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

Consultation on draft scope
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AGILE: Chartered Physiotherapists working with Older People	General	General	Involving various settings including private/voluntary organisations who may pick up unreported falls/trips and services (like emergency services, care line alarms, voluntary organisations) that helps fallers manage at home without accessing healthcare systems.	Thank you for your comment. As these are not generally publicly funded (NHS and Social Care) they do not form part of the NICE guideline remit. However, where these organisations are commissioned to deliver NHS health and social care services, they would be covered.
AGILE: Chartered Physiotherapists working with Older People	General	General	Separating primary and secondary falls prevention to aid easy identification and management.	Thank you for your comment. This will be determined by the committee when drafting the review question protocol. Frequency of falls is included as a main outcome in the scope.
AGILE: Chartered Physiotherapists working with Older People	002	018	Including private and voluntary organisations involved with people over 50s	Thank you for your comment. This is already captured in line 24, which states that, 'This guideline may be useful for: •Private sector and voluntary organisations involved in the provision of care and support.'
AGILE: Chartered Physiotherapists working with Older People	003	012	The draft scope excludes people under 50 who are at risk of falling. This group should be included to help identify and prevent falls.	Thank you for your comment. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided for younger adult populations within the disease specific guidelines.
AGILE: Chartered Physiotherapists working with Older People	003	016	Should this include private and voluntary organisations involved with people over 50	Thank you for your comments. As these are generally not publicly funded (NHS and Social Care) they do not form part of the NICE guideline remit. However, where these organisations are commissioned to deliver NHS health and social care services, they would be covered.

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AGILE: Chartered Physiotherapists working with Older People	006	020	May need to include routine questioning as most people don't report a fall unless it has caused them huge distress.	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
AGILE: Chartered Physiotherapists working with Older People	006	026	How to capture unreported falls?	Thank you for your comment. This will be considered by the committee as part of the 'methods of identifying people at risk of falls' section of the guideline update.
British Dietetic Association - Older People Specialist Group	001	013	The Dietetic profession welcomes a NICE for Falls in Older people assessing risk and prevention	Thank you for your comment.
British Dietetic Association – Older People Specialist Group	003	008	BDAOPGS welcome the scope to be covered of all setting where NHS health and social care service are delivered and the groups that will be covered.	Thank you for your comment.
British Dietetic Association – Older People Specialist Group	003	018	BDAOPGS welcome the opportunity for nutrition and hydration needs of this group as a key area for consideration. The rationale is 1. Nutrition is related to many risk factors for falls and has been shown to be a determining factor in not only the severity of injuries from falls, but also recovery time after the injury. As prevention of falls involves optimising muscular skeletal and bone health both nutrition and hydration needs including in this pathway. Key is early recognition of malnutrition to prevent loss of muscle mass and strength with resultant impact on mobility, weakness	Thank you for your comments and the references provided. Inclusion of hydration and nutrition within the review questions will be considered by the committee when developing the protocols. For each key area in the scope we have clarified that the lists are examples only.

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			and frailty. (Reference: Louise Nash (2016) How can dietitians contribute to reducing falls risk? A review of the links between nutrition, hydration and falls 2. Nutrition and hydration intervention are fundamental to optimising daily functioning. A core consideration is optimising and maintaining muscle mass. Emerging evidence suggests 3arcopenia is a risk factor for falls and a marker of frailty. Optimising muscle protein synthesis (MPS) is relevant for all population groups due to the role skeletal muscle plays in overall health, in heart health, bone health and weight management. With emerging evidence highlighting sarcopenia as a marker of frailty, prevention of sarcopenia is important in healthy ageing. Changes in muscle mass can start to decline from around 40 years of age by 0.5–1.0% year on year. An important part of interventions for sarcopenia is maintaining muscle strength and mass through both regular resistance exercise and adequate nutritional intake. (References: Landi et al (2012) Sarcopenia as a risk factor for falls in elderly individuals: results from the ilSIRENTE study. https://www.ncbi.nlm.nih.gov/pubmed/22414775; Sarcopenia: revised European consensus on definition and diagnosis 3. Good hydration can assist in preventing or treating dizziness and confusion. Falls injury is one of the top ten diagnosis for alcohol related hospital admissions. NICE	

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			2010 guidance recommends professionals from a range of health and social care settings should screen people who may be at risk of harm from the amount of alcohol they drink. Those identified as drinking at increasing or higher risk levels. Good bone health includes Vitamin D and calcium in both prevention and management on falls. (Reference: A Practical Clinical Guideline for Patient Management	
British Geriatrics Society	General	General	We recommend that; It would be helpful to consider frequent fallers and outcomes, regarding timeliness of assessment and intervention.	Thank you for your comment. Frequency of falls is included in the list of main outcomes. The committee will consider any specific recommendations required for this population from the evidence identified.
British Geriatrics Society	General	General	Our observations and recommendations: There is no distinction between acute and environmental conditions - patient group and profile differ. How will NICE differentiate?-need to ensure that different interventions in different settings are clearly defined NICE (National Institute for Clinical Excellence) should include patients under 50 - there is an increase in the number of patients under 50. The guidelines do not cover this and how we manage this group.	Thank you for your comments. The guideline will include acute and community settings, including people's homes and this has been made clearer in the scope. The committee will consider the different settings identified within the evidence and tailor recommendations accordingly. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided for younger adult populations within the disease specific guidelines. When reviewing the evidence identified for the education and information review question the committee will

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			Education and information for patients living alone or with a language barrier. Information and education should include issues with sensory impairment, cognitive or learning difficulties and be culturally sensitive. Link in the Falls guidelines scope to NICE and Head injury guidelines	consider any recommendations required to address any specific needs of people. Links to the head injury guideline have been added to the scope.
British Orthopaedic Association	General	General	I have no major concerns with the scope at all. My feelings are the provision of information in means useable both the patients, carers and relatives is really important. Measuring the impact of differing information transfer is key. Feedback is really important from those that have fallen and fractured. I would like to see more feedback from those identified as having fallen and been injured and use this population more closely to assess where an intervention could have helped.	Thank you for your comment.
Care England	001	013	Whilst we appreciate that falls are more prevalent in older adults, the rate and consequences of falls in younger adults in receipt of care warrants consideration. People with learning disabilities have a similar risk of falls throughout their lives as older people in the general population. Around one-third of falls by people with learning disabilities result in injury and the rate of fractures is higher than in the rest of the population.	Thank you for your comment. People with learning disabilities (within the age range defined in the scope, see below) have been added to the Equalities impact assessment and any equality issues identified will be addressed by the committee as part of the review of evidence and development of recommendations. To clarify, the guideline age range is: people over 65 and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling.

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Care England	002	007	Whilst consideration needs to be given to the prevention of falls in acute hospitals and mental health trusts, guidance must not overlook settings whereby the risk of falls may increase over the coming years.	Thank you for your comment. All settings where NHS health and social care services are delivered are included in the scope.
Care England	003	010	If the guidance is to consider settings such as mental health trusts, where risk of falls is high, the groups that will be covered in the guidance needs to also include working age adults that might be at higher risk of falls, such as those with learning disabilities or mental health needs, and not just adults over the age of 50.	Thank you for your comment. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided for younger adult populations within the disease specific guidelines. The Equality Impact Assessment includes people with mental disabilities (within the age range defined in the scope) and any equality issues identified will be addressed by the committee as part of the review of evidence and development of recommendations.
Care England	003	016	The guidance states that all settings will be covered. It is important that this focuses on all types of providers, including older and younger adults across residential to support living settings.	Thank you for your comment. The settings section has been amended to make clear that it will include NHS and social care services delivered in people's homes. The population covered is outlined in section 3.1 above.
Care England	003	021	Will this information and education cover training?	Thank you for your comment. Training for health and social care staff would need to be determined locally by service providers, it is not an area that will be included in the guideline.
Care England	004	004	Should consideration not be given to the importance of technological interventions in the role of prevention?	Thank you for this comment. There has been growth in the use of technology for assessment of falls risk and in supporting fall prevention interventions. The evidence syntheses designed to answer questions 3 (Individual risk factor assessment for people at risk of falls) and 4

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				(Interventions to reduce the risk of falls) should be designed to capture new evidence in this area.
Care England	006	018	Reference is made to information for carers. Given that the equality assessment talks about ethnic minorities, should consideration be given to adapting language and how to reach those with EAL?	Thank you for your comment. Availability of information in different languages is included in the patient experience in adult NHS services guideline (CG138). Reference will be made to this to this guideline within the recommendations.
Central & North West London NHS Foundation Trust	001	028	Mental health is included as an increased risk for falling but the draft guidance doesn't seem to include Mental Health. It could be included in page 6 Key issues and page 7 Outcomes	Thank you for your comment. People with mental health problems (within the age range defined in the scope, see below) have been added to the Equality impact assessment and any equality issues identified will be addressed by the committee as part of the review of evidence and development of recommendations. To clarify, the guideline age range is: people over 65 and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling.
Central & North West London NHS Foundation Trust	002	019	Good to include Carers and families in who the guidance is for	Thank you for your comment.
Central & North West London NHS Foundation Trust	003	006	In the inequalities section will the access to Physiotherapy for those in In-patient mental health units be considered as this is a current inequity. People do get access to physiotherapy in physical Health settings	Thank you for your comment. Access to physiotherapy services within inpatient mental health has been added to the Equalities Impact Assessment and will be considered by the committee where evidence is identified.
Central & North West London NHS Foundation Trust	007	005	Good to include patient, carers and families' experience of fall prevention interventions	Thank you for your comment.

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Essity UK	General	General	In response to the request for views on the following question "are there any cost saving interventions or examples of innovative approaches that should be considered for inclusion in this guideline?", we would request that the following is taken into consideration. A recent Delphi Consensus study sought the opinion of 181 healthcare professionals on 50 statements produced by a Steering Group, with the intention of reducing harm to patients living with incontinence (the agreement threshold was 66%). This study has highlighted how patient centred assessment and appropriate choice of continence products can help to mitigate the falls risk for patients with continence problems. The following statements from the study are pertinent to this point: • 'The patient's dexterity and gait position should always be assessed when considering suitability of a chosen continence pad' - 'strong agreement' from 98% of survey responders • 'Two-piece pads can affect a patient's gait, which may increase the risk of falls – 'strong agreement' from 68% of survey responders • 'Individual continence assessment must be mandated in any falls or frailty pathway in line with a comprehensive assessment in patients of any age' - 'strong agreement' from 68% of survey responders	Thank you for your comment.

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			• 'Improving individual assessment may reduce the risk of falls and the associated direct and indirect costs associated with incontinence' - strong agreement' from 98% of survey responders *'Establishing consensus on the appropriate selection of continence pads to achieve optimal care while reducing the risk of harm: part of a holistic approach for people with incontinence' (https://www.magonlinelibrary.com/doi/full/10.12968/nrec.2021.0013* Falls are estimated to incur an annual cost to the NHS in excess of £2.3 billion (NICE 2013). In the 2020–21 period, the number of non-elective falls of all types was 803,215 nationally at a cost to the NHS of £815 million, with a cost per episode of £1015 (NHS Digital, 2021). One-third of individuals over 65 years, rising to half of those aged over 80 years, experience at least one fall a year, 10–20% of which result in a serious injury such as hip fractures (NICE, 2013; Soliman et al 2016; NHS England 2018; Szabo et al 2018) Essity and NHS data indicates that the additional cost incurred in changing from a two-piece incontinence product to an alternative one-piece product, where judged appropriate to mitigate the risk of harm, is likely to represent a small	

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			proportion of the overall cost incurred by the NHS of treating and caring for patients who have a fall. *NB: 'two-piece products' constitute two separate components i.e. a shaped pad plus separate 'fixation' or elasticated pants. A 'one-piece product' is applied like a nappy style product. Two-piece products are often regarded as the lowest-cost option.* However, there has been a trend for providers/commissioners to rationalise the choice of products and withdraw more costly one-piece products such as 'pull-up pants' without accounting for individual patient need. This stems from a focus on acquisition cost rather than on the patient benefits and overall savings these products can provide. We would recommend adoption of a Valued Based Health Care approach to NHS procurement which considers the total cost of patient treatment and ensures appropriate product choice. This innovative approach to procurement could help to deliver true cost efficiencies to the wider ICS by mitigating the risk of falls, subsequent hospitalisation and residential care Developing digital tools and sensor technologies are also worthy of consideration as they can play a part in empowering people living with a risk of falls and incontinence to take more control of their care	

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Essity UK	001	022	According to the NICE clinical guideline (CG161) and quality statement (QS86), continence problems are recognised to be a risk factor for falls which should be identified as part of multifactorial assessment. We would suggest that this sentence is amended to include this risk factor.	Thank you for your comment. The risks stated in the introduction are given as examples and are not intended to be a comprehenisive list.
Essity UK	002	018	This should include reference to Integrated Care Systems (ICS) which will go live in July 2022. Falls impact on the whole of the system including social care and home settings.	Thank you for your comment. All settings where NHS health and social care services are delivered are included. The committee will take into consideration Integrated Care systems.
Essity UK	003	025	We would suggest this sentence is reworded as follows to highlight the role of continence assessments, given the key risk factor for falls that incontinence presents "Routine questioning, observation, screening tools, electronic records and use of continence assessments" The NICE clinical guideline (CG161) and quality statement (QS86) identifies continence problems as a risk factor for falls to be included as part of multifactorial assessment. The National Audit of Inpatient Falls (2021, HQIP) confirms that inpatients falling have a high prevalence of incontinence. It recommends that patients presenting with incontinence and at risk of falling should have tailored interventions and care plans established. A continence assessment and plan, if required, will form a Key Performance indicator for future audits. NHS	Thank you for your comment. The specific interventions which will be included for each of the review questions will be defined by the committee when developing the protocols. For each key area in the scope we have clarified that the lists are examples only.

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			England, Excellence in Continence Care also recognises that overactive bladder is an important risk factor for falls. A recent Delphi Consensus study sought the opinion of 181 healthcare professionals on 50 statements produced by a Steering Group, with the intention of reducing harm to patients living with incontinence (the agreement threshold was 66%). There was strong agreement from 97% of survey respondents with the statement that "Every patient who has contact with a healthcare professional should be asked 'Do you have problems with your bladder or bowel?' (as part of a risk assessment). *'Establishing consensus on the appropriate selection of continence pads to achieve optimal care while reducing the risk of harm: part of a holistic approach for people with incontinence'* **Error! Hyperlink reference not valid.***)*	
Essity UK	006	014	We would suggest adding a further question (see 1.2 below) to help prevent falls occurring: 1.2 "what are the education and information needs of people and their families and carers to prevent the risk of falls in patients diagnosed with over active bladder"	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.

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Essity UK	006	028	Given the strong association between overactive bladder and risk of falls highlighted in the NICE clinical guideline (CG161), National Audit of Inpatient Falls (2021) and NHS England Excellence in Continence Care report, we would suggest adding the following question 2.4 "How useful are continence assessments in identifying those at risk of falling"	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
Isle of Wight NHS Trust	General	General	Can the guidance make stronger reference to primary prevention of falls which would link more strongly to the Public Health physical activity guidelines and promote a more positive message of healthy active ageing?	Thank you for your comment. The scope includes both primary and secondary prevention of falls.
Isle of Wight NHS Trust	002	004 – 007	The draft scope states: "Falls can occur in any setting but are the most reported patient safety incidents in acute hospitals and mental health trusts in England and Wales. Therefore, the identification of people at risk of falls and measures to prevent falls in these settings require special consideration". In relation to this statement, we would ask that the same consideration and focus is given to the community setting. For example across Hampshire and the Isle of Wight our data shows that the majority of falls that result in a hip fracture happen in the persons place of residence.	Thank you for your comment. Community settings, including people's homes are included in the scope.

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			In order to prevent falls, identification of risk factors needs to be broader than in settings where NHS health and social care services are delivered.	
Isle of Wight NHS Trust	002	020	It would be useful to clarify if this includes adults with learning disabilities and if not, whether bespoke guidance for this audience will be produced and whether the age range will be lowered The guidance in relation to people aged 50-64 has previously referred to in-patient care only. This should also be extended to the community to include people living with LTC such as frailty, particularly with the impact of COVID -19 and associated deconditioning	Thank you for your comment. People with learning disabilities within the age ranges stated within the scope will be included, and any evidence found for this population will be considered by the committee. All settings where NHS health and social care services are delivered are included.
Isle of Wight NHS Trust	002	024	We disagree that this "may" be useful for this group, we feel that private sector and voluntary organisations should be included in Line 14-21. The private and voluntary sector are often the first point of contact in the community and are key at identifying people at risk of falls and/or recognising soft signs of deterioration. The important contribution that this sector makes is often underestimated. We also wonder about people in receipt of direct payments and self-funders.	Thank you for your comment. NICE guidance is commissioned for use within NHS and social care services, however other sectors such as voluntary or private organsiations can also opt to use the guidance.
Isle of Wight NHS Trust	002	014 – 021	Can the guidance be explicit in including primary care	Thank you for your comment. Primary care services are included in health and social care services. Additionally, section 3.2 Settings, states that this guideline will cover: all settings where NHS health and social care services are delivered.

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Isle of Wight NHS Trust	003	016	Clarification required on the settings required and/or considered. It talks about a person home (including outside space) in the guidance but isn't explicit in this section. Emphasise the role of primary care, particularly in relation to identification of risk and identification of reduction of physical activity	Thank you for your comment. The settings section has been amended to make clear that it will include NHS and social care services delivered in people's homes.
Isle of Wight NHS Trust	003	021	Although this is important for universal prevention, we feel this line gives a blanket approach rather and could be expanded to being personalised and tailored to the individual circumstances. Can the scope include advice in situations where falls risk cannot be eliminated such as how to manage post-fall or prevent a long-lie?	Thank you for your comment. The information and education key area has been amended to include falls risk and prevention in people who have had a fall.
Isle of Wight NHS Trust	003	012 – 013	Please extend to include the community e.g. people living with frailty	Thank you for your comment. The settings section has been amended to make clear that it will include NHS and social care services delivered in people's homes.
Isle of Wight NHS Trust	003	018 – 026	There is no mention of any aids or equipment to reduce the risk i.e. long handed grabber or chair raisers etc	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols. For each key area in the scope we have clarified that the lists are examples only.
Isle of Wight NHS Trust	004	001 - 012	There is no mention of any aids or equipment to reduce the risk i.e. long handed grabber or chair raisers etc Can we include a specific mention of vision assessment?	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols. For each key area in the scope we have clarified that the lists are examples only.

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Isle of Wight NHS Trust	006	006 - 013	Please extend to include consideration of demographics (e.g. city vs country dwelling) and social support/networks. Also to take into consideration the time of year and impact of COVID-19	Thank you for your comment. We would not provide this level of detail in the scope with regards to the economic aspects. The items you have listed for consideration could be incorporated in the health economic plan that is drafted with input from the committee during guideline development. We have made a note of these concerns and will raise them with the committee.
Isle of Wight NHS Trust	006	020 - 027	Please include consideration of near misses which will act as a trigger for further investigation and action	Thank you for your comment. The specific interventions (in this instance methods for identifying people at risk of falls) which will be included for each review question will be defined by the committee when developing the protocols.
Leeds Community Healthcare NHS Trust	General	General	The draft scope does not mention falls risk related to orthostatic hypotension. It is felt that this is a significant risk factor to highlight and include, identifying the evidence to support appropriate assessment and management of this	Thank you for your comment. The committee will consider this risk where it is identified in the evidence reviewed. Interventions targeting underlying conditions are not included within the scope.
Leeds Community Healthcare NHS Trust	004	005 - 006	The draft scope highlights multifactorial and multicomponent interventions including exercise programmes. It is felt that it would be beneficial to differentiate and determine the evidence for exercise in relation to primary and secondary falls prevention	Thank you for your comment. When designing the data extraction methods for the intervention related evidence syntheses, the committee will consider whether to collect the authors intentions for each intervention in terms of whether they are designed as primary or secondary prevention. The feasibility and utility of using study inclusion criteria (i.e. whether it is based on a participant having a previous fall – and if this is the key way in which a study can be designated as secondary prevention) will need to be explored.

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Leeds Community Healthcare NHS Trust	004	015	The draft scope excludes the management of complications of falls, but it is felt that this is part of assessing the risk as a result of a fall, so should be included	Thank you for your comment. It will not be in scope of the review to cover management of fall related injuries or post-fall management. However, if there are interventions that address post-fall related issues that may themselves be risk factors for further falls (i.e. ability to get up from the floor), these should be identified and covered in the process of answering questions 3 (Individual risk factor assessment for people at risk of falls) and 4 (Interventions to reduce the risk of falls).
Leeds Community Healthcare NHS Trust	004	019	It is felt that the published NICE guidance related to head injury (CG174, 2014) should be included in this list as relevant to this subject area	Thank you for your comment. This has been added to the scope.
Leeds Community Healthcare NHS Trust	006	031	It is felt that as part of the individual risk factor assessment for people at risk of falls that this should evidence and define the key components recommended as part of a multifactorial falls risk assessment	Thank you for your comment. The committee will consider the key areas of risk factor assessment when reviewing the evidence found.
Leeds Community Healthcare NHS Trust	007	021	The draft scope excludes the management of complications of falls, but one of the main outcomes cited in the draft scope is fall-related injury. This could be secondary to a long lie from a fall, so it is felt that this area should be covered in the updated guideline	Thank you for your comment. It will not be in scope of the review to cover management of fall related injuries or post-fall management. However, if there are interventions that address post-fall related issues that may themselves be risk factors for further falls (i.e. ability to get up from the floor), these should be identified and covered in the process of answering questions 3 (Individual risk factor assessment for people at risk of falls) and 4 (Interventions to reduce the risk of falls).

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				Fall related injury is in the scope as an outcome because it is quite common practice to measure this in trails and evidence for prevention of injuries (and not just prevention of falls) is powerful.
Manchester Metropolitan University	001	020	For accuracy of reporting, on this line it would be advisable to clarify whether the estimates of 18% and 33% relate to risk, prevalence or rates of mortality.	Thank you for your comment. These figures have been updated in the guideline's scope and 'mortality rate' has been added for clarity.
Manchester Metropolitan University	001	020	We recommend inclusion of a recognition that personality-related cognitive biases can mediate perceptions of pain and influence threat related behaviours linked to pain and fall avoidance. Excessive attentional biases towards pain have been hypothesized to contribute towards the promotion of pain-related anxiety, fear of pain-related activity, physical disability, and exacerbations in the pain experience (e.g., Vlaeyen, et al., 2000 Pain 85: 317–332.). We would recommend consideration of individuals with repressive coping styles who may be at more falls risk due to an avoidant style of processing negative information and defensive high anxious individuals who may actively attend to falls related cues and catastrophise post first fall.	Thank you for your comment. We will consider the evidence for this area as part of the guideline update process.
Manchester Metropolitan University	001	022	We recommend inclusion of 'slower muscle contraction speeds' in list of factors acknowledged to increase risk of falls. It is important to highlight that reductions in mechanical power (force x velocity of contraction) is a key factor in the risk of falling and the ability to generate joint torques quickly is the key to saving oneself from a fall (Pijnappels et al., 2008 J	Thank you for your comment. Please note that the factors detailed in the scope are there as examples rather than providing an exhaustive list. The committee will consider the evidence for this as part of the guideline update process.

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			Electromyog Kinesiol 18, 188-196; Pijnappels et al., 2008 Eur J Appl Physiol 102:585–592) and this feature of the dynamic aspects of muscle contraction is important to acknowledge.	
Manchester Metropolitan University	002	020	It is unclear why a specific age range needs to be specified in this final bullet point especially as there are significant number of people living with a condition or conditions that may put them at risk of falls across the full adult age range. While most evidence that is likely to be identified by this review will focus on older adults or adults in late midlife (aged 50-64) there would also be value in including any evidence from studies that include adults younger than 50 (e.g. Saverino et al., Disabil Rehabil. 2014;36(12):963-77. Doi: 10.3109/09638288.2013.829525; Cho et al., 2021 PloS ONE 16(4): e0250360. https://doi.org/10.1371/journal.pone.0250360). We would therefore advise simply to refer to adults aged 64 or younger. This is particularly important for equality considerations given there is growing evidence of increasing prevalence of multiple long-term conditions (that may precipitate falls) in younger adults from more deprived backgrounds (see for example Barnett et al Lancet 2012;380(9836):37-43, DOI: 10.1016/S0140-6736(12)60240-2)	Thank you for your comment. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided for younger adult populations within the disease specific guidelines. The Equality Impact Assessment includes people in lower socio-economic groups (within the age range defined by the scope) who may be at increased risk of falls because of financial disadvantage and related issues in their home circumstances , and this will be considered by the committee where evidence is identified.
Manchester Metropolitan University	002	020	We query whether it is necessary to restrict the guidelines to only those younger adults with specific conditions. There is a growing body of evidence that within the general population prevalence of falls starts to increase from midlife onwards (i.e.,	Thank you for your comment. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided

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			before age 50) and that many of the risk factors for falls in middle aged adults are similar to those in older adults whereby targets for intervention and guidelines on falls prevention may be similar. (see Peeters et al PloS One 2018;13(8):e0201989. Doi: 10.1371/journal.pone.0201989 and Peeters et al Osteoporos Int 2019;30(10):2099-2117. Doi: 10.1007/s00198-019-05034-2)	for younger adult populations within the disease specific guidelines.
Manchester Metropolitan University	003	006	To facilitate inclusivity, we recommend that the guideline also consider inequalities with regard sex and socioeconomic background. Sex differences in balance outcomes have been reported in some clinical populations at risk of falls (e.g., COPD Alsubheen et al., 2022 COPD 19(1):166-173 doi: 10.1080/15412555.2022.2038120; sarcopenia Soh and Won 2021 BMC Geriatr. 2021 Dec 18;21(1):716. Doi: 10.1186/s12877-021-02688-8). Equally, there is growing evidence of increasing prevalence of multiple long-term conditions (that may precipitate falls) in younger adults from more deprived backgrounds (see for example Barnett et al Lancet 2012;380(9836):37-43, DOI: 10.1016/S0140-6736(12)60240-2).	Thank you for your comment. Any evidence identified with regards to inequalities by sex or socioeconomic background will be considered by the committee.
Manchester Metropolitan University	003	012	See point 5 above – we query the need to impose a lower age limit of 50 years	Thank you for your comment. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided for younger adult populations within the disease specific guidelines.

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Manchester Metropolitan University	003	018	The key areas, as currently presented, seem to be in an illogical order. It seems more logical to first indicate a process of describing methods of identifying people at risk of falls (current point 2, line 024), the risk factor assessment, the interventions and then the education needs. It seems the education needs will need to incorporate understanding the previous factors, so will more logically follow than lead the other proposed key areas.	Thank you for your suggestion, however we think the current order is appropriate because the Information and education review will encompass the other key areas to be covered by the guideline. The specific interventions which will be included in the review question will be defined by the committee when developing the protocols.
Manchester Metropolitan University	003	024	We recommend a clear, standardised definition of the term fall is provided and used in the review. There is evidence that cultural differences can exist in the interpretation and meaning of 'falls', which includes differences in perspectives of health professionals and older people (Lamb et al., 2005 J. Am. Geriatr Soc 53:1618–1622. Doi. 10.1111/j.1532-5415.2005.53455.x), and may complicate the collation of evidence (e.g., reporting of falls rates). We suggest consideration of the recommendations from Lamb et al., which are: 1. A fall should be defined as ''an unexpected event in which the participants come to rest on the ground, floor, or lower level.'' 2. Ascertainment must consider the lay perspective of falls. Participants should be asked, ''In the past month, have you had any fall including a slip or trip in which you lost your balance and landed on the floor or ground or lower level?''	Thank you for your comment. The definition will be added to the 'context' section of the scope.

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			These definitions can be adapted to include consideration of the timeframe of the fall (e.g., how recent) as well as the context (e.g., riskier circumstances such as when climbing a ladder, versus more mundane scenarios such as crossing the living room) or other relevant information that may be available (e.g. in electronic patient records).	
Manchester Metropolitan University	006	014	The key issues and draft questions, as currently presented, seem to be in an illogical order. It seems more logical to indicate a process of: i) evaluating methods of identifying people at risk of falls; 2) individual risk factor assessment; 3) interventions and then 4) the education needs. It seems the education needs will need to incorporate understanding the previous factors, so will more logically follow than lead the other proposed key areas.	Thank you for your suggestion, however we think the current order is appropriate because the information and education review will encompass the other key areas to be covered by the guideline. The specific interventions included in the review question will be defined by the committee when developing the protocols.
Manchester Metropolitan University	006	018	We recommend consideration of a wide breadth of educational needs, not just specifically focused on preventing falls. The combination of intrinsic (e.g., medical conditions, poor vision, impaired balance) and extrinsic (e.g., cluttered rooms, poor lighting) risk factors as well as the different ways in which people fall (i.e., forwards, backwards, sideways) and the different locations (e.g., in the bathroom, when getting up from a chair, outside), make it difficult to establish effective overarching fall prevention interventions. Thus, complementary approaches to fall prevention interventions should also be considered. For example, approaches is to reduce the severity of fall-related injuries by teaching people how to safely land on	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols. The question has been revised to include people who are at risk of falls or who have had a fall.

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			the ground (Hsieh and Sosnoff 2021 J. Motor Behavior 53:663-667 doi: https://doi.org/10.1080/00222895.2020.1814195)	
Manchester Metropolitan University	006	020	Recommend collating methods currently used to assess risk of falls, so that a full picture of available tools is identified, before evaluating their use; We recommend this collation process considers the different modalities of assessment available, specifically including use of digital technology (e.g., smartphones Mellone et al., Z Gerontol Geriat 2012, 45:722–727 DOI 10.1007/s00391-012-0404-5; health apps Hsieh et al., JMIR Aging 2018;1(2):e11569 doi: 10.2196/11569) that can be used to assess risk outside traditional health services (e.g., in the home and/or community – Kim et al., 2017 Expt. Gerontology 88:25-31 DOI: http://dx.doi.org/10.1016/j.exger.2016.11.013) and in doing so that a standardised definition of the term assessment be identified and used.	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
Manchester Metropolitan University	006	029	Recommend collating methods currently used to assess risk of falls, before evaluating their use; also, here need to highlight the different modalities that are/could be available, as recommended in comment 12 above.	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
Manchester Metropolitan University	006	029	It is important to consider the differences between associations (identified at the population level) and prediction of risk, which is what the individual needs. This relates to the need for risk factors to be direct numerical equivalence between the relative odds and the detection rate for	Thank you for your comment. The review will look at methods for identifying older people at risk of falling in question 2. The committee will consider this suggestion when designing methods to synthesize the evidence to answer this question.

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			specified false positive rate that does not depend on falls incidence or prevalence (also considering any group differences) (Walk et al., *BMJ* 1999;319:1562–5). Equally, the clinical usefulness of any risk factor score or index of risk depends on the availability of effective treatments for the predicted outcome (Grady and Bercowitz, ARCH INTERN MED/VOL 171 (NO. 19), 2011), which should also be considered within the context of the proposed review.	For question 3 (Individual risk factor assessment for people at risk of falls), the same consideration will be made – although this question is more focussed on identifying areas for targeting intervention as opposed to question 2 where positive predictive value might be more important. The evidence reviewed for question 4 (Interventions to reduce the risk of falls) may provide an indication of which risk factors are most and least modifiable, but this may also require pragmatic considerations. The idea of the degree of modifiability, will be considered by the committee when designing the evidence syntheses.
Manchester Metropolitan University	007	017	Incidence (line 017) and risk (line 022) are the same thing from epidemiological perspective – so ensure clarity/distinction in terms use	Thank you for your comment. 'Risk of falling' has been removed from the list of outcomes.
National Care Association	002	003	With more older people being encouraged to live at home this is important for families and friends who may support them.	Thank you for your comment. Prevention of falls within the community have been included in the scope.
National Care Association	002	007	I believe care homes should also be in the special consideration category	Thank you for your comment. All settings where NHS health and social care services are delivered are included in the scope.
National Care Association	002	025	And families and friends as more push towards homecare	Thank you for your comment. This guideline may also be useful for family members and carers.
National Care Association	003	016	Should be explicit about homecare	Thank you for your comment. The settings section has been amended to make clear that it will include NHS and social care services delivered in people's homes.

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National Care Association	006	016	Can we make sure it is available in multiple languages	Thank you for your comment. Availability of information in different languages is included in the patient experience in adult NHS services guideline (CG138). Reference will be made to this to this guideline within the recommendations.
National Care Association	007	022	Should there be something about environment and risks…	Thank you for your comment. The outcomes listed are given as examples and other outcomes may be selected by the committee for individual review questions.
NHSEI	General	General	• Whilst there is a link to Mental Capacity Act 2005 there is nothing about deprivation of liberty safeguards, best interest assessment or restrictive practice in preventing patients mobilise against the recommendation of practitioners. There is nothing on being trauma-informed or professionally curious about wilful neglect or fabricated and induced injuries when "falls" occur.	Thank you for your comment. The remit of the guidline is assessing risk and prevention of falls in older people. Whilst we recognise safeguarding of people at risk of falls is an important issue, it is out of scope for the areas we are looking at.
NHSEI	General	General	• Need to consider infection - the relationship between infection and older people (UTI, sepsis etc) • Need to consider hydration as part of assessment / intervention • Relationship between single room placement / TBPs for infection and relationship with falls in hospitalised older patients	Thank you for your comment. The specific interventions included for each review question will be defined by the committee when developing the protocols.

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			Behavioural and psychological effects of isolation to the patient when cared for in a single room.	
NHSEI	General	General	Overall we are very supportive of this document	Thank you for your comment.
NHSEI	007	024	This should be amended to include social care resource as well	Thank you for your comment. Social care resource has been added to the examples of outcomes listed.
NHSEI	007	029	This should specifically include deterioration of mental health and capacity	Thank you for your comment. The outcomes listed are given as examples and other outcomes may be selected by the committee for individual review questions.
Older People's Advocacy Alliance	007	009	What barriers to participation in fall preventions strategy exist? E.g. If someone has never participated in regular exercise, for whatever reason, how can this barrier be brought down, especially at a time when the individual is feeling vulnerable.	Thank you for your comment. We think this is encompassed within question 4.3 on methods for maximising participation, adherence and continuation of falls prevention interventions. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
Older People's Advocacy Alliance	007	010	Where does the guidance take account of the "risky activities" older people may wish to enjoy, such as enjoying alcohol, or exerting themselves physically to do tasks they have previously done with ease (my 86 year old father in law has fallen over several times after a few whiskeys with his friends at the Probus Club, but the social benefits of him attending the club and having a few drinks far outweigh the risks to him.) The guidance also needs to recognise that in some instances people will simply not adhere to fall prevention practices, and allowance and provision needs to be made for this. For example, in the last days of his life, when my father was losing the battle to cancer, he was provided with incontinence pads, but he couldn't bring himself to use them. The urge to go to the	Thank you for your comment. Decisions on whether to have any treatment or intervention are made in consultation between the patient and the health care professional, and some people may choose not to have the interventions offered. The draft questions 4.2 on people's experiences of interventions to prevent falls and 4.3 on methods for maximising participation, adherence and continuation of falls prevention intereventions, are likely to address the issues raised in your comment.

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			toilet was so strong, that he repeatedly tried to get to the toilet, resulting in 3 falls, with the paramedics being called each time. He was aware of what was happening and knew what he was supposed to do, but he just couldn't bring himself to use the incontinence pads. This guidance needs to understand that a solution is only a solution if the user sees it as a solution. If they themselves do not see it as a solution, then there is still no solution.	
Parkinson's UK	General	General	Parkinson's UK consulted physiotherapists and occupational therapists in responding to this scope. They highlighted that there is no acknowledgement of the risk factors or mechanism behind falls and that they differ for people with Parkinson's and indeed those with other health conditions, that put them at higher risk of falls. They are concerned that this omission will lead to a more generic approach to falls management which is at odds with the move towards greater personalisation in health care. Therefore we would recommend the inclusion of sections within the guidance on specific conditions such as Parkinson's where there is a higher risk of falls and where guidance will differ from the general guidance.	Thank you for your comment. The committee will review the body of evidence found and where evidence relating to a specific population (within the age range desined in the scope, see below) is identified that indicates a different approach is required, the committee will consider recommendations targeting a particular population in order to meet individual needs. To clarify, the guideline age range is: people over 65 and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling.
Parkinson's UK	General	General	In answer to the question "Are there any cost saving interventions or examples of innovative approaches that should be considered for inclusion in this guideline?" - the UK Parkinson's Excellence Network is undertaking a quality improvement initiative on bone health in people with Parkinson's. As detailed in comment four below, people with	Thank you for your comment.

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			Parkinson's are twice as likely to have osteoporosis and twice as likely to be admitted to hospital with a hip fracture risk. The UK Parkinson's Audit has shown that rates of assessment of fracture risk are generally low (47.6% of patients in 2019). Parkinson's services have taken part in a UK wide initiative to improve the rate and quality of fracture risk assessment for people with Parkinson's. Services were encouraged to use a fracture risk algorithm (Emily J. Henderson, Veronica Lyell, Arti Bhimjiyani, Jigisha Amind, Christopher Kobylecki, Celia L. Gregson. (2019) Management of fracture risk in Parkinson's: A revised algorithm and focused review of treatments. Parkinsonism and Related Disorders) to assess their patients during a 4 month period and to enter anonymous data on each person into a custom designed tool. 43 services from across the UK took part in the project, and they entered data on 1,131 patients. Of these patients, 50% had a history of falls and over a third had a history of fractures (37%). 73% of cases were identified as being in need of a detailed fracture risk assessment. The categorisation of risk for the cases assessed was as follows: approximately 15% were red (treat), 37% were amber (request bone mineral density scan), and 45% were green (low risk provide lifestyle advice on smoking, diet and physical activity).	

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			We believe that the use of this algorithm is innovative and effective in identifying people with Parkinson's at risk of having poor bone health, leading to a fracture risk assessment and leading to treatment and thereby reducing the risk of falls and bone fracture. We would recommend that this approach is considered for inclusion in this guideline. A full report on this project is in development and we would be happy to share more information about the initiative with NICE.	
Parkinson's UK	004	004	Parkinson's UK received feedback from clinicians that there is a need for a greater emphasis to be placed on early rehabilitation and input from a multidisciplinary team as interventions to reduce the risk of falls. Physiotherapists can help improve confidence and reduce fears around falling, as well as working wit occupational therapists to remove tripping hazards in the home. We recommend including early rehabilitation and input from a multidisciplinary team in the fourth key area to be covered in the guideline under "interventions to reduce the risk of falls".	Thank you for your comment. For each key area in the scope, we have clarified that the lists are examples only. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols. A multidisciplinary committee will be recruited to provide the range of expertise required.
Parkinson's UK	004	018	We note that the NICE guideline (NG71) Parkinson's disease in adults is not listed as a related NICE guideline for this update. Many people with Parkinson's are admitted to hospital each year as a result of having a fall, which is increasing. In England in 2017/18, there were 11,185 emergency hospital admissions of people with Parkinson's with a fall, this increased to 12,305	Thank you for your comment. This has been added to the scope.

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			in 2018/19 and 13,440 in 2019/20 (data can be found on the UK Parkinson's Excellence Network data dashboard, which uses English Hospital Episodes Statistics (HES) data). There is evidence to show that 40-70% of people with Parkinson's fall each year, with a third falling repetitively (Balash Y, Peretz C, Leibovich G, et al. Falls in outpatients with Parkinson's disease: frequency, impact and identifying factors. J Neurol. 2005;252:1310–1315). People with Parkinson's are also twice as likely to have osteoporosis than the general population (Tornsey, K. et al. (2014). Bone health in Parkinson's disease: a systematic review and meta-analysis. Journal of Neurology, Neurosurgery and Psychiatry, 85(10).). They are also twice as likely to be hospitalised with a hip fracture than those without the condition (Low, V. et al. (2015). Measuring the burden and mortality of hospitalisation in Parkinson's disease: A cross-sectional analysis of the English Hospital Episodes). We therefore recommend that the NICE guideline (NG71) Parkinson's disease in adults is added to the related NICE guidance list.	

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Royal College of Nursing	General	General	Safe staffing is paramount for patient safety and prevention of harm including falls in older people. NICE should consider including RCN Nursing Workforce Standard in their guidelines.	Thank you for your comment. Implementation of professional standards would need to be determined locally and are not withn the remit of NICE guidance.
Royal College of Nursing	003	008	To add "including cognitive conditions" to ensure the focus is not purely on physical conditions.	Thank you for your comment. Cognitive conditions have been identified within the equality impact assessment and where evidence is identified will be considered by the committee.
Royal College of Nursing	003	021	Recommendations regarding clarity and provision of pathway for access to specialist advice and falls prevention services. (is there a falls prevention team and how is this accessed?)	Thank you for your comment. We agree that clear signposting to available services is important. The specific interventions that will be included for each review question will be defined by the committee when developing the protocols.
Royal College of Nursing	004	004	Add recommendations for access to specialist expertise in interventions relating to certain conditions i.e. Dementia.	Thank you for your comment. In answering question 4 (Interventions to reduce the risk of falls), any evidence supporting onward referral should be identified in the evidence searches and synthesis. The committee will consider any recommendations required to ensure that referral onward to appropriate services are made if new conditions are diagnosed as a result of a falls risk factor assessment.
Royal College of Occupational Therapists	General	General	RCOT welcomes the update of this important guideline. The prevention and management of falls presents significant challenges for health and social care. Occupational therapists can support those living with long-term conditions and our ageing population by building resilience and improving their health and wellbeing.	Thank you for your comment and reference to the RCOT guideline.

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			We would draw the developers' attention to the updated RCOT guideline which provides specific evidence-based recommendations that describe the most appropriate care or action to be taken by occupational therapists working with adults who have fallen, are at risk of falling or are fearful of falling (RCOT 2020). The guideline reflects key aspects in: 1. Keeping safe at home: reducing risk of falls 2. Keeping active: reducing fear of falling 3. Falls management: making it meaningful 4. Occupational therapy intervention: impact and cost effectiveness. Ref: Royal College of Occupational Therapists (2020) *Occupational therapy in the assessment and prevention of falls in adults.* London: RCOT. Available at: https://www.rcot.co.uk/node/396	
Royal College of Ophthalmologists	General	General	Previous guidance CG161 refers to assessment of visual impairment under multifactorial falls risk assessment and vision assessment and referral under multifactorial intervention. But under section 1.1.12 Interventions that cannot be recommended because of insufficient evidence it mention 1.1.12.4 - referral for correction of visual impairment (2004) not recommended. This is in the 2013 guidance, but there have been articles indicating strong evidence between falls and	Thank you for your comment. For each key area in the scope, we have clarified that the lists are examples only. The specific interventions and or assessments (some of which are likely to be related to vision) will be included for each review question will be defined by the committee when developing the protocols.

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			vision loss since 2013. We suggest this is reviewed as part of the guidance revision of previous recommendation. Patients experience falls directly because of loss of vision. This is an important message to consider explicitly as part of the scope if this revision that is currently absent.	
Royal College of Podiatry	001	013	Although the age of 65 is generally accepted in the literature as being the cut off for older age and risk of falling, it should be acknowledged that the decline in balance and age-related changes that lead to a fall start before this age. A wider conversation about wellbeing of the musculoskeletal system related to posture balance should commence before this. Many people with neurological conditions, under the age of 65, are at high risk of falling, and this should be reflected. This is common with diabetes and severe back pain, which affects adults of all ages.	Thank you for your comment. Interventions relating to conditions that increase the risk of falling are out of scope of this guideline. Most of the evidence around reducing the risk of falling relates to people aged 65 and over.
Royal College of Podiatry	003	014	It is not clear in which setting this guidance is provided for. Here it states in all NHS settings where previously it has stated there is a focus on hospital settings. It is well referenced in the literature that community-based falls in the home and care setting have a high prevalence of occurrence and often go unnoticed until serious injury occurs. Whilst the majority of falls clinics are acute based we would wish to see increased investment in the prevention of falls within Community Health Services and Residential Care.	Thank you for your comment. The settings section has been amended to make clear that it will include NHS and social care services delivered in people's homes.

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Royal College of Podiatry	003	021	Information about falls prevention and screening needs to be more accessible to all those healthcare services who provide care for older adults. We would also wish to see increased training provided to support workers within social care	Thank you for your comment. We agree information needs to be accessible to health services providing care. Training for health and social care staff would need to be determined locally by service providers.
Royal College of Podiatry	003	024	Screening methods need to be advanced and updated beyond tools and questionnaires. Using wearable technologies will improve the recorded information of patient activity and balance. McManus, K., Greene, B.R., Ader, L.G.M. and Caulfield, B., 2022. Development of data-driven metrics for balance impairment and fall risk assessment in older adults. *IEEE Transactions on Biomedical Engineering*. https://ieeexplore.ieee.org/abstract/document/9681291	Thank you for your comment. The specific interventions which will be included for each of the review question will be defined by the committee when developing the protocols. For each key area in the scope we have clarified that the lists are examples only.
Royal College of Podiatry	004	004	Compliance and longevity of methods of intervention need to be assessed and considered as often on discharge from an exercise programme patients stop engaging in the exercises and deteriorate.	Thank you for your comment. This is included within question 4.3 of the scope 'what are the best methods for maximiisng participation, adherence and continuation of falls prevention interventions.
Royal College of Podiatry	006	026	The usefulness of electronic records are only as good as the practitioners that fill them in and the outcome measures recorded.	Thank you for your comment.
Royal Free Hospital NHS Foundation Trust	General	General	We advise mentioning the importance of screening for and treating balance organ disorders and specifically, Benign Paroxysmal Positional Vertigo (BPPV). BPPV increases in prevalence with age and the incidence of this condition in Falls Clinics is high. The condition affects gait patterns and walking stability and is associated with an increased risk of falls. BPPV	Thank you for your comment. The committee will consider any appropriate interventions to be provided to treat conditions identified during the risk factor assessment process (determined by planned evidence syntheses on risk factor assessment). This review is not a review of the treatment and management of BPPV, so will not provide a summary of evidence for repositioning manoeuvres.

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			can also be quickly screened for and effectively treated at primary care level.	Reference can be made to NG127. If there is any evidence from intervention studies, which include falls as an outcome, that evaluate BPPV, this may be used to inform the guidance.
Royal Free Hospital NHS Foundation Trust	001	022	The term 'impaired balance' is too generic as balance depends on multi-sensory inputs from vision (as mentioned later in the sentence), the vestibular system (inner ear balance organ) and proprioception. The sentence should mention that impairment of these component senses and muscle weakness contribute to impaired balance, in turn leading to an increased risk of falls.	Thank you for your comment. Please note that the factors detailed in the guideline scope are there as examples rather than providing an exhaustive list. The definition has been expanded within the scope.
Royal Free Hospital NHS Foundation Trust	003	025	We recommend within the 'routine questioning' to note down any movement or positional triggers for symptoms of dizziness and vertigo, which would be suggestive of a possible balance organ disorder.	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols. For each key area in the scope we have clarified that the lists are examples only.
Royal Free Hospital NHS Foundation Trust	004	003	We strongly advise adding in an assessment for the most common balance organ disorder affecting the elderly, i.e., Benign Paroxysmal Positional Vertigo (BPPV). This would be done via a quick and well tolerated manoeuvre (Dix-Hallpike manoeuvre).	Thank you for your comment. Assessment of BPPV as a risk factor for falls will be considered by the committee when planning the evidence synthesis for question 3 in section 3.5 Key Issues and Questions (Individual risk factor assessment for people at risk of falls). Routine inclusion of a Hall-Pike manoeuvre for all older people at risk of falls may or may not be indicated by the evidence. The committee will consider this question when planning the evidence synthesis for question 3.

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Royal Free Hospital NHS Foundation Trust	004	006	Should BPPV be identified, then treatment manoeuvres e.g., Epley manoeuvre can be performed to resolve this effectively	Thank you for your comment. The committee will consider any appropriate interventions to be provided to treat conditions identified during the risk factor assessment process (determined by planned evidence syntheses on risk factor assessment). This review is not a review of the treatment and management of BPPV, so will not provide a summary of evidence for repositioning manoeuvres. Reference can be made to NG127 on recognition and referral for suspected neurological conditions. If there is any evidence from intervention studies, which include falls as an outcome, that evaluate BPPV, this may be used to inform the guidance.
Royal Glamorgan Hospital	General	General	Regarding patient management, are we to assume that any underlying conditions relating to balance and falls would already be assessed initially e.g. vestibular, neurological, visual, proprioceptive, cardiac etc. Again, this could be clearer with an appropriate patient pathway or decision tree perhaps	Thank you for your comment. People aged 50-64 who have a condition that may increase their risk of falling will be considered in the guideline. The committee will consider forms of patient management where it is identified in the evidence reviewed.
Royal Glamorgan Hospital	006	General	There is reference to balance training, could this be clarified? Is this balance rehabilitation or vestibular rehabilitation?	Thank you for your comment. The term 'balance training' is providing an example of a potential intervention that could be explored in the evidence synthesis used to address question 4 (Interventions to reduce the risk of falls). The committee will consider classifying the types of interventions identified in evidence searches to be able to provide clear evidence on the nature of interventions. Whether vestibular rehabilitation appears in the guidance will depend on the evidence supporting its inclusion.

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Royal Glamorgan Hospital	022	General	There is reference in the draft scope regarding "impaired balance". Does this mean that the balance status needs to be assessed in all people that are at risk of falling? How is this to be completed? Through "bedside" balance testing or formal assessment of vestibular function through an audiologist? Can the audiologist input be captured via a pathway / protocol	Thank you for your comment. The committee will need to consider the evidence found for the questions on risk factor assessment and make recommendations based on the evidence found.
St Andrews Healthcare	002	008	The new guidelines should reflect the change in evidence in 'mental health care setting' along with acute hospital setting. Perhaps there should be a separate section on preventing falls in patients with cognitive impairment over and above the other interventions. Some reference to distinguishing falls from voluntary act of lowering to floor/ psychogenic falls. Some evidence based guidance would be extremely useful for mental health trust.	Thank you for your comment. All settings where NHS health and social care services are delivered are included. People with mental health problems (within the age range defined in the scope, see below) have been added to the Equality impact Assessment and any equality issues identified will be addressed by the committee as part of the review of evidence and development of recommendations. To clarify, the guideline age range is: people over 65 and people aged 50 to 64 who have a condition or conditions that may put them at higher risk of falling.
St Andrews Healthcare	003	012	The draft scope currently excludes a younger people, who are deemed as very high falls risk due to acquired brain injury or neurodegenerative conditions like Huntington's disease. We feel this group should also include younger than 50 people, who have condition that puts them at risk of falls	Thank you for your comment. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided for younger adult populations within the disease specific guidelines. A guidline on rehabilitation for chronic neurological disorders including traumatic brain injury is currently in development.

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St Andrews Healthcare	004	002 - 003	Under the heading of 'risk factor assessment for people identified to be at risk of falls. − Risk assessment tools, gait assessment, frailty indices' should Cognitive assessment and screening for delirium be included ?	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols. For each key area in the scope we have clarified that the lists are examples only.
St Andrews Healthcare	004	018	This guidance should also make a reference to Delirium: prevention, diagnosis and management NICE guideline CG103	Thank you for your comment. This has been added to the scope.
UK Health Security Agency - National Falls Prevention Coordination Group	General	General	Would be helpful to consider frequent fallers and outcomes, regarding timeliness of assessment and intervention - perhaps - often missed opportunities as these are the ones who are most likely to have pretty quick poor outcomes.	Thank you for your comment. Frequency of falls is included in the list of main outcomes. The committee will consider any specific recommendations required for this population from the evidence identified.
UK Health Security Agency - National Falls Prevention Coordination Group	General	General	Vision is not given due consideration and is only mentioned once.	Thank you for your comment. For each key area in the scope, we have clarified that the lists are examples only. The specific interventions (some of which are likely to be related to vision) which will be included for each review question will be defined by the committee when developing the protocols.
UK Health Security Agency - National Falls Prevention Coordination Group	General	General	I think there needs to be a separation of prevention first fall and recurrent fallers in both assessment and treatment.	Thank you for your comment. This will be covered in the frequency of falls outcome.
UK Health Security Agency - National	General	General	There is currently a multinational process taking place to produce World Falls Guidelines which are going to be	Thank you for highlighting this. We are aware of it's development and will monitor progress.

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Falls Prevention Coordination Group			completed and disseminated at the end of Sept 2022. Link to website : https://imsva91-ctp.trendmicro.com:443/wis/clicktime/v1/query?url=https%3a%2f%2fworldfallsguidelines.com&umid=09F9C19F-DE59-6E05-9249-94531DE565EF&auth=78482d32dec9961112838c22863dcecbb5975911-474f8918404df9453d04459cf352136a4e2fac73	
UK Health Security Agency - National Falls Prevention Coordination Group	General	General	I am surprised that Paramedic is still not on the guideline development committee recruitment list. Consider a large proportion of community falls would be assessed and managed by paramedics in the community before a small proportion of those patients to be transported to a hospital emergency department. In terms of the scope itself, I would suggest it may beneficial to explore what are the best interventions to prevent recurrent falls and consider the importance of data sharing across stakeholders in terms of secondary falls prevention as fall prevention interventions are often being delivered by both NHS and Local authorities colleagues with support from VCSE sector.	Thank you for your comment. A paramedic will be co-opted onto the guideline committee if a gap in the expertise required is identified. Thank you for your comment. Interventions to prevent falls across all settings where NHS health and social care services are delivered will be included in the guideline.

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UK Health Security Agency - National Falls Prevention Coordination Group	General	General	I think there needs to be a separation of prevention first fall and recurrent fallers in both assessment and treatment.	Thank you for your comment. This will be covered by the frequency of falls outcome.
UK Health Security Agency - National Falls Prevention Coordination Group	General	General	The term 'multimorbidity' is extremely problematic - see our responsive piece of work and report undertaken in the early years of the Policy Research Unit, this has led to DHSC no longer using the term 'multimorbidity' but rather using people living with multiple conditions and/or multiple conditions. What matters to people living with multiple conditions (multimorbidity) and their carers.	Thank you for your comment. This has been edited to multiple conditions.
UK Health Security Agency - National Falls Prevention Coordination Group	001	022	I would rephrase to 'impaired visual function' rather than loss of vision as this can be interpreted as just visual acuity and actually it could be any of the visual functions.	Thank you for your comment. This has been edited as suggested.
UK Health Security Agency - National Falls Prevention Coordination Group	004	004	Interventions to reduce falls risk - I think the list underneath should be removed, it's leading and will potentially miss other interventions that may have a benefit i.e correction of visual deficit, treatment of incontinence etc.	Thank you for your comment. For each key area in the scope, we have clarified that the lists are examples only. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
UK Health Security Agency - National Falls Prevention Coordination Group	004	004	Interventions to reduce falls risk - I think the list underneath should be removed, it's leading and will potentially miss other interventions that may have a benefit i.e correction of visual deficit, treatment of incontinence etc.	Thank you for your comment. For each key area in the scope, we have clarified that the lists are examples only. The specific interventions which will be included for each review question will be defined by the committee when developing the review question protocols.

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UK Health Security Agency - National Falls Prevention Coordination Group	004	005	Need to include vision assessment in 'Interventions to reduce risk of falls' or remove all and have a more generic statement on interventions to reduce risk of falls need to be implemented following identification of risk factors during a multifactorial assessment	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols. For each key area in the scope, we have clarified that the lists are examples only.
UK Health Security Agency - National Falls Prevention Coordination Group	005	015	It's good that they have mentioned the guideline Safe Staffing in Acute Hospitals, however this was published in 2014 and no doubt due for an update and increase in scope to other areas of patient care.	Thank you for your comment. The guidelines are kept under review for updating by the NICE surveillance team.
UK Health Security Agency – National Falls Prevention Coordination Group	002	020	Page 002 & General It's disappointing that the scope doesn't appear to have changed following the feedback we gave at the stakeholder workshop. There needs to be greater clarity on who the scope covers " People aged 50 to 64, with a condition or conditions that may put them at risk of falls, and their families, and carers" – this is clear, how will people know if they or their patients fit into this category? Also excluding larger numbers of younger adults who are also at risk of falls that would benefit from intervention.	Thank you for your comment. Adults between 50 and 64 who have a condtion that is recognised as putting them at higher risk of falls will be included. People under the age of 50 are not included in this guideline because there is a lack of evidence in this age group. NICE guidance is provided for younger adult populations within the disease specific guidelines.
University College London Hospital NHS Foundation Trust	General	General	How we should manage patients with capacity who are still a risk of falls that attempt to mobilise without using their mobility aids or call bells, going outside. There is an increased number of falls in these groups of patients.	Thank you for your comment. The committee will consider this where it is identified in the evidence.

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University College London Hospital NHS Foundation Trust	001	004	Older people - older should be removed from the title. This is not reflecting younger patients.	Thank you for your comment. The title reflects the populations included in the scope: people 65 and over and people over 50 who have a condtion that may put them at higher risk of falling.
University College London Hospital NHS Foundation Trust	001	022	There are no guidelines for screening and evaluating patients with dizziness or vertigo.	Thank you for your comment. Initial assessment of symptoms and signs for dizziness and vertigo is included within the Suspected neurological conditions guideline. The committee will consider which risk of falls assessments wil be inlcuded when developing the review question protocols for this clinical area.
University College London Hospital NHS Foundation Trust	001	022	Bifocal glasses assessment of vision with appropriate intervention - this should be included in NICE.	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols for each clinical area.
University College London Hospital NHS Foundation Trust	002	001	How we identify patients at risk of falls in the community – more prevention approach..	Thank you for your comment. Risk and prevention of falls in the community have been included in the scope.
University College London Hospital NHS Foundation Trust	002	004	No distinction between acute and environmental conditions – patient group and profile differ.	Thank you for your comment. The scope provides a high level and brief overview of the topic. This section specifically focusses on care settings.
University College London Hospital	002	019 – 020	NICE (National Institute for Clinical Excellence) should include patients under 50 – there is an increase in the number of	Thank you for your comment. People under the age of 50 are not included in this guideline because there is a lack

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NHS Foundation Trust			patients under 50. The guidelines do not cover this and how we manage this group. The new guidelines should cover patients aged 18-64 years.	of evidence in this age group. Clinical advice is available for younger adult populations within disease or condition specific NICE guidelines.
University College London Hospital NHS Foundation Trust	002	019 – 020	Scoring assessment should not be used to assess the patients at risk of falls.	Thank you for your comment. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
University College London Hospital NHS Foundation Trust	004	004	The importance of follow-up visits after the intervention, incl. Exercise.	Thank you for your comment. Question 4.3 (p7) 'What are the best methods for maximising participation, adherence and continuation of falls prevention interventions?' is expected to encompass follow-up.
University College London Hospital NHS Foundation Trust	004	004	Technological intervention should be included within the scope.	Thank you for your comment. For each key area in the scope, we have clarified that the lists are examples only. The specific interventions which will be included for each review question will be defined by the committee when developing the protocols.
University College London Hospital NHS Foundation Trust	004	019	Link in the Falls guidelines scope to NICE and Head injury guidelines.	Thank you for your comment. Reference to the head injury guideline has been added to the scope.
University College London Hospital NHS Foundation Trust	006	018	Education and information for patients living alone or with a language barrier – what is the recommendation by NICE?	Thank you for your comment. Availability of information in different languages is included in the patient experience in adult NHS services guideline (CG138). Reference will be made to this to this guideline within the recommendations. The committee will consider any

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				special needs of people who live alone, as identified in the evidence.

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