NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Falls: assessment and secondary prevention in older people

Date of Quality Standards Advisory Committee post-consultation meeting:
06 January 2015

2 Introduction

The draft quality standard for falls: assessment and secondary prevention in older people was made available on the NICE website for a 4-week public consultation period between 05 November and 03 December 2014. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 36 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. For each quality statement what do you think could be done to support improvement and help overcome barriers?

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 1: Is there a specific element of the post-fall protocol that should be focused on in the statement?

5. For draft quality statement 2: The statement highlights the following as components that are essential parts of the multifactorial falls risk assessment: assessment of visual impairment; assessment of gait, strength, balance and mobility; assessment of osteoporosis risk; medication review. Does this list include all of the essential components for this type of assessment?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- Stakeholders welcomed the quality standard and stated that the draft document was good. Most stakeholders felt that it does reflect the key areas for quality improvement.
- Concerns were raised that the quality standard should also cover identifying those at risk of falls. Stakeholders suggested that identifying those at risk of falls should start on admission to hospital, or for people living in the community when they commence an assessment or intervention in the community.
- Concerns were raised that the quality standard focuses on action after a fall rather than seeking to put in place quality statements for interventions that might prevent falls in the first place or at least delay the first fall and the beginning of the decline into a recurrent pattern.
- Stakeholders suggested that fear of falling should be included within the quality statements as an issue that needs assessment.
- It was suggested that a definition of a ‘fall’ and of ‘secondary prevention’ is required.
- Concerns were raised that no timeframes for delivering assessments have been specified in the quality statements.
- Stakeholders highlighted the importance of hearing checks for people who are at risk of falling or who have experienced a fall.
- Stakeholders suggested that education to prevent falls should be highlighted in the standard.

Consultation comments on data collection

- The majority of stakeholders felt that it would be possible to collect the data but some issues were highlighted around data collection. For example, for some of the statements data collection would need to be coordinated across different providers; and there is evidence of varying definitions of a fall between providers.
- Stakeholders highlighted clinical coding as an issue stating that coding systems still do not routinely include a ‘fall’ when defining an admission or episode where

an injury has been sustained. The primary focus is often in relation to the identification and management of the resulting injury.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Older people who fall during a hospital stay are cared for in accordance with a post-fall protocol.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Stakeholders highlighted that the importance of including timescales in the protocol is mentioned but no guidance is given as to how quickly follow-up of inpatient fallers should take place.
- Stakeholders suggested that a good quality measure would be to ask for evidence of following the post-fall protocol on incident forms.
- Using Safety Thermometer data is not appropriate to measure hospital falls prevention in the context of the quality standard as it does not distinguish between falls in hospitals and falls before the admission that have occurred in certain settings.
- Stakeholders requested clarity around the definition of medical examination querying who would undertake the examination.
- Several suggestions for amending the definition of 'Post-fall protocol' were made. Examples of these include:
    - Rather than stipulating nursing staff, consider broadening to checks by those adequately trained to do so.
    - Specific mention of hip fracture.
    - Analysis of falls.
    - Actions to reduce the risk of further falls.

Consultation question 4: Is there a specific element of the post-fall protocol that should be focused on in the statement?

Stakeholders made the following comments in relation to consultation question 4:

- In terms of a 'post-fall protocol' it would be appropriate to focus on the 'timescales for medical examination following a fall'.
- Safe manual handling and neurological observations are important elements of the post fall protocol which should be focused on in the statement. Specific clarity and guidance should be provided for the essential components which need to be included within the protocol.
- There should be a particular focus on the checks for injury prior to moving the patient.
- The four key areas of initial injury check, safe manual handling, neurological observations and timescales of medical examination are all important. However, we feel that a particular focus should be on prompt and appropriate physical assessment and more detailed assessment for head injury and fractures.
- One element is of no more importance than the rest.
- We would argue that it is neither acceptable nor necessary for the quality standard to focus on only part of the post-fall protocol that reminds staff of essential care after an inpatient fall.

5.2 Draft statement 2

Older people who present for medical attention because of a fall have a multifactorial falls risk assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Stakeholders suggested that the population covered by this statement should be widened to include all older people presenting to a healthcare provider.
- Stakeholders highlighted that clarification is needed regarding what is meant by requiring 'medical attention' after a fall. It was suggested that this should be more specific and focus on those who present to ambulance services and the emergency department as it will not be possible to trace all patients who see a GP because of a fall.
- Concerns were raised about the focus on assessments being completed within secondary care or a specialist falls service. Stakeholders suggested that many aspects of assessment and falls prevention and management could be addressed within a variety of health services.
- Stakeholders welcomed the inclusion of an assessment of osteoporosis risk. However, it was felt that this phrase needs clarification regarding whether this is an assessment for osteoporosis or assessment of fracture risk.

Consultation question 5: The statement highlights the following as components that are essential parts of the multifactorial falls risk assessment: assessment of visual impairment; assessment of gait, strength, balance and mobility; assessment of osteoporosis risk; medication review. Does this list include all of the essential components for this type of assessment?

Stakeholders made the following comments in relation to consultation question 5:

- The list should be included in its entirety not split into definite and maybe's and form the basis of a multifactorial assessment. Specifically falls history and cardiovascular examination are fundamental. Splitting the list may mean that important diagnostic opportunities are lost.
- Yes it does include the essential components.

- Stakeholders suggested a number of components for inclusion in the essential list. These included: identification of falls history; fear of falling; footwear and podiatry assessments; cardiovascular and neurological assessments; continence assessments; home hazard assessment; cognitive function; assessment and management of unexplained falls; mental health assessment; measurement of lying and standing blood pressure; medical and surgical history; family/carer support; assessment of hearing impairment; environment; and assessment of nutrition.

5.3 Draft statement 3

Older people living in the community who have a known history of recurrent falls are referred for strength and balance training.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Stakeholders suggested that people living in the community that have a history of recurrent falls should also have a multifactorial falls risk assessment before they are referred for strength and balance training.
- The importance of emphasising that strength and balance training should be evidence-based was highlighted.
- Stakeholders requested that it is made clear that strength and balance training is not appropriate for some populations.
- Stakeholders highlighted the issue that increased resources are needed in order to achieve this statement.
- Concerns were raised that the outcome measure is not specific enough to be measured.
- It was suggested that recurrent falls should be defined.

5.4 Draft statement 4

Older people who have had treatment in hospital after a fall are offered a home hazard assessment and safety interventions

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Stakeholders suggested that the quality standard should clarify what is meant by hospital treatment.
- Clarification is needed around who the population is for this statement. Stakeholders suggested that the focus should be on older people who have fallen in their home or have a history of falling at home.
- Concerns were raised that adequate resources may not be available to deliver this intervention dependent on who the specific population is and who is expected to deliver the intervention.
- Stakeholders suggested that this incorporates a large occupational therapy service component but that the evidence base is proportionally stronger for other interventions e.g. exercise, muscle strengthening and multifactorial intervention.
- It was suggested that the statement should emphasise the importance of taking into account the risk factors identified during previous assessments when discussing this and other interventions.
- Stakeholders suggested that the outcome measures should be made more specific to the statement.
- It was suggested that the home hazard assessment should be occupational therapy led.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Stakeholders suggested that the quality standard should include a statement on preventing inpatient falls in addition to managing care after a fall in hospital.
- Stakeholders suggested that more emphasis should be place on medication review.

Appendix 1: Quality standard consultation comments table

ID	Stakeholder	Statement No	Comments[1]
1	Greater Manchester West Mental Health NHS Foundation Trust	General	We felt this draft quality standard for Falls and the statements were clear concise and useful.
2	College of Emergency Medicine	General	good, pragmatic quality standard
3	Cheshire West and Chester Council	General	Overall document is very good!
4	Digital Assessment Service, NHS Choices	General	The Digital Assessment Service welcome the guidance and have no comments on its content.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement No	Comments[1]
5	College of Occupational Therapists	General	Although the College acknowledges that this quality standard covers assessment and secondary prevention of falls of older people within existing services in hospitals, and that the community falls risk assessments are carried out and monitored, our respondents felt that this was not the starting point. Identifying those at risk of falls should start on admission to hospital, or for people living in the community when they commence an assessment/intervention in the community. There should be appropriate pathways in place to support the implementation of this. The Prevention and Management of Falls in the community outlines levels 1-3 of screening/assessment of falls and fractures. http://www.scotland.gov.uk/Publications/2014/10/9431/10 This screening should be a continuum where people move from community to hospital and vice versa. Following a level 1-3 screening/assessment Multifactorial Interventions should be put in place.
6	The Royal Society for the Prevention of Accidents	General	The Quality standard is welcome and contributes to overall provision of falls prevention by highlighting the types of assessment that should take place following recurrent falls. It pulls together the diverse range of outcome indicators under NHS, Public Health and Adult Social Care frameworks and sets out well the rationale for the development of quality standards. It also provides valuable links to the evidence base around falls prevention. As with many other examples of guidance to support falls prevention, however, it focuses on action "after" a fall (and in the case of statement 3, after recurrent falls), rather than seeking to put in place quality standards for interventions that might prevent falls in the first place or at least delay the first fall and the beginning of the decline into a recurrent pattern. Many of the quality standards described should be minimum requirements.
7	AGILE: Chartered Physiotherapists working with Older People	General	Fear of falling should be included within the standards as requiring assessment and being a trigger for strength and balance training in the presence of risk factors that will respond to such training.

ID	Stakeholder	Statement No	Comments[1]
8	Tees Esk and Wear Valleys NHS Foundation Trust	General	Is a definition of 'secondary prevention' required if this NICE quality standard is going to be relevant for all specialities including Mental Health and Learning Disabilities Trusts
9	College of Emergency Medicine	General	there are no time frames within which assessment post-fall or at home needs to be carried out; this has safety and capacity implications; it is not fair to park this with the patient and carers given older people are notoriously less demanding
10	Action on Hearing Loss	General	Hearing loss affects 10 million people in the UK, and is independently associated with an increased risk of falls. For example, a 25-dB hearing loss (equivalent from going from normal to mild hearing loss) is associated with a nearly threefold increased odds of reporting a fall over the preceding year. Research suggests that this risk could be reduced by ensuring auditory information is available . It is therefore vital that people who are at risk of -or have recently experienced- a fall have their hearing checked regularly and are referred for a full assessment and treatment as appropriate. For most people with hearing loss, the treatment will be the fitting of hearing aids.
11	NHS England	General	We welcome the quality standard and are particularly pleased to see that that the important patient safety issue of essential care after an inpatient fall has been recognised within the draft QS.
12	The Chartered Society of Physiotherapy	General	The Chartered Society of Physiotherapy (CSP) welcomes this quality standard and will support our members to use this quality standard to improve the quality of falls services. We also support the response made by the National Osteoporosis Society, with more detail on the assessment for osteoporosis.
13	The National Osteoporosis Society	General	We welcome this quality standard for Falls: assessment and secondary prevention in older people. It is important to recognise however, that improvement in the key areas identified (quality statements) will only happen if the right services are provided locally. It is important that NICE uses its communication channels to disseminate this quality standard to all relevant local stakeholders.

ID	Stakeholder	Statement No	Comments[1]
14	Royal College Physicians	General	The RCP is grateful for the opportunity to respond to the draft QS consultation. In doing so, we have liaised with the RCP Falls Audit, Falls and Fragility Fracture Audit Programme and would like to make the following comments. We also wish to endorse the submission of the British Geriatrics Society (BGS).
15	Royal National Institute of Blind People	General	About the RNIB: Royal National Institute of Blind People (RNIB) is the UK's leading charity providing information, advice and support to almost two million people with sight loss. We are a membership organization with over 12,000 members throughout the UK and 80 percent of our Trustees and Assembly members are blind or partially sighted. We encourage members to get involved in our work and regularly consult them on matters relating to Government policy and ideas for change. As a campaigning organization we act or speak for the rights of people with sight loss in each of the four nations of the UK. We also disseminate expertise to the public sector and business through consultancy on products, technology, services and improving the accessibility of the built environment. RNIB is pleased to have the opportunity to respond to this consultation

ID	Stakeholder	Statement No	Comments[1]
16	The Chartered Society of Physiotherapy	General	References 1. K Hanley and T O' Dowd. Symptoms of vertigo in general practice: a prospective study of diagnosis. British Journal of General Practice, October 2002, 809-812 2. V.B. Pothula et.al. Falls and vestibular impairments. Clin. Otolaryngol. 2004, 29, 179-182. 3. Oz Zur et.al. Correlation between vestibular function and hip fracture following falls in the elderly: a case-controlled study. Physiotherapy 92 (2006) 208–213 4. Yuri Agrawal et.al. Disorders of Balance and Vestibular Function in US Adults. Arch Intern Med. 2009;169(10):938-944 5. Oghalai JS, Manolidis S, Barth JL, et al. Unrecognised benign paroxysmal positional vertigo in elderly patients. Otolaryngology Head Neck Surgery 2000; 122: 630–34. 6. M von Brevern. Et.al. Epidemiology of benign paroxysmal positional vertigo: a population based study. J Neurol Neurosurg Psychiatry 2007;78:710–715. doi: 10.1136/jnnp.2006 7. Lawson J, Bamiou D, Cohen HS, Newton J. Positional vertigo in a falls service. Age Ageing 2008: 37 (5): 585–88 Eva Ekvall Hansson. 8. Eva Ekvall Hansson. Vestibular asymmetry predicts falls among elderly patients with multi-sensory dizziness. BMC Geriatrics 2013, 13:77 9. Kars, H.J.J., Eng, B., Hijmans, J.M., Geertzen, J.H.B. and Zijlstra, W. (2009) 'The effect of reduced somatosensation on standing balance: A systematic review', Journal of Diabetes Science and Technology, 3(4), pp.931-943 10. Nardone, A., Galante, M., Pareyson, D. and Schieppati, M. (2007) 'Balance control in sensory neuron disease', Clinical Neurophysiology, 118(3), pp. 538-550 11. Van der Linden, M.H., Van der Linden, S.C., Hendricks, H.T., Van Engelen, B.G.M. and Geurts, A.C.H. (2010) Postural instability in Charcot-Marie-Tooth type 1A patients is strongly associated with reduced somatosensation,' Gait & Posture, 31(4), pp.483-488 12. Natalia A. Ricci. A systematic review about the effects of the vestibular rehabilitation in middle-age and older adults. Rev Bras Fisioter. 2010;14(5):361-71. 13. Hillier SL, Holohan V. Vestibular rehabilitation for unilateral peripheral vestibular dysfunction (Review). Cochrane Database of Systematic Reviews 2007, Issue 4. 14. John D. Macias et.al. Efficacy of Vestibular Rehabilitation Therapy in Reducing Falls. Otolaryngology–Head and Neck Surgery (2005) 133, 323-325 15. Fernando Freitas Ganança et.al. Elderly falls associated with benign paroxysmal positional vertigo. Braz J Otorhinolaryngol. 2010;76(1):113-20.

ID	Stakeholder	Statement No	Comments[1]
17	The National Osteoporosis Society	General	The National Osteoporosis Society welcomes this quality standard and its quality statements and we responded to the engagement exercise on this last July. As a key member of the Falls and Fractures Alliance the Charity believes strongly that falls and fractures patient care must be joined-up and co-ordinated. We support in particular the response made by the Chartered Society of Physiotherapists to this consultation which includes detailed comments on areas such as vestibular rehabilitation.
18	Action on Hearing Loss	General	1 Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of Internal Medicine 172(4): 369-371; Viljanen et al (2009) Hearing as a predictor of falls and postural balance in older female twins. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 64(2): 312-7 2 Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of Internal Medicine 172(4): 369-371 3 Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of Internal Medicine 172(4): 369-371; Viljanen et al (2009) Hearing as a predictor of falls and postural balance in older female twins. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences 64(2): 312-7 4Chisholm et al (2007) A systematic review of health-related quality of life and hearing aids: Final report of the American Academy of Audiology task force on the health-related quality of life benefits of amplification in adults. Journal of American Academy of Audiology 18: 169
19	National Community Hearing Association and British Society of Hearing Aid Audiologists	General	BSHAA is the professional body for hearing aid audiologists providing hearing care to NHS and self-funding clients. They practise in large, medium and small companies and as sole practitioners; and they provide a professional, convenient and local service to people with hearing concerns in every community in the UK. The National Community Hearing Association (NCHA) represents community hearing providers in the UK. NCHA members are committed to good hearing for all and are responsible for the majority of adult community hearing care services in the UK with an excellent record of outcome, safety, and patient satisfaction.

ID	Stakeholder	Statement No	Comments[1]
20	National Community Hearing Association and British Society of Hearing Aid Audiologists	General	Action on Hearing Loss (2011) “Hearing matters” Chapter 5 in Shield (2006) “Evaluation of the Social and Economic Cost of Hearing Impairment - a report for hear-it” Lin FR and Ferrucci L. (2012) “Hearing loss and falls among older adults in the United States”. Arch Intern Med. 172(4): 366-7 Reeves et al. (2000) “Community Provision of hearing aids and related audiology services”. Health Technology assessment 4(4). Rumalla, K., Karim, A. M. and Hullar, T. E. (2014) “The effect of hearing aids on postural stability”. The Laryngoscope. doi: 10.1002/lary.24974 Saito et al. (2010) “Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese” J. Am. Geriatr. Soc. 58(1): 93-95
21	British Orthopaedic Association's Patient Liaison Group	General	On reflection the phrase 'medical attention' which is used throughout the document may be inappropriate wording: I wonder if “Clinical Intervention” might better explain the circumstance?
22	College of Optometrists & The Optical Confederation	General	Coordinated Services – We strongly suggest that an official link-up between community optical services, including low vision, and falls services should be established, especially when the result of a vision check in a falls service context highlights a problem. A basic protocol for reciprocal referral between eye health specialists and falls services should be implemented as part of local falls pathways and post-fall protocols. Open communication and feedback, through NHS mail, would help to navigate patients along the pathway, bolstering clinical continuity. Facilitating these links would help prevent significant numbers of falls in older patients with visual impairment.

ID	Stakeholder	Statement No	Comments[1]
23	Royal National Institute of Blind People	General	Equalities Act 2010: We believe that all NICE work should reflect the duties of public bodies under the Equalities Act 2010, not just in relation to communication and accessible information, but in relation to non-discriminatory treatment. We would expect NICE to take steps to meet their legal obligations. This not only requires public bodies to have due regard for the need to promote disability equality in everything they do - including the provision of information to the public - but also requires such bodies to make reasonable adjustments for individual disabled people where existing arrangements place them at a substantial disadvantage.
24	Royal National Institute of Blind People	General	Accessible information: We believe this guideline should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English." The Equality Act expressly includes a duty to provide accessible information as part of the reasonable adjustment duty. Online information on websites should conform to the W3C's Web Accessibility Initiative Web Content Accessibility Guidelines (WCAG) 1.0, level AA, as required by the NHS Brand Guidelines and the Central Office of Information. With regard to the accessibility of print materials, including downloadable content such as PDF files, we would request that wherever possible they comply with our "See it Right" guidelines: http://www.rnib.org.uk/professionals/accessibleinformation/Pages/see_it_right.aspx

ID	Stakeholder	Statement No	Comments[1]
25	Royal College of Physicians of Edinburgh	General	The aims of the quality standard document are valid and important in the context of the high morbidity associated with falls and their consequences. The College supports the aim of defining quality metrics and outcome data, but has concerns that this data is not collated robustly and coding systems still do not routinely include a 'fall' when defining an admission or episode where an injury has been sustained. The primary focus is often in relation to the identification and management of the resulting injury. Using future falls as a measured outcome to determine intervention success is flawed due to the inherent difficulties in obtaining this data accurately. Patient recall of falls has been evidenced to be unreliable, collating falls outcome information from patient diaries is highly time-consuming and other data collection methods are unreliable. The complications of falls are easier to measure – accurate data on fall-related fracture is likely to be the most reliable and consistently reproducible; fractures do not occur with the majority of falls, so data to support the judgement on the quality of the interventions will require fracture data collection over a prolonged period. There is a disproportionate emphasis on home environmental visits and modifications compared to the weight of evidence for this single intervention in the falls prevention literature. The evidence base remains strongest for environmental modification as an intrinsic component of a multifactorial intervention. There is no consistent and clearly defined recommendation for the duration of exercise as an intervention. It is critical that this is specified, as short duration exercise interventions have not shown benefit in falls reduction. Commissioners would need to recommend that exercise programme duration needs to be for a minimum of 12 weeks to be clinically effective.
26	The Royal Society for the Prevention of Accidents	General	Whilst it is accepted that services should strive to achieve 100%, does the absence of any kind of level measurement or minimum levels weaken the standards in making it difficult for organisations to assess precisely where they are against the standard?
27	Royal College Physicians	General	Although we do not have current plans to audit all of the quality standards as indicated above, there may be some scope to extend the audit within the next contract period (2015-2017). This would involve further discussion with HQIP and consideration of funding sources.

ID	Stakeholder	Statement No	Comments[1]
28	Surrey and Borders partnership NHS foundation trust	General	The training should include an awareness of issues related to mental health/Dementia and Learning disability
29	Royal College of Nursing	General	This is to inform you that the Royal College of nursing have no comments to submit to inform on the above draft quality standard consultation. Thank you for the opportunity to participate.
30	Department of Health	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
31	Surrey and Borders partnership NHS foundation trust	General	Post fall experience will contribute to wellbeing and deteriorate quality of life and result in the need for additional health care resources.
32	Surrey and Borders partnership NHS foundation trust	General	Should include other fracture which has resulted after fall including Colle's (wrist), Shoulder and lumbar fracture.
33	British Geriatrics Society	General	We welcome the key aim to co-ordinate service for falls prevention across all agencies providing a falls care pathway.
34	British Geriatrics Society	General	We welcome the statement that safe care is an essential consideration when planning falls services. We note that domains relevant to safety are prominent among the Outcomes Frameworks items highlighted in the introduction.
35	Syncope Trust and Reflex Anoxic Seizures (STARS)	General	STARS is very aware that falls amongst older people are too frequently passed off and not fully investigated to assess the actual cause such as an arrhythmia, leaving loss of consciousness untreated.

ID	Stakeholder	Statement No	Comments[1]
36	Royal College of Physicians of Edinburgh	General	Overarching measure 2A – Recommend that both permanent admissions and a change of residency to higher level care are considered eg to account for move from residential to nursing care. Overarching measure 2B – additionally look at hospital readmission with the same underlying diagnosis/cause. Overarching measure 2C – when deemed fit for discharge by multidisciplinary team.
37	Royal College of Physicians of Edinburgh	General	Recommend additional indicator of 'premature admission into 24 hour care'.
38	The Newcastle upon Tyne Hospitals NHS Foundation Trust	General	Outcome measure – should the primary outcome not be a patient related quality outcome rather than carer
39	The Newcastle upon Tyne Hospitals NHS Foundation Trust	General	Overarching measure 2A – should this not be a change of residency to higher level care rather than 'permanent admissions…' Overarching measure 2B – additionally look at hospital readmission with the same underlying diagnosis/cause Overarching measure 2C – should this also say 'when deemed fit for discharge under MDT'
40	The Newcastle upon Tyne Hospitals NHS Foundation Trust	General	2.24 Should this be all falls not just those which cause injury

ID	Stakeholder	Statement No	Comments[1]
41	The Newcastle upon Tyne Hospitals NHS Foundation Trust	General	Should there be an additional indicator of 'premature admission into 24 hour care'
42	Gloucestershire Hospitals NHS Foundation Trust	Questions for consultation	Yes we think the draft quality statement does accurately reflect the key areas for quality improvement.
43	Greater Manchester West Mental Health NHS Foundation Trust	Questions for consultation	- Yes they have covered the key areas for quality assessment
44	Barnsley Hospital NHS Foundation Trust	Questions for consultation	Yes, we agree that these quality standards reflect the key areas for improvement and would aspire to achieve these standards within the trust.
45	University Hospitals Birmingham	Questions for consultation	Does this draft quality standard accurately reflect the key areas for quality improvement? YES
46	Guy's and St Thomas' NHS Foundation Trust	Questions for consultation	The draft quality standard appears to accurately reflect the key areas for quality improvement, although some of these are broad statements/areas which may require more specific/detailed processes and outcome measures.
47	NHS England	Questions for consultation	Overall yes however we think some of the wording needs to looked at to ensure that people at risk of falls and those who have already fallen are offered appropriate assessments and interventions.

ID	Stakeholder	Statement No	Comments[1]
48	College of Emergency Medicine	Questions for consultation	Yes
49	South Tyneside NHS Foundation Trust	Questions for consultation	On the whole, this quality standard does reflect the key areas for quality improvement.
50	British Orthopaedic Association's Patient Liaison Group	Questions for consultation	Yes
51	Syncope Trust and Reflex Anoxic Seizures (STARS)	Questions for consultation	STARS does believe that with the points raised by STARS, this Quality Standard does accurately reflect key areas for quality improvement.

ID	Stakeholder	Statement No	Comments[1]
52	National Community Hearing Association and British Society of Hearing Aid Audiologists	Questions for consultation	Answer: NO Whilst the standard correctly identifies the groups at risk it does not go far enough in areas for quality improvement. There are two significant omissions. First Omission On page 14 there is no mention of an assessment to test for hearing impairment. Data on hearing impairment In England there are 8 million people with a hearing loss. 90% of these are aged 50 and over. Age-related hearing loss accounts for 90% of hearing loss. The Department of Health has also noted that 70% of 70 year olds have a hearing loss. These data are based on a large epidemiological study. The Quality Standards Advisory Committee can access this online using the POPPI tool. Falls in people with hearing impairment: People with hearing loss are more likely to suffer a fall than people without a hearing loss (Lin and Ferrucci 2012). Supporting people with their hearing loss might reduce the risk of falls (Rumalla et al. 2014). Our view NICE should include hearing assessments on page14. Second Omission The Health and Social Care Act (2012) makes it clear that the NHS must be committed to continuous quality improvement. Key to quality improvement is capacity management and delivering care at the right time in the right place by the right people. There are far too many documents advising commissioners to "…ensure that they commission services that have the capacity and staff who are trained to undertake …." (page 13). The guidance must go further and ask CCGs to submit evidence of assessing capacity to deliver the guidelines (or allow us to request this by Freedom of Information Requests). This guidance again calls for commissioners to plan capacity. There is no evidence that shows commissioners in England have assessed capacity in the core area of hospitals that deliver balance assessments; i.e. audiology departments. In the "Retirement, health and relationships of the older population in England. The 2004 English Longitudinal Study of Ageing (Wave 2)" the most underprovided form of care for older people was "balance" with only 15% of older people getting the indicated care they required. This is, at its root cause, a health quality problem. It is the single biggest area for quality improvement. Currently hearing care is a low priority for commissioners across England. Indeed since the NHS was founded it has on many occasions ignored hearing loss. One example was the Audit Commissions review in 2000 and 2002 and another example was the Health Select Committee's review of Audiology in 2007. What was not widely reported after the Health and Select Committee report was that in 2003 the NHS had predicted the problems in 2007. These were capacity issues and yet the NHS had not taken steps to avoid systems failure. We would be happy to forward the Quality Standards Advisory Committee text versions of documents supporting our concerns if required.

ID	Stakeholder	Statement No	Comments[1]
53	Hip Impact Protection Ltd.	Questions for consultation	Q1. No, because it sets no targets for falls prevention. In other words there is no commitment to reduce the number of falls.
54	Greater Manchester West Mental Health NHS Foundation Trust	Questions for consultation	- Yes collection of data is possible but time/ staff resources will be needed to access data.
55	Barnsley Hospital NHS Foundation Trust	Questions for consultation	Yes it would be possible to collect the data.
56	College of Emergency Medicine	Questions for consultation	Yes
57	British Orthopaedic Association's Patient Liaison Group	Questions for consultation	Yes
58	Chesterfield Royal Hospital NHS Foundation Trust	Questions for consultation	Data collection should be feasible as falls risk assessments / post fall actions are already documented in medical / nursing notes
59	Syncope Trust and Reflex Anoxic Seizures (STARS)	Questions for consultation	STARS also believes that with systems and structures in place, data could be collectd for quality measures.

ID	Stakeholder	Statement No	Comments[1]
60	South Tyneside NHS Foundation Trust	Questions for consultation	Collecting the data with appropriate systems in place should be possible for statements 1 & 4. Collecting the data for statements 2 & 3 could prove more challenging as it would require working across providers e.g. those who present for medical attention could be seen by an A&E, a community matron, or a GP, all of whom may work under different umbrellas of care. The same is true for statement 3. People may be referred by a GP, a care home staff member, or an Age UK provider. The systems required to collect data in these cases could be very challenging to implement and maintain. The accuracy of data collected across numerous providers would be rather difficult to ensure thus risking false reports of quality or lack thereof.
61	University Hospitals Birmingham	Questions for consultation	If the systems and structures were available, do you think it would be possible to collect data for the proposed quality measures? YES – but should be noted that significant Informatics investment required, and integrated data processes.
62	British Geriatrics Society	Questions for consultation	We feel that it would be possible to collect data for most of the QS statements, as all of the items are measurable. The data would however need to be collected locally as there are no plans within FFFAP, or other national audit programmes, to measure most of the standards (except in-patient multifactorial falls risk assessment). The NHS Safety Thermometer is included as a potential source of data on inpatient falls. However, there are a number of known issues with this methodology. The chief concerns are firstly that the sampling methodology, using a retrospective 72 hour timeframe means that falls in the community are included if patients have been admitted following a fall within that time. Secondly, there is evidence of varying definitions of a fall between hospital trusts. For example, some trusts exclude falls thought to be due to syncope, falls from an ultra low bed, and/or 'assisted' falls. We would recommend the inclusion of a clear statement reiterating that all falls are falls.

ID	Stakeholder	Statement No	Comments[1]
63	Gloucestershire Hospitals NHS Foundation Trust	Questions for consultation	General comments about quality statement 1/2/3/4: We feel it is possible to collect data for the post falls protocol Statement 1. Also possible for Statement 2 as we have a falls assessment care plan that is instigated for all patients who are initially assessed on admission as being at risk of falls. Statement 3 asks about consultations outside of the Acute Trust. This would need improvements in GP coding or considering a countywide Falls Register. We would need to work with the Community Trusts / public health to get the data on community dwelling older people who have had recurrent falls, we do have some data on how many patients have gone through our active balance classes in the community hospitals, so collecting this data should be possible. This would still only identify community dwelling people who attend/contact services because of a fall, there will be many more who will be unreportable. In theory it would be possible to count home hazards assessments from the ward (Statement 4) but there will be issues as to whether this is a hospital based service or following onward referral into community services. Occupational Therapy home hazard assessment is a very rare occurrence due to insufficient OT on the wards, therefore very little time to do a home visit. It would be difficult to collect data and we know that very few are done.
64	Hip Impact Protection Ltd.	Questions for consultation	Q2. If the right measures were taken, ie electronic measuring of falls and real-time gait analysis, then yes, it would be possible to collect the data, but at the moment the measures do not exist, nor are any proposed in this document.
65	Public Health Wales	Questions for consultation	The structures and systems are not available and unlikely to ever be available in a way that would facilitate data collection for these measures. We currently struggle to collect accurate data on the falls themselves, partly because of the numbers of fallers. Collecting data on the referrals process is also very difficult; monitoring these against a quality standard is likely to produce outcomes that do not accurately reflect service quality.
66	AGILE: Chartered Physiotherapists working with Older People	Questions for consultation	Guidance should be given by the guideline group for how data relating to falls rates should be collected and reported.

ID	Stakeholder	Statement No	Comments[1]
67	College of Occupational Therapists	Questions for consultation	Throughout the persons journey there should be opportunities for falls prevention through education; there is increasing evidence emerging regarding education and the value that it has on reducing further falls. This would include: Staff and carer education/training, A person who is at risk of falling or who has fallen education programme. These programmes should concentrate on the benefits of health and wellbeing. Suggestions: General falls information; Environment – Self-assessment; Fracture and Older Peoples Services education programme; Polypharmacy; Footwear and Footcare, Strength and Balance training should include an education component. Education should include confidence building/stress management to help reduce fear of falling.
68	South Tyneside NHS Foundation Trust	Questions for consultation	The largest barrier to overcome in terms of the Quality Statements would be the sharing of information and statistics between different providers. Some sort of area digital network could alleviate that barrier but the cost and logistics of developing such a system would be considerable if not insurmountable, especially for smaller Trusts in areas of greater deprivation or with fewer resources.
69	Royal College of Physicians of Edinburgh	Questions for consultation	2.24 The College would appreciate clarification on what measures will be put in place to ensure that the fall leading to an injury or admission is coded clinically. Frequently the injury is coded, leading to considerable underestimate of falls being the contributory factor.
70	British Orthopaedic Association's Patient Liaison Group	Questions for consultation	People admitted to hospital following a fall resulting in a hip fractureshould be treated post operation by an orthogeriatrician. This clinician should be responsible for initiating all post fall procedures and in- hospital and community based support. There must be better access to social services in hospital and there must be close liaison between hospital based social care providers and their community based colleagues especially when a patient in hospitalised in a different area from their home base. Historically cross border communication and co-operarion has been poor. The lack of standardised assessment and provissoin of services procedures between different Trusts has led to poor patient outcomes.
71	Syncope Trust and Reflex Anoxic Seizures (STARS)	Questions for consultation	STARS suggest that greater awareness amongst all those involved in the care of the elderly, including family members, would benefit from increased education and information on this QS to support improvement, full sharing of information and overcome barriers.

ID	Stakeholder	Statement No	Comments[1]
72	Gloucestershire Hospitals NHS Foundation Trust	Questions for consultation	General comments about quality statement 1/2/3/4: In relation to the post falls protocol covered in Statement 1 improvement in training and learning opportunities will certainly be required. To help support improvement in Statements 2&3 the same applies in terms of learning /training, and examples of best practice/case studies could be employed; as well as encouraging fully commissioned services. Also in relation to Statement 3 on exercise the need to train more instructors to lead on evidence based exercise for strength and balance and raise awareness to patients at risk of falling on the significant benefit of regular exercise in preventing falls. Statement 4 needs clarification as to whether Occupational Therapists are best placed to complete home hazard assessments which we think the evidence suggests they are or what else is meant by "staff with expertise in home hazard assessment"?(page 20). In addition for Statement 4 increase Occupational Therapy presence on wards with patients that are at risk of falling or allow better referral pathways for community Occupational Therapy home hazard assessments . Perhaps use other agencies more in the community to perform home hazard assessments e.g. Mears Group Safe at Home and Red Cross in Gloucestershire
73	British Geriatrics Society	Questions for consultation	A strong statement from NICE that national audits encompassing the four (five?) QS Statements would be essential would, of course, be welcomed by the BGS and by the falls prevention community.
74	Barnsley Hospital NHS Foundation Trust	Questions for consultation	Difficult to answer for National priorities but local action plans could be made to support improvement.
75	The Royal Society for the Prevention of Accidents	Statement 1	RoSPA supports the protocol and sees this as a minimum requirement for aiding recovery that may help to enable a patient to return to a more independent life outside of hospital. Questions include: Are protocols already in place to prevent initial falls? These do not appear to be covered in this document. The importance of including timescales in the protocol is mentioned but no guidance given as to how quickly follow-up of in-patient fallers should take place.

ID	Stakeholder	Statement No	Comments[1]
76	College of Occupational Therapists	Statement 1	A quality measure would be to ask for evidence of following the post fall protocol on incident forms – most of which are electronic now.
77	Royal College of Physicians of Edinburgh	Statement 1	Safety Thermometer data only measures falls within the last 72 hours, this also does not encompass post fall complications.
78	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 1	Safety Thermometer data only measures falls within the last 72 hours, this also does not encompass post fall complications
79	NHS England	Statement 1	Using Safety Thermometer data is not appropriate to measure hospital falls prevention in the context of the QS as it does not distinguish between falls in hospitals and falls before the admission that have occurred in certain settings (e.g. in a nursing home or at home with community nursing input). Additionally, as ST is a snapshot of prevalence taken on 3 days a month only, it is unlikely to have sufficient statistical power to detect significant improvements at the level of an inpatient service provider. There is however a robust alternative measurement source in the Hip Fracture Database which added a new reporting field for hospital acquired hip fracture in 2014.
80	Tees Esk and Wear Valleys NHS Foundation Trust	Statement 1	Timescales for medical examination: Do we require more clarity regarding the definition of medical examination e.g. does this need to be done by a doctor or equivalent or does this include nursing assessments e.g. EWS/GCS linked to post falls proforma.

ID	Stakeholder	Statement No	Comments[1]
81	South Tyneside NHS Foundation Trust	Statement 1	No mention is made of reassessment of fall risks in the post fall protocol. Although Fall Risk Assessment Tools have been discouraged in the recent literature, this should not be assumed to mean that individual risks should not be identified and acted upon after a fall. An item for Root Cause Analysis of each fall which identifies risks and actions to be taken to reduce those risks would be beneficial for patient safety. This is supported by this statement from the Rapid Response Report NPSA/2011/RRR001 Essential care after an inpatient fall January 2011 "actions to reduce the risk of further falls and fragility fractures, including identifying and acting on underlying risk factors, identifying and treating osteoporosis, and considering the need for falls prevention equipment or special observation"
82	The Chartered Society of Physiotherapy	Statement 1	Rather than stipulating nursing staff, consider broadening to checks by those adequately trained to do so. Consider including details about the allocation of responsibility within the protocol, and timeframes.
83	The National Osteoporosis Society	Statement 1	In the post-fall protocol, we welcome the checks made for signs or symptoms of fracture or potential spinal injury followed by safe manual handling methods for patients with these signs or symptoms. We would suggest that nursing staff be changed to "relevant qualified health professional". We would suggest that checking for injury prior to moving the patient is made a focus.
84	The Royal College of Radiologists in collaboration with The British Society of Skeletal Radiologists (BSSR)	Statement 1	The draft document specifically mentions head and spine injuries, recommending NICE guidance on head injury, with which we concur. We note that unstable spinal fracture is unlikely in a hospital fall from standing height scenario and the draft document, in alluding only to this most serious complication and by emphasizing the caution required to avoid serious spinal injury may detract from other, more common injuries: We believe hip fracture should also be mentioned, with regard to the need for MR or CT imaging if plain films are negative but clinical suspicion persists. Demonstration of a low trauma fracture (and therefore the requirement for radiologists to use the term "fracture") is important and should lead to investigation and treatment of osteoporosis if present. Any radiographs performed as part of a protocol should be reported promptly and may increase radiology workload.

ID	Stakeholder	Statement No	Comments[1]
85	College of Occupational Therapists	Statement 1	Post falls: Tool 8 and Tool 10B from Care Inspectorate's Managing falls and fractures in care homes for older people are appropriate for use following a fall. http://www.careinspectorate.com/index.php?option=com_content&view=article&id=7906:falls-and-fractures&catid=328&Itemid=725 In order to support improvement post falls protocol should include analysis of falls and appropriate actions following the fall. This should include time of fall, day and circumstances of the fall. This information should be used to support improvements within the setting either in hospital or at home. Evidence of post falls protocol must include the analysis of falls in order to effectively prevent future falls. Such analysis has been completed as part of Up and About in Care Homes Improvement project and care homes have found key times of falls are between 14:00 and 20:00, respite care, during fire alarm tests, when bank staff are being used - all of this is equally transferrable to hospital settings. This information is essential to improve quality of care and reduce falls/harm. http://www.knowledge.scot.nhs.uk/fallsandbonehealth/the-national-falls-programme/up-and-about-in-care-homes.aspx
86	College of Occupational Therapists	Statement 1	Definitions for terms used in this quality standard: It is vital to emphasise that patients should not be moved until an assessment for spinal injury or fracture is made. Moving a patient incorrectly may well lead to further injury.

ID	Stakeholder	Statement No	Comments[1]
87	Greater Manchester West Mental Health NHS Foundation Trust	Statement 1	post falls protocol could concentrate on clear timed access to medical investigations/ interventions. Also make sure staff are acting as per NICE guidance for unwitnessed falls which could have resulted in a head injury. Staff need to be vigilant in reporting unwitnessed falls and then following the NICE head injuries guidance as for a possible head injury
88	Barnsley Hospital NHS Foundation Trust	Statement 1	In terms of a 'post fall protocol' we feel it would be appropriate to focus on the 'timescales for medical examination following a fall'. As an adjunct to this we feel there is a need to standardise post fall medical assessments and structure them in a way so as to identify any underlying risk factors that may have caused the fall and not just the physical consequences of the falls.
89	Guy's and St Thomas' NHS Foundation Trust	Statement 1	Safe manual handling and neurological observations are important elements of the post fall protocol which should be focused on in the statement. Specific clarity and guidance should be provided for the essential components which need to be included within the protocol.
90	The Chartered Society of Physiotherapy	Statement 1	There should be a particular focus on the checks for injury prior to moving the patient.
91	Gloucestershire Hospitals NHS Foundation Trust	Statement 1	General comments about quality statement 1: Yes we feel that older people who fall during a hospital stay are cared for in accordance with a post fall protocol. The four key areas of initial injury check, safe manual handling, neurological observations and timescales of medical examination are all important. However we feel that a particular focus should be on prompt and appropriate physical assessment and more detailed assessment for head injury and fractures.
92	University Hospitals Birmingham	Statement 1	One element of no more importance than the rest, however, a clear history of circumstances of the fall, times and named witnesses should be included. Should include automatic referral to physiotherapy for inpatient falls assessment as part of the protocol. (Physiotherapy assessment often identifies injury as we assess patient's weight bearing ability, and any modifiable factors.)

ID	Stakeholder	Statement No	Comments[1]
93	NHS England	Statement 1	We would argue that it is neither acceptable nor necessary for the QS to focus on only part of the post-fall protocol that reminds staff of essential care after an inpatient fall. For example, being seen early by a doctor but not safely retrieved from the floor, or having neurological observations taken but not being seen by a doctor could not be defended as a quality standard. It may be helpful to think of the post-fall protocol in the same terms as multifactorial intervention – it would be no more acceptable for a quality standard to require only one aspect of essential care after a fall than it would for a quality standard to focus only on one specific element of multifactorial intervention
94	British Geriatrics Society	Statement 1	We feel that within the post fall protocol, specific emphasis should be placed on appropriate management of head injury. However, as stated above, we ask that prevention of falls included as well as post fall protocol.
95	Hip Impact Protection Ltd.	Statement 1	There is no procedure advocated to supply a system that automatically identifies and records the characteristics of a fall, eg direction, time, force and patient actions preceding the fall to aid investigation into its causes.
96	The National Osteoporosis Society	Statement 1	Given that the most common patient safety incidents reported to the National Patient Safety Agency (NPSA) are patients falling in hospital , we welcome this statement as a key area for quality improvement. In particular we welcome the reference to people being assessed promptly to see if they have a fracture or other injury.
97	Syncope Trust and Reflex Anoxic Seizures (STARS)	Statement 1	STARS is dedicated to ensuring that anyone presenting with unexplained loss of consciousness receives the correct diagnosis, the appropriate treatment, informed support and sign posting to the appropriate medical professional. The charity full supports QS 1 – Older people who fall during a hospital stay are cared for in accordance with a post-fall protocol.
98	AGILE: Chartered Physiotherapists working with Older People	Statement 1	Suggest change ‘manual handling’ to ‘moving and handling’.

ID	Stakeholder	Statement No	Comments[1]
99	AGILE: Chartered Physiotherapists working with Older People	Statement 1	Suggest standard should ensure all elements of post falls protocol are completed before s response can be given that care was given in accordance with the protocol.
100	The Chartered Society of Physiotherapy	Statement 1	The outcome of “level of harm caused by falls during a hospital stay” does not seem to align with the quality standard of being cared for in accordance with a post-fall protocol. The outcome should be more directly linked with whether the falls protocol has been followed or not.
101	Royal College Physicians	Statement 1	The draft quality standard indicates that the RCP (2012) Report of the 2011 in-patient falls pilot audit, section 2 collects audit data on the use of a post fall protocol. We would like to inform the authors that following this pilot we agreed with HQIP that the full audit would involve only acute hospitals and that only interventions for falls prevention would be audited, not assessments and interventions following a fall. This was following advice from NAGCAE that events after a fall were felt to be beyond the remit of clinical audit and not best suited to audit methodology. It was suggested that this might be a topic for investigation by NCEPOD
102	British Geriatrics Society	Statement 1	We suggest adding/amending : 1.Post fall protocol should include checks by staff for fracture, spinal injury and head injury 2. Page 11 line 6- "appropriate timescales for medical examination" (some hospitals will have protocols whereby this assessment is performed by suitably-trained nurses or physician associates).
103	British Orthopaedic Association's Patient Liaison Group	Statement 1	“timescales for medical examination following a fall (including fast track assessment for patients with signs of serious injury, or high vulnerability to injury, or who have been immobilised).” May be the word medica should be replaced by physical – to imply a full anatomical examination.
104	Cheshire West and Chester Council	Statement 1	Focus particularly on checks BEFORE the patient is moved.

ID	Stakeholder	Statement No	Comments[1]
105	Merck Sharp and Dohme	Statement 1	The post-fall protocol for older patients that fall during a hospital stay should include the essential parts of the multifactorial falls risk assessment: assessment of visual impairment; assessment of gait, strength, balance and mobility; assessment of osteoporosis risk; medication review.
106	Syncope Trust and Reflex Anoxic Seizures (STARS)	Statement 1	- STARS agrees with QS 1 and suggests that assessment post fall should include: Investigation as to whether fall was due to syncope. That patients vulnerable to episodes of low blood pressure as inactive for long periods and possibly on medication that affect blood pressure. Elderly patients should be investigated to see if they are prone to hidden infection eg bladder. It is quite common that during illness blood pressure tends to fall causing individual to fall and sometimes blackout.
107	Royal College of Physicians of Edinburgh	Statement 1	A post fall protocol should include: Checks by nursing staff for signs or symptoms of potential spinal injury before the patient is moved Checks by nursing staff for signs and symptoms of other fracture (e.g. limb) before the patient is moved
108	Royal College of Physicians of Edinburgh	Statement 1	Recommend additional post-fall items: Appropriate management of patients prescribed anticoagulants with a suspected or potential head injury (as per NICE guidance). Assessment of reversible medical risk factors for presenting fall. Assessment of need of increased falls prevention measures eg equipment, environment, observation (Nursing).
109	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 1	A post fall protocol should include: Should there be a separate bullet point separating spinal fractures from 'other' fractures e.g. Checks by nursing staff for signs or symptoms of potential spinal injury before the patient is moved Checks by nursing staff for signs and symptoms of other fracture (e.g. limb) before the patient is moved

ID	Stakeholder	Statement No	Comments[1]
110	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 1	A post fall protocol should include: Should there be an additional bullet points for the following: Appropriate management of patients prescribed anticoagulants with a suspected or potential head injury Assessment of reversible medical risk factors for presenting fall Assessment of need of increased falls prevention measures e.g. equipment, environment, observation (Nursing)
111	AGILE: Chartered Physiotherapists working with Older People	Statement 1	Suggest ensure reference to Duty of Candour if serious injury has occurred, informing next of kin and ensuring that the falls assessment / care plan is reviewed and updated following any inpatient falls as part of inpatient falls protocol
112	Surrey and Borders partnership NHS foundation trust	Statement 1	Should also include appropriate referral to other professionals, nutrition and mental health services.
113	Surrey and Borders partnership NHS foundation trust	Statement 1	Should also include nutrition and cognitive/mental health assessment
114	Greater Manchester West Mental Health NHS Foundation Trust	Statement 1	- about statement 1-a robust post falls protocol needs to be promoted constantly for staff to be aware, so they follow it.

ID	Stakeholder	Statement No	Comments[1]
115	College of Occupational Therapists	Statement 1	In response to the consultation question we would like to suggest that: If not already done so, consider a referral for occupational therapy and physiotherapy. Clear risk assessments carried out by therapists (occupational therapists and physiotherapists) for mobilisation and transfers should be conducted before the end of the episode of care. Clear weight bearing status is documented in the medical records.
116	South Tyneside NHS Foundation Trust	Statement 1	Please see above Quality Statement 1 Post Fall Protocol
117	British Orthopaedic Association's Patient Liaison Group	Statement 1	A post fall protocol must be mandated with standardised outcomes. The responsibility for managing this should be mandated to the Falls Prevention Group lead.
118	Chesterfield Royal Hospital NHS Foundation Trust	Statement 1	More emphasis should be given to actions undertaken to prevent further falls (eg updating the initial risk assessment for the patient).
119	University Hospitals Birmingham	Statement 1	Easy access to protocol, ideally electronic, with system prompts to use it, e.g. on electronic system cannot record fall without ticking a box to say protocol followed. Education and training for to all staff in relation to adherence of post fall protocol. Should be considered as mandatory training, like CPR. Have post fall protocol completion as a KPI for each specialty area – visible on ward dashboards
120	Guy's and St Thomas' NHS Foundation Trust	Statement 1	Older people who fall during a hospital stay are cared for in accordance with a post-fall protocol. A sampling approach would need to be used and incorporated into the process to enable data collection. In addition, the Outcome: level of harm caused by falls during a hospital stay needs to be clarified in relation to if this concerns the harm from the fall or the harm caused from non adherence to the post fall protocol.

ID	Stakeholder	Statement No	Comments[1]
121	NHS England	Statement 2	We think including the wording 'because of a fall' is likely to exclude all patients who are attending a health care provider for other reasons but who are still likely to have risks of falls, this is not compatible with what NICE 161 says 'older people in contact with healthcare professionals should be asked routinely whether they have fallen in the last year etc… ' The same is true for hospital populations; the RCP 2010 organisational audit included the audit standard 'does the inpatient assessment documentation include falls risk?' It does not limit the assessment to only patients who have attended following a fall. This statement fits with NICE 161 for patients presenting to hospital. Unpublished RCP / HQUiP feasibility audit 2013 Prevention of Falls in Acute Hospitals had the same audit standards and also went into more detail in line with NICE161. It is understood that this feasibility audit will progress to a full national version in 2015. The denominator should be older people presenting to the healthcare provider In the case of hospital patients this denominator should include patients aged 50-64 The numerator should be that all older people should receive a multifactorial falls assessment
122	AGILE: Chartered Physiotherapists working with Older People	Statement 2	Suggest clarify what is meant by requiring 'medical attention' after a fall. Make this more specific and focus on those who present to ambulance services and the emergency department. It will not be possible to trace all patient who see a GP because of a fall which will make audit against this standard unacheivable if this is also included, Suggest the role of primary care is elucidated further. The standard appears to suggest all assessments should be done by specialists whereas some assessments can be completed by primary care and more complicated cases referred on to secondary care.

ID	Stakeholder	Statement No	Comments[1]
123	College of Occupational Therapists	Statement 2	This statement needs clarification as it implies that falls assessments can only be done in secondary care and through specialist services. The College is aware of the discussions within the Falls and Fractures Alliance and within older peoples services that falls prevention and management should not be perceived as specialist. Many aspects of assessment and falls prevention and management could be addressed within all health services. We refer to David Oliver's comments 'We have probably made a mistake by 'silo-ing' services into specialist secondary clinics and community Falls teams. The sheer scale of the problem suggests that primary and community services must take the lead – especially for those not admitted to hospital. Falls prevention and better bone health also need to feature more highly in health and wellbeing strategies. Falls, frailty and bone fragility are long-term conditions par excellence, but are often unmentioned in long-term condition plans or strategies' (Ref: http://www.kingsfund.org.uk/blog/2013/09/what-are-real-costs-falls-and-fractures). In addition, discussion at PROFOUND conference - Falls are a population problem and as such we need to address the issue of falls on every level and make sure that appropriate levels of assessment and then intervention/action is completed http://www.scotland.gov.uk/Publications/2014/10/9431/10 A definition of specialist falls services may add clarity to this statement.
124	Guy's and St Thomas' NHS Foundation Trust	Statement 2	Older people who present for medical attention because of a fall have a multifactorial falls risk assessment This includes a range of healthcare settings including general practice and implies that most of the assessment will be done in specialist falls clinics. The principle is sound but may result in specialist falls clinics becoming overwhelmed, unless there is careful work and consideration around which patients should receive a multifactorial falls assessment in which setting, with specific clarity around those who should be referred to a specialist falls clinic. This may be problematic and possibly un-measurable as there is no way to capture these falls.

ID	Stakeholder	Statement No	Comments[1]
125	British Geriatrics Society	Statement 2	We feel that it should be made clear at the beginning of the QS that the multifactorial risk assessment and intervention (MFRA) may take place in a variety of healthcare settings and involve a variety of healthcare professionals. There is no consensus of the optimal model or staffing of a falls service, but there is consensus on what constitutes an effective MFRA.
126	NHS England	Statement 2	The language in this section appears unclear and we are concerned this statement could be construed that only people who present anywhere following a fall need to be assessed. The 'risk' bit is the confusing term here, the patient has already fallen therefore the risk is evident. There is also potential for confusion with regards what constitutes a falls assessment for a person who presents following a fall with what a falls risk assessment looks like to be applied across diverse populations such as all hospital admissions where the reason for the presentation may not be a fall however the risk is still there and needs to be identified in order to be managed. The difficulty we think is that in drafting the QS, NICE is trying to combine the guidance in 161 for people presenting to any healthcare provider (in community settings) who need to be referred for full falls assessment (falls clinic or similar) and the blanket statement that covers all older people admitted to hospital who need to be assessed, an intervention plan instituted or the identified falls risk factors managed if no remediable intervention is possible. Examples of the latter might include patients with chronic illness such as Parkinson's Disease or behavioural difficulties such as patients with learning disability or dementia. In order to properly reflect the two sections of the NICE CG, the QS may find it clearer to separate this into two separate statements For clarity and consistency we would prefer to see this statement wording changed to 'individualised multifactorial assessment' and 'individualised multifactorial interventions' to reflect the wording in the full guideline. Also we would like to add a sentence that specifically directs such assessments in hospital settings particularly not to be the type that assigns hierarchy of risk (low, medium, high etc.) This could be possibly included as a very visible footnote if not appropriate to include in the QS itself as without this there is a risk those reading only the QS and not familiar with the full NICE CG could incentivise the very type of numerical risk assessment that the NICE CG says 'do not use'.

ID	Stakeholder	Statement No	Comments[1]
127	British Geriatrics Society	Statement 2	Consider adding (such as specialist falls services, secondary care services and intermediate care teams)
128	British Geriatrics Society	Statement 2	We ask the authors to consider changing the wording of this paragraph to remove the word "specialist". NICE CG161 does not specifically say that a MFRA should be performed by “specialist healthcare professional”. The exact words used are “This assessment should be performed by a healthcare professional with appropriate skills and experience, normally in the setting of a specialist falls service” (this same statement appears at the bottom of Page 13). Many GP’s and nurses are capable of performing this MFRA and making onward appropriate referrals. As soon as we insist the MFRA is done by a specialist, we risk inundating the service and diluting the expertise needed for the more complex patients.
129	British Geriatrics Society	Statement 2	Again we ask the authors to change the emphasis and state this should be done by a healthcare professional with appropriate skills and experience. We also suggest removal of the phrase “normally in the setting of a specialist falls service” As an example, an appropriately trained nurse can carry out a MFRA and find the only risk factor is significant undiagnosed visual impairment. They would then arrange direct referral to opticians, not requiring specialist falls team.
130	The Chartered Society of Physiotherapy	Statement 2	We welcome the inclusion of an assessment of osteoporosis risk. However, this phrase is quite confusing, consider clarifying whether this is an assessment for osteoporosis or assessment of fracture risk.
131	The National Osteoporosis Society	Statement 2	We welcome, in particular, the inclusion of an assessment of osteoporosis risk in a multifactorial falls risk assessment. However, the term “osteoporosis risk” is confusing. Does this mean assessment of osteoporosis or assessment of fracture risk? Further clarification is needed.

ID	Stakeholder	Statement No	Comments[1]
132	National Community Hearing Association and British Society of Hearing Aid Audiologists	Statement 2	On page 14 there is no mention of an assessment to test for hearing impairment. Data on hearing impairment In England there are 8 million people with a hearing loss. 90% of these are aged 50 and over. Age-related hearing loss accounts for 90% of hearing loss. The Department of Health has also noted that 70% of 70 year olds have a hearing loss. These data are based on a large epidemiological study. The Quality Standards Advisory Committee can access this online using the POPPI tool. Falls in people with hearing impairment: People with hearing loss are more likely to suffer a fall than people without a hearing loss (Lin and Ferrucci 2012). Supporting people with their hearing loss might reduce the risk of falls (Rumalla et al. 2014). Our view NICE should include hearing assessments on page14.
133	Staffordshire University	Statement 2	*Comment:* *This comment relates to both Quality Statement 2 and Statement 4: There has to be an assessment of footwear. In addition an assessment of flooring and environment. In our opinion, if the foot – footwear- floor interaction can be sorted, we can reduce the number of falls both in the hospital and at home environment. There is no mentione of footwear or foot in the document.* *Given that foot is the main interface – there has to be an element of footwear assessment, foot exercises (we currently have a project in this area) within these guidelines.*
134	British Orthopaedic Association's Patient Liaison Group	Statement 2	Should include assessment by a podiatrist

ID	Stakeholder	Statement No	Comments[1]
135	NHS England	Statement 2	We are not clear why the list is split here from what is published in 161; no rationale is provided as to why this is the case. In our view the list should be included in its entirety not split into definite and maybe's and form the basis of a multifactorial assessment. Specifically falls history and cardiovascular examination are fundamental. Splitting the list may mean that important diagnostic opportunities are lost. An assessment can be provided by more than one health professional during an episode of care.
136	AGILE: Chartered Physiotherapists working with Older People	Statement 2	multi factorial falls assessment should include all bullet points listed not just the first 4 specified.
137	College of Emergency Medicine	Statement 2	Yes
138	Public Health Wales	Statement 2	Identification of falls history should always be included in a falls risk assessment; it is one of the most important predictors of future fall. It should not be a 'may' include.
139	Greater Manchester West Mental Health NHS Foundation Trust	Statement 2	Multifactorial factors – should also include- fear of falling, footwear and podiatry assessments, cardiovascular and neurological assessments and continence assessments.
140	University Hospitals Birmingham	Statement 2	There are some additional components that should be included and considered as essential: These are: Alcohol intake Lying and standing blood pressures Cognitive function (should be a must not a "may") Co morbidities

ID	Stakeholder	Statement No	Comments[1]
141	College of Occupational Therapists	Statement 2	The evidence base indicates that a home hazard assessment is as clear an indicator as osteoporosis risk. It should therefore be included with the points listed under 'A multifactorial falls risk assessment should include….' and not with the points listed under 'may also include'.
142	AGILE: Chartered Physiotherapists working with Older People	Statement 2	Content of mulitfactorial falls risk assessment . Needs to include emphasis on assessment and management of unexplained falls.
143	Surrey and Borders partnership NHS foundation trust	Statement 2	Should include mental health assessment, footwear and clothing (which may inhibit movements)
144	Guy's and St Thomas' NHS Foundation Trust	Statement 2	The statement highlights that assessment of visual impairment; assessment of gait, strength, balance and mobility; assessment of osteoporosis risk; medication review, are essential components of the multifactorial assessment. An assessment of home hazards should be included in this list of components, not as a *may* include.
145	Sense	Statement 2	We welcome the fact that this statement acknowledges the importance of visual impairment as a risk factor in falls management. This statement should be expanded out recognise that someone who has both hearing and sight loss, may have an increased likelihood of falling as demonstrated by research carried out by Brennan et al, 2005[1] which found that dual sensory loss significantly increases the risk of falls among older people compared to those with single sensory impairment. For those with dual sensory loss it is often difficult to compensate for some of the risk factors associated with sight loss, by using hearing, this can cause issues around receiving information about their environment and cause disorientation. People may also experience issues with balance as a result of their hearing condition. [1] Brennan, M., Horowitz, A., & Su, Y. (2005). Dual sensory loss and its impact on everyday competence. Gerontologist, 45, 337-346

ID	Stakeholder	Statement No	Comments[1]
146	Greater Manchester West Mental Health NHS Foundation Trust	Statement 2	about statement 2- again increased resources are required, more staff will be needed to carry out multifactorial falls risk assessments
147	College of Occupational Therapists	Statement 2	As the statement does not clarify where this should be undertaken it leaves it wide open. Hospitals should have the responsibility if a fall, in any way, contributed to the admission and should then have the responsibility to communicate that to the patient's GP and any community teams that may get involved in the future. Falls assessments have improved dramatically for those with a hip fracture since the National Hip Fracture Database (NHFDB) was instigated.
148	Cheshire West and Chester Council	Statement 2	Prevention is as important as assessment of risk after an event. Advice to people about services that are available locally and who to contact if they need help to maintain stability should be readily available.
149	Royal National Institute of Blind People	Statement 2	There is a higher risk of falls in older people with sight loss than their sighted peers, and the risks of falls can be reduced considerably through various interventions such as home adjustments and safety changes. In light of this, we welcome the inclusion of quality statement 2 'Multifactorial falls assessment', which includes a visual impairment assessment by health professionals in the setting of a specialist falls service.
150	Syncope Trust and Reflex Anoxic Seizures (STARS)	Statement 2	STARS would suggest that falls amongst older people living in care homes should also be subject to the same Quality Standard and post fall protocol.
151	British Orthopaedic Association's Patient Liaison Group	Statement 2	Should read medical and/or surgical.

ID	Stakeholder	Statement No	Comments[1]
152	College of Occupational Therapists	Statement 2	We agree asking services to fulfil the numerator and denominator data collection would help the process of assessing relevant patients. Community nursing teams would then be encouraged to refer patients on, having done an initial investigation themselves. For many teams, however, this would mean a change in practice and may be perceived as an extra demand.
153	South Tyneside NHS Foundation Trust	Statement 2	There is discrepancy in how this is worded when comparing it to "What the quality statement means for patients, service users and carers". In the process section the ratio compares those who have received a multi-factorial falls assessment against those who presented for medical attention because of a fall. This is different than the above section which states they are "offered an assessment". If a number of patients who have fallen refuse an assessment, this would reflect poorly on the provider through no fault of their own. The process section should mirror that later section and refer to those "offered" an assessment.
154	British Orthopaedic Association's Patient Liaison Group	Statement 2	Proportion of older people who present for medical and/or surgical attention because of a fall who have a multifactorial falls risk assessment
155	Royal College Physicians	Statement 2	The draft quality standard indicates that the RCP (2011) Falling Standard, Broken Promises report includes audit of multifactorial falls risk assessments. This is true but we would like to inform the authors that we do not currently have plans to audit the use of falls risk assessments outside of the hospital setting. Our proposed audit plan does however include auditing the use of multi-factorial falls risk assessments for in-patients in acute hospitals.
156	Surrey and Borders partnership NHS foundation trust	Statement 2	Specialist professional may need to include mental health professional
157	NHS England	Statement 2	The splitting of the list of multifactorial assessment items is of concern in that by not including a medical opinion early on there is potential to miss medical diagnostic and effective early intervention opportunities such as medication review and cardiac reasons for falling

ID	Stakeholder	Statement No	Comments[1]
158	The Chartered Society of Physiotherapy	Statement 2	Please consider including vestibular assessment as part of the multifactorial falls assessment. Vestibular assessment is not mentioned in the previous NICE Falls Guidelines or in this quality standard however there is evolving quality research regarding the prevalence and problems of vestibular deficits in the older population and for its treatment using vestibular rehabilitation. A prospective study found that 90% of primary care patients with vertigo have vestibular diagnosis such as BPPV, acute vestibular neuritis or Meniere's disease.(1) A survey conducted in the UK found that 80% of (older) people who attended A&E with unexplained falls showed symptoms of vestibular impairments.(2) A case-controlled study found a correlation between fall-related hip fracture and presence of impaired vestibule-ocular reflex (which could likely be identified in a bed-side vestibular assessment) in older people.(3) US based study estimated that prevalence of vestibular dysfunction among older people is ranging from 49.4% (60 -69 years) to 84.8% (>80years).(4) Nine per cent of elderly patients who were attending a community hospital department for various medical conditions were identified as suffering from unrecognised benign paroxysmal positional vertigo.(5) A population based study found that one year prevalence of BPPV in older people is seven times higher than people aged 18-39.(6) Positional vertigo and gait abnormalities are common risk factors for falls among the older people who were referred to Falls and Syncope Unit.(7) Simple vestibular tests could predict vestibular impairment in older people with multisensory dizziness.(8)
159	The Chartered Society of Physiotherapy	Statement 2	Please consider the inclusion of a somatosensory assessment. There is evidence that there is a correlation between sensory impairment in peripheral neuropathy patients [(9-11)] and a quick bedside test ion the acute setting would help to identify those with an increased risk of falling.
160	Syncope Trust and Reflex Anoxic Seizures (STARS)	Statement 2	STARS believes that multifactorial falls risk assessment should include review of any chronic medical problems, such as diabetes, congestive heart failure, coronary artery disease, strokes and Parkinson's disease as they can increase incidents of fainting in older person

ID	Stakeholder	Statement No	Comments[1]
161	College of Optometrists & The Optical Confederation	Statement 2	We are pleased that Visual Impairment is recognised as an essential component of the multi-factorial risks assessment and highlighted within the draft Quality Standard. With this in mind, service providers and health and social care practitioners should receive training in basic vision-testing. The Eyes Right Tool from Thomas Pocklington Trust (http://www.pocklington-trust.org.uk/researchandknowledge/publications/Eyes+Right+Toolkit) provides a peer reviewed and user friendly solution for quick and easy vision checks within a falls service setting.
162	Tees Esk and Wear Valleys NHS Foundation Trust	Statement 2	Components to be added to the multifactorial falls assessment: Do you need to consider assessment of fear of falling, assessment for constipation, assessment of sleep hygiene? These are significant issues which have been highlighted in our trust as potential contributing factors to falls
163	South Tyneside NHS Foundation Trust	Statement 2	When stating what a multifactorial risk assessment should include, medication review is rightly included, but lacks context without an accompanying measurement of lying and standing blood pressure readings. Although cardiovascular examination is listed as something an assessment may include, we have found that measuring the lying and standing blood pressure is essential to carrying out a medication review with context. We suggest that measurement of lying and standing blood pressure be added to What a risk assessment should include.
164	British Orthopaedic Association's Patient Liaison Group	Statement 2	Medical and surgical history: old prothetic hips and knees can be failing. Cognitive state and family/carer support need assessing
165	Merck Sharp and Dohme	Statement 2	MSD agrees that all the parts of the multifactorial falls risk assessment are critical and should remain.
166	Chesterfield Royal Hospital NHS Foundation Trust	Statement 2	Suggest that cognitive impairment should be included on the essential list as it relates to the patient's capacity to understand their risk of falls.

ID	Stakeholder	Statement No	Comments[1]
167	Action on Hearing Loss	Statement 2	Question for consultation: The statement highlights the following as components that are essential parts of the multifactorial falls risk assessment: assessment of visual impairment; assessment of gait, strength, balance and mobility; assessment of osteoporosis risk; medication review. Does this list include all of the essential components for this type of assessment? Response: No, this list is missing an essential component. Given the strong association between hearing loss and falls, assessment of hearing impairment should be included as an essential part of the multifactorial falls risk assessment
168	The Royal Society for the Prevention of Accidents	Statement 2	P14. A number of items in the assessment are included in a “may also” list. This implies that these are of less value. These should all be included in the assessment. In particular, for example a home assessment is critical if a faller is being discharged back to their home. An understanding of the falls history will help to gauge how often a patient is falling, probable causes, etc. Is there any scope for multifactorial falls assessments to take place if a patient presents with conditions/symptoms known to increase likelihood of falling before a fall has taken place. This may help to prevent or delay the initial fall.
169	Gloucestershire Hospitals NHS Foundation Trust	Statement 2	General comments about quality statement 2: We differed in our views in relation to visual impairment. One senior team member felt that assessment of visual impairment is essential whether in an acute setting or within the community. From an in-patient perspective whilst it may be non-modifiable an accurate assessment of visual impairment will highlight the need to adapt approaches to managing the patient on the ward. Two other senior staff felt that visual impairment was not an essential component as realistically what can be done in the acute setting and often it is not modifiable. We thought that the list should include assessment of home hazards/safety interventions as being an essential component and should reflect the most significant hospital risk factors and therefore include assessment of confusion/delirium, continence, possibly orthostatic hypotension (this is often not performed well while in hospital) and the hospital environment.
170	Surrey and Borders partnership NHS foundation trust	Statement 2	This list should also include Environment, footwear, hearing aid, mental health and nutrition

ID	Stakeholder	Statement No	Comments[1]
171	British Geriatrics Society	Statement 2	We feel this list includes all the important elements except the measurement of postural hypotension. We feel this is an essential component as it is frequently present in older fallers and easily managed by medication review and lifestyle adaptations. Management of postural hypotension is an important part of successful falls prevention.
172	University Hospitals Birmingham	Statement 2	Statement should include "and ongoing treatment of issues identified" not just having the assessment, but also follow up, addressing the issues. The need for an assessment should be identified on admission and the relevant electronic process should automatically trigger referral to relevant clinical teams.
173	Hip Impact Protection Ltd.	Statement 2	No, this does not include all the essential components since it is entirely a post-facto analysis based on, at best, anecdotal recall of the fall or falls recently occurring to the patient, no actual characteristics having been captured at the time of the fall. Real-time gait analysis should also be implemented so that falls can be prevented when the patient appears wobbly and could be about to fall. The risk will inevitably vary from day to day and a one-time only assessment of however many factors will only supply one part of the picture. Evidence for this is in the increasing incidence of hip fractures, despite multi-factorial assessments being implemented.
174	Staffordshire University	Statement 2	*Does this list include all of the essential components for this type of assessment?* *We do not think all of the essential components within gait and postural assessment have been covered. As it stands, the statement says ".. assessment of gait, strength, balance and mobility". Whilst we appreciate that it has to be a general statement, we think it will be better if it covers specific assessment protocols. For example if the intervention involves specific exercises (for example our project titled elbet), then the assessment should not only focus the assessment but also the effectiveness of intervention. As an additional comment – there is still a clear need for the development of clear protocols to assess each of these topics. As such there are general approaches to these assessments but we still need a "normative" database for various variables involved in this assessment.*
175	Barnsley Hospital NHS Foundation Trust	Statement 2	This list is not extensive enough. We believe that a multifactorial falls risk assessment should include ALL of the following components: vision; gait; strength; balance; mobility; osteoporosis risk; medication review; falls history; perceived functional ability and fear of falling; cognition assessment; neurological examination; continence assessment; home hazard assessment; cardiovascular examination.

ID	Stakeholder	Statement No	Comments[1]
176	College of Occupational Therapists	Statement 2	The multifactorial falls risk assessment may also include the following: footwear and foot care. fear of falling assessment of cardiovascular systems and vestibular systems to identify medical causes for falls.
177	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 2	Where it lists what should and may be included – should identification of falls history be in what should be included and assessment of osteoporosis risk be in the may be included. Medication review – this needs to be explicit to say identification of falls risk associated medication cessation/reduction as indicated Neurological examination should be a separate bullet point from cognitive impairment Assessment of cognitive impairment – does this need to identify a formal assessment tool and does it include dementia/delirium screening
178	Royal College of Physicians of Edinburgh	Statement 2	Where it lists what should and may be included – identification of falls history would be best placed in what should be included and assessment of osteoporosis risk in the may be included category. Medication review – recommend rewording - identification of falls risk associated medication and active cessation or dose reduction as clinically indicated. Neurological examination should be a separate item from cognitive impairment. Assessment of cognitive impairment – Recommend defining as assessment for delirium – reversible cognitive impairment. Assessment for dementia – irreversible cognitive impairment.
179	Merck Sharp and Dohme	Statement 3	Those people living in the community that have a history of recurrent falls should also have a multifactorial falls risk assessment including the key components from quality statement 2 before they are referred for strength and balance training.

ID	Stakeholder	Statement No	Comments[1]
180	Guy's and St Thomas' NHS Foundation Trust	Statement 3	Older people living in the community who have a known history of recurrent falls are referred for strength and balance training. Recurrent falls needs to be defined clearly within the statement. This includes all older persons in the community and care homes which is a vast number of people. This population will include a lot of people with dementia and other co-morbidities which make strength and balance training difficult. The outcome measures are problematic as nobody can easily track recurrent fallers- but a sampling approach may work. In addition, intervention should really focus on adherence to balance training rather than referral, with BGS guidelines followed for referral for balance training.
181	British Geriatrics Society	Statement 3	There are many examples of SABT classes which do not provide evidence based exercise provision, in particular exercise done for too short a time. We ask that it is made specific that commissioners should ensure evidence-based SABT is provided. This should be an evidence-based programme, carried out by appropriately-trained practitioners, with an adequate frequency of sessions and duration of programme. National audit data indicates that local exercise provision is nearly universal but that few programmes provide the quality or 'dose' of exercise suggested by the evidence.
182	Royal College of Physicians of Edinburgh	Statement 3	Strength and balance training should be for an evidence based duration (ie 12 weeks minimum).
183	Royal College of Physicians of Edinburgh	Statement 3	Specify the minimum duration of exercise for commissioning the programmes.
184	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 3	This needs to say explicitly 'of an evidence based duration (i.e. 12 weeks minimum)

ID	Stakeholder	Statement No	Comments[1]
185	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 3	There needs to be acknowledgement that when considering commissioning the programmes will need to be of 12 weeks duration as a minimum
186	British Geriatrics Society	Statement 3	We ask that it is made clear that there are exemptions from this statement. Strength and balance training (SABT) would not be beneficial in those with significant cognitive impairment and significant visual impairment. There is evidence that doing SABT training in these groups increase harm events.
187	British Orthopaedic Association's Patient Liaison Group	Statement 3	Those who have a record of falling and are in their 80's & 90's will find strength and balance exercises difficult to perform and will not do them... they need training in how to get about the house safely: wearing the appropriate footwear, use of a walking frame etc. Telling the elderly and just leaving them new equipment is inadequate.
188	Royal College of Physicians of Edinburgh	Statement 3	Older people living in a residential or nursing home – there is a lack of evidence to say this is effective in these population groups.
189	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 3	Older people living in a residential or nursing home – there is a lack of evidence to say this is effective in these population groups
190	Greater Manchester West Mental Health NHS Foundation Trust	Statement 3	about statement 3-again increased resources are needed to offer balance and strengthening training in the community as groups or in a patient's own home. –This needs adapting for dementia patients who will have cognitive problems and may need more time and repetition and adapting then programme

ID	Stakeholder	Statement No	Comments[1]
191	The Chartered Society of Physiotherapy	Statement 3	Consider making this outcome more specific. For example “Rates of recurrent falls in older people who have been referred for strength and balance training”.
192	Royal College of Physicians of Edinburgh	Statement 3	The outcome measure defined is laudable, but potentially unrealistic. ‘Rates of recurrent falls in older people’ – who will measure this and how? What method would be used which was reliable, reproducible, consistent and economical to collect? Accurate assessment of falls as an outcome is difficult to achieve in a research environment. It is not possible to accurately measure this outcome currently. A fall surrogate, such as the Falls Efficacy Scale, gait and balance measures could be used which can be measured before and after intervention. Alternatively, with a large data set, fall related fracture data could be measured.
193	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 3	‘Rates of recurrent falls in older people’ – who will measure this and how? Would it be more recommended to measure a quality outcome by using for e.g. Falls Efficacy Scale, gait and balance measures
194	AGILE: Chartered Physiotherapists working with Older People	Statement 3	Recurrent falls needs definition.
195	Hip Impact Protection Ltd.	Statement 3	Unless this is performed under supervision – which is very expensive – accidents will inevitably happen as people misinterpret the correct procedures and then have a fall. There is no provision for protective wear during such exercise, eg. hip or head protectors.

ID	Stakeholder	Statement No	Comments[1]
196	Royal College of Physicians of Edinburgh	Statement 3	There is a disproportionate emphasis on home environmental visits and modifications compared to the weight of evidence for this single intervention in the falls prevention literature. The evidence base remains strongest for environmental modification as an intrinsic component of a multifactorial intervention.
197	Staffordshire University	Statement 3	*Comment:* *There is no doubt that strength and balance training is warranted. In our opinion the research results in this area is rather inconclusive and some of the methodological approaches is not applicable to the United Kingdom. We are aware of some of the trails here in the UK, but there is a strong opinion within our extended research team some these projects needs to be revisited. A particular focus needs to be given on (1) the use of wearable technology (2) exercises at home with a capability to be monitored remotely.*
198	College of Occupational Therapists	Statement 3	Strength and balance training – this needs to be a continuum and again linked to health and wellbeing. Again there needs to be opportunity for self-referral and pathways to enable someone attending strength and balance to have access to a home hazards assessment or other multifactorial interventions.
199	NHS England	Statement 3	Appropriate, no comment to make
200	The Chartered Society of Physiotherapy	Statement 3	We support the specific mention of strength and balance training that is evidence-based and tailored to the individual.
201	Chesterfield Royal Hospital NHS Foundation Trust	Statement 3	Would support the provision of evidence-based programmes in the community provided this is properly resourced.
202	Guy's and St Thomas' NHS Foundation Trust	Statement 3	In addition, intervention should really focus on adherence to balance training rather than referral, with BGS guidelines followed for referral for balance training.

ID	Stakeholder	Statement No	Comments[1]
203	South Tyneside NHS Foundation Trust	Statement 3	This section states that older people living in their own home or in a residential or nursing home start a programme of exercises. The literature on the efficacy of exercise for the prevention of falls supports these programmes in those who are both physically and cognitively able to safely participate in them. The trials have mainly used female participants in their own homes and may not be reproducible in residential or nursing homes. This is supported by the latest Cochrane Review on Falls "Results from 13 trials testing exercise interventions in care facilities were inconsistent and overall did not show a benefit." (28 March 2013) and American Journal of Physical Medicine & Rehabilitation: October 2006 - Volume 85 - Issue 10 - pp 847-857. One does not wish to automatically exclude persons living in these environments, however the use of "physically and cognitively able to safely participate" will ensure that maximum benefit is achieved by those able and maximum safety is achieved for those not able.
204	The Chartered Society of Physiotherapy	Statement 3	Also consider including a statement that this exercise training should be delivered in a setting most appropriate to the individual e.g. in own home for those less mobile.
205	Cheshire West and Chester Council	Statement 3	Try to prevent falls before they occur. eg exercise sessions at older people's groups to help maintain stability.
206	Surrey and Borders partnership NHS foundation trust	Statement 3	These facilities should be available to patients with mental health/ cognitive needs and staff should have relevant training.
207	British Geriatrics Society	Statement 3	This should be the number of older people living in the community with a history of falls in whom SABT would be appropriate.
208	Royal College Physicians	Statement 3	The draft quality standard indicates that the RCP (2011) Falling Standard, Broken Promises report includes audit of strength and balance training. The previous audit did include a question about onward referrals and intervention plans in the organisational audit but we have no plans in the current programme to audit this more thoroughly.

ID	Stakeholder	Statement No	Comments[1]
209	Tees Esk and Wear Valleys NHS Foundation Trust	Statement 3	Service Providers: Cognitive impairment should not be in any exclusion criteria for specialist falls services. This is to ensure compliance with the protective characteristics
210	British Geriatrics Society	Statement 3	We ask the authors to consider replacing “district general hospitals” with “outpatient services of acute trusts”, as therapeutic exercise is more likely to take place in this setting.
211	British Orthopaedic Association's Patient Liaison Group	Statement 3	“and the expert will check how they are getting on with them.” It is essential that elderly folk are fully supported and encouraged to complete such a course...
212	AGILE: Chartered Physiotherapists working with Older People	Statement 3	The quality standard needs to state more specifically the type dose, progression duration and intensity of exercise required for it to be evidence based.
213	Royal College of Physicians of Edinburgh	Statement 3	There is no consistent and clearly defined recommendation for the duration of exercise as an intervention. It is critical that this is specified, as short duration exercise interventions have not shown benefit in falls reduction. Commissioners would need to recommend that exercise programme duration needs to be for a minimum of 12 weeks to be clinically effective.
214	South Tyneside NHS Foundation Trust	Statement 3	“Older people living in the community” is defined as “living in their own home or in extended care”. Does this include nursing homes as well as residential care homes? If so, it needs to be more clearly stated.

ID	Stakeholder	Statement No	Comments[1]
215	The Chartered Society of Physiotherapy	Statement 3	Please consider including a component of vestibular rehabilitation if a vestibular cause of falling has been identified. There is growing evidence supporting vestibular rehabilitation (a speciality incorporated in balance training) to treat vestibular disorders: Evidence has been gathered and analysed in a systematic review showing positive effects of vestibular rehabilitation for older people with vestibular disturbances.(12) A Cochrane review (most of the patients in the studies were older people) found that there was a moderate to strong evidence that vestibular rehabilitation was safe and effective approach for unilateral vestibular hypofunction.(13) A retrospective study found that vestibular rehabilitation is cost effective in improving the balance reducing risk falls among older people with risk of falls.(14) Successful treatment of BPPV in older people resulted in reduction in number of falls.(15)
216	The Royal Society for the Prevention of Accidents	Statement 3	P15 – "recurrent falls" – is the standard to be that only recurrent fallers have access to strength and balance training? How recurrent do the falls have to be before a patient qualifies? Strength and balance training may help to prevent recurrence after the initial fall. It is not clear why the emphasis is on recurrent falls only. "Expert" support – how often and for how many weeks? This will have a significant bearing on the quality standard and on the effectiveness of the intervention.
217	College of Optometrists & The Optical Confederation	Statement 3	There are additional falls risks associated with older adults who have poor vision (for example, a drastic reduction in mobility)* and no real evidence to suggest that standard rehabilitation programmes are actually effective for falls patients with visual impairment. Northumbria, Manchester, Newcastle and Glasgow Caledonian Universities are conducting research at the moment which is looking to adapt exercise programmes to improve falls prevention among older people with sight loss. (Funded by the National Institute for Health Research). We therefore urge the Quality Standards Advisory Committee to consider a caveat in this particular standard that takes the visually impaired into account. *Crews JE, Campbell VA. (2004), Vision impairment and hearing loss among community-dwelling older Americans: Implications for health and functioning. American Journal of Public Health, 94, 823-829

ID	Stakeholder	Statement No	Comments[1]
218	Public Health Wales	Statement 3	This is fine, but where are these people being referred to? NHS services or LA leisure / recreation services. If this is the latter, who will fund? This is the only real option for local service delivery. If NHS, can they realistically be held in places that are accessible?
219	University Hospitals Birmingham	Statement 3	Need a robust, effective and responsive Community Teams to cope with the potential patient demand this will create. Improved communications from acute care services to primary care services. CCGs Could consider a data base of known fallers who are regular attenders, their previous interventions, outcomes, management strategies to avoid wasteful and repeated interventions of low impact. For acute Trusts, clarity about “out of area” patients and their pathway is required. Who will be the responsible referral source? Currently there are too many barriers to seamless pathway management without the involvement of a named Dr – this creates delay.
220	Guy’s and St Thomas’ NHS Foundation Trust	Statement 4	Older people who have had treatment in hospital after a fall are offered a home hazard assessment and safety interventions. Hospital treatment is increasingly " interface " treatment so we need to be clear what hospital treatment means - this intervention comes from the KCH study of 20 years ago when there was very little out of hospital work. Falls rate in the community is very difficult to determine and outcome measures for falls rate is again tricky unless sampling is used.
221	British Geriatrics Society	Statement 4	We ask the authors to clarify whether it is expected a home hazard assessment (HHA) be done only after a patient is admitted to hospital or whether this includes those attending accident services and being discharged directly home.
222	British Geriatrics Society	Statement 4	We ask the authors consider denominator be those in whom a HHA is appropriate, rather than all fallers attending a hospital. For example, an older person falling while walking up a mountain will clearly not need a HHA! We suggest limiting the denominator to a HHA in all patients falling at home or with a history of falling at home.

ID	Stakeholder	Statement No	Comments[1]
223	University Hospitals Birmingham	Statement 4	Similar implications to statement 3, Who will be primarily responsible for these visits and in what timescale? Concern that adequate resources do not exist to meet this requirement across the board especially in light of 'a fall' which is a huge population. Can there be clarity on the patient group the statement is targeting e.g. 'explained fallers without a clear management plan or unexplained fallers'
224	The National Osteoporosis Society	Statement 3 & 4	We support the inclusion of both of these quality statements. Both outcomes, however, need to be made more specific to the statements themselves.
225	Royal College of Physicians of Edinburgh	Statement 4	This incorporates a large Occupational Therapy service component but evidence base is proportionally stronger for other measures for eg exercise, muscle strengthening and multifactorial intervention. Would it be more proportionate to look at these as a quality standard?
226	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 4	This incorporates a large Occupational Therapy service component but evidence base is proportionally stronger for other measures for e.g. exercise, muscle strengthening and multifactorial intervention. Would it be more recommended to look at these as a quality standard?
227	Sense	Statement 4	Hazard assessment and safety interventions are a welcome measure for delivering quality in falls prevention, however we feel that this section should reflect better the areas assessed in the multifactorial risk assessment recommended in statement 2. It is crucial that interventions to reduce falls take into account the risk factors identified during previous assessments, and in particular take into account whether someone has a sight and/or hearing loss which may impact on their ability to take part in the hazard assessment and receive any advice given. At this stage people should also be referred to specialist teams who can support them with their sight and/or hearing loss and the risks associated with this, and offered them a specialist assessment.
228	College of Occupational Therapists	Statement 4	Under 'Process' section (a) this should be an occupational therapy led home assessment.

ID	Stakeholder	Statement No	Comments[1]
229	College of Occupational Therapists	Statement 4	This should be an occupational therapy led home hazard assessment.
230	Greater Manchester West Mental Health NHS Foundation Trust	Statement 4	about statement 4- Again increased resources for home hazard checks are required. Collaboration with other public health services who could do this. Access to handyman/ removal services to physically move furniture around if needed as this can be difficult for patients/ carers and for health professionals to organise.
231	AGILE: Chartered Physiotherapists working with Older People	Statement 4	Ensure it is clear that removal of home hazards is not the main intervention in reducing falls risk for community dwelling older people.
232	NHS England	Statement 4	Appropriate, no comment to make
233	British Geriatrics Society	Statement 4	We ask the authors clarify at the beginning that the HHA assessment should be done in the patient's home. It is less clear until the end of the QS and is a significant change from current practice.
234	Chesterfield Royal Hospital NHS Foundation Trust	Statement 4	Current practice is to refer patients at significantly increased risk of falls to community physiotherapy services for further assessment, but the nature, extent and capacity of this service varies widely even within our county. To require an assessment for every patient who has been admitted to hospital with a fall would mean a significant increase in workload for our community colleagues, which would need to be appropriately resourced.
235	College of Occupational Therapists	Statement 4	Older people who have had treatment in hospital after a fall should be offered a home assessment, however there are other categories that also apply: anyone identified as being at risk of falls should be offered a home hazards assessment and interventions anyone living in the community who has recently sustained a fall or has a history of falls.

ID	Stakeholder	Statement No	Comments[1]
236	AGILE: Chartered Physiotherapists working with Older People	Statement 4	Home hazard assessment should not be restricted to those who have had falls and have been hospitalised. Home hazard assessment should be offered by qualified OTs or those trained by them as per guidance.
237	Merck Sharp and Dohme	Statement 4	Statement 4 says that older people who have had treatment in hospital after a fall are offered a home hazard assessment. The home hazard assessment should be expanded to all older people who have been referred for medical attention after a fall.
238	The Royal Society for the Prevention of Accidents	Statement 4	Why is this restricted only to people who have had treatment in hospital as a result of a fall? Assessment at an earlier stage may help to reduce hospitalisation in the first place. Assessment following interventions that don't result in hospital would also be important. The definition of "home hazard assessment" p21 is welcome and helps to reinforce the need for something more comprehensive than a simple tick box exercise.
239	Royal College of Physicians of Edinburgh	Statement 4	How will falls rates in the home for older people be measured and who would measure this? Would it be recommended to measure hospital readmission for fall related injuries?
240	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 4	How will falls rates in the home for older people be measured and who would measure this? Would it be recommended to measure hospital readmission or fall related injuries
241	The Chartered Society of Physiotherapy	Statement 4	Consider making this outcome more specific. For example "Fall rates in the home for older people who have been referred for home hazard assessment".
242	Royal College Physicians	Statement 4	The draft quality standard indicates that the RCP (2011) Falling Standard, Broken Promises report includes audit of home hazard interventions. There was a question about this in the past audit but we have no plans in the current audit programme to audit this more thoroughly in the future.

ID	Stakeholder	Statement No	Comments[1]
243	Royal College of Physicians of Edinburgh	Statement 4	The data source – 'local data collection' is the same as the process. How is this to be defined? What standardised method would be used?
244	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 4	The data source – 'local data collection' is the same as the process
245	Royal College of Physicians of Edinburgh	Statement 4	The important/significant factor should be the number of home hazard assessments carried out where changes are actually implemented
246	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 4	The important/significant factor should be the number of home hazard assessments carried out where changes are actually implemnted
247	Royal College of Physicians of Edinburgh	Statement 4	Should this read: "Older people who have had treatment in hospital after a fall will receive a multifactorial risk assessment, in order to identify the need for a home hazard assessment and safety interventions."
248	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 4	Should this say 'Older people who have had treatment in hospital after a fall and after a multifactorial risk assessment has been carried out, identifying the need for a home hazard assessment…'
249	AGILE: Chartered Physiotherapists working with Older People	Statement 4	Ensure it is clear that patients who are in the acute setting may have their home hazard assessments completed by community teams and audit against this standard will therefore require collaboration between providers.Q

ID	Stakeholder	Statement No	Comments[1]
250	British Geriatrics Society	Statement 4	We ask that “district general hospital trusts” be changed to “acute trusts”.
251	Hip Impact Protection Ltd.	Statement 4	There appears to be no recognition that the characteristics of previous falls be factored into this assessment. This can only really be done by implementation of falls identification and recording devices and systems which allow analysis of the factors involved in the fall, eg was it a trip or slip, how hard was the fall and when did it occur. Often the patient will have limited or no recall of the events leading up to the fall or of the actual fall itself. Without such evidence what the assessor thinks of potential hazards will inevitably only have a limited effect.
252	Royal College of Physicians of Edinburgh	Statement 4	Should this read: ‘Home hazard assessment should be more than a ‘checklist’ of hazards for those that it is appropriate …’
253	Staffordshire University	Statement 4	*Comment:* *This comment relates to both Quality Statement 2 and Statement 4: There has to be an assessment of footwear. In addition an assessment of flooring and environment. In our opinion, if the foot – footwear- floor interaction can be sorted, we can reduce the number of falls both in the hospital and at home environment. There is no mentione of footwear or foot in the document.* *Given that foot is the main interface – there has to be an element of footwear assessment, foot exercises (we currently have a project in this area) within these guidelines.*
254	The Newcastle upon Tyne Hospitals NHS Foundation Trust	Statement 4	Should this read: ‘Home hazard assessment should be more than a ‘checklist’ of hazards for those that it is appropriate…’

ID	Stakeholder	Statement No	Comments[1]
255	College of Occupational Therapists	Statement 4	Home hazard assessment: the statement that a home hazard assessment should investigate the dynamic interaction between a person and their environment should be supported. There will be occasions when a home assessment may not be required following hospitalisation, e.g. when there is a clearly identifiable medical reason for the fall and the patient is otherwise independent with no concerns over their function or their interaction with the environment.
256	College of Occupational Therapists	Statement 4	Equality and diversity considerations – Culture may also be a factor in implementing some interventions and should be added in – 'Age, socioeconomic status and culture may influence the willingness…'
257	Surrey and Borders partnership NHS foundation trust	Statement 4	All falls should be reported to GP's for medical records to be updated.
258	College of Emergency Medicine	Statement 4	equality & diversity - age and SE status but no mention of ethnicity - does this not affect access/acceptability?
259	College of Optometrists & The Optical Confederation	Statement 4	If vision was a known factor in the fall, it is imperative that the home hazard assessment is sensitive to the specific needs of the visually impaired patient. No matter how hazardous the objects in a person's home may seem to others, it may well be that, for the visually impaired person, they are crucial for enabling them to navigate their home environment. It is more lighting and contrast around stairs and doorways that play a fundamental role in preventing falls in the home of a visually impaired person. We recommend that caution should be used when moving or removing objects and a consultation with the visually impaired person (or their carer) should be standard practice. Housing for people with sight loss: A practical guide to improving existing homes, Good Practice Guide 4 (3rd edition) www.pocklington-trust.org.uk/researchandknowledge/publications/rf17
260	Public Health Wales	Statement 4	Again, fine, but the success will be very dependent on who carries out the assessment, what interventions are needed and the timeliness with which these interventions are implemented. See also answer in relation to Q3.

ID	Stakeholder	Statement No	Comments[1]
261	British Geriatrics Society	Additional statement	We feel that while managing the patient who has fallen using a post fall protocol is essential, much of the harm will have occurred as a result of the fall and cannot be mitigated against. The main way to reduce harm caused by falls during in-patient stay is to prevent the falls and use injury prevention measures such as low beds and bed rails (for a minority of appropriate patients).
262	British Geriatrics Society	Additional statement	We support the inclusion of inpatient falls but feel strongly that the QS should include a focus on preventing in-patient falls as well as managing patients after a fall. Not including inpatient falls is at odds with the Outcomes Frameworks and with the main update of NICE Clinical Guideline 161. Anecdotal evidence from trusts show that changing your focus from preventing the fall to managing the patient after a fall leads to an increase in injurious falls.
263	Chesterfield Royal Hospital NHS Foundation Trust	Additional statement	Would like to see a standard related to the prevention of falls in hospital, not just post fall actions (eg falls risk assessment undertaken for every patient on admission)
264	British Geriatrics Society	Additional statement	We feel that this QS does on the whole reflect the key areas for improvement, with some reservations: We support the inclusion of inpatient falls but feel strongly that the QS should include a focus on preventing in-patient falls as well as managing patients after a fall. Not including inpatient falls is at odds with the Outcomes Frameworks and with the main update of NICE Clinical Guideline 161. Anecdotal evidence from trusts show that changing your focus from preventing the fall to managing the patient after a fall leads to an increase in injurious falls. We support the inclusion of multifactorial falls risk assessment, but would recommend that this is appended with "...and intervention". We particularly like the focus on strength and balance training, though we would wish this statement to specify that this training must be evidence-based.
265	AGILE: Chartered Physiotherapists working with Older People	Additional statement	Does the guideline reflect key areas for improvement? No. More emphasis is required on medication review and investigation of unexplained falls.

Stakeholders who submitted comments at consultation

- Action on Hearing Loss
- AGILE
- Barnsley Hospital NHS Foundation Trust
- British Geriatrics Society
- British Orthopaedic Association's Patient Liaison Group
- Cheshire West and Chester Council
- Chesterfield Royal Hospital NHS Foundation Trust
- College of Emergency Medicine
- College of Occupational Therapists
- College of Optometrists & The Optical Confederation
- Department of Health
- Digital Assessment Service, NHS Choices
- Gloucestershire Hospitals NHS Foundation Trust
- Greater Manchester West Mental Health NHS Foundation Trust
- Guy’s and St Thomas’ NHS Foundation Trust
- Hip Impact Protection Ltd.
- Merck Sharp and Dohme
- National Community Hearing Association and British Society of Hearing Aid Audiologists

- NHS England
- Public Health Wales
- Royal College of Nursing
- Royal College of Physicians of Edinburgh
- Royal College of Physicians
- Royal National Institute of Blind People
- Sense
- South Tyneside NHS Foundation Trust
- Staffordshire University
- Surrey and Borders partnership NHS foundation trust
- Syncope Trust and Reflex Anoxic Seizures (STARS)
- Tees Esk and Wear Valleys NHS Foundation Trust
- The Chartered Society of Physiotherapy
- The National Osteoporosis Society
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- The Royal College of Radiologists in collaboration with The British Society of Skeletal Radiologists (BSSR)
- The Royal Society for the Prevention of Accidents
- University Hospitals Birmingham