionally, fewer falls would mean less strain on community health services and long-term care providers.<br>• **Support for Caregivers and Families**: Home hazard assessments can help caregivers and families by providing them with specific | |

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| | | | | advice and recommendations to improve the safety of the home environment, reducing the burden of caregiving and the risk of injury. | |
| | | | | **Conclusion:**<br>The draft recommendations on falls risk assessment, particularly those related to home hazard assessments and improved use of technology, would require significant investment upfront. However, their implementation could lead to long-term benefits for both patients and the healthcare system, including reduced falls-related injuries, improved patient outcomes, and overall cost savings. Key challenges lie in the availability of resources (staffing, technology), time constraints for risk assessments, and ensuring equitable access to services. Overcoming these challenges will require clear pathways for referrals, targeted training, and careful consideration of technology integration. The broader impact on the health and social care system is likely to be positive, with reduced pressure on acute services and long-term savings from prevention efforts.<br>To support successful implementation, clearer guidance on integrating home assessments with existing falls prevention | |

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| | | | | services would be helpful. At County Durham and Darlington NHS Foundation Trust (CDDFT), we have developed educational resources, including a falls prevention video, which can enhance public awareness and provide practical advice on minimising home hazards. This video is accessible here: https://www.youtube.com/watch?v=esWD81RBz-I.<br>The wider impact on the health and social care system would likely be positive, promoting improved patient safety, greater independence, and fewer hospital admissions due to falls. To ensure feasibility and effectiveness, pilot programmes could be conducted before implementing the recommendation on a larger scale. | |
| Dynamic Metrics Ltd | Evidence review C | 041 - 043 | General | This evidence is titled Accuracy of Screening tools. However, the economic models quoted are for screening plus intervention. Evidence Review F covers the assessment and prevention of falls. It is misleading to include measurement and intervention under 'Accuracy of screening'. The data is correct, does appears to be in the wrong section | Thank you for your comment. We have updated and removed the intervention data related to this study from this evidence review and have kept the data related to accuracy in this evidence review. The committee agreed that it was important to include the paper in accuracy of screening because it does show that QTUG (Quantitative Timed Up and Go) dominates TUG (Timed Up and Go). The intervention data is reported as health economic evidence in the exercise section of evidence review F1. |

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| Dynamic Metrics Ltd | Guideline | 007 | 024 | The box below line 24 refers the reader to 'Evidence Review C' | Thank you for your comment. All cross references have been checked for the published version of the guideline. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review A | 007 - 012 | 001, 002, 003 | No evidence on under 60 years. We suggest guidance age starts at 60 years in line with current evidence base | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review B | 007 - 010 | 001, 002 | No evidence on under 60 years. We suggest guidance age starts at 60 years in line with current evidence base | Thank you for your comment. It was agreed during scoping that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review C | 007 - 018 | 001, 002, 003, | Only one article referring to falls in under 60-related to a spinal cord injury cohort of patients. Standard deviation for age 54.3. Consideration of falls is part of Spinal injury: assessment and initial management, NG41, 2016. We suggest falls guidance starting at age 60, with reference to some fallers with | Thank you for your comment. It was agreed during scoping that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or |

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| | | | | specific needs, relating to other guidance, i.e. SCI or stroke | used their expertise and experience to make consensus recommendations where evidence didn't exist.<br><br>Where guidelines contain recommendations relevant to falls prevention recommendations then a cross link has been added. The NICE guideline on spinal injury covers the early management of spinal cord injury but does not contain any recommendations relevant to falls prevention. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review D | 007 - 015 | 001, 002, 003 | No evidence on under 60 years. We suggest guidance age starts at 60 years in line with current evidence base | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review E | General | General | No evidence on under 60 years. We suggest guidance age starts at 60 years in line with current evidence base | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise |

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| | | | | | and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review F1 | General | General | No evidence on under 60 years. We suggest guidance age starts at 60 years in line with current evidence base | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review F2 | General | General | No evidence on under 60 years. We suggest guidance age starts at 60 years in line with current evidence base | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review G | 009 - 031 | 001, 002, 003 | Only one article referring to patients 21 and over, this Singapore based study was conducted between April 2006 and Dec 2006. The mean age of participants was 70, ranging from 22 years to 100, but does not state the number of patients under 60 years (Ang et al, 2011). Considering the paucity | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated |

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| | | | | and age of this evidence we suggest guidance starts at age 60 years. | evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review H | General | General | No evidence on under 60 years. We suggest guidance age starts at 60 years in line with current evidence base | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Evidence review I | General | General | Only one study with age range 31-89, however standard deviation age is 61 (Cattaneo et al, 2019) Considering the paucity of this evidence we suggest guidance starts at age 60 years. | Thank you for your comment. It was agreed during scoping and supported by stakeholders at scope consultation that the guideline would cover people aged 65 and over, and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling. The committee either extrapolated evidence from the older group where they thought it appropriate; or used their expertise and experience to make consensus recommendations where evidence didn't exist. |
| East Lancashire Hospitals NHS Trust (HQ) | Guideline | 009 | 010 | 1.3.5 Home Hazards assessment. This recommendation will be challenging in practice as we work as a multi / interdisciplinary team and not all home hazard assessments and interventions are | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the |

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| | | | | carried out by an Occupational Therapist but are carried out by a suitably trained professional such as physiotherapist or Therapy Assistant Practitioner (TAP). We recommend changing this to 'a suitably trained professional'. | home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| East Lancashire Hospitals NHS Trust (HQ) | Guideline | 010 | 018 | 1.3.12 – same recommendation as above | Thank you for your comment. For this group (i.e. people who have fallen once in the last year and have a gait or balance impairment), the recommendation is a weaker 'consider' recommendation to reflect the uncertainty in the evidence. The recommendation is based on greater clinical benefit seen for people who had fallen more than once in the previous year when interventions were delivered by an occupational therapist. Health economic modelling also found that home hazard assessment and modifications are cost effective. |
| East Lancashire | Guideline | 018 | 001 | Following reading all the sections, there is a paucity of evidence suggesting comprehensive falls assessment and | Thank you for your comment. Assessment and interventions applicable to specific conditions were not considered as part of the reviews. |

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| Hospitals NHS Trust (HQ) | | | | intervention 50-64 with conditions that would increase the risk of falls. We suggest a recommendation for further research in this section. | |
| Epilepsy Action | Guideline | 017 | 014 | The list of conditions that increase the risk of falling should be more comprehensive. It should at least include epilepsy, given that many people with epilepsy are likely to experience seizures that cause them to fall. | Thank you for your comment. The committee did not want to make the list appear comprehensive because there could be many conditions increase the risk of falling and there would be a risk that some were missed off. The guideline did not include a review of risk factors. |
| First Community Health and Care | Guideline | 006 | 018 | Recommendation 1.2.2. We reflected that only including assessments to "consider" could result in large variations in assessment quality dependent on discipline, clinical judgement and experience, with an additional risk that unconscious biases may contribute to further health inequalities. More experienced clinicians are likely to be able to better prioritise which assessments are most important and what timeline they should be completed in.<br>It might therefore be useful to include recommendations regarding how experienced clinicians need to be, although it is recognised that this may have a significant resource impact, particularly in the community.<br>Although the rationale on page 022 (lines 006 and 007) states that the evidence did not identify which methods of assessment are most useful, we felt it might be useful to specify that there are no specific validated | Thank you for your comment. No evidence was available to state exactly what should be included in a comprehensive falls assessment. The committee agreed that each persons' needs would be different and not all aspects of the assessment would be appropriate in all cases. The recommendation has been updated to state Include the following assessments and examinations (where appropriate).<br><br>The rationale has been updated to state "The complex nature of comprehensive assessment means that clinical judgment would be needed to determine what to assess and when." NICE recommendations usually avoid making statements about the available evidence and limit that intervention to the rationale. The rationale for this section will appear immediately below the recommendations.<br><br>The rationale has also been updated to state that comprehensive falls assessment could be |

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| | | | | tools, or that tools and timelines for completion are down to clinical judgement, within the recommendation itself. | carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. The committee hope this should ensure the right expertise is involved in the assessments. |
| First Community Health and Care | Guideline | 007 | 015 | Within recommendation 1.2.2 - This statement seems insufficient as a stand-alone recommendation to complete a Dix-Hallpike, as this does not reflect a comprehensive vestibular assessment and is not followed up with treatment methods for benign paroxysmal positional vertigo (BPPV). It is highly possible that patients may have other vestibular issues, including generalised vestibular hypofunction, vestibular migraines, reduced vestibular-ocular reflex (VOR) etc. and these will not be captured within the recommended assessment. We feel it may be better to recommend a full vestibular assessment by a qualified clinician if initial screening indicates a primary vestibular impairment. | Thank you for your comment. The bullet point related to dizziness has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider performing a Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers recommendations on what to do when dizziness and vertigo are identified. |

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| First Community Health and Care | Guideline | 008 | 012 | Recommendation 1.3.2. Given the evidence on the clinical benefits of a medication review in the community setting, we wondered why a structured medication review is only recommended to be considered. Perhaps a different word to "consider" should be used to highlight its importance. | Thank you for your comment. The quality of the evidence wasn't good enough to make a stronger recommendation therefore only a consider recommendation was made. |
| First Community Health and Care | Guideline | 009 | 009 | Recommendation 1.3.5. The feasibility of an Occupational Therapist completing a home hazard assessment for all those at risk of falls would not be possible within all teams with our current resource. Some teams may be able to meet this requirement, but due to low staffing and a very high waiting list there would be long waits for this assessment. Other teams work more holistically across disciplines and, although not best practice as outlined in this guideline, would need to consider utilising other skilled clinicians to allow for completion of the home hazard assessment. | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| First Community | Guideline | 009 | 011 | Recommendation 1.3.5. It would be useful if an example of a recommended validated tool could be included. The current Royal College | Thank you for your comment. Evidence was not available to recommend a particular tool. The committee anticipated that the occupational |

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| Health and Care | | | | of Occupational Therapists (RCOT) guidance, as referenced in QS86, does not provide a validated tool so reference to one would be useful. | therapist would be best placed to decide what to use to do the home hazard assessment. |
| First Community Health and Care | Guideline | 010 | 004 | Recommendation 1.3.10. Who will be expected to provide the cognitive behavioural approach? | Thank you for your comment. The committee agreed that for some assessments and interventions that there would need to be an appropriate referral. Recommendation 1.1.3 has been updated to state "Offer a comprehensive falls assessment and comprehensive falls management to people who have fallen in the last year and meet any of the following criteria (this can be carried out in the same service or involve an appropriate referral)". The rationales have also been updated to reflect this. |
| First Community Health and Care | Guideline | 010 | 004 | Recommendation 1.3.10. We reflected that sometimes it can be challenging to distinguish between fear of falling and non-concordance/patient preferences and drivers. It might be useful to include some guidance around this and other interventions such as motivational interviewing. | Thank you for your comment. Evidence was not available to recommend motivational interviewing, and the reviews did not cover distinguishing between fear of falling and non-concordance or patient preferences. |
| First Community Health and Care | Guideline | 010 | 014 | Recommendation 1.3.11. Also linked to recommendations 1.3.8 and 1.3.9 on page 009.<br>It would be useful to have more specific recommendations about specific type, frequency, intensity and duration of prescribed exercise programmes, although we appreciate that the evidence may not be available to support this request. | Thank you for your comment. Evidence was not available to recommend specific information such as duration and frequency of exercise and the committee agreed it would need to be tailored to the person's specific needs. The committee recommend that programmes focus on functional components related to the |

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| | | | | | person's risk of falls, such as balance, coordination, strength and power.<br><br>The available evidence did not show harm from brisk walking. The committee were aware of old evidence that suggested harm, but because this was not shown in our review, they avoided making any statements on this. Rather they recommended that exercise programmes should focus on functional components related to the person's risk of falls, such as balance, coordination, strength and power. We have added a comment about this into the committee discussion.<br><br>Recommendation 1.3.9 (now 1.3.10) has been updated to state that the exercise programmes should be 'progressive and challenging'. Exercise progression has been defined in the terms used in this guideline section to state that 'Exercise progression can be defined through a tailored (or individualised) increase in one or more factors involving the intensity, frequency, duration and complexity of exercise selection. This will be based on performance over the programme period." |
| First Community Health and Care | Guideline | 010 | 014 | Recommendation 1.3.11. Also linked to recommendations 1.3.8 and 1.3.9 on page 009.<br>It would also be useful to reference any particular recommended resources, or recommendations to update such resources, | Thank you for your comment. Examples have been added to the Tools and resources tab on this guideline's web page. |

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| | | | | to support the prescribed exercise programmes. For example, we use the Get Up and Go leaflet as part of the inpatient Balance and Stability Classes, which was produced in 2015. | |
| First Community Health and Care | Guideline | 011 | 001 | QS86 and the Royal College for Occupational Therapists (RCOT) guidance indicate that older people who are admitted to hospital after having a fall are offered a home hazard assessment, but this does not appear to be captured in the "hospital inpatient settings" section of the recommendations. | Thank you for your comment. The committee agreed that this is covered by recommendation 1.3.16. This states "At discharge from hospital, consider referring the person to community services so that risk factors identified during their hospital stay that would also be relevant in their discharge destination can be addressed." The committee anticipate that community services would then assess the need for a home hazard assessment. Furthermore, the NICE Quality Standard is being updated to align with the guideline. |
| First Community Health and Care | Guideline | 015 | 001 | Recommendation 1.5. In the section about education/information to reduce falls risk, there is no mention of group education sessions. As we currently offer this as part of our programme alongside exercise, we would value information about the impact/recommendations for group education if available. | Thank you for your comment. Participating in a group programme is given as an example in the recommendation. Evidence was not available to make any stronger recommendation relating to this. |
| First Community Health and Care | Guideline | General | General | Overall, the guideline seems easy to follow and does not significantly deviate from our current practice. | Thank you for your comment. |
| First Community | Guideline | General | General | As the guidelines are quite broad and do not include specific timelines for assessments, | Thank you for your comment. |

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| Health and Care | | | | there are no other specific areas that we foresee to be challenging to implement. However, it's important to note that as some services have significant waiting times for routine patients, we would not be able to offer assessments in a timely manner and therefore would not be truly preventative in our input. | |
| Healthy Ageing Research Group, The University of Manchester | Evidence review C | General | General | We wonder why no mention of the eFalls approach to risk stratification. Archer L et al. Development and external validation of the eFalls tool: a multivariable prediction model for the risk of ED attendance or hospitalisation with a fall or fracture in older adults, *Age and Ageing*, 53, 2024, afae057, https://doi.org/10.1093/ageing/afae057 | Thank you for your comment. We did look at the eFalls approach and it was considered by the committee when making recommendations. However, this paper was included in evidence review D as it is based on patient records. |
| Healthy Ageing Research Group, The University of Manchester | Evidence review F2 | 267 | 006 | Anonymous (2023) – refers to rejection because it is a guideline amendment. Actually it is a correction of a misspelt author surname. But more importantly why are the two original papers [Seppala et al (2022) and Montero-Odasso et al (2022)] not referenced and included if they were relevant. | Thank you for your comment. This has been corrected and these studies added to the excluded studies table. These systematic reviews were assessed for eligibility earlier in the process and were used to source any eligible primary papers. |
| Healthy Ageing Research Group, The University of Manchester | Evidence Review I | General | General | If you are including feasibility trials we are unsure why this was not included: Using Smartphone TechnolOGy to Support an EffecTive Home ExeRcise Intervention to Prevent Falls amongst Community-Dwelling Older Adults: The TOGETHER Feasibility RCT - PubMed | Thank you for your comment. We agree this study is relevant and have added it to review I. However, the findings of this study do not change our recommendations. |

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| Healthy Ageing Research Group, The University of Manchester | Guidance | 009 | 022 | 1.3.9<br>Needs to include that exercise should be challenging and progressive | Thank you for your comment. Recommendation 1.3.9 (now 1.3.10) has been updated to state that the exercise programmes should be 'progressive and challenging'. Exercise progression has been defined in the terms used in this guideline section to state that 'Exercise progression can be defined through a tailored (or individualised) increase in one or more factors involving the intensity, frequency, duration and complexity of exercise selection. This will be based on performance over the programme period." |
| Healthy Ageing Research Group, The University of Manchester | Guidance | 011 | 005 | 1.3.13<br>The delirium assessment recommended as part of inpatient falls assessment (section 1.3.13) ought to reference NICE delirium guidance (in associated guidance section), and hence recommend use of the 4AT tool being 'the best option for most settings' as the tool of choice in the inpatient setting. Delirium: prevention, diagnosis and management in hospital and long-term care (nice.org.uk) [nice.org.uk] | Thank you for your comment. Following stakeholder comments the point about delirium has now been moved into recommendation 1.2.2 for comprehensive falls assessment and a cross reference added to the NICE guideline on delirium for assessment and diagnosis. |
| Healthy Ageing Research Group, The University of Manchester | Guidance | 014 | 002 | 1.4.1<br>Regarding delivery of exercise as face to face or virtual should include option of or both i.e. face to face with virtual top ups and when encouraging change with a person (line 11) it would be very useful to introduce behaviour change theory to ensure such change occurs | Thank you for your comment. The committee recommend that cognitive behaviour interventions are considered for people who have a fear or concerns about falling and who do not respond that is not helped by strength |

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| | | | | see for example Ahmed S, Lazo Green K, McGarrigle L, Money A, Pendleton N, Todd C. Behaviour change interventions to encourage physical activity or decrease sedentary behaviour in community dwelling adults aged 50 to 70: Systematic review with Intervention Component Analysis. *Journal of Ageing and Physical Activity* 2024 https://doi.org/10.1123/japa.2023-0140 | and balance exercises. Evidence was not available to recommend more than that.<br><br>Thank you for the citation. We checked this systematic review and all included references. None of the interventions were designed to reduce falls and no fall related outcomes were reported in any of the studies. Therefore, none of these studies were included as evidence in our review. |
| Healthy Ageing Research Group, The University of Manchester | Guideline | 004 | 002 | 1.1 further rationale would be helpful about why falls prediction tools are not recommended as (i.e. low sensitivity and specificity) as these are frequently undertaken in practice. | Thank you for your comment. The committee agreed that these tools are not useful in predicting falls and have made that clear in the recommendation. They agreed that risk assessment tools are not particularly useful and can be a distraction because they only stratify people into high- or low-risk categories without recommending any further intervention. This was explained in the rationale. |
| Healthy Ageing Research Group, The University of Manchester | Guideline | 005 | 020 | We recommend more careful wording and reiterating that programmes must be evidence-based for falls prevention, i.e. reducing falls rates, rather than simply improving strength and balance. Thus we recommend using "**evidence-based** falls prevention exercise programme" throughout the guideline to avoid services adopting their own programme which does not have evidence of effectiveness. We also believe there should be mention of improvement of confidence or better still reduction in concerns about falling. | Thank you for your comment. There wasn't evidence to suggest locally developed programmes would not be effective and therefore did not want to imply they could not be used. Examples of programmes have been included in the tools and resources section of the NICE guideline web page.<br><br>Concerns about falling was only addressed in the intervention recommendations in 1.3.10 where considering cognitive behavioural interventions is recommended for people who |

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| | | | | | have concerns about falling and do not respond to strength and balance exercises.<br><br>Concerns about falling was not included as an outcome in the reviews because the committee wanted to focus on the effectiveness of interventions on reducing falls. Therefore, the guideline did not cover evidence for interventions on improving a person's concerns about falling. Expanding this recommendation to everyone who had a fear of falling would mean recommending a wider group of people received this intervention without any evidence to suggest it was cost-effective. |
| Healthy Ageing Research Group, The University of Manchester | Guideline | 007 | 003 | Recommendation 1.2.2 says<br>• "assessing the person's perceived functional ability and asking about fear of falling"<br>Rather than simply asking about concerns about falling we would recommend that you recommend using a validated instrument to assess this problem in the same way as you recommend using a validated instrument for hazard assessment in para 1.3.5.<br><br>Please note for information our recent review provides strong evidence in favour of Falls Efficacy Scale-International (FES-I) and Short Falls Efficacy Scale-International (Short FES-I). The Short FES-I is especially suitable for clinical practice comprising of | Thank you for your comment. Interventions to address the fear of falling were outside the scope of this guideline. Therefore, the cited tool has not been included in the guideline. |

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| | | | | only 7 items and is free of charge www.fes-i.org<br>McGarrigle L, Yang Y, Lasrado R, Gittins M, Todd C. A systematic review and meta-analysis of the measurement properties of concerns-about-falling instruments in older people and people at increased risk of falls. *Age and Ageing* 2023; 52: 1–11 afad055 doi: https://doi.org/10.1093/ageing/afad055 | |
| Healthy Ageing Research Group, The University of Manchester | Guideline | 013 | 027 | Why exercise or movement in this guidance, what about 'appropriately tailored evidence based programme', the guideline may well result in lots of chair based delivery which will have no influence at all on falls risk and in fact may increase it. Also, no evidence of concerns about falling here yet we know they relate to inactivity and falls risk. | Thank you for your comment. The recommendation has been updated to state "For people able to exercise, consider the following that should be tailored to the person's abilities and preferences on an individual or group basis: interventions to encourage physical activity that addresses the person's risk of falls, such as balance, coordination, strength and power; an exercise or movement class or programme". Evidence was not available to recommend everyone should be considered for an appropriately tailored evidence-based programme.<br><br>The recommendation in the section on maximising participation cover concerns about falling. This includes discussing and addressing potential barriers, for example, if a person doubts that they can complete the exercises or has concerns about falling. |
| Healthy Ageing | Guideline | 015 | 018 | 1.5.1 | Thank you for your comment. Training was not included as part of the scope for this guideline |

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| Research Group, The University of Manchester | | | | should training be provided rather than simple information? Is there evidence that providing information works? There is of course evidence from the FaME programme that teaching people how to get up off the floor following a fall works. | therefore no recommendations have been made relating to this. Providing information is recommended in the NICE guideline on patient experience in adult NHS services. |
| Healthy Ageing Research Group, The University of Manchester | Guideline | General | General | We are surprised that there is no mention or correct referencing of the World Guidelines for Falls Prevention in the revised NICE Guidelines. Furthermore the evidence reviews and further documentation are also almost devoid of mention of the World Guidelines. Whilst we recognise NICE wishes to develop its own national guidelines it seems to us that this is missing an opportunity to link the two sets of guidelines which appear to concur on major issues. We strongly recommend that the NICE Guidelines are revised to include clear reference to the World Guidelines and highlight how the new NICE revision is in accord with the World Guidelines or if the NICE group have evidence which contradicts World Guidelines that this is explicitly stated. At present the only reference to the guidelines (unreferenced) is to be found at<br>1. F1 1.1.11.4 p.80 l.46<br>2. F1 1.1.12.2 p.135 l.20<br>3. F2 p267 see below comment 2 about incorrect referencing | Thank you for your comment. The World Falls Guidelines has been referenced where appropriate in some of the committee discussions within the reviews (multifactorial interventions and exercise reviews). However this guideline is narrower in scope in that it focuses on prevention of falls and does not attempt to address fear of, or concerns about falling. |

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| | | | | Montero-Odasso M, van der Velde N, Martin F, Petrovic M, Tan MP, Ryg J, Aguilar-Navarro S, Alexander NB, Becker C, Blain H, Bourke R, Cameron I , Camicioli I, Clemson L, Close J, Delbaere K, Duan L, Duque G, Freiberger E, Ganz D, Gómez F, Hausdorff J, Hogan D, Hunter S, Jauregui J, Kamkar N, Kenny RA, Lamb S, Latham N, Lipsitz L, Logan P, Lord S, Mallet L, Marsh D, Milisen K, Moctezuma-Gallegos R, Morris M, Nieuwboer A, Perracini M, Pieruccini-Faria F, Pighills A, Said C, Sejdic E, Sherrington C, Skelton D, d'Souza S, Speechley M, Stark S, Todd C, Troen B, van der Cammen T, Verghese J, Vlaeyen E, Watt J, Masud T, the Task Force on Global Guidelines for Falls in Older Adults. World Guidelines for Falls Prevention and Management for Older Adults: A Global Initiative. *Age and Ageing* 2022, 51 (9), afac205, https://doi.org/10.1093/ageing/afac205 | |
| Healthy Ageing Research Group, The University of Manchester | Guideline | General | General | The document uses the phrase "fear of falling". It is recommended that the term "concerns about falling" is used, because it is preferred by patients and is more congruent with the measurement instrument commonly used. See<br>Ellmers T, Freiberger E, Hauer K, Hogan D, McGarrigle L, Lim ML, Todd C, Martin F, Delbaere K, The World Falls Guidelines Working Group on Concerns About Falling, Why should clinical practitioners ask about | Thank you for your comment. Fear of falling has been changed to concerns about falling throughout the guideline. |

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| | | | | their patients' concerns about falling? *Age and Ageing*, 2023; 52, 4, afad057, https://doi.org/10.1093/ageing/afad057 | |
| Healthy Ageing Research Group, The University of Manchester | Guidelines | 009 | 019 | 1.3.8 More specific information about duration, frequency and type of exercise programmes needed. Brisk walking not indicated for person's at risk of falls as it has been shown to increase risk<br>1.3.9. Duration of programme needs specifying for behaviour change habit formation i.e. 24 weeks or more. | Thank you for your comment. Evidence was not available to recommend specific information such as duration and frequency of exercise and the committee agreed it would need to be tailored to the person's specific needs. The committee recommend that programmes focus on functional components related to the person's risk of falls, such as balance, coordination, strength and power.<br><br>The available evidence did not show harm from brisk walking. The committee were aware of old evidence that suggested harm, but because this was not shown in our review, they avoided making any statements on this. Rather they recommended that exercise programmes should focus on functional components related to the person's risk of falls, such as balance, coordination, strength and power. We have added a comment about this into the committee discussion.<br><br>Recommendation 1.3.9 (now 1.3.10) has been updated to state that the exercise programmes should be 'progressive and challenging'. Exercise progression has been defined in the terms used in this guideline section to state that 'Exercise progression can be defined through a tailored (or individualised) increase in one or |

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| | | | | | more factors involving the intensity, frequency, duration and complexity of exercise selection. This will be based on performance over the programme period." |
| Healthy Ageing Research Group, The University of Manchester | Guidelines | 017 | 000 | In terms of recommendations for future research – it is good to see a need for more research on:<br><br>• 1. Wearable technologies for falls risk assessment: but wearables are not the only technology requiring more research, ambient technologies for example, exergaming and other novel approaches also need more work. See for example<br><br>Exergames: Stanmore, E.K., Mavroeidi, A., de Jong, L.D. *et al.* The effectiveness and cost-effectiveness of strength and balance Exergames to reduce falls risk for people aged 55 years and older in UK assisted living facilities: a multi-centre, cluster randomised controlled trial. *BMC Med* **17**, 49 (2019). https://doi.org/10.1186/s12916-019-1278-9<br><br>In addition apps need more research as evident from McGarrigle, L., Boulton, E. Todd, C. Map the apps: a | Thank you for your comments. Examples of assistive technologies have been included the research recommendation protocol. The committee prioritised research for interventions rather than assessment. They noted lots of studies had tried to do research in this area without much success. |

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| | | | | rapid review of digital approaches to support the engagement of older adults in strength and balance exercises. *BMC Geriatr* **20**, 483 (2020). https://doi.org/10.1186/s12877-020-01880-6<br><br>• 4. Interventions for people in residential care settings with dementia. We know from our recent Dementia review of reviews (Eost-Telling C, Yang Y, Norman G, Hall A, Hanratty B, Knapp M, Robinson L, Todd C. Digital technologies to prevent falls in people living with dementia: A rapid review of systematic reviews. *Age & Ageing* 2024; 53: 1–16 https://doi.org/10.1093/ageing/afad238 and from unpublished ongoing systematic review of exergames for fall prevention (http://www.crd.york.ac.uk/PROSPERO/display_record.asp?ID=CRD42020214721), that there is very little high-quality research in this area<br>• 5. We wonder if it would be useful to more fully define what is meant by "Assistive technologies (this could cover everything from installing a | |

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| | | | | handrail or using a Zimmer frame to a fall alarm to a full sensor-based environmental monitoring system or apps.<br><br>Regarding the recommendation against using 'fall prediction tools,' whilst we would not challenge the evidence review and recognise the problems such tools have within the guidance there is clear acknowledgement that people who are at a moderate risk of falling may benefit more from interventions. However, this does not really address how these individuals should be identified. If prediction models are not yet accurate enough, we would expect this to be a recommendation for future research. | |
| Healthy Ageing Research Group, The University of Manchester | Guidelines | general | general | With regards to prevention 1.3.10, it was good to see this recognition of people who do not engage in prevention interventions due to concerns/fear about falling. This, however, is linked tin the guidance to cognitive behaviour approaches. I know we are not yet at the stage definitively to recommend other treatment options, but we potentially need to consider how this will be determined at the outset of referral to combat some of these concerns. As we know, there is not currently freely available interventions to reduce | Thank you for your comment. The guideline focuses on interventions to prevent falls rather than addressing fear of falling. Recommendation 1.3.11 is the exception because it directly related to improving a falls prevention intervention. |

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| | | | | concerns about falls and then re-refer individuals back into exercise avenues.<br><br>Following on from above comments Zijlstra et al's (2007) albeit rather old review demonstrated effects of multifactorial, exercise and tai chi etc interventions on fear of falling (sic we will use th phrase concerns about falls henceforth) whereas Kumar et al's (2016) more recent Cochrane review suggests that exercise interventions probably reduce concerns about falls immediately after intervention to a small/moderate degree but that evidence quality is low. Kruisbrink et al (2021) identified characteristics of intervention associated with reductions in concerns about falls; delivery by Tai chi instructor and in community settings appear to be associated with greater concerns about falls reduction, and holistic exercise such as Pilates was also associated with greater concerns about falls reduction. On the other hand delivery at home written materials and tailoring were less effective. How to reduce concerns about falls remains an important area for future research but implementation of programmes that do have evidence to support them is probably to be recommended. | |
| Healthy Ageing | Guidelines | General | General | It is disappointing to see that all exercise programmes are grouped together with no | Thank you for your comment. The committee have based recommendations on the available |

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| Research Group, The University of Manchester | | | | distinction regarding how they are delivered, (e.g. technology, virtual, or in-person, one-to-one or group or in terms of duration, frequency or specific content and to which sub-group of population. While there is a recommendation that fall prevention interventions should be tailored, the recognition of factors like dementia feels quite minimal, especially in the community setting. Importantly, there's no suggestion that programmes or interventions should have been co-produced with end users to ensure they align with their needs (which could also play a role in improving adherence and outcomes).<br><br>The exercise programme section covers largely what we would hope to see when implementing FaME (for example), tailored, progressive, regular progress reviews but no mention of home exercise to increase dose.<br><br>Given that the document is aimed at commissioners and leisure providers etc. there is no mention of implementation work on how best to increase national availability of evidence-based interventions or how to address barriers to the longevity of services. | evidence. The way exercise was delivered was not included as a factor in the review. The committee recognise it can be delivered in different ways and did not want to limit to one method only.<br><br>Examples of exercise programmes have been added to the tools and resources tab of this guideline's web page. |
| Healthy Ageing Research | Guidelines & evidence reviews | General | General | Uptake and adherence are very important issues and maximising them has long been recognised as important (for example Don't | Thank you for your comment. Although the committee agree that uptake and adherence is important, our protocol for interventions to |

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| Group, The University of Manchester | | | | mention the F-word was core to early thinking here). As with any concept it is useful to ensure that it is clearly defined so that it can be appropriately measured. It appears for example that in some tables adherence is 100% but that this represents one week only. We recommend that careful consideration to how adherence is measured becomes part of the guideline perhaps following recommendations in Hawley-Hague H, Skelton D, Horne M, Todd C. Review of how we should define (and measure) adherence in studies examining older adults' participation in exercise classes? *BMJ Open*. 2016; 6:e011560 doi: 10.1136/bmjopen-2016-011560 | prevent falls was based on a number of Cochrane reviews and therefore the outcomes were limited to those covered within all the Cochrane reviews. This included a review looking at the effectiveness of specific interventions to increase adherence and the way they reported adherence. However, defining and measuring adherence was not included. |
| Leeds and York Partnership NHS Foundation Trust | Guideline | 011 | 019 | In mental health inpatient settings, and for some dementia presentations, psychotropic medication is often needed to treat mental health or dementia symptoms. The part they play in increased falls should be recognised and balanced with the risk of the mental health symptoms not being adequately treated by reducing or stopping the psychotropic medication. The clinical rationale to maintain or adjust the medication should be documented. Any increased falls risk associated with psychotropic medication if continued should be addressed with specific falls prevention interventions and reviewed regularly. | Thank you for your comment. Detail about what to do as part of a structured medication review in hospital has not been included in this guideline because it is covered in the NICE guideline on medicine optimisation which has been cross referred to in this guideline. |

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| Leeds and York Partnership NHS Foundation Trust | Guideline | 015 | 003 | In inpatient dementia settings direct discussions with patients is often not possible. Carers or family members needs to be included, including providing written information about falls prevention in a format that is accessible | Thank you for your comment. This guideline cross refers to the NICE guideline on decision making and mental capacity which covers this. |
| Leeds and York Partnership NHS Foundation Trust | Guideline | 016 | 002 | In inpatient mental health and dementia settings patients often do not have insight into their needs or capacity to understand risks and ways to reduce risk of falling. See comment above | Thank you for your comment. The NICE guidelines on Decision-making and mental capacity and Advocacy services for adults with health and social care needs cover general recommendations about how to manage care for these patients. |
| Leeds Community Healthcare NHS Trust | Guideline | 001 | 004 - 005 | The title of the guideline is quite lengthy incorporating different age ranges which may be confusing across the different environments the guidance is aimed at. Suggest just having the title as "Falls: assessment and prevention in older adults", and then add the comment about "people 50 and over at higher risk" in the scope | Thank you for your comment. The title and age range were agreed when the scope was published in September 2022. The age range is usually included in NICE guideline titles. |
| Leeds Community Healthcare NHS Trust | Guideline | 004 | 003 | Rec 1.1.1 – does the use of falls risk prediction tools relate to in hospital only or in general? Has there been consideration of where the recent publication regarding the e-falls prediction tool may be appropriate in certain areas? | Thank you for your comment. The recommendation relates to prediction tools in general. The e-falls prediction tool was reviewed in evidence review D. however, there was only 1 study available on this and it was only assessing falls requiring an emergency department attendance. The committee agreed that this did not provide evidence to make a recommendation. |

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| Leeds Community Healthcare NHS Trust | Guideline | 005 | 006 | Rec 1.1.3 – suggest that there is a link to guidance on how the level of frailty is assessed so that there is consistency in the use of recognised tools and identifying the different the level of frailty | Thank you for your comment. A link has been added to the section on How to assess frailty in the NICE guideline on multimorbidity. |
| Leeds Community Healthcare NHS Trust | Guideline | 005 | 007 | Rec 1.1.3 – suggest giving examples of what classifies as an injury. Is this related to for example a fracture or head injury, or could this be any injury including a small graze or bruise? | Thank you for your comment. This has been updated to "injured in a fall requiring medical (including surgical) treatment". |
| Leeds Community Healthcare NHS Trust | Guideline | 007 | 009 | Rec 1.2.2 – suggest defining what is best practice for measuring a lying and standing blood pressure i.e. lying, standing, standing after 3 minutes, as this can vary in clinical practice | Thank you for your comment. Detail on how to do assessments of specific factors has not been included in this guideline because this would be covered by other guidelines. Where an existing NICE guideline exists with details of how to assess that are relevant to falls prevention, we have added a cross link to this. |
| Leeds Community Healthcare NHS Trust | Guideline | 009 | 010 | Rec 1.3.5 – suggest there is consideration that this could be a multi-agency approach, as other health and care professionals can complete an environmental home hazard assessment. This does not just need to be an occupational therapist | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy |

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| | | | | | assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Leeds Community Healthcare NHS Trust | Guideline | 017 | 014 | Conditions that increase the risk of falling – suggest that this includes more examples of long-term health conditions | Thank you for your comment. The committee did not want to make the list appear comprehensive because there could be many conditions increase the risk of falling and there would be a risk that some were missed off. The guideline did not include a review of risk factors. |
| Leeds Community Healthcare NHS Trust | Guideline | 020 | 011 | Reference to stratification into level of falls risk categories – has this been considered to align with the World Falls Guidelines for a consistent approach, as level of falls risk is stratified as low, intermediate and high with recommendations for further interventions | Thank you for your comment. Risk stratification was included within the protocol for falls risk tools and those within the review mostly used low, intermediate and high. However, the guideline committee did not think the evidence was strong to recommend any one tool. |
| Midlands Partnership University NHS Foundation Trust | Guideline | 004 | 003 | - The guidance recommends that risk prediction tools are not used, does this include the risk stratification approach included in the World falls guidelines 2022? | Thank you for your comment. The committee has not included risk stratification approach used by the World falls guideline in this guideline because it only classifies people into high- or low-risk categories without recommending any further intervention. The committee decided to focus on |

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| | | | | | recommendations defining who needs assessment and intervention. |
| Midlands Partnership University NHS Foundation Trust | Guideline | 004 | 005 | - Community services are already struggling to meet current demand. Whilst it is clinically appropriate to assess those over 50 years, how can this be achieved without additional resource? | Thank you for your comment. It was agreed at scoping to include this age group in the guideline. The recommendations are focussed on those with the greatest need in people aged 50 to 64 by limiting it to those with factors that increase the risk of falls. The committee agreed that preventing falls in this group could also prevent the need for treatment as a consequence of injuries by falls.<br><br>NICE guidelines aim to develop recommendations for best practice based on the best available evidence. It is up to individual ICBs how they implement these recommendations given their local health needs and resources. |
| Midlands Partnership University NHS Foundation Trust | Guideline | 005 | 006 | (1.1.1) - How should we determine frailty – is NICE in agreement that those with a Rockwood score of 4 and above should be classed as high risk and so require a comprehensive falls assessment? | Thank you for your comment. A link has been added to the section on How to assess frailty in the NICE guideline on multimorbidity. |
| Midlands Partnership University NHS | Guideline | 005 | 008 | (1.1.3) - Many services lack a clear pathway for those who have lost consciousness – more detailed guidance would be welcomed. | Thank you for your comment. A cross referral has been added to the NICE guideline on Transient loss of consciousness ('blackouts') in over 16s. |

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| Foundation Trust | | | | | |
| Midlands Partnership University NHS Foundation Trust | Guideline | 006 | 003 | (1.1.7) - Does NICE advocate the use of the 3 trigger questions documented in the World falls guidelines 2022? ie: Have you fallen in the past 12 months, do you have a fear of falling and do you have strength and balance/gait/mobility issues? | Thank you for your comment. This guideline does not cover the 3 trigger questions. It differs from the World falls guideline in that it focuses on what assessments and interventions should be offered to people who have fallen, rather than everyone who may have a fear of falling. The committee did not think that near miss or fear of falling equates to actual falling nor that everyone who has a near fall would need an assessment. They also agreed that it was not feasible for practitioners to give a comprehensive assessment to all these people. |
| Midlands Partnership University NHS Foundation Trust | Guideline | 008 | 002 | (1.3) - How do you anticipate outpatients will have the time to complete a comprehensive falls risk assessment? We are struggling to get them to complete a simple checklist. This would significantly impact waits and so potentially impact patient outcomes for their health condition for which they are visiting outpatients. Could this be for just some outpatients where risks are highest? | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added |

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| | | | | | to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| Midlands Partnership University NHS Foundation Trust | Guideline | 009 | 010 | (1.3.5) - Stipulating that a home hazard assessment should be completed by an OT is surprising given that we are trying to create a more flexible and responsive health and social care offer. Surely this should be about competency rather than title? The World guidelines talks about competent person, which we feel is much more appropriate and achievable. Also, could there be a self-assessment option for home hazards in the spirit of self-management/empowering the patient? | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy |

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| | | | | | assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Midlands Partnership University NHS Foundation Trust | Guideline | 009 | 018 | (1.3.6/7) - From a cardiology and neuro perspective, it would be really helpful to have some more detailed guidance on what is expected in terms of what should be done within a community falls/rehab team vs what should be referred to a specialist service. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added |

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| | | | | | to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| Midlands Partnership University NHS Foundation Trust | Guideline | 012 | 014 | (1.3.18) - The rapid turnover of care home staff makes it very challenging to deliver training in a way that maintains competency across the workforce. More guidance on tools for care homes to use for assessment would be helpful. | Thank you for your comment. Unfortunately, evidence was not available to recommend specific assessment tools. A link has been added to the section on falls and falls prevention in NHS England's Providing proactive care for people living in care homes – enhanced health in care homes framework which provides more detail. |
| NHS England | Guideline | 001 - 002 | General | A physiotherapist, Occupational therapist and Exercise Professional are included in the membership which gives assurance. | Thank you for your support. |
| NHS England | Guideline | 004 | 006 | Would be helpful to providers for some more detail as to what 'appropriate' should look like e.g. managing the 'here and now' or this plus | Thank you for your comment. This recommendation has been updated. The clause "determine the most appropriate falls |

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| | | | | a recommendation for further referral assessment etc. | assessment and management approach" has been deleted. The recommendation is now just about asking people about the details of any falls. |
| NHS England | Guideline | 005 | 006 | I like the more positive framing phrase 'living with frailty' as opposed to judging the person as 'frail'. | Thank you for your comment. |
| NHS England | Guideline | 005 | 018 | The recommendation to assess gait and balance is possibly a limited intervention than to consider other identified assessments included later in the guidelines such as structured medication review and vision assessment. | Thank you for your comment. There was no evidence to recommend that everyone without the factors listed in recommendation 1.1.3 needed further assessments. However, in line with our Patient experience guidelines, care should be individualised and tailored to a person's needs and so would expect Health Care Practitioners to investigate further on a case-by-case basis. |
| NHS England | Guideline | 006 | 018 | It is a pity that the strength of recommendations for components of a comprehensive falls assessment are 'consider' rather than a stronger recommendation of 'should' or even better 'must' as in practice I think the list of components if often shortened. I appreciate that strengthening the recommendation may be challenging due to lack of evidence on individual components as part of a bundle. | Thank you for your comment. No evidence was available to state exactly what should be included in a comprehensive falls assessment. The committee agreed that each persons' needs would be different and not all would be appropriate in all cases.<br><br>The rationale has also been updated to state "The complex nature of comprehensive assessment means that clinical judgment would be needed to determine what to assess and when." |
| NHS England | Guideline | 007 | 009 | Appreciate the addition of lying standing BP to be more prominent here as was previously | Thank you for your comment. |

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| | | | | rather hidden in the text of previous guideline versions. This will make it easier for care providers to implement. | |
| NHS England | Guideline | 007 | 014 | Really appreciate this addition as is I believe currently very overlooked risk factor. | Thank you for your comment. |
| NHS England | Guideline | 011 | 004 | I know not using risk prediction tools is 1,1,1 however readers will scroll straight to their clinical field so may miss this recommendation for inpatient settings so should be repeated or linked here. In practice these prediction and screening tools are still being used in hospital care. | Thank you for your comment. There will also be a visual summary to go with the guideline to make it easier for readers to follow the guideline pathway. |
| NHS England | Guideline | 011 | 005 | I like the way this section is phrased to highlight addressing individual multiple risk factors (not blanket interventions) and appreciate the previous phrase of 'improved or managed' has been retained to take into account some patients for whom some risks are not ameliorable to intervention therefore risks will persist throughout their admission. | Thank you for your comment. The recommendation has been updated following stakeholder comments to 'Ensure that interventions to reduce the risk of falls are tailored to the individual so they promptly address any fall risk factors (see the section on comprehensive falls assessment). This can be done by taking into account whether the risk factors can be resolved, improved or managed. |
| NHS England | Guideline | 011 | 010 | Like the addition of this, could there be a hyperlink to examples of this e.g. 4AT? | Thank you for your comment. Following stakeholder comments the point about delirium has now been moved into recommendation 1.2.2 for comprehensive falls assessment and a cross reference added to the NICE guideline on delirium for assessment and diagnosis. |

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| NHS England | Guideline | 011 | 011 | This is a potentially good addition but as written does not tell the reader much, could it link to committee discussion or evidence review to detail specifically what environmental factors they should consider | Thank you for your comment. There was no available evidence which would allow specific interventions. However, there is a little more detail in the rationale on what interventions were looked into and why a research recommendation has also been made for environmental factors. |
| NHS England | Guideline | 011 | 012 | Should this read education sessions about the persons identified individual risk factors ? could it hyperlink to section 1.5 for ease of reference | Thank you for your comment. A hyperlink has been added as suggested. |
| NHS England | Guideline | 012 | 002 | Welcome the addition of this section which will help providers to prioritise this | Thank you for your comment. |
| NHS England | Guideline | 014 | 002 - 017 | The recommendations regarding provision of supervised exercises and life style changes is positive, however, they are likely to impact on provision of resources and funding in primary care. | Thank you for your comment. The committee were aware that the recommendations may result in more people adhering to supervised exercise interventions, and this could require more staff time to provide supervision. However, there is flexibility in how supervision can be undertaken. Often, an exercise programme can be a mixture of supervised and unsupervised. For example, a programme can start as face-to-face then people can do it themselves with regular telephone check-ins. The committee agreed that, in their experience, not everyone would opt for supervised exercise. A definition of supervised exercise has been added to the terms used in this guideline to make this clearer.<br><br>The committee also agreed that supervised exercises can be carried out in the community |

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| | | | | | by a trained fitness instructor and do not always need NHS staff input. |
| NHS England | Guideline | 023 | 003 - 009 | The benefits and value of medication reviews have been highlighted (here and elsewhere on the document), however, there seems to be a missed opportunity to recognise the impact of SMRs on GP services and funds for provision of clinical pharmacists in general practice who could carry out regular SMRs and identify patients at risk of falls and offer preventive interventions. | Thank you for your comment. The detail behind structured medication reviews has not been covered in this guideline as it is covered in the NICE guidelines on medicines optimisation and managing medicines in care homes both of which have been linked to from our guidelines. |
| NHS England | Guideline | 028 - 029 | 026 - 030 | It is positive to note committee's recommendations regarding benefits of sharing information and education about falls. Other specific prevention strategies for referrals/signposting to opticians or podiatry services are likely to happen from the platform of general practice. Opportunities offered in general practice and provisions of health and wellbeing coaches in delivering such messages could be positively highlighted in the recommendations so that further resources and funds can be provided in general practice to enable preventions and coordination of interventions that community services that deliver. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added |

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| | | | | | to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| NHS England | Guideline | 1.3.17 | General | Welcome the review of the evidence for low low beds and chair/ bed sensors etc but think it would be helpful to have included them in the recommendations in some way as not recommended | Thank you for your comment. There was limited evidence for low-low beds and chair/bed sensors. The evidence that was available was very low quality and did not show them to be cost effective. Therefore, the committee included these as part of the research recommendation covering ward environment. See evidence report G on hospital interventions. |
| NHS England | Guideline | General | General | While acknowledging that prior knowledge of patients and continuity of care offers greater opportunity to identify those at risk of falls the guidelines do not include observations, interventions or recommendations for GPs who are likely to have most knowledge of patients and possibly first port of call in the | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been |

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| | | | | community to learn about falls/increased risk of falls and take relevant steps to address them. | updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| NICE Medicines Optimisation team | Guideline | 008 | 023 | When making a decision about treatment, you would never just consider the risks you would need to discuss risks and benefits. Please consider rephrasing. | Thank you for your comment. The committee agreed it is the risk of falling that is the key point to discuss here. More detail has been added to the rationale to state "The committee agreed it was important to highlight to the person that |

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| | | | | | there is a risk of falling with psychotropic medicines and therefore withdrawal of these if appropriate would be beneficial to them. This would need to be done in consultation with mental health services to assess whether the benefits of those treatments are outweighed by the risks of continuing with them so that the person can make an informed decision." |
| NICE Medicines Optimisation team | Guideline | 011 | 013 | Is there a reason why we have phrased this differently than the other settings. I am sure that medicines will be reviewed as part of an inpatient stay but just wondering why we phrased this differently than the rec above and below. | Thank you for your comment. This has been phrased differently because a structured medication review always happens in hospital. Whereas the committee note that it doesn't always happen for other settings. |
| Northern care Alliance | Guideline | 011 | 010 | Please consider reference to updated delirium NICE guidance, link to this guidance, and also recommendation for use of the 4AT tool. Delirium: prevention, diagnosis and management in hospital and long-term care (nice.org.uk) | Thank you for your comment. Following stakeholder comments the point about delirium has now been moved into recommendation 1.2.2 for comprehensive falls assessment and a cross reference added to the NICE guideline on delirium for assessment and diagnosis. |
| Nottingham City Care Partnership | Guideline | 009 | 010 | Concerned that this is specifically stating occupational therapist (and I am an OT) would 'appropriately trained professional' be better – in our MDT both physios and AP's complete a home hazard assessment and would refer onto OT for complex cases. If all home hazard assessments need to be completed by a qualified professional from | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and |

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| | | | | one discipline this would have significant impact on services | intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Older People's Advocacy Alliance | Guideline | 004 | 001 | This recommendation should include NICE guideline NG227 Published: 09 November 2022, with particular reference to 1.3.3:<br><br>"Local authorities, health authorities, NHS trusts, health and social care providers and advocacy services should provide everyone who would benefit from advocacy (whether or not they are legally entitled to it) with information about:<br>• what advocacy services are available to them<br>• how an advocate could help them<br>• how to access and contact advocacy services." | Thank you for your comment. A link to the NICE guideline on Advocacy services for adults with health and social care needs has been added to the at the start of recommendations along with links to other generic NICE guidance. |

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| Peak MedTek Ltd | Guideline | 015, 016, 028, 029 | 008 – 017, 002 – 026, 022 – 029, 012 - 020 | Section 1.5 Information and Education. 'Bide' can offer the information and education required on an ongoing basis. This can be bespoke messaging from family carers or professional carers. With the increasing use of single rooms, particularly with the new hospitals programme, Bide has the potential to be an appropriate method of informing/reminding/supporting the user, without disturbing others, both in the hospital setting and the residential care setting, as well as in the community. | Thank you for your comment. Evidence was not identified relating to 'Bide' and therefore it is not included in any recommendations. |
| Peak MedTek Ltd | Guideline | 019 | 005 - 006 | Section 9. Recommendations for Research. 5. Assistive technologies. Please view recently published small feasibility study: Exploring the feasibility of using a bedside device to help prevent nighttime falls - PubMed. | Thank you for your comment. While the technology would be included in the review had it been published at the time of the search reruns, this study would not fit our protocol because it is not a randomised controlled trial. |
| Peak MedTek Ltd | Guideline | 022 | 027 - 029 | Recommendation 1.3. Interventions to reduce the risk of falls for people presenting in community and hospital outpatient settings depend on the person's individual factors, and the characteristics and context of any falls that they have had. This could be potentially addressed by bedside device 'Bide' as described in Exploring the feasibility of using a bedside device to help prevent nighttime falls - PubMed. | Thank you for your comment. While the technology would be included in the review had it been published at the time of the search reruns, this study would not fit our protocol because it is not a randomised controlled trial. |

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| Peak MedTek Ltd | Guideline | 024 | 012 - 013 | Recommendation 1.3 Interventions to reduce the risk of falls. Community and hospital outpatient settings. "The evidence did not include fear of falling, but the committee discussed how this can have a significant detrimental effect on quality of life." This could be potentially addressed by bedside device described in Exploring the feasibility of using a bedside device to help prevent nighttime falls - PubMed. Findings in this small study were of increased confidence to mobilise at night in users of 'Bide'. | Thank you for your comment. While the technology would be included in the review had it been published at the time of the search reruns, this study would not fit our protocol because it is not a randomised controlled trial. |
| Peak MedTek Ltd | Guideline | 027 | 010 | Section 1.4 Maximising ongoing participation in falls prevention interventions. The Bide device http://getbide.com continues with helpful reminders allowing ongoing supportive advice. | Thank you for your comment. While the technology would be included in the review had it been published at the time of the search reruns, this study would not fit our protocol because it is not a randomised controlled trial. |
| Peak MedTek Ltd | Guideline | General | General | Could comment be made on nighttime vs daytime falls? | Thank you for your comment. The committee did not include the distinction between nighttime and daytime falls when setting the review questions therefore recommendations covering his have not bee made. |
| Peak MedTek Ltd | Guideline and Evidence Review F | 024 | 028 - 031 | Recommendation 1.3 Interventions to reduce the risk of falls. Community and hospital outpatient settings. "There was not enough evidence on assistive technologies such as footwear and foot devices, self-care and assistive devices" Exploring the feasibility of using a bedside device to help prevent | Thank you for your comment. This study does not fit our protocol because it is not an RCT and therefore has not been included. |

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| | | | | nighttime falls - PubMed. This recently published small study was not available when draft guidance was written – please consider. | |
| Public Health Agency Northern Ireland | Guideline | 004 | 003 | Why are predicative tools such as Rockwood are now advised not to be used. HCPs feel that as part of a comprehensive assessment that they do add value | Thank you for your comment. While the committee discussed that some healthcare professionals use these tools and that they can add value they wanted it to be clear that they do not predict a person's risk of falling. It may be that some healthcare professionals use them to help with comprehensive falls assessment. |
| Public Health Agency Northern Ireland | Guideline | 004 | 007 | Lowering the age to 50 years which I agree with (e.g. people in Prison Health and people living within areas of deprivation and also people with a learning disability) will have issues in NI where HSC services are only commissioned for people aged 65years and above. This covers many points in the guideline. | Thank you for your comment. NICE guidelines aim to develop recommendations for best practice based on the best available evidence and focussed on those with the most need.<br><br>On publication, this guideline will go through the usual process to assess whether it will be adopted in NI.<br><br>Where issues with implementation are identified, the NICE Implementation consultant is able to support with these. |
| Public Health Agency Northern Ireland | Guideline | 005 | 001 | Great to see case finding -but could maybe widened to include asking people have they a fear of falling, near misses etc-Primary Prevention | Thank you for your comment. The guideline focuses on interventions to prevent falls rather than addressing fear of falling. The committee did not think that near miss or fear of falling equates to actual falling and did not think that everyone who has a near fall would need an assessment. They also agreed that it was not |

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| | | | | | feasible for practitioners to give a comprehensive assessment to all these people. |
| Public Health Agency Northern Ireland | Guideline | 005 | 010 | Should it not be offered to people with, near misses, fear of falling and had 1 fall? | Thank you for your comment. The guideline focuses on interventions to prevent falls rather than addressing fear of falling. The committee did not think that near miss or fear of falling equates to actual falling. This recommendation applies to people who have had 2 or more falls in the last year to align with the World Falls Guideline. In both the above cases the committee agreed that it was not necessary or feasible for practitioners to give a comprehensive assessment to all these people. |
| Public Health Agency Northern Ireland | Guideline | 005 | 016 - 024 | Only assessing gait and balance and restricted assessment could miss identifying risk factors and thus secondary prevention opportunity missed | Thank you for your comment. There was no evidence to recommend that everyone without the factors listed in recommendation 1.1.3 needed further assessments. However, in line with our Patient experience guidelines, care should be individualised and tailored to a persons needs and so would expect Health Care Practitioners to investigate further on a case-by-case basis. |
| Public Health Agency Northern Ireland | Guideline | 006 | 003 | Lowering the age to 50 years which I agree with (e.g. people in Prison Health and people living within areas of deprivation and also people with a learning disability) will have issues in NI where HSC services are only commissioned for people aged 65years and above, in care homes | Thank you for your comment. NICE guidelines aim to develop evidence-based |

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| | | | | | recommendations that focus on those with the most need.<br><br>On publication, this guideline will go through the usual process to assess whether it will be adopted in NI.<br><br>Where issues with implementation are identified, the NICE Implementation consultant is able to support with these. |
| Public Health Agency Northern Ireland | Guideline | 007 | 005 - 006 | Really welcome the focus on sensory issues such as hearing and vision | Thank you for your comment. |
| Public Health Agency Northern Ireland | Guideline | 007 | 008 | Do all need a neurological exam? | Thank you for your comment. Not everyone will need every assessment in the list consequently the committee made this a consider recommendation. A statement has been added to the rationale to explain that the complex nature of comprehensive assessment means that clinical judgment would be needed to determine what to assess and when. |
| Public Health Agency Northern Ireland | Guideline | 008 | 013 | Medication reviews should be at least annual | Thank you for your comment. Frequency of medication reviews was not part of the guideline review question so no recommendations have been made on this. |
| Public Health Agency Northern Ireland | Guideline | 008 | 021 | Good to see pshycotropic medicines here | Thank you for your comment. |

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| Public Health Agency Northern Ireland | Guideline | 009 | 004 | Vit D evidence is emerging and needs to monitored as more evidence comes | Thank you for your comment. If more evidence becomes available, then the guideline may be updated in line with Developing NICE guidelines: the manual. |
| Public Health Agency Northern Ireland | Guideline | 009 | 010 | Does it need to OT led? Councils offer this service here, if it becomes OT led this will have significant workforce planning | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Public Health Agency Northern Ireland | Guideline | 010 | 004 | Welcome this | Thank you for your comment. |

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| Public Health Agency Northern Ireland | Guideline | 010 | 006 | This needs reflected in the opening pages about people who have fallen once and need a comprehensive assessment | Thank you for your comment. Comprehensive falls assessment is not recommended for people who have fallen once in the last year; rather a 'gait and balance' assessment is recommended. It may be that by doing this it raises a concern that the person needs a more detailed assessment. In those cases, the committee would expect the healthcare professional doing the assessment would determine that and act accordingly. |
| Public Health Agency Northern Ireland | Guideline | 014 | 017 | Programmes need to have full appreciation of falls risk factors beyond physical activity. These are teaching points for the full risk factors and empower people with understanding and what they can do | Thank you for your comment. Evidence was only available to make the recommendations specific to exercise here and not the wider areas of falls prevention. Taking into account where risk factors can be resolved is recommended at the beginning of the intervention recommendations for each setting. |
| Public Health Agency Northern Ireland | Guideline | 017 | 006 | Welcome involvement with loved ones | Thank you for your comment. |
| Public Health Agency Northern Ireland | Guideline | 017 | 020 | Would love to see National links to advice | Thank you for your comment. Links to some resources have been added to the Tools and resources section of the guideline. |
| Public Health Agency Northern Ireland | Guideline | General | General | I welcome the onward recommendations for research | Thank you for your comment. |
| Public Health Agency | Guideline | General | General | I don't think putting care homes into an umbrella guideline for recommendations in | Thank you for your comment. The committee have defined residential care further in the |

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| Northern Ireland | | | | the guideline, Residential, assisted living, nursing homes and dementia units have very different needs, I think this needs pulled out more | 'terms used in this guideline' section to avoid overlap with assisted living. It is defined as accommodation that provides 24-hour care. This includes:<br>• residential care: - providing personal care, such as help with washing, dressing, going to the toilet and taking medication.<br>• nursing care: - providing personal care, with qualified nurses on duty at all times.<br><br>Assisted living is not included with this as the committee anticipate that people who have assisted leaving would fall under the community settings.<br><br>Overall, the committee agreed that while residential care covers a wide range of settings grouping them all into one set of recommendations was the most practical way of presenting the guideline. |
| Public Health Agency Northern Ireland | Guideline | General | General | I don't think Home hazard assessment needs to be OT led, but certainly informed by, onward referrals etc | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy |

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| | | | | | assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Public Health Agency Northern Ireland | Guideline | General | General | I think the guidelines don't go far enough around primary and secondary prevention, especially around case finding, near miss, fear of falling I believe they all need a full comprehensive assessment | Thank you for your comment. The guideline focuses on interventions to prevent falls rather than addressing fear of falling. The committee did not think that near miss or fear of falling equates to actual falling and that it was not possible for practitioners to give a comprehensive assessment to all these people. |
| Royal College of General Practitioners | Guideline | 005 | 004 | This looks like a specialist-based intervention rather than a GP-led intervention. Do we want falls to be only a specialist service? Rec1.1.3 *Offer comprehensive falls assessment and management for people who 4 have fallen in the past year….*We fully support the need for falls assessments but there is a risk that this leads to knee jerk falls referrals without optimising general practice interventions / quick wins. Eg, GP should do BP & check medication as a minimum, ideally a fuller assessment.<br>This is particularly important as a person with falls may go onto a long waiting list. Falls | Thank you for your comment. The committee agree that some assessments can be done by quick wins in general practice. Following this and other stakeholder comments we have updated the recommendations to make it clearer that the comprehensive falls assessment and management could be done at the first point of contact, or by an appropriate referral. The rationale was also updated to give an example where a risk factor identified at an outpatient appointment could be highlighted to the GP. The committee did not want to specify in too much detail who should do what as they were aware |

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| | | | | services are run by MDT with variable medical input so risks missing important brief interventions. | that there are a variety of ways this can be delivered.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| Royal College of General Practitioners | Guideline | 005 | 016 | We are concerned that this misses their medications and blood pressure. | Thank you for your comment. There was no evidence to recommend that everyone without the factors listed in recommendation 1.1.3 needed further assessments. However, in line with our Patient experience guidelines, care should be individualised and tailored to a person's needs and so would expect Health Care Practitioners to investigate further on a case-by-case basis. |
| Royal College of General Practitioners | Guideline | 005 | 024 | We question if readers have the energy to understand/remember what this recommendation is suggesting i.e. who the population is? | Thank you for your comment. We have updated the guideline so that the population is defined at the beginning of the recommendations without |

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| | | | | | the need to repeat the age groups in all recommendations.<br><br>This particular recommendation is for everyone who do not meet the criteria in the preceding recommendations. We have produced a visual summary to make recommendations clearer. |
| Royal College of General Practitioners | Guideline | 007 | 001 | An examination of carotids and physical activity (a bit different from mobility) could be included. Additionally, we recommended putting medication review first along with including a link to a trusted resource on medicines implicated in falls such as National Falls Prevention Coordination Group. Lastly, when moving from GP to GP extended role frailty, it was curious that falls clinics largely don't include a physical assessment for underlying/optimising medical conditions. This seems an important part of minimising the risk of falls. Where should that fit within the falls assessment pathway? | Thank you for your comment. There was no evidence to suggest that assessment of carotids or physical activity should be added to the list. The committee agreed that although different the point on gait balance, mobility and muscle strength assessment would likely include an assessment of physical activity.<br><br>The committee agreed no one tests was more important than the other and not all would apply to everyone. Therefore, the list has been put in alphabetical order. |
| Royal College of General Practitioners | Guideline | 007 | 013 - 024 | The recommendation to offer a comprehensive falls assessment that includes assessments of mobility, gait, cognitive function, and cardiovascular status requires time, skilled professionals, and coordination. GPs and community healthcare providers could struggle with the added workload of these comprehensive assessments, particularly in areas already facing workforce shortages. Older patients who require multi-specialist input might | Thank you for your comment. The committee focused on what to do rather than how to deliver it for the consultation version. Following yours and other stakeholder comments they have added further detail to recommendations and rationales specifying that make it clearer that the comprehensive falls assessment and management could be done at the first point of contact, or by an appropriate referral. |

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| | | | | experience delays. To address the shortage of time and resources, general practices could implement streamlined pathways where screening is done by healthcare assistants or nurses, with referrals to specialists only for those identified as high risk. Training programs could focus on enabling more staff to conduct simple assessments of mobility, cognition, and cardiovascular function. | The committee did not want to specify in too much detail who should do what as they were aware that there are a variety of ways that care can be delivered. They added this to the rationale specifying that comprehensive falls assessment and management carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist.<br><br>Pathways of care and training for staff were not part of the scope therefore the committee have not made recommendations in this area. |
| Royal College of General Practitioners | Guideline | 008 | 013 | Conducting a structured medication review, especially for patients on psychotropic medicines, may require input from pharmacists, GPs, and potentially specialists. This can significantly increase consultation times and potentially result in the need for more frequent reviews if medications are adjusted. | Thank you for your comment. The recommendation is the same as the recommendation from the last version of the guideline (CG161) and the committee do not anticipate this making a huge difference. A cross reference to liaising with mental health services has been added to ensure the appropriate healthcare professionals are involved in discussions hopefully ensuring the decision more efficient. |

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| Royal College of General Practitioners | Guideline | 009 | 004 - 008 | We believe that national campaigns or the integration of vitamin D promotion into routine consultations, such as during annual reviews or flu clinics, could increase adherence. | Thank you for your comment. This is beyond the scope of this guideline to make a recommendation in this area. |
| Royal College of General Practitioners | Guideline | 009 | 010 - 023 | We are concerned that the recommendation to "offer a home hazard assessment and intervention, carried out by an occupational therapist, using a validated tool" could present logistical challenges. These assessments require the involvement of trained OTs, which could strain local health systems where there are existing staff shortages or long waiting times for assessments. Access to OTs can be limited particularly in rural settings, where the availability of home visit services is already constrained. This challenge can result in delayed interventions, increasing the risk of falls before assessments can be completed. Implementing a program of home hazard assessments would likely require expanded OT services, including recruitment, training, and possibly contracting private OTs to meet demand. This would be more feasible in urban centres where OTs are more readily available, but rural and underserved areas may face delays due to workforce shortages. Given that the numbers would be too great and to not solely make this the job of the OT, it may be helpful to train non-specialist staff, such as community nurses or healthcare | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to 'consider' the OT doing the home hazard assessment and intervention. |

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| | | | | assistants, to perform basic hazard checks while waiting for OT assessment, or explore telehealth options for preliminary assessments. | |
| Royal College of General Practitioners | Guideline | 010 | 004 - 005 | We believe access to CBT can be limited, especially in areas with long waiting lists for psychological services. We recommend developing self-help CBT resources tailored for people with a fear of falling. | Thank you for your comment. Self-help guides were not assessed in this recommendation therefore no recommendations have been made on this. |
| Royal College of General Practitioners | Guideline | 010 | 020 - 028 | Offering tailored falls prevention exercise programs that include individualised strength and balance exercises, as well as regular reviews, requires the availability of trained professionals to deliver these programs. Local health and community care providers, especially those in areas with a lack of resources for regular follow-up. Patients with mobility issues or those who lack access to community centres offering such programs might face barriers. To reduce the resource burden, community care services could consider group-based exercise programs or virtual programs, which might be more scalable than individual in-person programs. The use of existing social prescribing networks or volunteer-based services could also alleviate the pressure on healthcare providers. | Thank you for your comment. The committee made the recommendation based on the best available evidence. They agreed that people with gait and balance impairments who have fallen are more likely to fall again. They are also the group most likely to see benefit from exercise. The committee anticipate that exercise programmes can be delivered by qualified fitness instructors and do not need to be prescribed through NHS settings in all cases.<br><br>The recommendations on maximising participation recommend that exercise interventions are flexible enough to accommodate each person's individual needs and preferences, and to consider supervised exercises and offering people a choice in how exercises are delivered, for example individual or group exercise. |
| Royal College of General Practitioners | Guideline | General | General | We believe that the falls assessment should be implemented by a multiprofessional team and include someone who is a prescriber and | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, |

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| | | | | able to make changes to medication and do a SMR. The challenge however is that falls teams may not have a prescriber as part of their team.<br>Multidisciplinary proactive community teams could do this, and comprehensive assessments are needed - Holistic, individualised assessment by an appropriate multiprofessional team. | assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |

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| Royal College of Ophthalmologists | Guideline | 007 | 005 | "Assessment of vision impairment" This does not specify what level of impairment this should be. We suggest that this statement is further qualified by:<br>**a.** asking about date of last NHS sight test and if not in last year then get one done. Uncorrected refractive error is the most common cause of avoidable sight impairment at all ages, and in addition a sight test could pick up other ocular comorbidity.<br>**b.** checking local blind and partial sight registers for people at risk of falls from significant sight impairment / sigh loss – especially when assessing risk in community settings. | Thank you for your comment. Detail on how to do assessments of specific factors has not been included in this guideline because this would be covered by other guidelines. Where an existing NICE guideline exists with details of how to assess that are relevant to falls prevention, we have added a cross link to this. |
| Royal College of Physicians | Guideline | 004 | 008 | Strengthen the recommendation to ask about falls during routine appointments. This could be done by amending "This can be done" to "This should be done" or to "Do this". | Thank you for your comment. The committee found there was no evidence to recommend asking about falls at routine appointments in all cases. They also discussed this again and agreed that it may not be appropriate for everyone and that strengthening the recommendation could lead to a significant resource impact. Therefore, the recommendation has been left as a 'consider' recommendation. |

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| Royal College of Physicians | Guideline | 007 | 002 | I am wonder if an "osteoporosis risk assessment" should actually be a "Fracture risk assessment" | Thank you for your comment. This has been left as osteoporosis risk assessment. There may be an initial step before fracture risk assessment. A link to the NICE guideline on osteoporosis which is currently been updated has been added. |
| Royal College of Physicians | Guideline | 008 | 009 & 010 | Currently reads: "Ensure that interventions to reduce a person's risk of falls promptly address their individual multiple fall risk factors" For clarity might be better phrased: "Ensure that interventions to reduce a person's risk of falls are individualised to promptly address their multiple fall risk factors" | Thank you for your comment. The recommendation has been updated as suggested. |
| Royal College of Physicians | Guideline | 008 | General | For the section on medication review I feel it should also state clearly that medications should be reviewed to reduce the risk of harm from falls should they occur eg reviewing PPI as increases long bone fracture risk | Thank you for your comment. Evidence was not identified to make a recommendation in this area. |
| Royal College of Physicians | Guideline | 009 | 007 | reads "…health" but would be better to add "…health and reduce the risk of harm should a fall occur" indicating good bone health reduces fracture risk | Thank you for your comment. There was no evidence to state that vitamin D reduces the harm from falls therefore the committee did not add this to the recommendation. |
| Royal College of Physicians | Guideline | 011 | 005 | Currently reads: "Ensure that interventions to reduce a person's risk of falls promptly address their individual multiple fall risk factors" For clarity might be better phrased: "Ensure that interventions to reduce a person's risk of falls are individualised to promptly address their multiple fall risk factors" | Thank you for your comment. This has been updated to 'Ensure that interventions to reduce the risk of falls are tailored to the individual so they promptly address any fall risk factors.' |

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| Royal College of Physicians | Guideline | 011 | 020 | Currently reads: "appropriate adjustments to their medicines to reduce the risk of falls." I would add "…reduce the risk of falls and reduce the risk of harm from a fall should it occur" | Thank you for your comment. There was no evidence to suggest a medication review reduced the risk of harm from falls therefore the committee did not add this to the recommendation. |
| Royal College of Physicians | Guideline | 012 | 048 | Same alteration as above for lines 9-10 | Thank you for your comment. The recommendation has been updated to "Ensure that interventions to reduce a person's risk of falls are individualised to promptly address their multiple risk factors' as suggested. |
| Royal College of Physicians | Guideline | 013 | 003 | Same alteration as above for page 8 on medication review to reduce the risk of harm from falls | Thank you for your comment. There was no evidence to suggest a medication review reduced the risk of harm from falls therefore the committee did not add this to the recommendation. |
| Royal College of Physicians | Guideline | 015 | 007 | Another topic for discussion might be whether an osteoporosis risk assessment would be desirable | Thank you for your comment. This recommendation has been kept general because each person would need different risk factors highlighted. The committee anticipate that healthcare professionals would discuss any relevant risk factors and not just osteoporosis. |
| Royal College of Physicians | Guideline | 019 | 001 | Is more research also needed into how to prevent falls when people with dementia are in hospital? | Thank you for your comment. The committee did not think this was a key area for research. They have made two other research recommendation for hospital inpatients that would also cover people with dementia: environmental factors and enhanced supervision. |
| Royal College of Physicians | Guideline | 023 | 016 - 022 | I very much welcome the recommendation that a home hazard assessment should be offered. I recognise that there will be resource implications and staff capacity | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using |

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| | | | | issues but the savings from preventing even a few falls and hence reducing demands on ambulances and hospitals are considerable. The benefit to the individual and their carers are also great, giving them more confidence in day to day living and enabling them to manage in their own home for longer. The costs of implementing the recommendation will be immediate while the savings will be in the future and accrue to different organisations. It might therefore be desirable to spell out more fully the cost benefit arguments for this recommendation. | a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to 'consider 'the OT doing the assessment and intervention.<br><br>A more detailed discussion around the cost benefits is laid out in the evidence report F1 and the Falls modelling write up. There is also a resource impact tool published alongside the guideline. |
| Royal College of Physicians | Guideline | 025 | 014 - 020 | Elderly people and those with dementia often need frequent intervention to get them moving and to do any exercises which have been recommended for them. Should there be a recommendation that such support and encouragement should be provided? | Thank you for your comment. Recommendations specific to particular conditions were not included as part of the guideline. The committee gave more general advice on what to do. Recommendation 1.4.1 covers encouraging change and addressing potential barriers. There is also a link to the |

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| | | | | | NICE guideline on decision making and mental capacity. |
| Royal College of Physicians | Guideline | General | General | The Royal College of Physicians (RCP) is grateful for the opportunity to comment on the draft guidelines. In doing so, we have liaised with the RCP Falls and Fragility Fracture Audit Programme (FFFAP) and wish to share the following views from members of the National Audit of Inpatient Falls Advisory Group. | Thank you for your comments. We have responded to each comment. |
| Royal College of Physicians | Guideline | General | General | Good to see osteoporosis risk assessment is mentioned. Please could we encourage use of FRAX where indicated and to follow NOGG guidance. | Thank you for your comment. Osteoporosis risk assessment is covered in the NICE guideline on osteoporosis which is currently being updated. |
| Royal College of Physicians | Guideline | General | General | Could we consider encouraging teams to quality methodology to improve multifactorial falls risk assessments in the hospital setting. | Thank you for your comment. We are not sure what you are suggesting. |
| Royal College of Physicians | Guideline | General | General | There might be more emphasis on reducing the harm from falls. Osteoporosis risk assessment is mentioned in one context but could be given more prominence | Thank you for your comment.<br><br>No evidence was identified on harm from falls therefore this has not been mentioned in the recommendations.<br><br>Osteoporosis risk assessment is covered in the NICE guideline on osteoporosis which is currently being updated. |
| Royal College of Physicians | Guideline | General | General | I am 80 and have never been asked about falls. | Thank you for your comment. |
| Royal College of Physicians | Guideline | General | General | The overall tone is very risk averse. There is an emphasis in almost every point about reducing risk. I worry this leads to | Thank you for your comment. The main aim of the guideline is to highlight particular risks associated with falls to healthcare professionals |

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| | | | | encouraging immobility, particularly in healthcare settings as the 'least risky' option but by consequence leads to deconditioning and a longer-term increased risk. Perhaps re-phrasings could be consider throughout as suggested in NAIF's latest publications about encouraging 'mobilising safely' rather than emphasising 'reducing falls risk' | and make recommendations on how to prevent them. This has meant it has been important to highlight reducing the risk of falls. The committee agree that communication is important and that healthcare professionals would consider appropriate ways to do this. |
| Royal College of Physicians | Guideline | General | General | Would we consider renaming a "comprehensive falls risk assessment" to a "multi-factorial assessment to optimise safe activity (MASA)" | Thank you for your comment. The committee discussed this and agreed that comprehensive falls assessment is a better term. This aligns with other documents which use terms such as comprehensive geriatric assessment (NHS enhanced health in homes frameword, British Geriatric Society comprehensive geriatric assessment in primary care). |
| Royal College of Physicians of Edinburgh | Guideline | 004 | 003 | Some Fellows suggested it might be unhelpful to use the phrase 'do not use falls risk prediction tools' and think this should be replaced with, for example, 'falls risk prediction have not been shown to be useful and the following approach should be adopted.' | Thank you for your comment. The committee agreed that these tools are not useful in predicting falls and have made that clear in the recommendation. They agreed that risk assessment tools are not particularly useful and can be a distraction because they only stratify people into high- or low-risk categories without recommending any further intervention. This has been explained in the rationale. |
| Royal College of Physicians of Edinburgh | Guideline | 006 | 010 | Some Fellows suggested the boxes with the explanation disrupts the flow of the document and would be better left out with a signpost to all the reasoning at the end. | Thank you for your comment. The boxes are only there for the consultation version of the guideline. In the final version the rationale is a drop-down box immediately below the recommendation. Overall, the guideline will be easier to follow. |

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| Royal College of Physicians of Edinburgh | Guideline | 006 | 013 | Some Fellows stated it would be better to state the criteria rather than linking back which again disrupts the flow. | Thank you for your comment. A visual summary has been produced to go with the guideline to make it easier to follow. |
| Royal College of Physicians of Edinburgh | Guideline | 008 | 013 | Some Fellows considered that the medication review should be mandatory and not just considered. | Thank you for your comment. Evidence was not available to make a stronger recommendation. |
| Royal College of Physicians of Edinburgh | Guideline | 009 | 007 | Some Fellows questioned why only cardioinhibitory carotid sinus hypersensitivity (CCSH) was mentioned here and suggested that unexplained falls should have broad assessment, not only restricted to CCSH. | Thank you for your comment. This section only relates to surgical interventions. |
| Royal College of Physicians of Edinburgh | Guideline | 009 | 013 | Some Fellows questioned why only cataracts were mentioned here and suggested any relevant ophthalmic presentation should be referred as appropriate to an ophthalmologist. | Thank you for your comment. It was only surgical interventions that were covered in this review. However, we also include recommendation 1.2.2 assessment/examination as part of a comprehensive assessment, for risk factors such as visual impairments. |
| Royal College of Physicians of Edinburgh | Guideline | 011 | 010 | It was suggested by some Fellows that not only should delirium be assessed but also confusion and capacity. Fellows emphasised the importance of assessing capacity so that approaches to managing issues can be adapted accordingly. | Thank you for your comment. Following stakeholder comments the point about delirium has now been moved into recommendation 1.2.2 for comprehensive falls assessment and a cross reference added to the NICE guideline on delirium for assessment and diagnosis.<br><br>Confusion and capacity are included in recommendation 1.2.2. as cognition. |
| Royal College of Physicians of Edinburgh | Guideline | 012 | 017 | Some Fellows suggested that relatives/carers should be reassured, as well as patients, that it was appropriate to mobilise. In addition, it was thought that the importance of getting up to sit out of bed | Thank you for your comment. The recommendation has been edited to reassuring |

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| | | | | rather than being left in bed should be referenced. | them that they should not avoid getting up and moving around, and<br>helping them to be less sedentary and more active by having a structured daily routine to ensure that they have opportunities to regularly stand up and walk around, as appropriate. |
| Royal College of Physicians of Edinburgh | Guideline | 017 - 019 | General | Recommendations for research section - In addition to the proposals set out- which we very much support- some Fellows indicated that they considered focus should be given to improved public health education about the practicalities of ageing such as educating people to consider living arrangements like steps at house entrances/exits, downstairs toilets and bedrooms and trip hazards in the home. | Thank you for your comment. Public health education was not included as part of the scope of this guideline. The committee anticipate that people who have a home hazard assessment would be given this information by the healthcare professional. |
| Royal College of Physicians of Edinburgh | Guideline | General | General | Fellows of the Royal College of Physicians of Edinburgh consider this is a broadly helpful guideline. Some Fellows suggested that the guideline should include a definition of 'frailty' and 'comprehensive falls assessment.' In addition, some Fellows felt if it was possible to simplify the guideline into an algorithm that could be hugely beneficial to those who are less experienced in falls, especially Health &Social Care professionals. | Thank you for your comment.<br><br>A link to the section on how to assess frailty in the NICE guideline on multimorbidity has been added where frailty is mentioned in the recommendations.<br><br>The definition for a comprehensive falls assessment has been updated in the 'Terms used in this guideline' section to "An assessment that aims to identify a person's risk factors for falling. This can be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, as appropriate: primary care services, community teams or |

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| | | | | | specialist outpatient clinics (such as falls or geriatric medicine assessment clinics)."<br><br>A visual summary has been produced to make it easier to follow the recommendations. |
| Royal College of Physicians of Edinburgh | Guideline | General | General | Some Fellows indicated that more emphasis needed to be given to the involvement of relatives/carers where relevant and also to key partners including social care colleagues. Some noted that occupational therapy input was mentioned a few times but they felt the role of physiotherapy should also be made explicit. | Thank you for your comment. The expectation is that family and carers are included in discussions where appropriate. This follows the principles laid out in the NICE guideline on patient experience in adult services.<br><br>Occupational therapists are mentioned in relation to home hazard assessments because this is directly linked to the evidence and economic modelling showed their input to be the most cost-effective approach. No other recommendations covered the role of specific healthcare professionals therefore the committee have avoiding making reference to them. They agreed that a variety of healthcare professionals could carry out specific recommendations. |
| Royal Society for the Prevention of Accidents (RoSPA) | Guideline | 004 | 003 | Rec 1.1.1 – we agree that fall risk prediction tools should not be used, rather we recommend that all people that can be categorised by Rec 1.1.6 are familiarised with risk reduction techniques applicable to their home environment, and their health and lifestyle. | Thank you for your comment. Recommendation 1.1.6 also links to the patient information recommendations in section 1.5 where more detail on what to include in the information is mentioned and may be helpful. This also suggests sources for further information. However, the committee did not have the evidence to suggest it was cost effective to offer everyone detailed advice following a fall. |

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| Royal Society for the Prevention of Accidents (RoSPA) | Guideline Question 3 | 009 | 009 | Rec 1.3.5 – We encourage home hazard assessment and intervention given its potential to address root causes and prevent falls in the home. However, we recognise the bottleneck caused by poor availability of Occupational Therapists. We would support extending this task to 'Trusted Assessors' who may conduct home hazard assessment for non-complex cases. This would reduce waiting times and the opportunity for further falls to occur whilst waiting for assessment. We have produced a risk assessment tool for housing association staff to use with vulnerable customers which has been piloted in Staffordshire-based Trent & Dove Housing with great success.<br>The impact of allowing a wider diversity of professionals to undertake home hazard risk assessment would be shortened waiting times, particularly for those in social homes where the implementation may require interaction with social landlords (local authority or housing association). In this instance, assessment and intervention is streamlined by allowing qualified housing staff ('Trusted Assessors' or the like) to conduct the assessment. | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Royal Society for the Prevention of Accidents (RoSPA) | Guideline | 009 | 019 | Rec 1.3.8 – We are aware of issues surrounding the commissioning and funding of falls prevention exercise programmes despite their proven return on investment. We support the FaME programme and | Thank you for your comment. The committee were aware that there are issues in commissioning exercise programs however, there was evidence that exercise programs can help reduce the risk of falls. Therefore, the |

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| | | | | findings of the FLEXI study which emphasise the importance of stable funding streams, facilitating the retention of qualified instructors and venues, which in turn secure positive outcomes for users. | committee felt that it was important to recommend exercise. However, there was not clear evidence on which exercise program was the most effective and cost effective therefore, the committee left it open to local areas to choose a program that works the best for their area. The committee did acknowledge which areas the exercise program should address. |
| Royal Society for the Prevention of Accidents (RoSPA) | Guideline | 015 | 004 | We feel that 'if a person is at risk of falling' is too vague and should be amended to 'if a person meets the criteria outlined in Rec 1.1.6'. | Thank you for your comment. The clause has been removed for the recommendations and the section title has been made clearer to note this applies to people receiving falls assessments and interventions. |
| Royal Society for the Prevention of Accidents (RoSPA) | Guideline | General | General | We agree in principle with the draft guidelines and the stratification of treatment based on risk associated with gait and balance, frailty, health, lifestyle and history of falls.<br>We do however suggest more is done to raise awareness of preventative steps that community-dwelling adults can they themselves take prior to their first injurious fall, particularly given the resulting tendency for falls to subsequently reoccur. By extending case finding activity, for example to opticians, people who do not have annual health checks or routine appointments may also be signposted to fall prevention information they wouldn't otherwise receive. As an accident prevention charity, we would like to draw attention to the public education | Thank you for your comment. General public health guidance was beyond the scope of this guideline. |

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| | | | | material we have produced to highlight the risk reduction steps for older adults at home in the community. It is freely available from our Fall Fighter campaign webpage at rospa.com/falls | |
| Royal Society for the Prevention of Accidents (RoSPA) | Question 1 | | | We feel it would be challenging to implement timely home hazard assessment solely using Occupational Therapists given the scarcity of people in these roles. However partnership working with social landlords, many of whom have Occupational Therapists on payroll, could present an opportunity to streamline access to assessment for those in social homes. An example of this practice was piloted in 2023 at Trent & Dove Housing and we have since developed a fall prevention toolkit to guide social housing providers through the process. Developing functional and efficient ways of working in partnership would yield benefits for people in need of home hazards assessment. | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Society of Teachers of the Alexander Technique | Guideline | 018 – 019 | 001 – 009, 001 – 007 | We are concerned that the *Recommendations for Research* focus mainly on technological and environmental approaches, rather than on interventions aimed at empowering the individuals who are | Thank you for your comment. The committee did not identify the Alexander technique as an intervention to include in our review and nor did the Cochrane reviews mention within their |

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| | | | | at risk of falling. Further, those interventions reviewed in the guideline that do entail an active role for the population in question tend to fall into separate categories of either physical exercise or education, rather than encompassing both.<br><br>For older individuals at risk of falling in community and hospital outpatient settings, we suggest that further research is warranted on the Alexander Technique, a taught self-care intervention that addresses physical, cognitive and behavioural attributes simultaneously. Lessons in the Alexander Technique, provided by registered Alexander Technique teachers, have the principal aims of improving balance, movement coordination and postural support, as well as increasing self-efficacy to enable desired behavioural change.<br><br>A diverse range of qualitative and quantitative research suggests that learning and practising the Alexander Technique leads to improved ability for self-care, and self-efficacy or agency – belief and confidence in one's own capabilities, including managing fear of falling.[1–5]<br><br>There is evidence that Alexander Technique training leads to improved balance, postural | reviews. Therefore, there is no mention of it within the guideline. |

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| | | | | support, and movement co-ordination,[6–12] and that this intervention therefore has potential in falls prevention.[2,13,14] It has been successfully taught to older adults[2,10,13,14] and has a high degree of acceptability to participants.[4,15] Evidence shows that the skills learned are retained in the long term by those who attend lessons.[16] Two major randomised controlled trials demonstrate the long-term effectiveness of Alexander Technique lessons in improving chronic back pain[17] and chronic neck pain,[18] both of which are common in older people and can contribute to fear and likelihood of falling. A third randomised controlled trial demonstrated significant long-term improvement in the ability of people living with Parkinson's to carry out daily actions such as walking.[19] These findings led to the following recommendation in the NICE guidelines for Parkinson's disease in adults: "Consider the Alexander Technique for people with Parkinson's disease who are experiencing balance or motor function problems."[20]<br><br>The Alexander Technique is a gentle, self-management approach which can help individuals to increase their confidence around fear of falling, and develop the ability to co-ordinate themselves quickly and | |

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| | | | | efficiently in any situation thus allowing improved balance and movement. We believe there is merit in further research on the potential of Alexander Technique as an intervention to promote falls prevention for adults at increased risk.<br><br>**References**<br>1. Kinsey D, Glover L, Wadephul F (2021). How does the Alexander Technique lead to psychological and non-physical outcomes? A realist review. European Journal of Integrative Medicine; 46: https://doi.org/10.1016/j.eujim.2021.101371.<br>2. Glover L, Kinsey D, Clappison DJ, Jomeen J (2018). "I never thought I could do that…": Outcomes from an Alexander Technique pilot group for older people with a fear of falling. European Journal of Integrative Medicine;17:79–85.<br>3. Woodman J, Ballard K, Hewitt C, MacPherson H (2018). Self-efficacy and self-care-related outcomes following Alexander Technique lessons for people | |

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| Solihull Metropolitan Borough Council | Guideline | 001 | 007 | Who is it for? 3rd Sector should be included | Thank you for your comment. NICE guidelines are not aimed at the 3rd sector however the 3rd sector can adopt them should they wish. |
| Solihull Metropolitan | Guideline | 004 | 003 | Agreement that a falls risk prediction tool should not be used to predict a person's risk of falling | Thank you for your comment. |

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| Borough Council | | | | | |
| Solihull Metropolitan Borough Council | Guideline | 005 | 024 | Agreement that it needs to include people aged between 50-64 | Thank you for your support. |
| Solihull Metropolitan Borough Council | Guideline | 006 | 018 | Many of the tests there are medical and not in the control of a care home to undertake or even their GP, so will there be something mandated for community and acute health to add the comprehensive assessment in care homes by facilitating the appropriate tests? Are the guidelines going to apply to the GP contractual expectations for supporting care homes? | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving |

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| | | | | | any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist.<br><br>The committee were aware of the NHS plan on Enhanced health in care homes and have linked to this in the recommendation. |
| Solihull Metropolitan Borough Council | Guideline | 007 | 017 | Include another risk factor to understand physical activity levels | Thank you for your comment. There was no evidence to suggest a specific mention for the assessment of physical activity should be added to the list. The committee agreed that although different the point on gait balance, mobility and muscle strength assessment would likely include an assessment of physical activity. |
| Solihull Metropolitan Borough Council | Guideline | 012 | 002 | This could include getting dressed and giving the patient a handout with appropriate exercises and explaining the importance of physical activity. | Thank you for your comment. Getting dressed has been added to the recommendation. Giving handouts was not included as part of this review so no recommendations have been made regarding this. |
| Solihull Metropolitan Borough Council | Guideline | 012 | 020 | Clarity about roles in settings – care homes can request but most don't have staff who are able to do medications review etc and are reliant on GP or outpatient support. | Thank you for your comment. More detail covering this is in the section on reviewing medicines in the NICE guideline on managing medicines in care homes which is cross referred to in the recommendation. |
| Sunderland City Council - | Guideline | 009 | 010 - 011 | We understand the importance of the environmental hazard assessment. However, | Thank you for your comment. Following stakeholder comments the recommendation has |

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| Multiagency Falls Group | | | | we believe it's unrealistic to solely recommend Occupational therapist to perform environmental hazard assessment. Given the demography we are facing with the ageing population this is just not realistic. We feel that any health care professional could perform a simple environmental hazard assessment using tools such as Non-OT HOME FALLS AND ACCIDENTS SCREENING TOOL (HOME FAST) and make further referral if appropriate would be more realistic and practical option. | been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Sunderland City Council - Multiagency Falls Group | Guideline | 010 | 018 - 019 | We understand the importance of the environmental hazard assessment. However, we believe it's unrealistic to solely recommend Occupational therapist to perform environmental hazard assessment. Given the demography we are facing with the ageing population this is just not realistic. We feel that any health care professional could perform a simple environmental hazard assessment using tools such as Non-OT HOME FALLS AND ACCIDENTS SCREENING TOOL (HOME FAST) and | Thank you for your comment. For this group (i.e. people who have fallen once in the last year and have a gait or balance impairment), the recommendation is a weaker 'consider' recommendation to reflect the uncertainty in the evidence. The recommendation is based on greater clinical benefit seen for people who had fallen more than once in the previous year when interventions were delivered by an occupational therapist. Health economic modelling also found that home hazard assessment and modifications are cost effective. |

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| | | | | make further referral if appropriate would be more realistic and practical option. | |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 001 | 005 | Unable to understand the reason behind age limit mentioned. Whilst the risk of serious injury is higher in older people, we are finding working age adults with multiple physical comorbidities alongside their mental health/autism/Learning Disability diagnosis, which can put them at risk of frailty and injurious falls. This is particularly the case where patients also have osteoporosis e.g. in patients with a diagnosis of an eating disorder, some of whom also have multiple falls with or without delirium. Also, people with Learning Disabilities often succumb to frailty at an earlier age – e.g. age 30 years in the case of some Learning Disability patients with Down Syndrome and Dementia. I do think we need to be person centred and inclusive and reduce the age limit.<br>I understand there are no evidence-based means to assess frailty in younger people, however, this should be a focus of future research. | Thank you for your comment. The age range was agreed when the scope was published in September 2022. People under the age of 50 were not included in this guideline because they have a lower risk of falls and are not impacted as much by them as people over the age of 50. Stakeholders also pointed out that there is also a lack of evidence in this age group. NICE guidance for younger adult populations is available within the disease specific guidelines for some conditions.<br><br>Following stakeholder comments people with learning disabilities have been added to the younger age group (50 to 64). This group has been described as 'Factors that increase the person's risk of falls.' |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 004 | 007 | Please see comments as above. | Thank you for your comment. The age range was agreed when the scope was published in September 2022. People under the age of 50 were not included in this guideline because they have a lower risk of falls and are not impacted as much by them as people over the age of 50. Stakeholders also pointed out that there is also a lack of evidence in this age group. NICE |

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| | | | | | guidance for younger adult populations is available within the disease specific guidelines for some conditions.<br><br>Following stakeholder comments people with learning disabilities have been added to the younger age group (50 to 64). This group has been described as 'Factors that increase the person's risk of falls.' |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 005 | 018 | There is no mention of who should be completing gait and balance assessments. Should this state that, it should be a suitably qualified person such as a Physiotherapist. | Thank you for your comment. The committee noted that an assessment of gait and balance can be done by a simple test such as the Time up and Go test (TUG) which is designed to be done with minimal training. Although this does not predict a person's risk of falling it may help identify people who need a more detailed assessment.<br><br>The recommendation has also been updated to note that this can be carried out in the same service or involve an appropriate referral. |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 006 | 004 | Please see comments as above. (referring to previous comment which stated: Unable to understand the reason behind age limit mentioned. Whilst the risk of serious injury is higher in older people, we are finding working age adults with multiple physical comorbidities alongside their mental health/autism/Learning Disability diagnosis, which can put them at risk of frailty and | Thank you for your comment. The age range was agreed when the scope was published in September 2022. People under the age of 50 were not included in this guideline because they have a lower risk of falls and are not impacted as much by them as people over the age of 50. Stakeholders also pointed out that there is also a lack of evidence in this age group. NICE guidance for younger adult populations is |

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| | | | | injurious falls. This is particularly the case where patients also have osteoporosis e.g. in patients with a diagnosis of an eating disorder, some of whom also have multiple falls with or without delirium. Also, people with Learning Disabilities often succumb to frailty at an earlier age – e.g. age 30 years in the case of some Learning Disability patients with Down Syndrome and Dementia. I do think we need to be person centred and inclusive and reduce the age limit.<br>I understand there are no evidence-based means to assess frailty in younger people, however, this should be a focus of future research.) | available within the disease specific guidelines for some conditions.<br><br>Following stakeholder comments people with learning disabilities have been added to the younger age group (50 to 64). This group has been described as 'Factors that increase the person's risk of falls.' |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 006 | 018 | States 'Consider including'. This only therefore only states things to consider however does not state what should be completed as part of a comprehensive falls assessment. This could lead to some of the items on the list not being completed and this could then lead to a regression to falls only being about balance, gait and mobility, which would contradict page 21 – line 10-11 where it states, 'comprehensive falls assessment should include a range of assessments.'<br>The Royal College of Physicians through their NAIF programme calls this Multifactorial assessment to optimise safe activity and they focus on six factors – vision, lying to standing blood pressure, medication review, delirium, mobility, and continence assessments as a | Thank you for your comment. No evidence was available to state exactly what should be included in a comprehensive falls assessment. The committee agreed that each persons' needs would be different and not all would be appropriate in all cases. The recommendation has been updated to state Include the following (where appropriate).<br><br>All the factors included in the cited report are also included as part of recommendation 1.2.2 on what could be included in a comprehensive falls assessment. Of the points you mention delirium was only mentioned in the recommendations related to hospital in patients and residential care settings in the consultation version of the guideline. Following stakeholder |

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| | | | | minimum. Please consider inclusion of this evidence: examples-of-how-to-use-assessment-to-optimise-safe-activity-annual-report-2024.pdf | comments the point about delirium has now been moved into recommendation 1.2.2 for comprehensive falls assessment and a cross reference added to the NICE guideline on delirium for assessment and diagnosis.<br><br>The rationale has also been updated to state "The complex nature of comprehensive assessment means that clinical judgment would be needed to determine what to assess and when." |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 008 | 022 | Should this state, 'the prescriber should review any psychotropic medication, discuss risk and plan withdrawal'. | Thank you for your comment. The recommendation has been updated to state "plan withdrawal and consider liaising with specialist mental health services as appropriate". |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 008 | 025 | Should it include a statement 'and consider liaising with specialist psychiatric services as appropriate'. | Thank you for your comment. The recommendation has been updated to state "plan withdrawal and consider liaising with specialist mental health services as appropriate". |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 009 | 010 | Home hazard assessments can be done by a range of health and social care professionals. Should this therefore state 'a suitably qualified professional e.g. physiotherapist, Occupational Therapist or Nurse'. | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained |

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| | | | | | healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 010 | 019 | An Occupational therapist is not the only professional that can carry out a home hazard assessment in relation to falls. Could this be re phrased to 'suitably qualified professional'? | Thank you for your comment. For this group (i.e. people who have fallen once in the last year and have a gait or balance impairment), the recommendation is a weaker 'consider' recommendation to reflect the uncertainty in the evidence. The recommendation is based on greater clinical benefit seen for people who had fallen more than once in the previous year when interventions were delivered by an occupational therapist. Health economic modelling also found that home hazard assessment and modifications are cost effective. |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 012 | 007 | Should add where possible, 'start supervised falls prevention exercises.' Should there be caution with the statement about people not being in hospital long enough to complete falls prevention exercises. If it states in this guidance that there is no benefit to prescribed structured exercise for falls prevention whilst in hospital, that person may | Thank you for your comment. Evidence was not available to provide much detail in the recommendations for hospital inpatients. That included not being able to make a recommendation for supervised exercise. Therefore, the committee only recommended encourage physical activity. The recommendation has been updated to suggest |

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| | | | | not commence the exercise programme in a timely manner that will be of benefit, increasing the risk of deterioration and deconditioning. The exercises could start in hospital and be followed up within the community. Attempts should be made to start exercises of this type to avoid deconditioning, which is particularly important where patients experience delayed discharges or long stays within an inpatient environment. | the type of exercise or physical activity to encourage physical activity that are related to the person's risk of falls, such as balance, coordination, strength and power.<br><br>Recommendation 1.3.16 advises considering referral to community services to address any risk factors. This could include the need for an exercise intervention.<br><br>Although supervised exercises have not been mentioned in the hospital inpatient recommendations, they are considered in the recommendation to help maximise participation in section 1.4.<br><br>The rationale has also been updated. |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 017 | 009 | Remove 'specialist falls team' and add a multidisciplinary team as Mental Health Trusts do not always have access to s Specialist Falls Team however, have the relevant clinical professions to contribute/ undertake a comprehensive falls assessment. | Thank you for your comment. This has been updated to 'specialist service' to reflect the variety of ways comprehensive falls assessment can be delivered. |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 025 | 014 - 017 | Please see comment as above. | Thank you for your comment. Evidence was not available to provide much detail in the recommendations for hospital inpatients. That included not being able to make a recommendation for supervised exercise. Therefore, the committee only recommended encourage physical activity. The recommendation has been updated to suggest |

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| | | | | | the type of exercise or physical activity to encourage physical activity that are related to the person's risk of falls, such as balance, coordination, strength and power.<br><br>Recommendation 1.3.16 advises considering referral to community services to address any risk factors. This could include the need for an exercise intervention.<br><br>Although supervised exercises have not been mentioned in the hospital inpatient recommendations, they are considered in the recommendation to help maximise participation in section 1.4.<br><br>The rationale has also been updated. |
| Tees, Esk and Wear Valleys NHS Foundation Trust | Guideline | 027 | 005 | Please see comment as above. | Thank you for your comment. For this group (i.e. people who have fallen once in the last year and have a gait or balance impairment), the recommendation is a weaker 'consider' recommendation to reflect the uncertainty in the evidence. The recommendation is based on greater clinical benefit seen for people who had fallen more than once in the previous year when interventions were delivered by an occupational therapist. Health economic modelling also found that home hazard assessment and modifications are cost effective. |
| Tees, Esk and Wear Valleys NHS | Guideline | General | General | Although this guideline is for assessment and prevention of falls, it does not mention what to do in the event of a fall i.e. post falls | Thank you for your comment. Management immediately following a fall was not included as part of the scope of the guideline therefore no |

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| Foundation Trust | | | | checks - check for signs of injury and use appropriate methods to get the person up from the floor, what to do if an injury is suspected etc.. Should this be included or will it be the subject of separate guidance – please refer to the NAIF 2024 annual report Annual report 2024 and expansion 2025 The Royal college of Physicians advocate 4 post falls Key Performance Indicators for patients - KPI 1 – High quality multifactorial assessment to optimise safe activity. KPI 2 – Check for injury before moving. KPI 3 – Safe lifting equipment used to move the patient from the floor in the event of an injury. KPI 4 – Medical assessment within 30 minutes. | recommendations have been made in relation to this. |
| The Association of Chartered Physiotherapists interested in Vestibular Rehabilitation | Guideline | 004 | 002 | The connection between aging, falls, imbalance and vestibular dysfunction has been demonstrated for at least the last 2 decades. Authors such as;<br>a. Oghalai, Manolidis, Barth et al 2000<br>b. Pothula, Chew, Lesser, and Sharma 2004<br>c. Hansson, Mansson, Haransson 2005 | Thank you for your comment. The bullet point on dizziness in recommendation 1.2.2 related to what to include in a comprehensive falls assessment has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider performing a Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added as suggested. |

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| | | | | d. Lawson and Bamiou 2005<br>e. Von Breverin, Radtke, Lezius, et al 2007<br>f. Furman, Raz, Whitney 2010<br>g. BMJ Best Practice BPPV 2019<br>h. Donovan, Desilva, Cox, et al 2023<br>i. Li, Smith, Whitney, et al 2024<br>Have clearly documented the correlation between dizziness, vestibular dysfunction, and falls. The World Falls Guidelines have recognised this and incorporated it into their work of 2022. We respectfully ask the same of this committee, through the addition of vestibular disorders[1] to conditions that increase the risk of falling (point 1.1.2).In addition, this guideline could cross refer to NICE CG 127 on assessing and managing dizziness. This would maintain consistency and help users with assessment and treatment. | |

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| The Association of Chartered Physiotherapists interested in Vestibular Rehabilitation | Guideline | 006 - 007 | General | 1.2 - Comprehensive falls assessment, we ask the committee to consider:<br>1. The assessment of dizziness and potential use of the Dix-Hallpike manoeuvre (please correct the identification of this technique as it is not known as the Hallpike-Dix) is not just for hospital inpatients. Restricting assessment to hospital in-patients does not address a large number of people who experience the effects of Benign Paroxysmal Positional Vertigo (BPPV) in the community. Assessment and treatment of BPPV in the community may actually reduce unnecessary falls and hospitalisations. This is supported by the recent work of:<br>a. Li: Yuxiao Li, Rebecca M Smith, Susan L Whitney, Barry M Seemungal, Toby J Ellmers, Association between dizziness and future falls and fall-related injuries in older adults: a systematic review and | Thank you for your comment. The bullet point related to dizziness has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider performing a Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers recommendations on what to do when dizziness and vertigo are identified.<br><br>Thank you for the cited studies. These did not meet the review criteria and were not included in our review. Li 2024 is a systematic review and meta-analysis about association between dizziness and future falls as we did not do a risk factor review this would not be included. Metz 2024 is not an RCT so would not be included. |

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| | | | | meta-analysis, *Age and Ageing*, Volume 53, Issue 9, September 2024, afae177, https://doi.org/10.1093/ageing/afae177<br>b. Metz: Metz D, Bryce K. The rationale and recommendations for inclusion of screening for benign paroxysmal positional vertigo in falls clinics. *The Journal of Laryngology & Otology*. 2024;138(S2):S32-S34. doi:10.1017/S0022215123002049 | |
| The Association of Chartered Physiotherapists interested in Vestibular Rehabilitation | Guideline | 006 - 007 | General | 1.2<br>2. Older adults with Benign Paroxysmal Positional Vertigo do not always present with vertigo but remain at substantial risk of falling. As per recent work (Li et al. 2023) clinicians should be encouraged to examine older adults who have fallen with positional testing for BPPV regardless of the presence of vertigo. | Thank you for your comment. The bullet point related to dizziness has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider performing a Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers |

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| | | | | *ACPIVR Recommendation: We ask that the use of the Dix-Hallpike test be included in all patient populations who have had a fall or who are at risk of falling, irrespective of symptomatic complaint.* | recommendations on what to do when dizziness and vertigo are identified.<br><br>Evidence was not available to recommend all people who had a fall or are at risk of falling should receive a Dix-Hallpike test. |
| The Association of Chartered Physiotherapists interested in Vestibular Rehabilitation | Guideline | 008 - 013 | General | 1.3 Interventions to reduce the risk of falls, we ask that the committee consider the following:<br>1. There is no detail in the interventions section for patients who have a positive Dix-Hallpike test (i.e. they have BPPV). Clinicians are therefore unclear how to treat this effectively. There is a wealth of evidence supporting the use of Canalith Repositioning Manoeuvres (CRM) in treating BPPV.<br><br>*ACPIVR Recommendation: We ask that patients presenting with a positive Dix-Hallpike test are treated with a CRM such as the Epley or Semont manoeuvres. If staff are not skilled to provide this intervention, then referral should be made to an appropriately trained professional. This would align with CG 127 which states:* | Thank you for your comment. This has been addressed in recommendation 1.2.2 related to comprehensive falls assessment. In that recommendation the bullet point related to dizziness has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider and performing a Hallpike–Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers recommendations on what to do when dizziness and vertigo are identified.<br><br>Detailed advice on managing a risk factor if it is identified as the cause of a fall has not been included in the scope of this guideline. |

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| | | | | For adults with transient rotational vertigo on head movement:<br>• Offer the Dix- Hallpike manoeuvre to check for BPPV if a healthcare professional trained in its use is available. If there is no healthcare professional trained in the Dix-Hallpike manoeuvre available, refer in accordance with local pathways.<br>• If BPPV is diagnosed, offer a canalith repositioning manoeuvre (such as the Epley manoeuvre) if a healthcare professional trained in its use is available and if the person does not have unstable cervical spine disease. If there is no healthcare professional trained in a canalith repositioning manoeuvre available, or the person has unstable cervical spine disease, refer in accordance with local pathways.<br>• Be aware that BPPV is common after a head injury or labyrinthitis. | |
| The Association of | Guideline | 008 - 013 | General | 1.3 A second aspect of the guideline that we feel would benefit through reviewing- to | Thank you for your comment. The second bullet point you mention in recommendation 1.3.17 |

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| Chartered Physiotherapists interested in Vestibular Rehabilitation | | | | ensure the guidance is proactive and is more explicit in placing an expectation on Trusts to deliver, rather than more passive, advisory guidance- relates to deconditioning. Section 1.3.17 (pg 12 lines 5-7) suggests, "helping them to be less sedentary and more active, for example, encouraging them to get out of bed, regularly stand up and walk around, and participate in exercise activities, if appropriate."<br>Deconditioning during hospital stay is one of the most damaging[4,5,6], yet overlooked, causes of harm to many patients, but particularly those at risk of falls (as identified earlier in the guideline). Its definition as, "a complex process of physiological change that can affect multiple systems and often results in functional decline"[4], highlights its multi-system impact. This effect is often not seen until that individual moves out of the hospital bed and back into the community. It plays out through failed discharges, increased care needs, reduced independence and higher falls rates[7,8], amongst many other undesirable outcomes. There is evidence acute staff recognise their role, but often lack training/confidence to address it and that the value of implementing interventions is not always recognised[9]. This is despite a significant evidence base showing, implementing exercise to reduce deconditioning can produce multiple benefits- | (now 1.3.19) has been split into two and updated to:<br>• helping them to be less sedentary and more active, for example, encouraging them to get out of bed, get dressed and regularly stand up and walk around **and**<br>• for people able to exercise considering opportunities that focus on functional components related to the person's risk of falls, such as balance, coordination, strength and power.<br><br>Thank you for the citations. The guideline did not include a review of the impact of deconditioning on falls. The studies were checked for eligibility and none met the protocol inclusion criteria and therefore were not included in the guideline. |

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| | | | | function, mental health, future risk of falls/re-admission [10,11,12]. We suggest changing "if appropriate" at the end to "unless unsafe to do so".<br><br>1. Arshad Q, Seemungal BM. Age-Related Vestibular Loss: Current Understanding and Future Research Directions. Front Neurol. 2016 19;7:231. Erratum in: Front Neurol. 2017 Aug 21;8:391.<br>2. Cohen, Helen S.. Side-Lying as an Alternative to the Dix-Hallpike Test of the Posterior Canal. Otology & Neurotology 25(2):p 130-134, March 2004.<br>3. Halker, Rashmi B. Barrs, David M. Wellik, Kay E. Wingerchuk, Dean M. Demaerschalk, Bart M. Establishing a Diagnosis of Benign Paroxysmal Positional Vertigo Through the Dix-Hallpike and Side-Lying Maneuvers: A Critically Appraised Topic. The Neurologist 14(3):p 201-204, May 2008.<br>4. Timmer, A.J., Unsworth, C.A. & Taylor, N.F. (2014) Rehabilitation interventions with deconditioned older adults following an acute hospital admission: a systematic review. Clinical Rehabilitation; vol. 28(11) p. 1078-1086. | |

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| | | | | 5. Creditor, M.C. (1993) Hazards of hospitalization of the elderly. Annals of Internal Medicine; vol. 118: p. 219–23.<br>6. Hoenig H and Rubenstein L. (1991) Hospital-associated deconditioning and dysfunction. Journal of American Geriatric Society; vol 39: p.220–222.<br>7. Mahoney JE, Palta M, Johnson J, et al. Temporal Association Between Hospitalization and Rate of Falls After Discharge. Arch Intern Med. 2000;160(18):2788–2795.<br>8. Anne-Marie Hill, Steven M McPhail, Terry P Haines, Meg E Morris, Christopher Etherton-Beer, Ronald Shorr, Leon Flicker, Max Bulsara, Nicholas Waldron, Den-Ching A Lee, Jacqueline Francis-Coad, Amanda Boudville, Falls After Hospital Discharge: A Randomized Clinical Trial of Individualized Multimodal Falls Prevention Education, The Journals of Gerontology: Series A, Volume 74, Issue 9, September 2019, Pages 1511–1517.<br>9. Gillis, A. MacDonald, B. & MacIsaac, A. (2008) Nurses' knowledge, attitudes, and confidence regarding preventing and treating deconditioning in older adults. | |

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| | | | | The Journal of Continuing Education in Nursing vol. 39(12) p. 547-554.<br>10. McCullagh, R., O'Connell, E., O'Meara, S. (2020). Augmented exercise in hospital improves physical performance and reduces negative post hospitalization events: a randomized controlled trial. BMC Geriatrics vol. 20 article 46.<br>11. Siebens H, Aronow H, Edwards D, Ghasemi Z. (2000) A randomized controlled trial of exercise to improve outcomes of acute hospitalization in older adults. Journal of American Geriatric Society vol. 48(12) p.1545-52.<br>12. Jason R. Falvey, Kathleen K. Mangione, Jennifer E. Stevens-Lapsley (2015) Rethinking Hospital-Associated Deconditioning: Proposed Paradigm Shift, Physical Therapy, vol. 95(9) p. 1307–1315. | |
| The Association of Chartered Physiotherapists interested in Vestibular Rehabilitation | Guideline | General | General | With the release of the World Falls Guidelines in 2022, we were heartened to see the inclusion of evaluation and treatment of dizziness mentioned on seven different occasions. Whilst we are pleased to see the addition of it mentioned in the *assessment* of hospital inpatients at risk for falls, we feel the | Thank you for your comment. The bullet point on dizziness in recommendation 1.2.2 related to what to include in a comprehensive falls assessment has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider performing a Dix-Hallpike manoeuvre." A cross referral to the |

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| | | | | absence of recommendations regarding treatment is insufficient and negligent for people suffering from vestibular dysfunction and at substantial risk of falls. | NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers recommendations on what to do when dizziness and vertigo are identified. |
| University College London (UCL) | Guideline | 004, 017 | 007, 013 | When referring to a condition that could increase the risk of falls we recommend including postural hypotension (PH). PH is one of the commonest causes of falls and poorly detected in general practice – see our evidence here: https://bjgp.org/content/73/726/e9 | Thank you for your comment. The committee did not include all conditions in the definition because the list is not exhaustive. The committee agreed postural hypotension should be picked up in a comprehensive falls assessment by the bullet point on dizziness. A cross referral to the section on dizziness and vertigo in the NICE guideline suspected neurological conditions has also been added. This covers recommendations on what to do when dizziness and vertigo are identified. |
| University College London (UCL) | Guideline | 008 | 012 | We agree medication review is an important intervention to reduce a person's risk of falls. We would recommend that medications causing drug-induced postural hypotension is paid particular attention to, and these span a large range of groups including psychotropic, antihypertensive & urological medications. See our evidence here: https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1003821 There is also a risk when these are prescribed together and the combinations of medications that patients are on should also | Thank you for your comment. Evidence was only found for the effect of psychotropic medicines on falls. Neither study mentioned look at falls and were not included in the guideline reviews. |

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| | | | | be considered; see our evidence here: https://pubmed.ncbi.nlm.nih.gov/37974394/ | |
| University College London Hospital NHS Foundation Trust | Guideline | 004 | 005 | What mechanisms will be implemented to monitor this? | Thank you for your comment. The updated quality standard is being published at the same time as this guideline. This advises that data are collected related to the number of people asked about falls. |
| University College London Hospital NHS Foundation Trust | Guideline | 005 | 004 | Is this approach feasible in typical outpatient settings? | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an |

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| | | | | | appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| University College London Hospital NHS Foundation Trust | Guideline | 005 | 016 | Can this be effectively addressed and managed by GP's? | Thank you for your comment. The committee noted that an assessment of gait and balance can be done by a simple test such as the Time up and Go test (TUG) which is designed to be done with minimal training. Although this does not predict a person's risk of falling it may help identify people who need a more detailed assessment.<br><br>The recommendation has also been updated to note that this can be carried out in the same service or involve an appropriate referral. |
| University College London Hospital NHS Foundation Trust | Guideline | 005 | 019 | Due to the time constrains for the OP appointment and expertise required from staff, this issue cannot be effectively addressed or evaluated within the general OP settings. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be |

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| | | | | | carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| University College London Hospital NHS Foundation Trust | Guideline | 007 | 002 | Who should perform the osteoporosis risk assessment and when in the acute setting – what is the time frame for this assessment? | Thank you for your comment. Detail on how to do assessments of specific factors has not been included in this guideline because this would be covered by other guidelines. Where an existing NICE guideline exists with details of how to assess that are relevant to falls prevention, we have added a cross link to this. A link to the |

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| | | | | | NICE guideline on osteoporosis which is currently been updated has been added.<br><br>We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure |

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| | | | | | and medication checks), whereas others may require referral to a specialist. |
| University College London Hospital NHS Foundation Trust | Guideline | 007 | 008 | Who is responsible for conducting the neurological assessment in the acute care environment, and what is the recommended timeframe for this evaluation? | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For |

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| | | | | | example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| University College London Hospital NHS Foundation Trust | Guideline | 008 | 013 | Who should carry out the structured medication review, and what are the proposed timelines for this process? Could the NICE guidelines be more specific by clearly delineating the responsibilities assigned to pharmacists and doctors? | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist |

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| | | | | | outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| University College London Hospital NHS Foundation Trust | Guideline | 009 | 004 | Vitamin D Supplement Recommendation: - To what extent is this being visible within outpatient settings? - How will this recommendation be managed in outpatient contexts, where appointments typically last 15 minutes and may not adequately address such issues? It is essential that these aspects are addressed and monitored by general practitioners rather than being handled in outpatient and acute care settings. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving |

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| | | | | | any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| University College London Hospital NHS Foundation Trust | Guideline | 010 | 004 - 005 | Who would be best suited to address this matter? | Thank you for your comment. The committee agreed that for some assessments and interventions that there would need to be an appropriate referral. Recommendation 1.1.3 has been updated to state "Offer a comprehensive falls assessment and comprehensive falls management to people who have fallen in the last year and meet any of the following criteria (this can be carried out in the same service or involve an appropriate referral)". The rationales have also been updated to reflect this. |
| University College London Hospital NHS Foundation Trust | Guideline | 011 | 024 | Vitamin D – while the evidence is limited, it raises the question of why this supplement is included and recommended by NICE. | Thank you for your comment. Vitamin D has been included as a specific intervention in the guideline because it was included in the scope and the committee agreed it would be advisable to link to existing NHS and NICE guidelines to ensure everyone is aware of government guidance on taking vitamin D. |
| University Hospital Southampton NHSFT | Guideline | 005 | 004 | In certain specialties –e.g. gastroenterology, dermatology, surgery – 'the opportunistic asking' is very unlikely to be possible given all the other GIRFTFF activities we have to fit into the allocated clinic time. Also, | Thank you for your comment. The committee realise this may not be possible in every circumstance and have worded the recommendation as 'this can be done' to reflect this. |

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| | | | | consultants already struggle with balancing the time given to the patients and time required to interact with our IT system. There is not enough time to provide a wide holistic consultation and therefore it is impossible to achieve the NICE falls recommendation for all Outpatients settings | |
| University Hospital Southampton NHSFT | Guideline | 005 | 019 | Not every region will have a dedicated falls prevention intervention in place. Therapy services are already stretched with long waiting list for patients discharged from hospital required community therapy. Whilst it is a very good suggestion, implementing this guideline will incur huge costs and require a significant increase in workforce and resources to deliver. This may not be feasible in the current climate and trusts will inevitably fall short in terms of implementing this guidance. | Thank you for your comment. The committee made the recommendation based on the best available evidence. They agreed that people with gait and balance impairments who have fallen are more likely to fall again. They are also the group most likely to see benefit from exercise. The committee anticipate that exercise programmes can be delivered by qualified fitness instructors and do not need to be prescribed through NHS settings in all cases. The cost effectiveness evidence showed that exercise can be beneficial in preventing falls, it showed that a home-based exercise programme or group exercise are more likely to be cost effective compared to usual care or no exercise (evidence review F1). However, the committee agreed that there was not enough evidence to state explicitly which type of exercise should be used.<br><br>Recommendation 1.1.3 has also been updated to advise that comprehensive falls assessment and comprehensive falls management can be carried out in the same service or involve an appropriate referral. It is down to individual ICBs |

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| | | | | | as to how these recommendations are implemented, based on their local population needs' or resources. |
| University Hospital Southampton NHSFT | Guideline | 006 | 12 | The comprehensive falls assessment is brilliant. However, not many will have the competencies to undertake this. Not many clinicians from a wide range of specialties are trained to undertake Dix HallPike for example, or comfortable deprescribing. Will these patients require referral to geriatrics outpatient service? If so, again, there may not be the capacity to undertake this without adequate resource and workforce. Significant challenge in real life implementation. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care services, community teams or specialist outpatient clinics (such as falls or geriatric |

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| | | | | | outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 005 | 004 | 1.1.3 – Majority of our outpatient settings won't be able to complete comprehensive falls assessments due to time restrictions but after identifying patients benefitting from one can refer patients to falls services for more detailed assessment. This may increase number of referrals to falls services. | Thank you for your comment. We have made the distinction of who is acting on the recommendations clearer between identification, assessment and management. These recommendations in section 1 are about identification of people for comprehensive falls assessment and management. They have been updated to make it clearer that comprehensive falls assessment and management can be carried out in the same service or involve an appropriate referral. The rationale has also been updated to explain that these recommendations may not be practical in all settings because not every service would have all of the relevant expertise or time to carry this out. Outpatient appointments have been given as an example of where any risk factor identified could be added to the letter usually sent to the GP to update them about the person's appointment.<br><br>The rationale for recommendations in section 1.2 on comprehensive assessment has also been updated to note that comprehensive falls assessment could be carried out by an appropriately trained single healthcare professional or a multidisciplinary team involving any of the following services, primary care |

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| | | | | | services, community teams or specialist outpatient clinics (such as falls or geriatric outpatient services or assessment units). For example, some assessments could easily be done in primary care (such as, blood pressure and medication checks), whereas others may require referral to a specialist. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 005 | 016 | 1.1.4 – We are concerned that not every clinician has skills to assess gait and balance in detail and identify possible problems. This is a welcome recommendation but may be challenging to implement unless investment is put in place for falls/therapy service to meet the demand. | Thank you for your comment. The committee noted that an assessment of gait and balance can be done by a simple test such as the Time up and Go test (TUG) which is designed to be done with minimal training. Although this does not predict a person's risk of falling it may help identify people who need a more detailed assessment.<br><br>The recommendation has also been updated to note that this can be carried out in the same service or involve an appropriate referral. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 005 | 019 | 1.1.5 – We agree with the recommendation. However, Dorset has work to do to map out available evidence based falls prevention exercise programmes that follow fidelity and validity and are able to offer recommended number of sessions and access for on-going long term programmes. | Thank you for your comment. The committee made the recommendation based on the best available evidence. They agreed that people with gait and balance impairments who have fallen are more likely to fall again. They are also the group most likely to see benefit from exercise. The committee anticipate that exercise programmes can be delivered by qualified fitness instructors and do not need to be prescribed through NHS settings in all cases. The cost effectiveness evidence showed that exercise can be beneficial in preventing falls, it |

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| | | | | | showed that a home-based exercise programme or group exercise are more likely to be cost effective compared to usual care or no exercise (evidence review F1). However, the committee agreed that there was not enough evidence to state explicitly which type of exercise should be used.<br><br>Recommendation 1.1.3 has also been updated to advise that comprehensive falls assessment and comprehensive falls management can be carried out in the same service or involve an appropriate referral. It is down to individual ICBs as to how these recommendations are implemented, based on their local population needs' or resources.<br><br>It is also worth noting that the evidence in evidence review F1 includes some relating to specific exercise programmes shown to be potentially effective.<br><br>Examples of programmes have been included in the tools and resources section of the NICE guideline web page. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 006 | 003 | 1.1.7 This is already in place within our organisation – all inpatients over the age of 50 have falls assessment completed. | Thank you for your comment. |

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| University Hospitals Dorset NHS Foundation Trust | Guideline | 006 | 018 | 1.2.2 Would be beneficial if there was a national template what the comprehensive falls assessment should look like – this would support aligning electronic health/patient records if same template is used nationwide. | Thank you for your comment. Evidence was not available to create a template for what a comprehensive falls assessment could look like. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 007 | 002 | Osteoporosis risk assessment is a welcome addition to guideline. If expectation is to complete FRAX – would be helpful if FRAX can be imbedded and used with different digital systems instead of using the Sheffield website. | Thank you for your comment. A link to the NICE guideline on osteoporosis which is currently been updated has been added. Currently, the guideline recommends using either QFracture or FRAX although this may change with the update. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 007 | 015 | We agree with this statement but challenge may arise with having sufficient number of clinicians available to complete Hallpike-Dix manoeuvre and maintain clinicians competencies. | Thank you for your comment. The committee made the recommendation based on it being good practice. It is a weaker 'consider' recommendation to reflect the lack of evidence. The bullet point related to dizziness has been updated to "asking about presence and nature of dizziness. If rotational vertigo is reported, consider performing a Dix-Hallpike manoeuvre." A cross referral to the NICE guideline on suspected neurological conditions for further assessment and management of symptoms of dizziness and vertigo has also been added. This covers recommendations on what to do when dizziness and vertigo are identified. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 009 | 010 | 1.3.5 – Home Hazard assessment to be completed only by a registered occupational therapist will be challenging to meet. We currently rely on other registered professionals and support workers | Thank you for your comment. Following stakeholder comments the recommendation has been updated and split in two to state "Offer a home hazard assessment and intervention using a validated tool." and "Consider having the |

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| | | | | completing home hazard assessments and their competency to complete these has been assessed by an OT. Currently there is not a large enough OT workforce to meet the demand and OT's would not have capacity to focus on complex case management if expectation is for them to be completing all home hazard assessments. | home hazard assessment and intervention from recommendation 1.3.5 carried out by an occupational therapist. If an occupational therapist does not carry out the assessment and intervention, it may be done by a trained healthcare professional or a trained therapy assistant or technician, with supervision from a trained healthcare professional."<br><br>Economic modelling found that having the occupational therapist deliver the home hazard assessment and intervention is the most cost-effective approach, but the committee recognise that the recommendation may be difficult to implement. Therefore, they amended this to consider' the OT doing the home hazard assessment and intervention. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 009 | 022 | 1.3.9 This is a welcome addition with more detail and structure what Falls Prevention Exercise Programmes should look like. | Thank you for your support. |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 010 | 004 | 1.3.10 Access and availability of cognitive behavioural therapy is a concern | Thank you for your comment. The committee agreed that this would not be for everyone, just people who did not respond to treatment. They made the recommendation based on it being good practice. It is a weaker 'consider' recommendation to reflect the lack of evidence. |
| University Hospitals | Guideline | 011 | 012 | Within our organisation there are some initiatives started that will help to meet | Thank you for your comment. |

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| Dorset NHS Foundation Trust | | | | demand for this recommendation. Trust has a need to increase workforce that has skills and ability to individually tailor exercise sessions. Funding for training can be a barrier. | |
| University Hospitals Dorset NHS Foundation Trust | Guideline | 011 | 015 | 1.3.14 We agree with this statement. However, community services need to have resources to meet the demand to complete and respond to referrals following discharge. | Thank you for your comment. NICE guidelines aim to develop evidence-based recommendations that focus on those with the most need. The committee consider this to be good practice to ensure future falls are prevented. They also believe it is likely to already be happening in a lot of cases. However, this is a 'consider' recommendation to reflect the lack of evidence. |
| University of Portsmouth | Evidence review F | General | General | Evidence review F: Exercise, multicomponent/ multifactorial and environment - We note that wider environmental interventions (e.g. street environments, public spaces) did not fall within the scope of this review. Healthcare professionals could have a role to play in supporting individuals at risk in these environments (for example in providing evidence-based advice around handrail use, or carrying of objects on escalators), Integrated Care Boards may facilitate the implementation of evidence-based design principles across local authorities, and members of the public may also desire guidance in these areas. There is emerging research in this area that both highlights the increased falls risk for older adults when | Thank you for your comment. The scope of the guideline was to cover NHS health and social care settings, including in residential care and people's homes. Interventions in public spaces was not part of the guideline. |

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| | | | | using an escalator (e.g. https://doi.org/10.1016/j.ssci.2021.105597), and evaluation of interventions aimed at reducing falls risk (e.g. https://doi.org/10.1016/j.exger.2023.112117). We would advocate for the panel to recommend further research to better understand how community environments could be better designed to reduce falls. | |
| University of Portsmouth | Evidence review F2 | 009 | 014 | The text currently reads: "*A new Cochrane (Drahota 2024 unpublished)*" – this review is now published: https://doi.org/10.1002/14651858.CD013480.pub2. Can this text be updated to say: "A new Cochrane review (Drahota 2024)" | Thank you for your comment. This has been amended to say 'a new Cochrane review (Drahota 2024)'. |
| University of Portsmouth | Evidence review F2 | 009 | 015 | The text currently reads: "*This has different categorisation of the interventions than Gillespie 2012, but included Cognitive Behavioural Interventions, motivational interviewing, other psychological interventions (health coaching, guided imagery, mental practice) and multifactorial and multicomponent education*." We believe the categorisation was broadly similar between both reviews. More studies were included in the updated review, since over a decade of research separates them, hence the updated review gave rise to the opportunity to explore educational interventions in more depth, and it assesses more categories of psychological interventions (which were not available in the | Thank you for your comment. The evidence review has been updated in line with your suggestions. |

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| | | | | Gillespie review). One study (Reinsch, 1992) was evaluated differently in the updated Cochrane review, which had taken a closer look at the component parts of the intervention and determined that it was not cognitive behavioural therapy. We acknowledge that different review teams may evaluate studies slightly differently, and there are situations whereby certain studies may be classifiable into more than one category, hence the updated split reviews on the Cochrane Library (e.g. exercise, multiple component, multifactorial, environmental, and education/psychological) may also demonstrate a degree of overlap in the studies they have included. We request that the text be updated to say: "*This incorporated additional categorisations of the interventions compared to Gillespie 2012, including Cognitive Behavioural Interventions, motivational interviewing, other psychological interventions (health coaching, guided imagery, mental practice) and single-topic, multifactorial, and multicomponent education.*" | |
| University of Portsmouth | Evidence review F2 | 009 | 019 | The report states "*Most of the studies they included can be found in our reviews on psychological, educational, multifactorial and multicomponent, and environmental interventions*."<br>We are not sure that this is an accurate statement, since we believe at least 7 studies | Thank you for your comment. The technical team cross-checked every study included in the Cochrane review to assess eligibility of inclusion based on our pre-specified review protocols developed for the evidence reviews. Any studies that did not fulfil the inclusion criteria were not included. To make this clearer we have |

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| | | | | that contributed outcome data to the Cochrane review have not been incorporated in to the NICE review (two of these 7 were non-English language so may not have been eligible for the NICE review).<br><br>The Cochrane review included 24 studies on education, albeit 11 of these did not report on the key outcomes of interest (Alipour 2020; Baskaran 2019; Gustafson 2021; Harari 2008; Li 2014; Midha 2015; Mozaffari 2018; Nick 2013; Sá 2020; Schepens 2011; Ziden 2014; NB. the reporting of specific outcomes did not form part of the eligibility criteria in the Cochrane review). Only five of the 13 'education' studies measuring key outcomes have been included in the NICE review and classified as education (Dapp 2011; Hill 2019; Huang 2010; Robson 2003; Ryan 1996). Three studies (Kamei 2015; Lord 2005; Tannenbaum 2019) have been classified as environmental (Kamei 2015), multifactorial (Lord 2005) or multiple component (Tannenbaum 2020). A further five studies which contributed outcome data on educational interventions to the Cochrane review, do not appear to have not been incorporated into the NICE review or listed in the excluded studies to indicate they had been assessed (Bustamante-Troncoso 2020; Gholamzadeh 2021; NCT02774889 2016; Pekkarinen 2013; Zareipour 2020). | amended the text as follows: '*Studies included in the Cochrane review that fulfilled our inclusion criteria can be found in the evidence reviews on psychological, educational, multifactorial and multicomponent, and environmental interventions.'*<br><br>With regard to the studies on education, studies without fall outcomes were not included. Kamei 2015 was classified as environmental as it is in the Clemson Cochrane review; Lord 2005 was classified as multifactorial in the Hopewell Cochrane review and Tannenbaum 2019) was classified as multiple component. The further five studies which have not been incorporated into the NICE review are due to the following reasons: (Bustamante-Troncoso 2020 (non-English language); Gholamzadeh 2021 (only relevant outcome QoL); NCT02774889 2016 (not published); Pekkarinen 2013 (no relevant outcomes); Zareipour 2020 (non-English language).<br><br>Regarding the cognitive behavioural interventions: Zijlstra 2009 was categorised as multifactorial in the Hopewell Cochrane review. Lim 2022 and Liu 2014 do not have the outcomes that were in our protocol.<br>Those studies not included in the reviews have been added to the exclusion lists. |

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| | | | | Of the six studies the Cochrane review classified as cognitive behavioural interventions (Dorresteijn 2016; Huang 2011; Lim 2022; Liu 2014; Parry 2016; Zijlstra 2012), the NICE review has included three of these in the same category, and Zijlstra 2012/2009 has been classified as multifactorial in the NICE review. Lim 2022 and Liu 2014 do not appear to have been assessed or included in the NICE review.<br><br>We request that NICE review take better account of the Cochrane evidence. One option is for the panel to evaluate the conclusions of the Cochrane review on psychological and educational interventions against the conclusions of their own review, if the conclusions are broadly similar (which we believe they are), and do not therefore change the NICE panel's recommendations, we request a change to the wording to this section, along the lines of:<br><br>*Whilst additional studies were incorporated into Drahota 2024, the overall conclusions have been assessed against the findings of the present review, to establish that our recommendations should remain the same.* | |
| University of Portsmouth | Evidence review F2 | 010 | 014 | Typographical error (insert h): Where standard errors | Thank you for your comment. This has been amended. |

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| University of Portsmouth | Evidence review F2 | 010 | 017 | Typographical error (were instead of was): Only trials with complete data were used | Thank you for your comment. This has been amended. |
| University of Portsmouth | Evidence review F2 | 011 | 005 | The text currently reads: "*One Cochrane review (Gillespie, 2012)22 was identified in the search, which included 4 randomised controlled studies. One study (Hill 2019)29 was identified from our search of the evidence, which although was initially in hospital the intervention continued in the community. These studies are summarised in Table 2 below.*"<br>We suggest an additional sentence or two be incorporated to highlight that the recently published Cochrane review (Drahota 2024) also identified that the evidence for educational interventions was of low, or very-low certainty. The review concluded that personalised (multifactorial) education made little-to-no difference to the rate of falls, and the evidence for other types of education (multiple topic, or single topic) on rate of falls was very uncertain. Drahota 2024 concluded that the effect of education (personalised, multiple topics, or single-topic) on number of fallers and fall-related fractures was very uncertain. | Thank you for your comment. This section of the review describes the included studies. It does not include reporting the quality of the evidence or findings which are discussed in committee discussion section of the report. We have instead added this information to the committee discussion section of the review. |
| University of Portsmouth | Evidence review F2 | 013 | 001 | In the comments column of Table 3, it is stated "*benefit of education*" in the row for number of fall-related fractures. Since the 95% CI crosses both MIDs (into both benefit and harm), it appears as though the statement that the there is a benefit maybe | Thank you for your comment. The MID's stated are in relation to the confidence intervals around the effect size and whether imprecision is present. The benefit/harm ratings are just a guide for the committee and are based on the effect estimate. The committee take into account |

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| | | | | misleading. Similarly, there is a statement that there is "no difference" to rate of falls, yet again here the 95% CI crosses both MIDs. We suggest it might be more accurate to state that the evidence is very uncertain in these instances. | the overall quality and uncertainty of the finding when making their decisions. The committee discussion has been updated to note that there was no benefit for rate of falls and there was uncertainty in the results for rate of fracture. |
| University of Portsmouth | Evidence review F2 | 013 | 004 | We suggest the team consider the following health economic study for eligibility: https://link.springer.com/article/10.1007/s10433-019-00505-1 | Thank you for your comment. This paper would not be included in the evidence review as it has a societal perspective and does not report the healthcare only costs. |
| University of Portsmouth | Evidence review F2 | 014 | 014 | The report states:<br>"*The review on education interventions for falls prevention only found evidence for the outcomes rate of falls and number of fallers. No evidence was found for the outcomes of number of people sustaining one or more falls, adverse events and for the outcome of health-related quality of life.*"<br>We believe there is a typographical error here, as it states that evidence was found for the number of fallers, but not the number of people sustaining one or more falls. However, the 'number of fallers' and 'number of people sustaining one or more falls' is the same outcome just expressed in different words. Evidence is also reported on the number of fall-related fractures in the table above this statement (Table 3), but is not mentioned here.<br><br>Data exists from studies that do not appear to have been assessed for inclusion in the | Thank you for your comment. Evidence is reported for rate of falls, number of fallers and number of fall related fractures. The sentence has been amended to include 'number of fall related fractures'.<br><br>Studies were only included if they reported a falls outcome. Gholamzadeh 2021 does not report fall outcomes, only health related quality if life and this has been added to the exclusion list. NCT02774889 2016 has not been included because it did not have a publication. |

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| | | | | NICE review on quality of life (Gholamzadeh 2021; NCT02774889 2016). These data are summarised in the Cochrane review - Drahota 2024, as are some limited data for adverse events. The NICE evidence could better incorporate this review to inform the findings. | |
| University of Portsmouth | Evidence review F2 | 014 | 037 | We suggest the team consider the following health economic study for eligibility: https://link.springer.com/article/10.1007/s10433-019-00505-1 | Thank you for your comment. This paper would not be included in the evidence review as it has a societal perspective, and does not report the healthcare only costs. |
| University of Portsmouth | Evidence review F2 | 065 | 009 | Section 1.1.38.1.<br>'Reinsch, 1992' has been classified as a study comparing cognitive behavioural treatments (CBT) to control. This terminology maybe commonly confused with cognitive behavioural therapy (which is the more common use of the acronym CBT, and is used elsewhere in the documentation). However, a closer inspection of the intervention provided in Reinsch 1992 study suggests that this was not cognitive behavioural therapy. Whilst the study authors describe the intervention as a "*cognitive-behavioural intervention*" (not CBT), what this actually entailed was education, relaxation training, and videogame playing to improve reaction time. This does not fit with the common notion of cognitive behavioural therapy. | Thank you for your comment. When updating a Cochrane review, we checked the studies against our own inclusion criteria and categorise them according to our protocol. Generally, we keep the studies under the same strata as the Cochrane reviews unless they do not fit with our protocol, or we have a clear reason to change them. This study was also included in another more recent Cochrane review by Lenouvel 2023 which focused on CBT intervention only. The reviewers here also state that it included a CB protocol, so we believe that the study has been included under the correct intervention. |

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| | | | | There are a number of other research studies exploring cognitive training interventions, that have not been included in any of the Cochrane reviews or the NICE review (for example that aim to improve memory, reaction time, orientation, and attention); Additional studies evaluating cognitive training are listed in the characteristics of excluded studies section of Drahota 2024. Later on (Table 16), a cognitive training intervention is listed as included (Chantanachai 2024) however this section (1.1.38.1) does not indicate that cognitive training interventions have been incorporated, or clearly defined what 'cognitive behavioural treatments' means.<br><br>We request that Reinsch 1992 is not classified as a study evaluating Cognitive Behavioural Therapy (or in a way that could be easily confused as such). If the study is to be combined with other studies evaluating CBT, then the language could be updated to call these interventions "cognitive behavioural interventions" (for example) and a definition provided of what is eligible to include within this category. In this situation, other cognitive training studies may need to be considered for inclusion in the review, and a consideration made around whether it makes sense to combine them. | |

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| | | | | Alternatively Reinsch 1992 maybe reclassified as cognitive training, or a multiple component intervention, and combined with any other studies of a similar nature. | |
| University of Portsmouth | Evidence review F2 | 065 | 016 | The table number requires updating to match the appropriate table. | Thank you for your comment. This has been amended. |
| University of Portsmouth | Evidence review F2 | 065 | 018 | Since the recent Cochrane review (Drahota 2024) incorporated more studies than were included in this evidence review, we recommend that an evaluation is made as to whether the conclusions differ from those of the NICE review and any impact of this on the NICE recommendations. Mention of this could be made in section 1.1.38.1. Alternatively, rather than basing the evidence review of psychological interventions on the out-dated Gillespie 2012 review, the evidence could be more directly based on Drahota 2024, akin to how other updates of Gillespie 2012 have been incorporated elsewhere (e.g. for exercise and multifactorial interventions). | Thank you for your comment. Drahota 2024 was published after the search cut-off date for this guideline, therefore it has not been included. However, the studies included in Drahota 2024 were assessed for inclusion against our protocol eligibility criteria. Studies from this review had either been included in our other reviews or did not meet the inclusion criteria for our protocols. Drahota 2024 will also be taken into consideration for future updates of this guideline. |
| University of Portsmouth | Evidence review F2 | 065 | 018 | A link error needs to be resolved. | Thank you for your comment. This has been corrected. |
| University of Portsmouth | Evidence review F2 | 067 | Table 16 | 2nd column - Reinsch 1992 did not deliver cognitive behavioural therapy (the CBT acronym could be easily confused as such). This study delivered a combination of education, relaxation training, and videogame playing (to improve reaction time). | Thank you for your comment. We have changed the recommendation to cognitive behavioural interventions to ensure that these studies are labelled correctly. This study was included in the Gillespie Cochrane review and a more recent Cochrane review by Lenouvel 2023 which focused on CBT interventions only. The |

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| | | | | | reviewers here also state that it included a CB protocol, so we believe that the study is okay to be included within the review. |
| University of Portsmouth | Evidence review F2 | 068 | 005 | The row associated with 'Number of fallers' has a comment that the CI crosses 1 MID however this is not the case, as the lower CI is >0.8 and the upper CI is <1.25 | Thank you for your comment. This has been corrected. |
| University of Portsmouth | Evidence review F2 | 069 | Table 17 | Final column - The rows associated with: 'Number of fall-related fractures' and 'Number of adverse events'. These findings have a comment that the CI crosses 1 MID, however the CI crosses 2 MID (incorporating both potential benefit and harm). It therefore feels potentially misleading to make the comment that there is a benefit of CBT. It feels more appropriate to say that the evidence<br>is very uncertain. The footnote 'c' requires updating in relation to this point (amend to 'd'). | Thank you for your comment. The footnotes have been corrected. The MID's stated are in relation to the confidence intervals around the effect size and whether imprecision is present. The benefit/harm ratings are just a guide for the committee and are based on the effect estimate. The committee take into account the overall quality and uncertainty of the finding when making their decisions. |
| University of Portsmouth | Evidence review F2 | 070 | Table 18 | Final column - The comments for rate of falls on Table 18 imply that the intervention makes no difference, however the 95% CI extends into possible harm. It feels more appropriate to conclude that the results are uncertain with these wide confidence intervals. | Thank you for your comment. The MID's stated are in relation to the confidence intervals around the effect size and whether imprecision is present. The benefit/harm ratings are just a guide for the committee and are based on the effect estimate. The committee take into account the overall quality and uncertainty of the finding when making their decisions |
| University of Portsmouth | Evidence review F2 | 070 | Table 18 | 4th column - The data for number of fallers are quite different to the Cochrane review (Drahota 2024), which reports: RR 1.44 (0.97 | Thank you for your comment. The data included in this review was taken directly from the 1-year follow-up publication (Tuvemo-Johnson 2021). |

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| | | | | to 2.14) [implying uncertainty] vs. RR 1.58 (1.06 to 2.36) in the NICE data [implying potential harm]. There are numerous study reports associated with Arkkukangas 2019, with some of them providing conflicting information, and multiple follow-up points. A sensitivity analysis on these data would likely suggest more uncertainty. | The data reported in the Cochrane review, although also 1 year data, is taken from the subsequent publication Arkkukangas 2020 which itself is the 2-year follow-up publication of the same trial. It is unclear why the 1-year data reported in Arkkukangas 2020 differs to the 1-year follow-up trial publication (Tuvemo-Johnson 2021). We prioritise extraction from the original source where available. |
| University of Portsmouth | Evidence review F2 | 070 | Table 18 | Final row - Data are presented on 4 RCTs reporting on quality of life (identical numbers to cognitive behavioural treatments above), despite there only having been mentioned one RCT on motivational interviewing. We believe some of these data on this row are entered in error. | Thank you for your comment. This has been corrected. |
| University of Portsmouth | Evidence review F2 | 073 | 012 | Here CBT is described as referring to cognitive behavioural *therapy*, which contradicts earlier uses of the acronym (cognitive behavioural *treatments*) and the data that have contributed to the analyses (which were not all cognitive behavioural therapy). | Thank you for your comment. The evidence report, rationale and recommendation have been updated to state cognitive behavioural intervention to reflect the included evidence. The included studies for this section have been reassessed to ensure they contain a cognitive behavioural intervention. |
| University of Portsmouth | Evidence review F2 | 073 | 023 | The data for motivational interviewing come from a single study which is reported across numerous articles. There are reporting discrepancies between the papers, but the study concludes that the findings were non-significant. It may not be accurate to state | Thank you for your comment. We have updated the discussion to state that there were discrepancies between the papers. We have checked and the study favoured the standard care arm for number of fallers. We have made it clear that this was just for the outcome for number of fallers. |

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| | | | | that the intervention favoured the standard care arm. | |
| University of Portsmouth | Evidence review F2 | 73 | 15 | It would be appropriate to refer to the Cochrane review here (Drahota 2024), which did assess concerns about falling as an outcome, and found a small benefit in favour of cognitive behavioural interventions. These findings could better substantiate the NICE guideline developers' conclusions. See also the Cochrane review by Lenouvel et al (2023). | Thank you for your comment, our protocol did not include concerns about falling as an outcome so this would not be included in the review. |
| University of Portsmouth | Evidence review F2 | 73 | 15 | We recommend the language "concerns about falling" as opposed to "fear of falling". For a rationale behind this amendment, please see: https://doi.org/10.1093/ageing/afad057 | Thank you for your comment and the rationale. This has been amended. |
| University of Portsmouth | Evidence review F2 | General | General | Chantanachai 2024 (described as a cognitive training study) is presented in Table 16 (pg 65) as an included study, however it is not described as one of the included studies in section 1.1.38.1. and no mention of including cognitive training interventions has been made up until this point. A number of other cognitive training studies may have been missed if these are to be included (see list of excluded studies in the Cochrane review, Drahota 2024 for example). This study has been combined with other studies under "CBT" which are later summarised as contributing evidence on cognitive behavioural therapy. This study did not | Thank you for your comment. We have changed the recommendation to cognitive behavioural interventions to ensure this is the correct terminology for the evidence that we have. The included studies for this section have been reassessed to ensure they contain a cognitive behavioural intervention. Since Chantanachai 2024 contains a cognitive training intervention rather than cognitive behavioural intervention, it has now been excluded. |

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| | | | | explore cognitive behavioural therapy and it would not be appropriate to include it in a meta-analysis of this nature. | |
| University of Portsmouth | Evidence review F2 | General | General | Suggest that the acronym CBT is updated throughout, as it does not appear to consistently stand for cognitive behavioural therapy, and this could be easily misinterpreted as such. | Thank you for your comment. The acronym CBT in this guideline does refer to cognitive behavioural therapy. However, we have updated the recommendation to 'cognitive behavioural interventions' after reassessing the included studies for this section. Since Chantanachai 2024 contains a cognitive training intervention rather than cognitive behavioural intervention, it has now been excluded. |
| University of Portsmouth | Evidence review F2 | General | General | Some of the data extracted/calculated to inform the analyses for psychological and educational interventions does not completely tally with the Cochrane review (Drahota 2023). These are mostly minor discrepancies which are unlikely to make a big difference to the findings, and may be a result of having the choice of multiple time-points, multiple scales, adjustments for clustering, analysis techniques, rounding, or potential extraction errors. However, it would be good if the NICE guidelines and Cochrane review more closely aligned to avoid potential confusion and ensure the quality of the data underpinning the guidelines. The review team could work with the corresponding author of the Cochrane review to try and resolve these discrepancies. | Thank you for your comment. Drahota 2024 was published after the search cut-off date for this guideline, therefore it has not been included. However, the studies included in Drahota 2024 were assessed for inclusion against our protocol eligibility criteria. Studies from this review had either been included in our other reviews or did not meet the inclusion criteria for our protocols. Drahota 2024 will also be taken into consideration for future updates of this guideline. |

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| University of Portsmouth | Evidence review G | 038 | 006 - 027 | Environmental interventions - A discussion is provided around the use of vinyl flooring being standard practice in hospitals and how this maybe better than carpet for falls prevention. There is emerging evidence around the relative shock-absorbency of floor coverings in hospitals, however there is currently no guidance on suitable levels of shock-absorbency, and the use of shock-absorbent underlays or special floors (that have the same cleaning properties as vinyl) is not standard practice. Harder floors (i.e. standard vinyl) may provide more stability underfoot to prevent falls, however these may also be more of a risk to land upon. Evidence suggests that certain shock-absorbing floors may not increase the risk of falls, and may help prevent severe falls, however that evidence is of very-low certainty and so further research is warranted in this area. Observational evidence from care homes also suggests that wooden subfloors (versus concrete subfloors) may help prevent severe falls, and this could have implications for hospital layouts and where to locate wards that support predominantly older adults. See: https://doi.org/10.3310/ZOWL2323 for a summary of the evidence. We request that the NICE panel broaden their considerations of floor properties to include a discussion of | Thank you for your comment.<br>We have checked the evidence from the document you have provided and only three studies were RCTs, and were included in our reviews as follows: Mackey 2019: included in review G for residential<br>Donald 2000 included in hospital review H.<br>Drahota 2013 was excluded from the included Cochrane review. There is not enough RCT evidence to include a discussion of the relative hardness/shock-absorbency of floor coverings. It could be a consideration in future updates of the guideline |

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| | | | | the relative hardness/shock-absorbency (also called 'compliance') of floor coverings. | |
| University of Portsmouth | Evidence review G | General | General | There is a Health Technology Assessment systematic review on flooring interventions in hospitals and care homes that could help underpin the 'environment' recommendations in the guidance: https://doi.org/10.3310/ZOWL2323. This included an assessment of rate of falls, fallers, fractures, and adverse events, and economic studies. RCTs and observational studies are assessed separately. Donald 2000 has been identified and included in the NICE evidence, however a further pilot cluster RCT on flooring has been omitted (https://doi.org/10.1093/ageing/aft067). | Thank you for your comment. The HTA was a systematic review of observational studies as well as RCTs. The committee agreed when setting protocols that RCT was the best evidence to use and therefore all our reviews only included these. We have used the original Cochrane reviews as the basis of our evidence rather than doing original searches. Donald 2000 was included in the Cameron Cochrane review whereas the pilot cluster study you mention was excluded because it assessed an intervention to reduce injuries from falls rather than reducing falls. The systematic review has been checked, and all relevant studies were included in our review. |
| University of Portsmouth | Evidence review H | 077 | 011 - 016 | Environmental interventions - Wider consideration could be given to the evidence on flooring interventions here (https://doi.org/10.3310/ZOWL2323). It could also be considered that for certain environmental interventions, randomised controlled trials may not always be the most appropriate form of evidence to draw upon, and observational research maybe better. For example, observational research has compared concrete versus wooden subfloors in care homes on fracture rates, and this would not have been feasible to do with an RCT. | **Thank you for your comment. The committee agreed when setting protocols that RCT was the best evidence to use and therefore all our reviews only included these. The systematic review cited included both observational and RCT data. We have cross-checked the RCTs to ensure we have these included in our reviews.** |

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| University of Portsmouth | Evidence review H | General | General | There is a Health Technology Assessment systematic review on flooring interventions in hospitals and care homes that could help underpin the 'environment' recommendations in the guidance: https://doi.org/10.3310/ZOWL2323. This included an assessment of rate of falls, fallers, fractures, and adverse events, and economic studies. RCTs and observational studies are assessed separately. There is an RCT of a flooring intervention in care homes that has not been included in the NICE review of evidence (https://doi.org/10.1371/journal.pmed.1002843) | Thank you for your comment. The HTA was a systematic review of observational studies as well as RCTs. The committee agreed when setting protocols that RCT was the best evidence to use and therefore all our reviews only included these. We have cross-checked the RCTs to ensure we have these included in our reviews.<br><br>Mackey 2023 the FLIP study was included in our evidence review H as Mackey 2019. |
| University of Portsmouth | Guideline | 018 | 005 | We believe that this recommendation (interventions addressing the environment) could also be applicable to care home settings, since these are also high-risk environments for falls with limited environmental research. | Thank you for your comment. We agree and have now added a similar research recommendation for residential care. |
| University of Portsmouth | Guideline | 024 | 008 | The guideline states: "*The committee discussed the small amount of evidence for psychological interventions, all of which were for cognitive behavioural therapy (CBT), which showed some benefit although results were mixed. The committee discussed that in their experience, a small number of people who have a fear of falling may be referred for CBT. The evidence did not include fear of falling, but the committee discussed how this can have a significant detrimental effect on* | Thank you for your comment. The aim of this review was to assess cognitive behavioural interventions and not cognitive training. We have changed the recommendation to cognitive behavioural interventions. The included studies for this section have been reassessed to ensure they contain a CB intervention. Since Chantanachai 2024 contains a cognitive training intervention rather than CBI, it has now been excluded. |

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| | | | | *quality of life. Although there was not enough evidence to support a CBT programme, the committee agreed cognitive behavioural approaches could be considered for people who have a fear of falling and do not respond to strength and balance exercises."*<br>The evidence underpinning this decision was not all based on what would be considered typical 'cognitive behavioural therapy'. Some of the studies included involved cognitive training interventions (e.g. playing videogames - Chantanachai 2024; Reinsch 1992). Clarity is required around what is meant by 'cognitive behavioural therapy'. The committee could have made better use of the Cochrane review evidence which has assessed the influence of psychological interventions on concerns about falling to underpin their decision (e.g. Lenouvel 2023; Drahota 2024). | Reinsch 1992 was included in the Gillespie review and in a more recent Cochrane review by Lenouvel 2023 which focused on CBT interventions only. The reviewers here also state that it included a CB protocol, so we believe that the study is okay to be included under this intervention. |
| University of Portsmouth | Guideline | 025 | 029 | We recommend that 'flooring' is included within the example interventions listed for addressing the ward environment (alongside ward layout, beds and alarms), since further research is warranted in this area. See Health Technology Assessment: https://doi.org/10.3310/ZOWL2323 | Thank you for your comment. Flooring has been added as an example. It is also mentioned in the research recommendation protocol covering ward environment. |
| University of Portsmouth | Guideline | General | General | (Rec 1.2.2; Rec 1.3.10; Rec 1.4.1) - We recommend the language be changed from "fear of falling" to "concerns about falling" throughout the guideline. For a rationale | Thank you for your comment. This has been changed in line with your suggestions. |

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| | | | | behind this amendment, please see: https://doi.org/10.1093/ageing/afad057 | |
| University of Portsmouth | NICE guideline: methods | 12 | 24 | Insert reference: "such as psychological and educational interventions (Drahota 2024)" | Thank you for your comment, this has been added. |