# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

# HEALTH AND SOCIAL CARE DIRECTORATE

# QUALITY STANDARD CONSULTATION

# SUMMARY REPORT

## 1 Quality standard title

Falls in older people: prevention

Date of Quality Standards Advisory Committee post-consultation meeting:
28 September 2016

## 2 Introduction

The draft quality standard for Falls in older people: prevention was made available on the NICE website for a 4-week public consultation period between 28 July 2016 and 25 August 2016. 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 50 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. It provides a basis for discussion by the committee as part of the final meeting. 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 Appendix 1.

The table in Appendix 1 shows the full comments submitted. Each comment has been assigned an 'ID number' so it can be referenced. Comments are grouped by statement and ordered by the ID number. Below the table is a list of the full names of the stakeholders alongside the abbreviation used in the main body of the report (see page 80).

# 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. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

5. Do you have any comments on combining this quality standard with the existing quality standard on falls in older people which covers assessment after a fall and preventing further falls (secondary prevention) in older people living in the community and during a hospital stay?

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

6. For draft quality statement 1: This draft statement applies to health and social care practitioners in contact with older people across a range of settings. Do you think the statement is measurable in each setting to support quality improvement?

7. For draft quality statement 2: Do the audience descriptors adequately describe what the statement means for the different types of service providers that carry out multifactorial falls risk assessments? If not, please identify the type of service provider not adequately covered and what the statement would mean for them in in practice.

8. For draft quality statement 3: Do the audience descriptors adequately describe what the statement means for the different types of service providers that carry out multifactorial interventions? If not, please describe the type of service provider and what the statement would mean for them in in practice.

# 4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard. Responses to consultation questions 1 to 5 are also summarised in this section of the report. Responses to questions 6 to 8 are summarised under the heading for the relevant statement in section 5 of the report.

General comments included:

- The draft quality standard was specifically welcomed by certain stakeholders.
- One stakeholder identified a potential disconnect between the target population of the quality standard (65 and over, including those who do not consider themselves

old or at risk) and the population covered by existing falls services ('much older and frailer' people).
- Equality and diversity considerations should include barriers to communication, such as hearing difficulties, and reference the Accessible Information Standard.

The inclusion within the scope of past fallers and secondary prevention was recognised and commented on by two stakeholders:
- The boundaries between primary and secondary prevention of falls are blurred.
- Title and scope have improved since topic engagement.

Some stakeholders made comments on risk factors, assessments, interventions and audiences that were not statement specific. These included:
- Hearing loss should be assessed as part of multifactorial risk assessments and referral to audiology for a full hearing test, management and hearing aids should be included as a multifactorial intervention.
- There should be specific mention of 'dizziness' and 'vertigo' as risk factors for falls, in addition to 'balance' problems; and the need for timely and appropriate management of any vestibular disorders in this population.
- It is not clear if or how the statements apply to ambulance services.
- The recognition of the role of pharmacists in falls prevention is welcomed. This stakeholder highlighted the role of pharmacists working within care homes and believes that care home residents must receive a falls assessment on admission and regularly thereafter, and that a pharmacist should be involved in assessing falls risk from the medicines the resident takes.
- The role of families and carers could be further emphasised.

Some stakeholder made general comments on measures:
- CCG Assessment Framework indicator 'Injuries from falls in people aged 65 and over' could be included as it is intended, in part, to reflect falls prevention.
- NHS Outcomes Framework indicator '2.4 Health related quality of life for carers' should be included in the outcomes listed.

### Comments on consultation question 1

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

Stakeholders responded to this question as follows:

- Yes: 12 stakeholders
- Partially: 5 stakeholders
- No: 1 stakeholder

Some stakeholders identified what they thought were the key areas within the draft standard, or areas that they felt should be emphasised:

- Making conversations about falls history a routine part of all forms of health and social care is key to primary prevention and addressing falls risk.
- Draft statement 3 is the key area for quality improvement as it deals with actually preventing falls through interventions that are not widely in place.
- Broad content of interventions is correct, but statements should require auditing to ensure that specific interventions follow internationally recognised guidance.
- Exercise provision is not emphasised enough given the very strong evidence base as a single intervention and as part of a multifactorial intervention.

The stakeholder who answered ‘no’ to the consultation question supplemented their answer by noting that the role of ambulance survey is omitted and the quality standard does not offer anything new.

### Comments on consultation question 2

Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place?

Mixed views were expressed in relation to this question. Stakeholders who answered ‘yes’ or ‘no’ were as follows:

- Yes: 3 stakeholders
- No: 6 stakeholders No

However, not all stakeholders answered this question with a simple yes / no answer. Many responses suggest that measurement of the quality standard will be a significant challenge. Comments included:

- No consistent or reliable systems and coding are in place across organisations to accurately record falls. In addition, recording of falls can be problematic due to under-reporting by individuals, and poor recollection of fall events.
- Local systems are not currently in place to systematically and consistently collect community health and social care practitioner data.
- Existing structures to capture data for many of the quality measures are patchy.
- Local systems do not record if people are asked about falls, multifactorial assessments are not coded.
- Data on number of falls are collected in secondary care, but not on asking older people about falls.
- The biggest challenge in relation to delivering this QS is how to record whether people are being asked about falls (statement 1) and sharing that information between agencies.

Some stakeholders took a different view, though, and suggested that data collection would not be a significant challenge, or that audits could be used to address the lack of consistent, reliable systems:

- Measurement would be straightforward.
- Existing local systems and structures to collect data are varied, but standardising comprehensive data collection is both possible and desirable.
- If systems are not in place, measuring this would not be difficult for most organisations in health and social care.
- Data collection would likely be through sample based audits.
- National audit could be used to collect this data.
- Data would be difficult to collect except through small audits.

**Comments on consultation question 3**

Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to the NICE local

practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Examples suggested by stakeholders included:

- Staying Steady MK (Milton Keynes Falls Service): Has a multifactorial assessment that incorporates the components of assessment in the quality standard.
- SystmOne: A clinical system which has a feature that allows falls to be identified and interventions to be measured.
- Stand Up, Stay Up – Taking the rise out of falls: Falls prevention programme funded by the Department of Health covering 10 local authority areas. Preliminary visits to the ten areas have shown work under way that underpin elements of, if not all of, this draft standard. Examples could be provided as the programme develops.

**Comments on consultation question 4**

Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

- Only a minority of stakeholders who responded to this question considered the statements achievable given the net resources needed.
- One of these stakeholders also identified a synergy with greater community service integration and focus on prevention, as set out in the GP Forward View, which support harm reduction through proactive case identification in community settings. They also stated that introduction of systematic frailty identification will also aid this process and support the quality improvements set out in the quality standard.

Most stakeholders who responded to question 4 identified potential resource impacts. Broad themes included resources being needed for specialist falls clinics if they are to cover more than those at highest risk of falling; recognition that falls and

other primary and secondary care services are struggling to meet existing demands placed on them; and that resources may be required in specific geographical areas to address variations in service provision. Comments included:

- “Immense” resources required to establish falls clinics and to refer all people at risk of falling. Pathways are needed to recognise that assessment may occur within non-specialist falls services with onwards referral for more complex cases.
- Capacity for multifactorial assessment and intervention to be delivered effectively to the whole at-risk population would require significant resource.
- Local resources mean that NHS providers are likely only to be able to provide services for those at highest risk of falling, or who have a significant history of falling.
- Resources and additional capacity required for specialist falls services.
- Adding in a further layer of screening questions for primary care and further referrals to organise is likely to be unrealistic as primary and secondary care are struggling to cover the range of current clinical demand.
- Doubtful if statements are achievable or sustainable. Demand for falls services locally already exceeds supply.
- Additional services such as strength and balance training are needed in some areas.
- Statements should be achievable by local services, but provision of falls services varies so resources may be needed.
- Statement 1 should be achievable, but there is a risk of duplication by each healthcare provider leading to inefficiencies.
- Resources will be required for training, development of pathways, strength and balance classes and the staffing to help provide appropriate assessment services.
- Resources needed for a local co-ordinator who can help the different agencies to work more effectively together and support information sharing.
- Resource impact arising from IT and shared records across health and social care.

Only one potential cost saving was identified in responses:

- Decommissioning non-evidence based services (e.g. exercises classes which are of too short duration to meet minimum levels of effectiveness).

**Comments on consultation question 5**

Do you have any comments on combining this quality standard with the existing quality standard on falls in older people which covers assessment after a fall and preventing further falls (secondary prevention) in older people living in the community and during a hospital stay?

- The vast majority of stakeholders that responded to this question supported merging with the existing quality standard, or saw no reason why they should not be combined.
- One stakeholder suggested that combination would require modification of the existing quality standard to address role of carers.
- Only one stakeholder supported having two separate quality standards, as a combined standard could result in secondary prevention being the main focus at the expense of primary prevention.

# 5 Summary of consultation feedback by draft statement

## *5.1 Draft statement 1*

“Older people are asked about falls when they have routine reviews or health checks with primary care services, if they are admitted to hospital, and in regular conversations with their community healthcare and social care practitioners.”

**Comments on ‘asking older people about falls’**

A number of comments question whether the main action of the statement, asking older people about falls, would be effective as described in the draft statement:

- One stakeholder pointed out that many people are unwilling to admit they have fallen, or may not be aware of past falls due to dementia or syncope.

- Others suggested that the question asked should probe more than just falls and probe other matters such as balance, stability, unsteadiness, eyesight, dizziness, fear of falling, feeling frail and ability to carry out everyday tasks.
- Some stakeholders suggested that the action should also include observations of strength and balance, and queried whether 'Timed up and Go' and 'Turn 180' screening tools would be used.
- Several stakeholders recommended that the statement should reflect the links between the falls and frailty; and the screening process should cover frailty as well as falls.
- One stakeholder considered that the opportunistic asking about falls should be extended to include targeted and proactive / systematic case finding.
- One stakeholder suggested that the statement should be reworded as per 'The Prevention and Management of Falls in the Community A FRAMEWORK FOR ACTION FOR SCOTLAND 2014/2016'. [Note for members this document includes an action to identify individuals at risk of falling: "Health and social care services have a level 1 conversation with an older person who reports a fall or an injury or functional decline caused by a fall." A level 1 conversation is simple process which aims to identify people who have fallen / are at high risk of falling and may benefit from further support and/or intervention. The framework considers risk assessment as a continuum: A simple, level one conversation; a level 2 screen (multifactorial falls risk screening process); and a level 3 assessment (specialist assessment which aims to assess further the risk factors identified, with a view to providing tailored intervention).

When, and how often, older people should be asked about falls was also the subject of comments from stakeholders:

- Routine asking about falls by all practitioners may result in patients being over-asked about falls, resulting in it becoming a tick box exercise.
- Different timing options were suggested by some stakeholders. These included asking patients about previous falls once during an episode of care; and letting healthcare professionals determine when and if questions are asked about falls.

**Comments on who should ask older people about falls**

The statement applies to a range of health and social care practitioners. Some stakeholders were of the view that this range needed extending by reference to additional groups including:

- The ambulance service.
- Pharmacists, as they have regular contact with patients across a wide range of settings.
- Other (non-NHS) healthcare professionals such as Alexander Technique teachers who are trained to identify difficulties with balance, gait and posture.
- Housing professionals.
- Third sector providers and volunteers who provide services for older people.
- Voluntary and other public sector providers, e.g. fire and rescue services are already involved in falls prevention work in some areas.
- Carers, who could be asked about falls as part of the carer's assessment.

In contrast, one stakeholder felt that the range of practitioners should be more limited:

- Only qualified professionals should take a falls history; social workers and many healthcare workers should not be expected to do this. Older people will attempt to rationalise their fall and attribute it to a non-existing external factor; unqualified staff may then miss an opportunity for onward referral.

Three stakeholders made comments specifically about GPs and primary care. Two warned that GPs may not have sufficient time in a consultation to ask about or act upon a previous fall; and this would reduce the time available to deal with the matter a patient has presented with. In contrast, another considered that falls is essentially a primary care matter (as opposed to a matter for specialised falls clinics) and that a simple, holistic assessment could be carried out by GPs.

**Comments on measuring the statement (including consultation question 6)**

This draft statement applies to health and social care practitioners in contact with older people across a range of settings. Do you think the statement is measurable in each setting to support quality improvement?

Most stakeholders did not respond with a simple yes or no answer to consultation question 6 (above). Of those that did:

- 7 stakeholders considered the statement to be measureable.
- 2 stakeholders said the statement was not measureable.

The majority of responses identified potential measurement issues including:

- Collecting and coordinating information across organisations, professions and settings would be difficult and could result in duplication of effort or double counting.
- Measurement would be challenging in community health and social care settings due to lack of consistent, systematic and interoperable recording processes.
- For successful implementation, the statement should be limited to healthcare professionals and exclude social care practitioners.
- Falls data may be difficult to collect as there is a reluctance of people to report falls, and different questions may need to be asked if a person has cognitive impairment.

As well as responding to the consultation question, some stakeholders made comments on specific measures as set out in the document. These are not summarised here as they mainly flag up technical issues that can be addressed by the NICE team when reviewing the quality standard, or repeat some of the broader points above. Such comments were made on structure measures, process measures and outcome measures and can be found in the appendix.

**Other comments**

- The terms and descriptions relating to hospital settings, such as attendances and admissions could be improved.
- Several stakeholders said the statement should say what happens if someone answers yes to having fallen in the past. Suggestions include MFRA as per statement 2; and signpost to other services or patient organisations and charities.
- One stakeholder questioned what happens for people who have only had one fall (as these do not get covered by statement 2).

- Minor amendments were suggested to the rationale by some stakeholders.
- Older people definition includes 'extended care setting': Nursing homes and residential homes are different and should not be used interchangeably. All references to care setting should be explicit as to whether they are nursing or residential homes.

## *5.2 Draft statement 2*

"Older people at risk of falling are offered a multifactorial falls risk assessment."

**Comments on who should have a multifactorial falls risk assessment**

Statement 2 says that older people who have had two or more falls in the last year, or who demonstrate abnormalities of gait or balance, should have a multifactorial falls risk assessment (MFRA).

- Some stakeholders suggested that this target population should be widened to include people who have had one or more falls in the last year to make the statement more effective.
- Other stakeholders suggested assessment tools, such as a level 1 falls screen (see The Prevention and Management of Falls in the Community: A FRAMEWORK FOR ACTION FOR SCOTLAND 2014/2016) or timed up and go tests, to help identify who should have an MFRA.
- A number of stakeholders suggested that the statement needs to clarify how to identify / measure those 'at risk' of falling in comments made on the process measures.

**Comments on what multifactorial falls risk assessment should cover:**

The draft statement lists components that a MFRA may include. Stakeholders made suggested additions to the components including:

- Frailty: Assessment processes should ensure that falls and frailty are linked, as MFRAs overlap with recommended content for comprehensive geriatric management of the frail older patient.
- Lack of sleep: This can increase a person's risk of a fall.
- Hearing loss.

- Vestibular system: assessment including test for Benign Paroxysmal Positional Vertigo.
- Foot disorders.
- Osteoporosis and signposting of individuals for further bone health assessment.
- Nutrition assessment: This can affect risk of osteoporosis.
- Syncope: Consideration whether a past fall could have been due to syncope.

Other comments suggested changes to the components listed in the MRFA definition, or changes to the emphasis given in the statement:

- Medication review should be listed alongside polypharmacy rather than with cardiovascular assessment.
- Medication review should be listed separately from cardiovascular assessment as they are separate processes.
- Postural blood pressure should be included as a specific assessment rather than being included within the polypharmacy bullet point.
- Where a patient has cardiovascular disorders, more detailed assessment may be needed in falls associated with syncope such as echocardiography, Holter monitoring and tilt testing.
- Fracture risk using FRAX or QFracture should be listed instead of osteoporosis, as fracture is the consequence of a fall.
- Bone health as a component could be given more prominence and included in the statement wording.
- Urinary incontinence should be broadened to include ‘frequent night-time voiding (>2 voids per night)’.

In contrast to the comments above, one stakeholder felt that the inclusion of a list in the definition was unnecessary.

**Comments on who should perform multifactorial falls risk assessments**

Draft statement 2, like the underpinning guideline, says that assessment should be performed by a healthcare professional with skills and experience in falls prevention,

often in the setting of a specialist falls service. Several stakeholders suggested that this would make implementation difficult as:

- MFRAs represent the most detailed end of the assessment process and are likely to only be offered to a very limited number of people. This statement needs to offer an alternative that can be delivered at a more basic level by a wider range of staff and organisations.
- The number of assessments would be far too high to be done mostly ‘in a specialist falls service’.
- Not all secondary care providers will have experienced falls prevention professionals readily accessible across all wards / departments / units.
- Demand for falls service in local area already exceeds capacity (6 month plus waiting list experienced). With funding and efficiency changes, it is doubtful if the statement is achievable or sustainable.
- There are delays for patients waiting to be seen in specialist falls services and expansion of fall teams is needed.

One stakeholder asked if MFRAs could be performed in primary care. Another stated that good MFRA could occur outside of a specialist falls service, with onward referral to a falls service if complex needs are identified or to others for a single issue is (say an optician in relation to poor vision).

Suggestions were made as to who could perform MFRAs and what competencies and knowledge they should have. These included:

- Ambulance services: Currently have established referral pathways to refer patients after a fall for further falls assessments.
- Pharmacists: Relevant components include identification of falls history; identification of polypharmacy; and identification of chronic conditions that affect mobility or balance.
- Community nurses, therapists, GP practices and others seeing patients: These could be trained to perform a good MFRA without referring to a specialist service.

- Those undertaking MFRA should be trained in home hazard assessment and understand who to contact for advice on housing interventions.
- Professionals undertaking MFRA should have a knowledge and understanding of Parkinson's.
- An MFRA can be completed by health, social care, and care home staff. See Level 2 screen in The Prevention and Management of Falls in the Community: A FRAMEWORK FOR ACTION FOR SCOTLAND 2014/2016.

**Comments on consultation question 7**

Do the audience descriptors adequately describe what the statement means for the different types of service providers that carry out multifactorial falls risk assessments? If not, please identify the type of service provider not adequately covered and what the statement would mean for them in in practice.

This question also probed who should perform MFRAs. Not all stakeholders answered the first part of the question directly. Of those that did:

- 9 stakeholders considered the audience descriptors adequate.

No stakeholder said that the descriptors were incorrect. Some suggestions were made though:

- Housing Associations are an important audience for the statement.
- The most effective methodology for is a comprehensive geriatric assessment.

Some stakeholders made specific comments on the audience descriptors set out in in the draft document:

- Reference to GPs needs expanding, so that older people at risk of falling who are also presenting in other healthcare settings are referred on to a falls prevention service.
- 'Healthcare Professionals' is not defined well.

**Comments on measures**

Many of the comments on the measures are on technical aspects of the measures, or may not be relevant if members decide to tweak the statement. Such comments are not summarised below but will be considered by the NICE team when the quality standard is revised. More generally:

- Statement 2 is measurable and auditable according to one stakeholder, and the national audit of inpatient falls could be adapted by services wishing to audit those patients at risk of falling out of hospital.
- Several stakeholders also questioned if the outcome measures were direct outcomes of statement 2, or if they were actually outcomes for statement 3.

**Other comments**

- Equality and diversity considerations should include barriers to communication, such as hearing difficulties, and the statement should reference the Accessible Information Standard.
- There is potential for confusion between risk assessment (risk of falling, stratification) and risk factor assessment (part of falls prevention if linked to risk factor modification). Statement 2 should focus on risk assessment / stratification and statement 3 should cover falls risk factor assessment and modification as a single process.
- One stakeholder commented that references to care setting should be explicit as to whether they are nursing or residential homes. [Note for members: The definition of older people refers to extended care settings which includes both types of home. It is taken directly from the guideline]

## *5.3 Draft statement 3*

“Older people assessed as at risk of falling receive an individualised multifactorial intervention.”

**Comments on components of multifactorial interventions**

Most comments on this statement related to the type of intervention, and the definition of an individualised multifactorial intervention. In general, comments

suggested additional interventions, or challenged and queried interventions described in the statement as ‘not recommended’. One stakeholder also felt that the listing of some interventions is problematic, as it implies other interventions are less important. In contrast, a different stakeholder said the statement is clear and concentrates on key interventions.

Additional interventions suggested included:

- Hip protectors: Use is ruled out based on evidence not updated since 2004, and does not take account of modern hip protectors that are more effective.
- Alexander Technique: Lessons to improve balance and postural support.
- Audiology, hearing assessment and management.
- Vestibular rehabilitation, and repositioning manoeuvres in cases of BPPV as part of strength and balance training.
- Hypotension intervention: Postural hypotension, if identified through postural blood pressure management; and postprandial hypotension (symptoms may be subtle; advice is for people to avoid large portions, and to sit in chair with feet raised following a meal).
- Nutrition intervention: This is linked to muscle strength and can maximise benefits of exercise.
- Dehydration interventions: Syncope can occur if a patient has not drunk enough fluids. Advice is for patient is to drink 2 litres of water daily.
- Intervention to address frequent night time voiding (nocturnal polyuria).

**Comments on home hazard assessment and interventions**

The achievability and effectiveness of the statement in relation to home hazard assessment and intervention was commented on by several stakeholders:

- One stakeholder considered that home hazard assessment and interventions could not be delivered if they are required to be performed by an occupational therapist. In contrast, another stakeholder stated that home environment assessments are most effective if done by an occupational therapist, and that there should be a home hazard screen that would signpost to occupational

therapy. [Note for members: CG161 actually says that home hazard assessment / interventions should be carried out by "…a suitably trained healthcare professional"]

- Occupational therapists, along with physiotherapists and consultant geriatricians, are unlikely to be involved in home hazard assessments according to a different stakeholder.
- Limited capacity of specialist falls services means they can only deal with very high risk patients who have already fallen according; home hazard assessment and intervention should only apply to people over 75 and / or those who have already fallen in order to be achievable.
- There are delays in achieving the outcomes following home hazard assessment and intervention; 1 in 5 carers are still waiting for adaptions to be actually made.
- Housing professionals need to be engaged to ensure that assessments represent the optimum home hazard intervention.

**Comments on interventions that are not recommended**

The statement definition of an individualised multifactorial intervention lists some interventions that are not recommended in the source guideline. Some stakeholders challenged specific interventions described as not recommended. Other comments suggested that their inclusion makes the definition unclear:

- Vitamin D: There is evidence that Vitamin D reduces falls risk for people in care homes; and not recommending Vitamin D goes against advice that older people need Vitamin D in winter, and the guideline does not specifically advise against it.
- Group exercise: There is evidence that such exercises (FaME) can reduce falls. Untargeted group exercises should be not recommended, but the wording could make clearer that targeted group exercise (such as FaME) is recommended.
- Vision assessment is described as a successful component of a multifactorial falls assessment, but then then referral for correction of visual impairment is not recommended. Is the advice that the intervention is not recommended as a single intervention but only as part of a multifactorial falls assessment?
- Is there a link between incontinence programmes and low intensity exercise?

- What is the difference between low intensity exercise and brisk walking?

**Comments on who should perform multifactorial interventions**

Several stakeholders suggested additional groups of staff or services that the statement should reference including:

- Audiology; Audiovestibular Medicine; or Ear, Nose and Throat.
- Physiotherapy.
- Pharmacists.
- Non-medical services: Some are experienced and trained in home hazard assessment and intervention (e.g. fire services, environmental health, third sector organisations, some housing improvement agencies and some care organisations).

Consultation question 8 also probed the roles of different groups in relation to multifactorial intervention.

Do the audience descriptors adequately describe what the statement means for the different types of service providers that carry out multifactorial interventions? If not, please describe the type of service provider and what the statement would mean for them in in practice.

In response:

- Seven stakeholders considered the audience descriptors to be described appropriately.
- Two stakeholders suggested minor changes to the descriptors.

**Comments on making interventions effective**

Comments included:

- Whilst an individual multifactorial intervention is ideal, delivery would be more achievable in group settings.
- Consenting to, and complying with, interventions needs consideration; some people may not agree to recommended interventions.

- Interventions need to be more explicitly linked to the evidence base, e.g. strength and balance training has to be of the right intensity and frequency to be effective. One stakeholder commented that there is a lack of provision of exercises to reduce falls in most regions, and what exists is often not evidence based.
- Multifactorial approach is supported, but statement needs to distinguish between primary and secondary prevention.
- Everyone with Parkinson's, regardless of age, who is at risk of falling should be offered a multifactorial intervention.
- Timely referral is required from health professionals to ensure that interventions are effective and outcomes are measurable.
- Older people are more likely to change behaviour and follow prevention activities if they have a say and can take ownership. The statement wording should therefore reflect shared decision making to shift away from seeing older people as passive recipients of care.

**Consultation comments on measures**

One stakeholder said that statement 3 is auditable at a national and local level. Most of the other comments received focussed on outcome measures and raised practical and conceptual issues, questioning whether they can actually be measured and whether they represent outcomes for the statement.

# 6 Suggestions for additional statements

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

- Health promotion initiative to reduce primary falls in older people who are currently mobile and do not report balance problems. This group of people could be targeted and advised to do 3 exercises a day to maintain balance and strength through a leaflet and poster campaign.
- "Older people assessed as at risk of falling should be provided with opportunities for self-management through information, advice and reablement."

# Appendix 1: Quality standard consultation comments table – registered stakeholders

The comments are sorted by statement order in the following table. Please note that 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 | Comments |
|---|---|---|
| **General comments (including non-statement specific comments)** | | |
| 1 | Action on Hearing Loss | Action on Hearing Loss is the charity formerly known as RNID. Our vision is of a world where deafness, hearing loss and tinnitus do not limit or label people and where people value and look after their hearing. We help people confronting deafness, tinnitus and hearing loss to live the life they choose. We enable them to take control of their lives and remove the barriers in their way. We give people support and care; develop technology and treatments and campaign for equality.<br><br>Action on Hearing Loss welcomes the development of the 'Falls in older people: prevention' quality standard. Given the age-related nature of both hearing loss and falls, and robust evidence showing that hearing loss increases the risk of falls, we feel the quality standard needs to make reference to the importance of identifying and addressing hearing loss in risk assessments and mitigation strategies, and highlight the importance of meeting people's communication and information needs, to ensure people are aware of the dangers of falling, the support that's available, and to enable them to contribute to plans that will prevent unnecessary injury.<br><br>There are 11 million people in the UK with hearing loss, about one in six of the population. Over 71.1% of over 70 year olds have some form of hearing loss, and with the ageing population the number of people with hearing loss is set to increase1. If hearing loss is not identified and addressed it has a serious impact on someone's ability to communicate, their physical and mental health and their ability to access services, stay safe and remain independent2. |

[1] Action on Hearing Loss (2015) Hearing matters. Available at: www.actiononhearingloss.org.uk/hearingmatters

[2] Action on Hearing Loss (2015) Hearing matters, Available at: www.actiononhearingloss.org.uk/hearingmatters; Ringham (2012) Access All Areas. Available at: www.actiononhearingloss.org.uk/accessallareas; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica. 28(2): 61-6; Arlinger (2003) Negative consequences of uncorrected hearing loss – a review. International Journal of Audiology 42(2): 17-20; Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. Age and Ageing 41(5): 618–623; Action on Hearing Loss (2013) Joining Up (available at www.actiononhearingloss.org.uk/joiningup; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58(1): 93-7; Mulrow et al (1992) Sustained benefits of hearing aids. Journal of Speech & Hearing Research 35(6): 1402-5; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head & Neck Nursing. 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, Archives of Gerontology and Geriatrics, 52(3): 250-2; Lin et al (2011) Hearing loss and

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| | | Hearing loss is independently associated with an increased risk of falls3. For example, a 25 dB hearing loss4 is associated with nearly threefold higher odds of reporting a fall over the preceding year compared with someone with no hearing loss. There is then a 1.4 increase in odds for every 10 dB increase in hearing loss5. Research suggests that this risk could be reduced by ensuring auditory information is available, for example by wearing hearing aids6.<br><br>The age-related incidence of hearing loss and falls means that there will be many people living in the community who have a hearing loss and will be at risk of injuring themselves through falling, and 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. This is particularly important because currently approximately two thirds of people who could benefit from hearing aids aren't accessing them7, which means that many people are at significant increased risk of falling because they are not addressing their hearing loss.<br><br>As well as ensuring people have their hearing checked and managed, given the high likelihood of a person at risk of falling having a hearing loss, it's very important for services helping mitigate against avoidable falls to communicate and provide information in a way that meets the needs of service users. The Accessible Information Standard8, which became mandatory on 31st July 2016, requires all NHS and statutory-funded adult social care providers to have systems in place to identify, record, flag, share and meet communication needs of people with disabilities and sensory loss, which includes providing accessible |

incident dementia. Archives of Neurology 68(2): 214-220; Lin et al (2013) Hearing loss and cognitive decline in older adults. Internal Medicine 173(4): 293-299; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology & Neurotology 35(5): 775-81; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. Alzeimer's and Dementia Journal, 11 (1), 70-98; Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. Archives of Ophthalmology 124(10): 1465-70; McKee et al (2011) Perceptions of cardiovascular health in an underserved community of deaf adults using American Sign Language. Disability and Health 4(3): 192-197; Margellos-Anast et al (2006) Cardiovascular disease knowledge among culturally Deaf patients in Chicago. Preventive Medicine 42(3): 235-9; Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. Otology and Neurotology 24(3): 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. Diabetic Medicine 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. Diabetes Education 36(6): 956-64; Formby et al (1987) Hearing loss among stroke patients. Ear and Hearing 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. Stroke 40(4): 1496–1498

[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

[4] Hearing loss is defined by the quietest sound the person is able to hear, measured in decibels.

[5] Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of Internal Medicine 172(4): 369-371

[6] 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

[7] Action on Hearing Loss (2011) Hearing Matters

[8] NHS England (2015) Accessible Information Standard, SCCI 1605 https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

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| | | information, communication support, and creating an environment where good communication can take place. This should be referenced in all relevant places in this quality standard to ensure people at high risk of falls can access these services.<br><br>In summary:<br>- Hearing loss should be assessed as part of multifactorial risk assessments and referral to audiology for a full hearing test, management and hearing aids should be listed as a multifactorial intervention in this quality standard<br>- The communication and information needs of those undertaking a risk assessment and identifying appropriate multifactorial interventions should be taken into account, and there should be adequate reference to this and the requirements of the Accessible Information Standard throughout the quality standard |
| 10 | Action on Hearing Loss | The requirements of NHS England's Accessible Information Standard9 should be included in this section, and in order for the risk assessment and multifactorial planning process to be effective there should be more reference to the importance of ensuring people are able to be part of discussions about their care, through good communication practices.<br><br>The following paragraph included in other NICE quality standards (such as the draft quality standard for 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs) could be helpful, as well as the summary below about the Accessible Information Standard:<br><br>Barriers to communication can hinder people's understanding of risk assessments and intervention planning and prevent them from participating as fully as they are able to. For example, learning or cognitive difficulties; physical, sight, speech or hearing difficulties; difficulties with reading, understanding or speaking English. These needs should be taken into account and adjustments made to ensure all older adults identified as being at risk of falling understand the risks and can be involved in making decisions about their care, if they have the capacity to do so.<br><br>Providers must also ensure compliance with the Accessible Information Standard, which became mandatory on 31st July 2016 and requires all NHS and statutory-funded adult social care providers to have systems in place to identify, record, flag, share and meet communication needs of people with disabilities and sensory loss, which includes providing accessible information, communication support, and creating an environment where good communication can take place. |
| 11 | Action on Hearing Loss | NHS England's Accessible Information Standard should be added in the policy context section: https://www.england.nhs.uk/ourwork/accessibleinfo/<br><br>The Standard became mandatory on 31st July 2016 and requires all NHS and statutory-funded adult social care providers to have systems in place to identify, record, flag, share and meet communication needs of people with disabilities and sensory loss, |

[9] NHS England (2015) Accessible Information Standard, SCCI 1605 https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

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| | | which includes providing accessible information, communication support, and creating an environment where good communication can take place. |
| 12 | Age UK | Age UK welcomes this quality standard as an opportunity to clarify the key steps that service commissioners and providers must take to better prevent falls among older people. Falling, and the fear of falling, has a significant impact on the health and wellbeing of older people. It can result in increased anxiety and depression, reduced activity, mobility and social contact, higher reliance on medication and greater dependence on medical and social services and other forms of care. Age UK, including our network of local partners, have a long track record of providing services to identify and support older people at risk of falling. |
| 13 | Age UK | The topic overview states that the focus of this quality standard is on the primary prevention of falls. However, the scope of the draft appears to include people who may have already experienced a fall and to therefore include secondary prevention (see last paragraph on page 11 for example). NICE should clarify what is intended by 'primary prevention', 'secondary prevention' and 'previous falls', especially if secondary prevention is to remain outside of the scope of this quality standard. Our experience of supporting older people suggests that the boundaries between primary and secondary prevention are blurred, particularly when it comes to falls. This is in part to do with the understanding of what constitutes a 'fall'. For example an older person who stumbles backwards onto a chair or bed may not consider themselves as having fallen. Equally, some healthcare professionals may only refer to falls as events that lead to injuries and ill health. In other cases older people might have had one or several fall(s) in the past and not reported them or received any support to prevent further falls. Our response therefore addresses the prevention of all types of falls, whether they result or not in serious harm and injury or whether they were preceded by other falls. As such, and in response to question 5 on page 7, we would support the idea of combining this quality standard with the existing quality standard on falls in older people (QS 86). |
| 25 | Association of ambulance chief executives | In summary, it would be very unclear for ambulance services to know whether these statements are applicable to them. It doesn't appear that anyone from ambulance services was involved with the development of this draft quality standard. We would support combining the quality standards of falls in older people and prevention, but with further clarity on the role of ambulance services being recognised and consideration given to how data could be collected. At AACE we would be happy to be involved in further consultation and some dialogue to ensure that the role of ambulance services in falls in older people and falls prevention is clear. |
| 44 | British Society of Audiology (BSA) Balance Interest Group (BIG) | The British Society of Audiology (BSA) Balance Interest Group (BIG) steering committee has considered the document and feels that overall there needs to be the specific mention of "dizziness" and "vertigo" amongst the risk factors for falls, as well as "balance" problems as a broader term. The need for timely and appropriate management of any vestibular disorders in this population should be highlighted, and in particular reference to Benign Paroxysmal Positional Vertigo (BPPV) should be made considering the high prevalence of BPPV in fallers. It should be emphasised that all stakeholders need education in vestibular disorders and dizziness, with a particularly emphasis on BPPV in this population. Reference should be made to a need for all stakeholders to forge links between related services, to include specialist vestibular services, specialist Falls service, specialist physiotherapy services, occupational therapy services, community physiotherapy services and others, where appropriate and |

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| | | available. This will enable related services to establish clear management pathways and encourage mutual sharing of expertise.<br><br>More specifically we wanted to highlight the following sections of the document for further comment, as below in the further comments below.<br><br>Highlighting all these areas in the guidelines will help support the continuation of these traditionally under-resourced but vital services. Hopefully it might aid the development of further specialist services, considering the extremely patchy coverage across the country currently.<br>We thank you for the opportunity to contribute to the consultation on this document and would ask that the British Society of Audiology (specifically the BSA Balance Interest Group), the Chartered Society of Physiotherapy (CSP), and the Association of Chartered Physiotherapists in Vestibular Rehabilitation (ACPIVR) be included in any future consultation on this and similar documents in the future, if possible. |
| 51 | Cardiff and Vale University Health Board | This quality standard takes an important step towards primary falls prevention amongst older people, rather than just focusing on those who have fallen before. This is a key area for improvement and is vital that more is done to prevent initial falls |
| 52 | Cardiff and Vale University Health Board | The fact that falls history is a significant risk factor and predictor of further falls is clearly correct and right to have a key focus, but the whole purpose of this quality standard is to try to prevent falls in the first place. Therefore it would seem pertinent at this point in the document to list some of the other risk factors so that the person reading has a clear understanding of the breadth of factors. |
| 63 | Carers UK | One of the outcomes that the draft standard seeks to improve is the ability of carers to provide care safely in the home. |
| 64 | Carers UK | The NHS Outcomes Framework indicator 2.4 Health related quality of life for carers should be included in the outcomes listed. |
| 65 | Carers UK | With the majority of care in the community provided by family and friends i the draft standard rightly recognises the central role of families and carers in preventing falls. This could be highlighted further, especially as carers and families are vital to making decisions about interventions to prevent falls. Carers must be involved in decisions around home improvements to prevent falls as carers who live with the person they care for will also be affected by this. Prevention work can also be beneficial to carer's health: home hazards are a contributing risk factor to falls which can affect carers too. Carers' health can also be affected by falls if they have to do any lifting as a result. |
| 76 | The Chartered Society of Physiotherapy (CSP) | AGILE (the CSP professional network for Physiotherapists working with older people) and the National Osteoporosis Society have both submitted detailed responses which the CSP fully supports. We have pulled out some key points we would like to emphasise below [see ID 77 and ID 78] |

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| 79 | Guy's and St Thomas' NHS Foundation Trust | At GSTT the Trust and community falls group continue to work together to review and ensure compliance with NICE Falls guidance and quality standards, ensuring that our falls prevention and management work is evidence based and based on NICE guidance. We regularly review our practice and complete audits to ensure compliance with our falls prevention & management and Trust wide action plans. We are delighted to have been involved in previous quality standard drafts as well as the recent topic engagement for the current NICE falls prevention quality standard; as such we currently do not have anything significant to contribute to this draft other than our previous comments in the engagement exercise. |
| 163 | NHS England | We suggest that you include falls indicator - Injuries from falls in people aged 65 and over from the CCG Assessment Framework. Inclusion of this indicator is important in order to promote prevention and not simply health care. We have chosen this indicator to represent falls in the work that we promote – there are no perfect measures but this is the best blend of being measurable, modifiable and it has a preventative element. |
| 165 | NHS Improvement: Patient Safety | The title and scope of this draft would seem to be improved following the topic engagement feedback. I note the future NICE ambition mentioned in the document to publish a further standard on population based approaches to falls prevention which would be entirely appropriate and would benefit from the findings of the impending Cochrane review.<br><br>This draft does reflect priority areas for quality improvement and the measures described for each of the three standards appear to be appropriate and achievable through local data collection. |
| 216 | Royal College of Physicians | The RCP is grateful for the opportunity to respond to the above consultation. In doing so we would like to endorse the response submitted by The British Geriatrics Society. We have also liaised with our Falls and Fragility Fracture Audit Programme and would like to make the following comments. [see ID 217 to 228 for comments referred to] |
| 254 | Royal Pharmaceutical Society | The Royal Pharmaceutical Society is the professional membership body for pharmacists and pharmacy in Great Britain.<br>The Royal Pharmaceutical Society (RPS) welcomes the quality standard for Falls in older people: prevention.<br>We are pleased with the recognition of the role of pharmacists in GP practices and Community in the prevention of falls. We would like to also highlight the role of pharmacists working within Care homes to help prevent falls.<br><br>We have recently produced the Ultimate Guide for Pharmacists working in care homes http://www.rpharms.com/landing-pages/working-in-care-homes-hub.asp which highlights the role of<br><br>• Pharmacists working within care homes,<br>• Working in a community pharmacy that provides services to care homes<br>• GP practice pharmacists providing services to care homes<br><br>Examples of pharmacists improving patient care in care homes » |

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| | | • Pharmaceutical Journal article "The Care Homes Clinician"<br>The SHINE project demonstrated the value of pharmacist-led medication reviews in care homes, in this article, independent prescriber Carmel Copeland describes the impact she has made. It mentions how her work included medication reviews for patients admitted following a fall at home.<br>• Pharmaceutical Journal article "Pharmacists offer a clinical service to vulnerable care home residents"<br>which mentions that the risk of falls has gone down because of improved medicines monitoring and management, and there has also been a reduction in the use of "inappropriate polypharmacy"<br>• List of shared examples from the NICE website (good examples in what is currently being done and its success).<br>• Better care for care home residents vanguard<br>East and North Herts Clinical Commissioning Group (CCG) is working with Hertfordshire County Council and the Hertfordshire Care Providers Association on an NHS England Care Homes (vanguard) project to provide planned, proactive and preventative support to elderly care home residents with complex care needs.<br>• The Proactive Care Homes Project – Central London Community Healthcare NHS Trust & CLARHC.<br>A multidisciplinary proactive care project started in December 2013 across Kensington and Chelsea and Hammersmith and Fulham. The project aims were to reduce medication errors, patient falls and prevent unexpected hospital admissions. A total of 981 patients were seen in 11 months, with 6414 interventions made by the pharmacist, with a cost saving of £168,661. The key outcomes of the project included a reduction of falls by 35% and a 26% reduction in London Ambulance Service callouts from falls.<br><br>The Ultimate guide includes Clinical guidance and support tools specific to Falls and Frailty. The RPS recommends that a resident must receive a falls assessment on admission into a care home and regularly thereafter, and a pharmacist should be involved in assessing falls risk from the medicines that the resident takes.<br><br>As well as in care homes, pharmacists are ideally placed in both community and within GP practices to interact with patients via conversation, Medication Use reviews or health checks to identify patients at risk of falls.<br><br>We also have examples of pharmacists involvement to reduce falls in the following The Right Medicine: Improving Care in Care Homes http://www.rpharms.com/promoting-pharmacy-pdfs/care-homes-report.pdf<br>• See page 8 - Falls in care homes<br>• Page 2 – Executive Summary |
| 258 | Sandwell MBC – Public Health (and partners) | The document reads that falls prevention services should be commissioned and coordinated across relevant agencies and encompassing a robust pathway. This is a good way to strengthen and integrate partnership working however it will depend on the designated approach. Organisations need to understand the valuable resource in staff time and skill sets. It would be useful at all levels to engage staff to gain their support and 'buy-in' for any improvement effort and to help tailor practices in fall |

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| | | prevention. The communication and systems sharing process works best within a robust pathway framework that clearly states how the quality standards will be measured. |
| 259 | Sandwell MBC – Public Health (and partners) | Just a comment that it is important to recognise that those practitioners involved in falls prevention should have relevant and appropriate training. Agreed that this will be picked up in the QS development but it should be noted that without it there can be variable levels of advice or service given. This can be significant especially within a pathway setting that each stakeholder organisation is giving the same level of advice and information. |
| 261 | Sandwell MBC – Public Health (and partners) | Role of family and carers – recognition for the role of family and carers is important and an asset in engaging with clients particularly when it may be an opportunistic or awareness raising session. It could be appropriate to include supporting family and carers within project plans |
| 269 | Syncope Trust And Reflex anoxic Seizures (STARS) | Fainting (syncope) is an important cause of disability in older people and is not a normal part of ageing. This can be a significant reason for a person suffering a fall. However, falls in the older person are often not fully investigated to assess underlying causes, such as an arrhythmia |
| 300 | Cheshire West and Chester Council | We welcome this set of quality standards and feel they are achievable in their current form. |
| **Consultation question 1** | | |
| 19 | AGILE (special interest group for Physiotherapists working with Older People – part of the Chartered Society of Physiotherapy | Only partially.<br><br>The quality standard makes reference to the broad content of interventions that older people should receive but does not make a strong enough link to those interventions being provided in strict accordance with the evidence base. For example, a provider might have strength and balance classes in place but those may not be evidence based and therefore the care offered may be ineffective. We recommend that for key interventions relating to :-<br><br>1) Medication review<br>2) Exercise provision<br>3) Syncope assessment and management<br><br>that the guideline requires providers to provide audit evidence that their services and pathways are effective and follow internationally recognised guidance. e.g.<br><br>1) Medications reviews following STOPP / START guidelines |

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| | | 2) Exercise provision following recommendations on type, intensity and duration of exercise available such as are described in the AGE UK document : “Falls Prevention Exercise: following the evidence.” 2013. http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Falls_Prevention_Guide_2013.pdf?dtrk=true<br>3) European Society of Cardiology Guidance on the Assessment and Management of Syncope. http://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Syncope-Guidelines-on-Diagnosis-and-Management-of<br><br>Overall the quality standard does not emphasise exercise provision sufficiently given the very strong evidence base behind exercise as a single intervention and as part of a multifactorial intervention.<br><br>We refer to AGILE’s earlier submission as part of the topic engagement exercise embedded below:- [attachment deleted from table] |
| 30 | British Geriatrics Society | Yes, this draft quality standard accurately reflects the priorities for improvement |
| 70 | Central and North West London NHS Foundation Trust (CNWL) | Reflects key areas for improvement<br><br>Even though people may be asked if they have fallen or have poor balance or mobility when they have contact with a Health Care Pratitioner and are identified as having no falls risk, some of these people fall because they are suddenly medically unwell and do not have much psychological reserve to cope with the illness and their balance and coordination are temporarily adversely affected. Or an older person who is mobile but has normal ageing of their body may stumble eg due to a raised paving slab and not be able to prevent themselves falling.<br><br>It may be difficult to reduce primary falls in older people who are currently mobile and do not report balance problems, but when they trip are unable to prevent themselves falling due to a gradual reduction in strength, reaction time etc due to the ageing process. This group of people could be targeted by being advised to do 3 exercises a day to maintain balance and strength. A health promotion initiative rather like "have you had your 5 a day?" Referring to fruit and veg intake. A simple leaflet could be given to all older adults who do not report mobility and balance problems. A poster campaign could be done in libraries and Health Centres. |
| 103 | National Osteoporosis Society | The Quality Standard accurately reflects the key areas for quality improvement. |
| 117 | Newcastle University | Yes, this QS addresses key areas for improvement. However, I am not convinced that much of it will be measurable or achievable, as described below. |
| 135 | The Newcastle upon Tyne Hospitals NHS | The quality standard does accurately reflect some key areas for quality improvement in falls prevention. There is limited evidence that older people who come into contact with Healthcare Professionals (HCP’s) are routinely asked about falls or have risk |

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| | Foundation Trust | factors identified during these conversations/consultations. However it is important to recognise that older people can often present with numerous co-morbidities and the HCP's primary goal will be to assist with the reason for consultation but may not have the experience, knowledge or time to enquire about additional issues or conduct an in depth assessment<br><br>It is important that the number of older people who are assessed as being 'at risk' then referred for a multifactorial risk assessment and intervention is measured. It is also of equal importance that the type of intervention is recorded to measure with referral to evidence-based interventions. However, to measure this reliably it will rely on consistent documentation, coding of falls and recording of referrals across a wide range of health and social care providers where the current systems are often not compatible.<br><br>There already exists a non-consistent/non-standardised recording and coding of falls between organisations and the concern would be that implementing this quality standard prior to these being standardised could lead to organisations submitting poorly validated data to meet standards. |
| 156 | NHS England | Yes. However we suggest the addition of frailty identification be considered to improve case finding as set out in Statement 1. There is a clear association between falls, frailty and poor outcomes among older people. We suggest that in addition there should be a targeted and proactive approach to falls risk identification in addition to opportunistic screening through health checks and contacts with community services and hospitals. There is evidence that frailty is significantly associated with time to second fall: http://link.springer.com/article/10.1007/s00198-013-2303-z . While not of itself superior to falls history, success of the draft QS does rely on opportunistic case finding. Systematic case finding using frailty screening is now possible via the validated electronic frailty index: http://ageing.oxfordjournals.org/content/early/2016/03/03/ageing.afw039 |
| 185 | Orders of St John Care Trust | Yes I believe this draft standard accurately and comprehensively reflects the key areas for quality improvement. |
| 193 | Parkinson's UK | We believe this draft quality standard reflects the key areas for quality improvement, however we are concerned that younger people with Parkinson's may slip through the net. While the condition is more prevalent in those over 65, around a third of people with Parkinson's develop symptoms before the age of 65, and one in 100 before the age of 40. Parkinson's UK recommends that everyone with Parkinson's, regardless of age, is offered support to prevent, and deal with the impact of, falls.<br><br>Parkinson's UK therefore recommend that there is no age limit put on those who can be advised about falls and how to prevent them. |
| 197 | Primary Care Neurology Society | In answer to question 1:- does the quality standard reflect the key areas for quality improvement?<br>Only partially. The quality standard makes reference to the broad content of interventions that older people should receive but |

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| | | does not make a strong enough link to those interventions being provided in strict accordance with the evidence base. For example, a provider might have strength and balance classes in place but those may not be evidence based and therefore the care offered may be ineffective. We recommend that for key interventions relating to :-<br><br>4) Medication review<br>5) Exercise provision<br>6) Syncope assessment and management<br><br>that the guideline requires providers to provide audit evidence that their services and pathways are effective and follow internationally recognised guidance. e.g.<br><br>4) Medications reviews following STOPP / START guidelines<br>5) Exercise provision following recommendations on type, intensity and duration of exercise available such as are described in the AGE UK document : "Falls Prevention Exercise: following the evidence." 2013. http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Falls_Prevention_Guide_2013.pdf?dtrk=true<br>6) European Society of Cardiology Guidance on the Assessment and Management of Syncope. http://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Syncope-Guidelines-on-Diagnosis-and-Management-of<br><br>Overall the quality standard does not emphasise exercise provision sufficiently given the very strong evidence base behind exercise as a single intervention and as part of a multifactorial intervention. |
| 205 | Royal College of General Practitioners | The RCGP feels that the key areas for quality improvement are accurately reflected.<br>(JD) |
| 210 | Royal College of Nursing | Yes, the draft quality standard seem to accurately reflect the key areas for quality improvement. |
| 225 | Royal College of Physicians | This draft quality standard does reflect some of the key issues with regard to quality improvement in falls. The key statement is QS3 which concentrates on actually preventing falls following a MFFRA using exercise, home hazard assessments and vision interventions etc. These interventions are not in place on a wide scale at present and this QS will help to implement these further. |
| 229 | Royal College of Physicians of Edinburgh | Yes: the quality standard does accurately reflect key areas for quality improvement in falls prevention. Specifically, there is limited evidence that older people who come into contact with health professionals are routinely asked about falls, or have falls risk factors considered during a consultation. With the high prevalence of falls in all older people living in the community, it would |

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| | | be appropriate to include this aspiration in the quality standard. However, it is also important to recognise that practitioners, particularly in primary care, have restricted time available to enquire about additional issues in depth when already having to manage patients with multiple comorbidities and the presenting problem at consultation.<br><br>Having a measure and reporting how many older people are subsequently referred for a multifactorial falls assessment and evidence based intervention is an important quality standard. The greatest challenge is in ensuring that the documentation of falls, coding of falls, and recording of the referral for this assessment is consistent and accurate across a broad range of both healthcare and social care settings where currently IT functionality and inter-service data sharing is sub-optimal. Fellows have expressed concerns that difficulties in recording number of falls sustained accurately will lead to organisations attempting poorly validated means to record this information in order to demonstrate the standards are being met. Experience in other areas where data is difficult to measure for complex issues has previously resulted in unintentional adverse consequences for healthcare due to the administrative demands to meet data requirements. |
| 267 | Syncope Trust And Reflex anoxic Seizures (STARS) | STARS does believe that with the following points [ID 269 to 272] taken into consideration, this Quality Standard does accurately reflect the key areas for quality improvement. |
| 280 | Yeovil District Hospital NHS Foundation Trust | The standards do reflect key areas for improvement. However it is all very well to encourage everyone to ask about falls but it needs to be extremely clear what constitutes a person at risk of falling and exactly what then subsequently happens. This is actually clear in the NICE Clinical knowledge Summaries - Falls - risk assessment, Last revised in January 2014 but this is the first time that I have read this. After identifying someone at risk you then need a very clear pathway for where these people are seen next and where the capacity will be to see them for a multidisciplinary assessment without this being a very expensive service possibly at a level that is not required – possible some sort of triage and advice service. |
| 281 | Yeovil District Hospital NHS Foundation Trust | Existing falls services are set up for much older and frailer people than the 65+ group who are at risk but do not consider themselves old or necessarily at risk. The design and appeal of services that address mainly strength, balance and common sense practical issues, rather than a medical cause, need to be easily accessible for referrers and attendees as well as low cost in terms of delivery and payment. I suggest strength and balance exercise for many of the fracture Liaison patients that I assess (virtual assessments i.e. patient not seen) but I am sure they do not get referred. If it was easy to refer (including self-referral), and attend, I think that these sessions would be well attended with the right format and pricing for people that the existing falls services do not think need to attend their service because they are too 'good' for it. Most people just need a wakeup call to get fitter, stronger and develop better balance within the remit of other existing conditions e.g. OA of the knee which frequently stops people doing what they want to in terms of exercise. |
| 291 | Yorkshire Ambulance | For YAS, this quality standard does not address new and innovative ways of preventing falls. It omits the role of the ambulance |

| ID | Stakeholder | Comments |
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| | Service | service and does not offer anything new in terms of referral to community teams which are already well embedded. The use of frailty assessment in relation to falls patients has not been addressed in the standard. As falling can be a symptom of frailty, this is an area worthy of further exploration. |
| 292 | Public Health Wales | Making conversations about falls history a routine part of all forms of health and social care, traditional and less traditional (including FRS and C&R), is key to primary prevention and addressing falls risk (statement 1).<br><br>Realistically, the "key areas" are all organisations that are in regular contact with older people, whether in primary or secondary care or in the community. The challenge in all cases is to ensure that messages about the referral pathway are clear for everyone so that statement 2 can be achieved. |
| 306 | College of Occupational Therapists | [suggested additional statement]<br>Older people assessed as at risk of falling should be provided with opportunities for self management through information, advice and reablement.<br><br>Prevention must be considered as part of the falls agenda. |
| 314 | The Royal Society for the Prevention of Accidents | This draft quality standard only really addresses the issues around assessment and identification of fallers and those at high risk (ie those who have fallen twice in 12 months already). It does not address the need to put in wide ranging programmes around home hazard assessment, postural stability training, medicine use reviews, eyesight testing etc., some of which may be covered in other quality standards. It is useful as far as it goes but is limited in its scope and probably only really reflects what is already in place in many areas. |
| **Consultation question 2** | | |
| 31 | British Geriatrics Society | All items are measurable. However, existing structures to capture data for many of the proposed quality measures are patchy. Further comment on specific measures can be found below. |
| 71 | Central and North West London NHS Foundation Trust (CNWL) | Currently there are not local systems in place to collect data e.g. multifactorial asst is not coded on current version of SystmOne. (the electronic system used within CNWL) - Similarly there is not a code that records if people are asked about falls |
| 104 | National Osteoporosis Society | Existing local systems and structures to collect data are varied, but standardising comprehensive data collection is both possible and desirable with the support of local leadership to implement change |

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| 118 | Newcastle University | No. There are no consistent or reliable structures in place to accurately measure/record falls.<br>Data concerning falls are hugely challenging: many older people 'hide' their falls or see them as a normal part of ageing so they go under-reported. 30% of people who have fallen in the previous 3 months do not recall having fallen – this figure is higher in those with cognitive impairment. People who present to health services with a fall-related injury (such as wrist fracture) may not be coded as having a fall – rather they are coded as their injury.<br>The QS recommends using Fear of Falling as an outcome. However this is a poor outcome measure at this population level as 50% of older people who have NOT fallen suffer from Fear of Falling. |
| 136 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | Current local systems are not in place for the proposed quality measures due to the data recording issues mentioned above. Coding of falls is often inaccurate as the associated injury of the fall is often used as the coding for admission/referral therefore accurate measurement of this would require systems and coding improvements.<br><br>As previously mentioned, enquiring about falls routinely in older people is not yet embedded in all healthcare settings therefore again this would require improvements. In addition to this, it is well recognised that a high percentage of patients who have sustained a fall do not recall events after 3 months of it occurring. In patients with cognitive impairment, accuracy of reporting events can be poor as can recall of how many falls have occurred leading to both under reporting or over reporting of incidents. Specifically, patients will under report falls which result in minor or no physical harm.<br><br>It is therefore a concern that many of the outcome measures described in the quality standard will require accurate systems of recording falls in older people. |
| 157 | NHS England | Statement 1: Process measures. Local systems are not currently in place to systematically and consistently collect health data to support local data collection for older people in contact with community health and social care practitioners. For adults there is likely to be a delay in the implementation of community services data as set out currently by NHS Digital: 'The central flow of adult community data is now unlikely to take place before 2017. The intention is that the CIDS Information Standard will be retired, and the scope of the CYPHS data set expanded to include adult data (hence the need to keep the data sets in step). The new combined data set will be named the Community Services Data Set (CSDS)' http://digital.nhs.uk/comminfodataset While it may be feasible to collect such data from hand held or paper records this may not be continuous and more likely to be derived through sample based audits.<br><br>Statements 2 & 3: Process measures. As point above the absence of robust community data systems, where multifactorial risk assessments and interventions are more likely to occur as services integrate and become more community focused will render data collection for the quality measures challenging. |
| 178 | Optasia Medical | We believe that the measurements are straightforward to measure. |

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| 186 | Orders of St John Care Trust | I believe that the local systems and structures are largely in place to gather the information for the proposed quality measures. |
| 206 | Royal College of General Practitioners | We are aware there are local systems and procedures in place to collect data for the proposed quality measures.<br>(JD) |
| 211 | Royal College of Nursing | Local systems in place to collect data? If they are not in place, we do not envisage that measuring this would be difficult for most organisations in health and social care. |
| 226 | Royal College of Physicians | There are currently no wide spread systems and structures in place to collect data for this QS. National audit could be used to collect this data and RCP FFFAP could assist if commissioned to develop a these audits |
| 230 | Royal College of Physicians of Edinburgh | A significant challenge for commissioners in determining whether the quality standards have been achieved will be in relation to data. Data recording for falls is often inconsistent within and between healthcare organisations and social care organisations. Coding of falls may be incomplete as coding for fall-related injury may be the surrogate for the fall event. Enquiring about falls is not embedded in primary care or secondary care systems and it is also to be recognised that patient recall of falls is subject to a range of confounders. Research has demonstrated that up to a third of patients who have sustained a fall, do not recall the fall event three months after it has occurred. In patients with cognitive impairment data accuracy is poor due to poor recall of a fall, or over-reporting or duplication of reports of more significant falls. Older people under-report falls which are non-injurious as they do not wish to medicalise the event. Many of the outcome measures described in the quality standard will require accurate and embedded systems of recording falls in older people. These systems are not in place, are not consistently applied or embedded in primary, secondary or social care reporting. Falls which result in injury, particularly fractures, are more likely to be consistently recorded. |
| 268 | Syncope Trust And Reflex anoxic Seizures (STARS) | STARS also believes that with systems and structures in place, data could be collected for quality measures. |
| 282 | Yeovil District Hospital NHS Foundation Trust | Data on the number of falls is collected in 2ndary care but this does not include that older people are routinely asked about falls and if they are this data would be extremely difficult to collect except through small audits or if the question was mandatory on computerised digital systems.<br>The NHFD and FLS-DB databases could be used for collecting data about injurious fallers. |

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| | | Those who do multidisciplinary risk assessments would hopefully already be recording this for activity data. |
| 293 | Public Health Wales | It is not clear what data this question is referring to but the biggest challenge in relation to delivering this QS is how to record whether people are being asked about falls (statement 1) and sharing that information between agencies. It is easy to see how general practice could record this, but less easy to see what would happen in unscheduled, secondary or community care (NHS and non-NHS). Even more difficult then is sharing such information.<br><br>The multi-factorial falls risk assessment (MFRA) may, initially, be carried out in primary care with the highest risk individuals then being referred to secondary care for further assessment. Again, recording and sharing this information is likely to be difficult, as is ensuring that the MFRA is comprehensive and covers in-home environmental risks as well as personal risk.<br>Here, we are trying to investigate some of these data sharing issues, as well as looking to establish local partnerships to support the referral, assessment and information, however we do not anticipate that this will be an easy issue to resolve. |
| 315 | The Royal Society for the Prevention of Accidents | No local systems are in place as far as RoSPA is aware to routinely collect data on the fear of falling, ability of older people to maintain activities for daily living, though there may have been some studies around these aspects. There is some hospital admissions data on falls and hip fractures but there seems to be very limited reliable A&E data that gives a clear picture of falls, location, causes and other key information that could lead to future prevention both for the individual and the over 65s population in general. There does not appear to be any readily available GP data that provides reliable data on the picture with regard to the treatment of falls at GP surgeries. This is unfortunate as it maybe that GPS and practice nurses are the first health professionals to come into contact with people showing the early signs of a risk of falling (ie before they've had two falls which have landed them in hospital). |
| **Consultation question 3** | | |
| 72 | Central and North West London NHS Foundation Trust (CNWL) | Staying Steady MK (MK refers to Milton Keyne - one area CNWL covers) has a multifactorial assessment that incorporates the components of assessment as detailed in the Quality Standrd |
| 212 | Royal College of Nursing | Example from practice of implementing the quality standard: SystmOne (http://www.tpp-uk.com/) has a feature that allows falls to be identified and for interventions to be measured. |
| 294 | Public Health Wales | No. |
| 316 | The Royal Society for the Prevention of Accidents | RoSPA has just launched a major Falls Prevention Programme, Stand Up, Stay Up – Taking the rise out of falls, funded by the Department of Health which will involve working closely with ten partner local authority areas and exchange best practice with a far larger network. Although the programme is in its early stages, preliminary visits to the ten areas have shown a considerable |

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| | | amount of best practice in action. Most areas have work under way that underpin elements if not all of this draft guideline. Whilst it is too early to share any concrete examples, the aim of the programme is to share best practice as widely as possible and we will be pleased to provide examples as the programme develops. |
| **Consultation question 4** | | |
| 20 | AGILE (special interest group for Physiotherapists working with Older People – part of the Chartered Society of Physiotherapy | AGILE feels there are resource implications in terms of IT and shared records across health and social care. NICE recommend falls clinics as best practice but the resources to set up such a service and refer all people at risk of falls are immense. There are many examples of integrated services using the same falls risk assessment and referring to a specialist clinic if required.<br><br>Quality standards A, B and C on page 13 should be re-written to make it clear that local providers should be required to have clear pathways which show how patients access evidence based falls assessment and management locally recognising that initial assessments may occur within non-specialist falls services with referral on for patients with complex or challenging issues related to falls, or unexplained falls. |
| 32 | British Geriatrics Society | Most of these statements are achievable, some without additional investment. However, capacity for multifactorial assessment and intervention at scale is far from adequate in most localities (evidence from previous National Audits of Falls and Bone Health) and would require significant resource to be delivered effectively to the whole at-risk population, even if targeted only at those at highest risk |
| 74 | Central and North West London NHS Foundation Trust (CNWL) | Depending on how many people are identified as requiring a multifactorial assessment, this could provide an issue to meeting needs within a specialist falls service |
| 105 | National Osteoporosis Society | We believe that it would be challenging for each of the statements within the draft quality statement to be achievable by local services without additional resource. For example:<br>• Some areas will need to invest in additional services, such as strength and balance classes.<br>• Additional capacity will need to be built to meet statement 2, which requires a multifactorial risk assessment being carried out by someone with the skills to do it “often in the setting of a specialist falls service”. Specialist falls services often have capacity issues. |
| 119 | Newcastle University | Local services should easily be able to ask about falls, record this information and refer onwards to a falls service. However, if this were to be duplicated by every healthcare provider (as suggested) it risks significant duplication and inefficiencies. |

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| | | Savings could be made if non-evidence based services were decommissioned (e.g. community dance classes to prevent falls or exercises classes which are of too short duration to meet minimum levels of effectiveness).<br><br>There is no good evidence for the primary prevention of falls. The best opportunity would be after a first fall when people are at their highest risk of falling again. |
| 137 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | The statements in relation to enquiring about falls, assessing for risk factors and referring on for multifactorial risk assessments and interventions should be achievable by local services. However the provision of falls services varies and therefore Commissioners would need to identify local service provision and benchmark against the quality standards to identify resource issues. Evidence-based exercise provision of sufficient duration and components (i.e. targeted strength and balance training) needs to be invested in where areas identify services are limited or inadequate. |
| 158 | NHS England | Yes: Greater community service integration and focus on prevention as set out in the GP Forward View https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf and Five Year Forward view https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/5yfv-exec-sum support harm reduction through proactive case identification in community settings. Introduction of systematic frailty identification will also aid this process and support the quality improvements set out in this QS. |
| 198 | Primary Care Neurology Society | P-CNS supports AGILE's view that there are resource implications in terms of IT and shared records across health and social care. NICE recommend falls clinics as best practice but the resources to set up such a service and refer all people at risk of falls are immense. There are many examples of integrated services using the same falls risk assessment and referring to a specialist clinic if required.<br><br>Quality standards A, B and C on page 13 should be re-written to make it clear that local providers should be required to have clear pathways which show how patients access evidence based falls assessment and management locally recognising that initial assessments may occur within non-specialist falls services with referral on for patients with complex or challenging issues related to falls, or unexplained falls. |
| 207 | Royal College of General Practitioners | At the present time both primary and secondary care are struggling to cover the range of current clinical demand. Adding in a further layer of screening questions for primary care and further referrals to organise is likely to be unrealistic.<br>It is important to consider a system in which referral to the falls clinic can be direct from other health and social care professionals and not only via a GP referral. However, it is unlikely that secondary care has enough capacity for a higher level of referrals.<br>(JD) |

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| 213 | Royal College of Nursing | Draft statement achievable by local services given net resources? Yes. We do not really understand why we do not already do this across all organisations although we are aware of some good work nationally. |
| 227 | Royal College of Physicians | QS 1- this should be achievable and measurable by local services. It requires a fair degree of co-ordination of different services but this would improve the patient pathway.<br>Note- Effort should be made to understand that a patient should be asked about previous falls only once in an episode of care and therefore, not everyone attending the patient during this episode should ask about previous falls. In my experience, patients do not like asking the same questions endlessly by different members of staff in quick succession. |
| 231 | Royal College of Physicians of Edinburgh | The statements of the draft quality standard in relation to enquiring about falls, assessing for fall risk factors, and referring for a multifactorial falls risk assessment and subsequent interventions should all be achievable by local services. There is evidence of significant variability in falls service provision as identified through the Royal College of Physicians of London national audit of falls and bone health. Commissioners would need to benchmark local service provision against the quality standards to determine if there is a resource shortfall locally. Opportunities for disinvestment should focus on de-commissioning and disinvestment in services for which there is no supporting evidence base eg exercise programmes which are group based, not individualised, are of insufficient duration to be effective, and do not incorporate the range of strength and balance exercise detailed in successful falls prevention intervention studies. |
| 265 | South Tyneside NHS Foundation Trust | We are fortunate to have MDT led falls services in both localities this Trust serves. The drawback is that the demand far exceeds capacity. Our waiting list was over 6 months for an assessment at one point. With funding and efficiencies becoming tighter each fiscal year, It is doubtful this standard would be achievable or sustainable. This standard also places an inequitable burden on areas of deprivation that also have a higher percentage of older adults. |
| 283 | Yeovil District Hospital NHS Foundation Trust | Resources will be required for training, development of pathways, strength and balance classes and the staffing to help provide appropriate assessment services. A cultural change by both staff and older people is required to see how falls prevention work is beneficial to them - that would require TV campaigns and other media pushes to raise awareness. Everyone needs to see the benefits of falls prevention (better balance and keeping strength, etc) and how to do this in simple effective messages. |
| 295 | Public Health Wales | There are many local services that are already delivering on statement 1 or in a position to deliver on statement 1 with a little guidance and support.<br>Without statement 1 being delivered on, statements 2 and 3 become largely irrelevant since these are already in place, but usually only for those people who have suffered serious falls with significant injuries.<br>The challenge is “joining up” all of the local services that can deliver on statement 1. Realistically, therefore, the resources needed would be a local co-ordinator who can help the different agencies to work more effectively together and support information sharing. |

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| 317 | The Royal Society for the Prevention of Accidents | Developing the protocols is the easy bit and in fact many areas are already reasonably advanced with this. Local resources mean that NHS providers are likely only to be able to provide services for those who are at the very highest end of the risk scale or have already a significant history of falling. The only way of making a serious contribution to the overall problem of falls will be to widen partnerships and to mobilise as many non NHS organisations from the public, private and third sector to contribute to falls prevention wherever they can. Multifactorial Falls Assessments are a key aspect for dealing with those most at risk but must only be a starting point, with additional levels of assessment and referral provided for those at lower, but still significant, risk in order to increase opportunities for early prevention. |
| **Consultation question 5** | | |
| 21 | AGILE (special interest group for Physiotherapists working with Older People – part of the Chartered Society of Physiotherapy | AGILE feels that the quality standard should be combined with the falls standards already published to provide one place where all falls standards are available to support commissioners and providers in assessing and improving service delivery. Have multiple separate standards on falls will not be as effective. |
| 33 | British Geriatrics Society | It would be entirely appropriate to combine these quality standards as there is significant overlap. |
| 62 | Care & Repair England | In our view it would be appropriate to bring this standard together with the standard on falls in older people to set up a comprehensive approach to falls which has prevention at its heart. |
| 66 | Carers UK | The standards can only be combined if the existing guidance on falls in older people is modified to address issues around carers begin involved in the discharge process and the importance of putting in place ongoing support for carers to enable them to provide care safely in the home. |
| 102 | Lancashire Care NHS Foundation Trust] | It would be beneficial to combine Falls Prevention with CGL 161 for cohesion and to prevent missed opportunities. |
| 106 | National Osteoporosis Society | We would support combining this document with the existing quality standard on falls in older people. |
| 120 | Newcastle University | Yes it would be better combined with the existing QS as this document appears very aspirational and at times a bit vague. |

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| 138 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | It would be sensible to combine this quality standard with the existing quality standard on falls in older people (QS86) as there is significant overlap between the two areas. The measures outlined in this quality standard may impact on the quality standard measures in QS86 and it is important to recognise that if risk factors for falls are identified prior to a fall then falls in the secondary care setting may be, in some instances, avoided. Additionally falls services do not differentiate in terms of assessment and intervention whether the patient has risk factors for falls or has in fact already fallen therefore a combined quality standard would seem appropriate. |
| 159 | NHS England | Given the greater focus on integration of health and social care services for older people, the increasing need for reduction in harm through prevention we support the combining of these two quality standards into a single standard, which can operate across the health and social care system to deliver both primary and secondary prevention. The need for multifactorial falls risk assessment and intervention is just as important in those who are at risk of falling as those who have sustained a first fall. This is particularly important for older people with frailty as set out above who may have a short window of opportunity for risk modification after a first fall. |
| 187 | Orders of St John Care Trust | I think that the two quality standards would complement each other – this draft standard concentrates on identifying older people at risk of falls and them having the opportunity to have access to a multifactorial risk assessment with the aim of providing targeted assistance to reduce the risk of falling. |
| 194 | Parkinson's UK | Parkinson's UK believe that combining this quality standard 'Falls in older people: prevention' with the existing quality standard on 'falls in older' covering assessment after a fall and preventing further falls (secondary prevention) would work well. However Parkinson's UK recommend the quality standards should widen their scope to cover younger people at risk of falls as well. |
| 199 | Primary Care Neurology Society | P-CNS supports AGILE's recommendation that the quality standard should be combined with the falls standards already published to provide one place where all falls standards are available to support commissioners and providers in assessing and improving service delivery. Have multiple separate standards on falls will not be as effective |
| 214 | Royal College of Nursing | Combining this quality standard with the existing quality standard on falls in older people which covers assessment after a fall and preventing further falls: It would make sense to link this quality standard with previous falls guidance/standard. |
| 228 | Royal College of Physicians | Combining this QS with the previous QS on falls would be very useful for clinicians. |
| 232 | Royal College of Physicians of Edinburgh | There is logic in combining this quality standard with existing quality standard on falls in older people relating to secondary prevention, as there is significant overlap between the two areas. Fall prevention services do not distinguish between older people who have fall risk factors and are referred for falls prevention, and those older people who have already sustained a fall. The range of fall risk factors which may be identified, and subsequent range of individual interventions may vary between the primary and secondary prevention groups. However, the service provision will still require skilled and experienced health care |

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| | | professionals, particularly medical practitioners trained in medication review and modification, physiotherapists skilled in gait and balance assessment, and occupational therapists to deliver an effective intervention. Randomised control trials have shown that a multifactorial intervention delivered by a single individual are less effective than those where specifically skilled practitioners from different disciplines provide the multifactorial input. |
| 253 | Royal College of Psychiatrists | There's no clear reason this standard cannot be combined with the Falls in Older people quality standard. |
| 279 | The Whiteley Homes Trust | This draft standard would combine well in enhancing the current quality standard for falls in older people. |
| 284 | Yeovil District Hospital NHS Foundation Trust | Combining the standards may work as there is a lot of focus on 2ndary prevention so it may help with joining up the work and get providers to focus on both – more integrated approaches perhaps?<br>Hospitals are very focused on inpatient fallers and how to stop them falling and more holistic services have been developed for high risk fallers. It is largely only the high risk faller that gets attention – perhaps we could stop some people from becoming high risk fallers by focusing on lower and medium risk. |
| 296 | Public Health Wales | We feel that it is very important that this quality standard remains separate from the existing standard to emphasise the value and importance of primary prevention. To date, falls prevention has focused mainly on secondary prevention and if the standards were to be combined here, the risk is that, again, the secondary prevention aspects would be focused on. One of the reasons for this is that, relative to primary prevention, secondary prevention is relatively straightforward. |
| 318 | The Royal Society for the Prevention of Accidents | Combining the falls quality standards to give an overarching approach and avoid any confusion between the two seems a sensible approach and will hopefully help to maximise implementation. |
| **Statement 1** | | |
| 2 | Action on Hearing Loss | Although previous fall history is the most important risk factor and predictor for falls, for those who have not yet fallen but are at risk because of other factors, such as sight loss or hearing loss, there could still be preventative measures taken that would be helpful. We therefore think there should be a sentence added to the end of this section explaining that 'For those who have not yet fallen, health and social care practitioners should signpost to services that can help mobility, balance, sight loss, hearing loss or provide adaptations in the home if they would be helpful.' |
| 3 | Action on Hearing | There are a signification number of health and social care professionals listed as responsible for checking up on older patients' |

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| | Loss | fall history. As many people will be accessing various parts of the health and social care system at once, there is a chance they could be over-asked and it could therefore be helpful to include here that: 'Discussions about fall history should be included on patient records, so health and social care practitioners know when it is timely to ask patients about falls.' |
| 14 | Age UK | We believe the language around 'asking older people about falls' in the first quality statement should be amended, including the wording of the quality statement itself. Research carried out by Age UK has found that older people tend to dislike mention of 'falls' and find that the language doesn't resonate with them (Age UK, Don't Mention the F-word, 2012). This may relate to the lack of consensus between the public and healthcare professionals around what constitutes a fall (as highlighted above). But this may also be down to negative perceptions and stigma attached to the word 'falls'. Some older people, including many of the over-75s in our studies, consider the subject of falls only relevant to people that are older and in poorer health than themselves. Some people who have fallen do not accept that it may happen again because they attribute their falls to momentary inattention or illness. Communicating falls prevention messages in a way that resonates with older people and ensures they engage with risk-reduction strategies remains an important challenge. Recent research commissioned by Age UK and the British Geriatrics Society (BGS) highlighted similar issues when it comes to using the medical term 'frailty', which can provoke strongly negative reactions from older people because of its perceived association with loss of independence and end of life (Age UK and BGS, Frailty: Language and Perceptions, 2014). It found that older people prefer to describe their needs in more 'everyday' terms, e.g. as starting to struggle with things, or being worried about their health. As such, we would recommend using terminology that chimes more with older people's perspectives, for example rather than asking about falls, we would recommend asking how people feel they are coping at home and if they feel they are finding moving around more difficult. Likewise, focusing conversations on retaining balance and strength and the benefits of exercise in positive terms rather than dwelling on the risk of falling is likely to generate better engagement with the topic. We therefore suggest changing the quality statement to "Older people are asked about their strength and balance and ability to carry out everyday tasks when they have routine reviews or health checks […]" |
| 18 | AGILE (special interest group for Physiotherapists working with Older People – part of the Chartered Society of Physiotherapy | The falls standard should reflect the links between the frailty and falls agendas and no reference is made.<br><br>Older people should be screened for falls and frailty in a joined-up manner using evidence based screening tools and the standard should make this clear to prevent unnecessary duplication and waste of healthcare resource.<br><br>Multifactorial falls risk assessments overlap with recommended content for comprehensive geriatric management of the frail older patient. Providers should ensure that their assessment processes ensure that domains relating to falls and frailty are incorporated in their assessments in a linked manner. |
| 23 | Association of ambulance chief executives | We are not sure whether the statements are applicable to ambulance services. 999 calls to people who fall are one of the most common reasons for people calling 999 and the majority of these are for people over age 65. There is mention within the document of providers, of GPs and specific mention of many other professionals but no mention of ambulance staff or paramedics. The statement specifically refers to primary care and social care practitioners -ambulance staff and paramedics are |

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| | | not either of these. It also mentions in the statement community healthcare staff-technically paramedics are not community health care practitioners but could be seen as such. |
| 37 | British Geriatrics Society | We recommend that specific mention is made of the ambulance service as another source of falls risk case-finding |
| 38 | British Geriatrics Society | Where there is good information sharing and recording, it should not be necessary for an older person to be asked about falls if this has been recorded as having been asked at a recent contact. However, the process measure proposed would penalise services/practices where such a system was in place. A better measure would be: Numerator- older patients with a documented answer to “have you fallen in the last year”. Denominator- older people with a health/social care contact in the last year. |
| 39 | British Geriatrics Society | We think you have got inclusion and exclusion the wrong way round. |
| 40 | British Geriatrics Society | We suggest rate per 1000 population or per 1000 older population would be more meaningful than the number. |
| 53 | Cardiff and Vale University Health Board | This statement focuses again on asking about previous falls. In my opinion this is missing the point of a quality standard that is about primary prevention. Someone already fallen is at high risk of another, but that is what the quality standard 86 is about. This statement should focus on asking some key questions at opportune times, for example about level of fear of falling, whether the person feels dizzy when they get up, etc. There should also be a focus on observing strength and balance at this point, and perhaps offering a test such as ‘Timed Up and Go’ to assess stability |
| 54 | Cardiff and Vale University Health Board | Balance impairment and weaking muscles are key prevalent risk factors and need to be addressed early enough to prevent a fall. If strength and balance training is undertaken it is an effective falls prevention intervention and should be promoted for older people at increasing risk |
| 55 | Cardiff and Vale University Health Board | Data would be able to be collected from primary care on whether older people are being asked about falls (though as above there should be a broader assessment). |
| 56 | Cardiff and Vale University Health Board | This data could be collected from unscheduled care and hospital admissions |

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| 57 | Cardiff and Vale University Health Board | This could be more difficult to collect, processes for data collection and recording would need to be put in place for all health and social care practitioners |
| 59 | Care & Repair England | We welcome the proposal that older people are asked about falls on routine reviews with health and care practitioners though would like to see this extended to include housing, alongside healthcare and social care, practitioners. There will be many occasions where housing professionals come into contact with older people at risk of falling –for example housing advisers from home improvement agencies and local authorities plus scheme managers and staff in supported housing.<br><br>It would be helpful for this Quality Standard to expect a falls risk to be considered on these routine housing contacts/reviews to extend the opportunities available to prevent falls.<br><br>The use of a simple proforma for housing professionals might help to support all staff that come into contact with older people to determine if a person requires a multifactorial risk assessment due to their risk /history of falling. |
| 68 | Carers UK | The suitability of the home should be looked at in both needs' and carer's assessments and is part of the eligibility criteria for those with care needs and carers. Carers should be asked about the suitability of housing for continuing their caring role in their carer's assessments, especially when caring for an older person. This would be an opportune moment to ask about risk of falls as well as whether the person they care for is able to get around outside in cases where they are caring for an older person as it may be that the home hazards are the reason for the falls. This could be included in the guidance as another way of ensuring that those people at risk of falling are identified.<br><br>Carers UK's research (of over 5,000 carers) shows that the suitability of housing for caring roles is not always given sufficient consideration in carer's assessments. 59% of carers found that their carer's assessments did not properly consider or gave only insufficient consideration to the suitability of their housing for their caring role. |
| 80 | IHip Impact Protection Ltd | Many people are unwilling to admit to falling because they are frightened that such and admission will make it more likely that they are sent to a care home. Many others have dementia and are not aware subsequently that they fell. Others have syncope and just found themselves on the floor/ground without realising they had fallen. |
| 110 | National Osteoporosis Society | Process measure (c) asks for the proportion of older people in contact with community health and social care practitioners who were asked about falls in the last 3 months. We believe that this should be falls in the last 12 months. |
| 122 | Newcastle University | In the rationale section it states that a single fall is the greatest risk factor for a further fall. I agree with this. Later in the document |

| ID | Stakeholder | Comments |
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| | | it states that people with 2 or more falls should be referred to falls services. |
| 123 | Newcastle University | A falls history should only be taken by someone qualified to do so. Social workers and many healthcare workers should not be expected to do this. In my years of experience in a falls clinic, older people will attempt to rationalise their fall and attribute it to a non-existing external factor. Unqualified health/social care staff may then miss an opportunity for onward referral. |
| 124 | Newcastle University | Where has the 3 months value come from? Is it a mis-interpretation of the evidence? |
| 125 | Newcastle University | 1. As an outcome measure 'number of falls' does not address the quality standard. It should simply be outcome A.<br>2. Number of falls will not be a reliable outcome measure |
| 126 | Newcastle University | I am concerned that asking the question about falls will become a chore, a tick-box exercise and people will come to resent falls rather than seeing them as a genuine issue. This has happened with VTE and dementia/delirium screening. |
| 127 | Newcastle University | As stated above, only qualified professionals should take a falls history. |
| 128 | Newcastle University | At the bottom of page 11 is states people will be asked regularly about falls. I think the guidance will lead to people being asked about falls too often and people are going to get frustrated by the question. |
| 142 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | The denominator does not make sense<br>'the number of routine reviews or health checks of older people in a (?) by a primary care service.' |
| 143 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | Needs further explanation of what us meant by asked about falls on admission to hospital i.e. does this include out-patient clinics (e.g. fracture clinics), A&E attendance with discharge home, A&E attendance with admission to hospital?<br>The denominator definition is also requires further clarification as it is ambiguous – it states to exclude inpatient admissions therefore is an A&E admission solely an A&E attendance which results in admission , or does it mean only include patients who attend A&E and are discharged home?<br><br>It would be easier to ensure that a question is asked about falls with every encounter i.e. when attending routine outpatient appointments, attending for day case intervention, on arrival to A&E (regardless of admission or discharge from there) and also for all older people admitted to in-patient services through other mechanisms e.g. GP referrals. |
| 144 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | A concern is that to measure the proportion of older people in contact with community health and social care practitioners who were asked about falls in the last 3 months is an impracticable measure to obtain accurate data. The spectrum of practitioners this includes is huge and although some would have capacity to ask the question about falls within the last 3 months, they may not have the training or knowledge to appropriately enquire further if the answer was 'yes' to be able to make a clinically reasoned decision whether the patient requires onward referral. |

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| | | Additionally, as explained in comment number 2 above, there is a concern about accuracy of data given the inaccuracies by older people when recalling falls events within the last 3 months. |
| 145 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | Identifies the number of multifactorial risk assessments performed as the outcome yet statement 1 is Identifying people at risk of falls. Should this not therefore be included in statement 2?<br><br>Additionally, further clarification would be required at this point to specify what would constiutue a multifactorial risk assessment i.e. what is the minimum standard? |
| 146 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | Identifies the number of falls in older people as an outcome measure but how will this data be collected accurately when there is not a centralised reporting system for falls in older people? |
| 164 | NHS England | We recommend that you consider expanding statement 1 to allow voluntary and other public sector providers (for example the Fire and Rescue Service) to ask about falls so that it's not just limited to community health and social care practitioners.<br><br>Many Fire and Rescue Services (FRS) include falls as part of a safe and well visit. There are also a number of case studies where FRS are working collaboratively with health and care and the voluntary sector to focus on falls prevention. We will be asking the most established/evaluated to complete a NICE case study submission. |
| 166 | NHS Improvement | Page 9 – how would providers be monitored against the local data collection. How frequently should the local data collection be undertaken? |
| 167 | NHS Improvement | Page 10 the definition of patients admitted to hospital is not what providers would use this is how they'd describe attendance at hospital. Day case units would be an admission not attendance. |
| 168 | NHS Improvement | Page 11 is this all outpatient clinics? Patients are not admitted to wards as day cases they are admitted to day care units |
| 169 | NHS Improvement | Page 12 – nursing homes and residential homes are different and should not be used interchangeably. All references to care setting should be explicit as to whether they are nursing or residential homes |
| 177 | North Bristol NHS Trust | Could we be clear about terminology? Do you mean by "Older People Admitted to Hospital" that you wish to include all those who present to Outpatients service (eg do not then subsequently get admitted) but are coming for a new or routine appointment and Older People who present to ED (but are not subsequently admitted)?<br>I think this needs clarifying. If all outpatient attendance then I would be concerned about the title being misleading b) Proportion of older people asked about falls on admission to hospital.<br>Also, are we clear about what we want healthcare professionals in hospital to do once they have asked about falls in |

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| | | outpatients? Thanks |
| 179 | Optasia Medical | There is some confusion in scope – whilst this is stated as for those at risk of a first fall, the "What the quality statement means…" section concentrates on whether they've fallen and if so, how many times. By definition, this would come under the Falls in Older People Quality Standard, not this one. We would have expected questions about their risk of falling e.g. are you scared of falling, do you feel frail etc. The same is true of the equivalent section for Statement 2. |
| 183 | Orders of St John Care Trust | In accident and emergency departments, which are often extremely busy, I would see this perhaps not being given the priority it should, mainly due to time constraints and the level of priority. If older people are to be admitted into a hospital bed, this would probably present a better opportunity to gather information. Admissions into accident and emergency departments need to be dealt with quickly. All other opportunities mentioned in this section seem more relevant and realistic, in my opinion. |
| 188 | Parkinson's UK | People with Parkinson's are at high risk of falls due to some of the symptoms associated including freezing, loss of balance, general muscle weakness, problems with gait or shuffling, low blood pressure, and eye problems. Also some Parkinson's medications can also be a cause of falls.<br><br>We agree that older people should be asked regularly about whether they have fallen, or been at risk of falling, when they come into contact with health and social care professionals. |
| 189 | Parkinson's UK | While the condition is more prevalent in those over 65, around a third of people with Parkinson's develop symptoms before the age of 65, and one in 100 before the age of 40. Parkinson's UK recommends that everyone with Parkinson's, regardless of age, is offered a multifactorial risk assessment to help reduce the risk of falling. Workaround falls prevention should be symptom specific not age related.<br><br>Parkinson's UK recommends that this guideline should specifically include information signposting people who fall and their families towards patient organisations and charities as a good source of reliable information, as well as often having support groups and activities. |
| 195 | Primary Care Neurology Society | The falls standard should reflect the links between the frailty and falls agendas and no reference is made.<br><br>Older people should be screened for falls and frailty in a joined-up manner using evidence based screening tools and the standard should make this clear to prevent unnecessary duplication and waste of healthcare resource.<br><br>Multifactorial falls risk assessments overlap with recommended content for comprehensive geriatric management of the frail older patient. Providers should ensure that their assessment processes ensure that domains relating to falls and frailty are incorporated in their assessments in a linked manner. |
| 204 | Royal College of General Practitioners | The RCGP feels that asking about falls in all patients over the age of 65, in all reviews, presents a number of problems:<br>• It amounts to a screening programme that has not been properly evaluated |

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| | | • It has (small) opportunity costs in that doctors have to ask a question that takes them away from the problems that the patients are consulting about<br>• By the same token, it presents GPs with an agenda for themselves that could take precedence over the patients' agenda, specifically working against patient-centred approaches.<br>It would make much better sense to leave it to health care professionals to decide when it is and is not appropriate to ask such questions.<br><br>Falls in older people is essentially a primary care problem. However this statement has been written with the implication that it is one for specialists to deal with. For instance under structure it states 'older people at risk of falling are referred to healthcare professionals with skills and experience in carrying out multifactorial falls risk assessment. Why is it assumed that what is a simple, holistic, home-based assessment cannot be carried out by GPs? and if it is accepted that this is something that should be within the capacity of ordinarily skilled GPs, should it not be stated explicitly within the document?<br><br>This comment is underlined by the helpful list of factors on page 16 under 'Multifactorial falls risk assessment', all of which factors are familiar aspects of good generalist primary care. The RCGP agrees with the wording 'An assessment may include' as this could helpfully be made more explicit by stating that it should not be used as a checklist. |
| 218 | Royal College of Physicians | Quality statement and rationale<br>• Effort should be made to understand that a patient should be asked about previous falls only once in an episode of care and therefore, not everyone attending the patient during this episode should ask about previous falls. In our experience, patients do not like asking the same questions endlessly by different members of staff in quick succession.<br>• Throughout QS1 there is talk of 'those admitted to hospital' but then excludes inpatients. It would be better to phrase differently eg: those attending hospital but not admitted (including A and E).<br>• It would be better to state a timeframe for asking about previous falls eg: falls in last year/last 6 months/since you were last seen etc. |
| 219 | Royal College of Physicians | Quality Measures (Process)<br>Quality measure, process, c) asks about falls in the last 3 months but there are no timeframes elsewhere. It then goes on to say the denominator is the number of older people in contact with community health and social care practitioners in the last 3 months. This is confusing and not consistent with the rest of QS1.<br><br>Quality Measures (Outcome)<br>Or experts believe that the outcome measures for QS1 (the number of MFFRA and the number of falls) are too far removed from QS. A suggested outcome measure would be an increase in MFFRAs in those being seen by health and social care in all settings. This would also be more easily measurable. |

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| 236 | Royal College of Physicians of Edinburgh | The denominator description is incomplete as written – 'number of routine reviews or health checks of older people in a ….. by a primary care service'. |
| 237 | Royal College of Physicians of Edinburgh | More specificity is required about falls on admission to hospital. Is this any hospital encounter eg outpatient clinic, A&E attendance with discharge home, A&E attendance with admission to hospital?<br><br>The denominator definition is also ambiguous/incomplete. If the denominator states to exclude inpatient admissions, is an A&E admission solely an A&E attendance which leads to a hospital admission, or to only include patients who attend A&E and are discharged home after this encounter?<br><br>It would be easier from a hospitals' systems perspective to ensure that a question about falls is asked with every encounter – eg when attending for a day case, routine outpatient appointment, on arrival at triage in A&E (so would capture all patients who are either seen and discharged, or seen and admitted), and also any older people who are admitted to hospital through other mechanisms eg GP referrals to a medical or surgical admissions unit. |
| 238 | Royal College of Physicians of Edinburgh | Though laudable, concerns have been raised that a measure which seeks to assess the proportion of older people in contact with community health and social care practitioners who were asked about falls in the last 3 months is an unrealistic and impractical measure to obtain data on accurately. The definition for this group of practitioners is very broad and crosses a range of organisations that interact with older people. Many of these organisations may be able to develop capacity to ask a simple question such as 'have you fallen in the last 3 months', but would not have the training or capacity to appropriately expand on the question if it is in the affirmative to ensure that an older person is appropriately referred for an action if indicated.<br><br>Additionally, there are concerns about data accuracy given recognized inaccuracies by older people when recalling falls which have occurred in the last 3 months – recall, over and under-reporting of events. |
| 239 | Royal College of Physicians of Edinburgh | Greater clarity would be helpful on what would be expected to constitute a multifactorial falls risk assessment at this stage in the process. Should this outcome be included in the Quality Statement (QS) 2 markers rather than QS 1?<br><br>In order to demonstrate that this outcome is being obtained, it is feasible that participating organisations will generate a lower quality 'rapid' falls risk assessment tool which lacks robustness, in order to apparently meet the QS target. |
| 240 | Royal College of Physicians of Edinburgh | Doubts have been raised as to how it will be practical to collect data locally on the number of falls in older people as there tends not to be a consistent or accurate method to collect this data. |

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| | | The closest approximation for any organization would be to define its population size of people over the age of 65, and then apply the established epidemiological criteria of 30% of this population sustaining a fall per year. If the Guidelines group has identified a method by which organisations can collect data on the number of falls in older people, this should be included in the quality statement so all reporting bodies are consistent in their methods. |
| 255 | Royal Pharmaceutical Society | Pharmacists have regular contact with patients across a wide range of settings, community pharmacy, within GP practices and within care homes. They can routinely be involved in asking questions about patient's falls history to identify older people who may be at risk of falling, and if so refer them to or advise them to see a healthcare professional or service to further assess their risk. |
| 262 | Society of Teachers of the Alexander Technique (STAT) | We suggest that some consideration is given to additional means by which information relevant to falls prevention can be gathered. In addition to the channels described in Statement 1, other (non-NHS) healthcare professionals routinely gather information relevant to falls prevention. For example, and from our perspective, Alexander Technique teachers may provide a further potential resource for asking older people about falls. The median age of individuals who seek Alexander Technique lessons is 48 (IQ3 – 60)1. Alexander Technique teachers routinely work with people as they age, with the aim of improving functioning and wellbeing. Teachers of the Alexander Technique are specifically trained to identify difficulties with balance, gait and posture and are frequently approached by people with such issues.<br><br>Reference<br>1. Eldred J, Hopton A, Donnison E., Woodman J. & MacPherson H. (2015). Teachers of the Alexander Technique in the UK and the people who take their lessons: A national cross-sectional survery. Complementary Therapies in Medicine 23, 451-461. |
| 264 | South Tyneside NHS Foundation Trust | After discussing with GPs in our service area, their concern is that this will simply become another "ticky box exercise". They have expressed concerns with sufficient time in a consultation to act effectively should a previous fall be discovered and this will also negatively impact upon their allotted time to address the original complaint the patient presents with. Asking about fall history is already part of the risk assessment for inpatients and A&E attenders in this Trust. |
| 270 | Syncope Trust And Reflex anoxic Seizures (STARS) | Syncope is a symptom not a condition and there can be different underlying causes for a fall caused by fainting. Some complex and others easily treated. |
| 275 | The Care Forum | Commissioned services provided by the Voluntary and Community Sector (e.g. social prescribing and re-enablement) involved in falls prevention and post-falls care should be approached regarding Quality Statement 1, and asking older people about falls. Care pathways should exist for referral to relevant practitioners in this sector. |

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| 276 | The Whiteley Homes Trust | This statement may be difficult to measure because finite resources may dictate that all data may not be captured consistently in some settings. However, it is absolutely fundamental in capturing information to tailor intervention for older people. |
| 286 | Yeovil District Hospital NHS Foundation Trust | The guidance seemed very specific about using Timed up and Go and Turn 180 as screening tools, who would be expected to complete these? – If we are looking at preventing a first fall would it be expected that this was completed for those admitted to hospital. |
| 289 | Yorkshire Ambulance Service | Falls in patients over 65 yrs old make up approximately 8% of all call volume. This population is also the highest call volume for YAS. We also have frequent interaction with patients who are at risk of falling but have not called for that reason. With this in mind, I feel the standard needs to specifically reflect the role that Ambulance Service has in the prevention of falls. We are currently not mentioned although the majority of other service providers are. |
| 303 | College of Occupational Therapists | [suggested statement wording]<br>Statement 1. Older people are asked at the earliest opportunity about falls when they have routine reviews or health checks with primary care services, if they are admitted to hospital, and in regular conversations with their community healthcare and social care practitioners.<br><br>The College suggests that emphasis of this standard should not be on healthcare services and primary care review it should be everybody's business to ask about falls. Suggest rephrasing as per framework for action: http://www.gov.scot/Resource/0045/00459959.pdf<br><br>Further info available at http://www.knowledge.scot.nhs.uk/fallsandbonehealth.aspx<br><br>Lanarkshire have developed a community pathway model from level 1 to level 3 specialist falls assessment. For further info contact liannemcinally@nhs.net |
| 307 | The Royal Society for the Prevention of Accidents | This is fine as far as it goes but it will not address the question of whether people are experiencing symptoms that may lead to them having a first fall. Many people will not regard trips and stumbles as a fall or indicative of a wider problem. Questions may need to be a bit more probing than simply asking have you had a fall. The scope of this statement needs to be considered to enable it to influence early prevention more clearly. Questions about balance, stability, unsteadiness, eyesight, dizziness, etc. will also be important. |
| 308 | The Royal Society for the Prevention of Accidents | Agree that protocols should be in place but the key aspect is the measurement of how the implementation of these protocols are implemented. The data sources mentioned are usually incomplete and unreliable and it will be difficult to assess how well the protocols are implemented. The number of people asked will provide some output data but this will give no evidence of follow up action taken or whether following this protocol has contributed to a reduction in falls. |
| 309 | The Royal Society for | The quality statement gives a clear steer to what service providers need to be doing in relation to those who have had falls but |

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| | the Prevention of Accidents | provide little in the way of guidance for action with those who might be at risk of a fall. There does not appear to be any mention of third sector providers and volunteers who are often involved most directly in providing services for older people and have an opportunity to contribute to identifying those most at risk of falling. |
| 320 | AESOP | Quality Measures rely on local collection. Our experience has shown us that older people's services including falls prevention services are delivered through a wide range of providers, therefore provision needs to be made locally for co-ordinating data collection from numerous sources. |
| 321 | AESOP | There needs to be greater detail about the quality measures and the information collected. The information collected needs to be standardised across all collection points. In this Statement, the types of information recommended to be collected and the types of questions recommended to be asked vary for each group/audience point. |
| **Statement 1: Consultation question 6** | | |
| 34 | British Geriatrics Society | All items are measurable in the settings described, though routine data collection is not the norm in all settings and localities. We suggest that ambulance services are specifically included, as another important opportunity for case-finding. |
| 75 | Central and North West London NHS Foundation Trust (CNWL) | Different systems in use by health and social care may end up with duplication of numbers of people reporting a fall.<br>Extra note. It's hard to get accurate falls data. We have found in Camden that some falls are counted more than once-in hospital data, London Ambulance data and community NHS data. Some are not reported to anyone as the person does not want to have intervention that may affect their lifestyle. |
| 107 | National Osteoporosis Society | We believe that statement 1 is measurable in both health and social care. Consideration should be given to how this statement is measured by ambulance services. Ambulances are often called upon to visit fallers who may not be transferred into hospital. Where this is the case, information about the fall should still be recorded. |
| 121 | Newcastle University | No. Older people come into contact with a great many health and social care professionals. It seems 'overkill' for each of these professionals to be asking about falls on every consultation, every three months. For some older people this would mean being asked about falls several times every months for every year of their life after 65.<br>If an older person has had a fall and is asked by their GP, practice nurse, optitian, dentist, social worker and physiotherapist and diabetes nurse – who is going to coordinate the onward referral when the person answers yes? If it is the GP – they will receive the request for onward referral six times for the same fall.<br>Each health/social care professional will have to amend their clinical proforma/record to catch this information about falls, someone will have to handle and then coordinate the data – who? |
| 139 | The Newcastle upon Tyne Hospitals NHS | The fact that the quality standard applies to HCP's in a very broad range of services, and with very different specialities, knowledge and skill will make this extremely difficult to implement successfully. Specifically, it would be a high expectation that |

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| | Foundation Trust | certain professions e.g. care home workers, social workers, home care workers and sheltered housing staff would be competent/confident in assessing risk and referring to appropriate falls services unless they receive adequate training.<br><br>Additionally, there would be a requirement that data recording systems be improved to allow sharing of information if an older person is assessed and has been referred so to prevent unnecessary duplication of assessment and referral.<br><br>A concern about including professions from social care in this quality standard would be that they may develop reporting tools that meet the data request but not necessarily to drive improvement in patient care due to demands on services and resources. It is recommended that the quality standard be specific to identification of risk of falls in older people and referral for multifactorial risk assessment and intervention on contact with healthcare professionals in primary care and/or on presentation to secondary care organisations with a fall or fall related issue. |
| 160 | NHS England | See comments above (comments 1, 2 & 3)[ID 157]. The process measures are measurable in hospital where there are clearly defined processes for systematic falls risk identification. This is likely to be combined increasingly with systematic identification of frailty and cognitive disorder as these risk factors are often coincident. In community health and social care settings this measurement of this statement through process data collection is likely to be challenging due to lack of consistent, systematic and interoperable recording processes at the present time. |
| 201 | Ramsay Health Care | Yes I do feel statement 1 is measureable in each setting, it should be easy to put these measures in place. Would need standardising and a data base. Data collection /input would need addition admin support. This would support quality improvement |
| 208 | Royal College of General Practitioners | We think the statement is measurable in each setting to support quality improvement.<br>(JD) |
| 211 | Royal College of Nursing | Local systems in place to collect data? If they are not in place, we do not envisage that measuring this would be difficult for most organisations in health and social care. |
| 217 | Royal College of Physicians | This statement is measurable and auditable in all settings. |
| 233 | Royal College of Physicians of Edinburgh | Fellows have expressed concern that it may be aspirational and probably unrealistic to expect social care practitioners (particularly social workers; care home workers; home care workers and sheltered housing staff) to routinely enquire about falls and refer appropriately into services unless they have all received adequate training, and data recording systems allow there to be sharing of data about falls and whether an older person has already been assessed for falls risk. For example, in Newcastle |

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| | | upon Tyne, The Newcastle upon Tyne Hospitals NHS Trust has worked collaboratively with Your Homes Newcastle (the community care falls alarm provider for Newcastle City Council) to develop a referral pathway for older people with falls to be used by care home and home care workers and social workers. Challenges to implementation included ensuring appropriate training was delivered and maintained, and in appropriateness of referrals. The number of referrals into local falls service did not equate to the expected number of falls by the population. A significant proportion of older people did not wish to undergo a falls assessment even when identified.<br><br>Concerns about including this group specifically within the falls quality standard focus on the issue that social care organisations will develop reporting tools that meet the request to do so, but that the primary outcome of improving the quality of care for older people who fall is not achieved, as the pressures on social care systems will result in this reporting being a 'tick box' exercise. It may be more effective to concentrate the quality standard on effective identification of those at risk of falls through consistent identification and reporting at the time an older person is in contact with a health care professional, either in primary care, or if presenting to secondary care facilities with a fall or fall-related issue. |
| 250 | Royal College of Psychiatrists | The statement is measurable but should be made clearer and wider equality/diversity issues should be considered. Many older people who have falls might also have cognitive impairment and asking about falls history alone is not enough, especially if they don't have regular carers. More sources of information (including carers) need to be considered and explored including questions suggestive of falls such as unexplained bruising, the older person expressing a request for help with walking especially if they also have cognitive impairment. |
| 285 | Yeovil District Hospital NHS Foundation Trust | No I don't think that the standards are easily measurable in every setting unless you make it very simple, make it mandatory and use technology to do this. |
| 297 | Public Health Wales | Please see previous comments [ID 292].<br>In short, current systems do not adequately allow all of the agencies involved in health and social care to record and share information. |
| **Statement 2** | | |
| 4 | Action on Hearing Loss | We think the mention of GPs in this section needs expanding, so that older people at risk of falling who are also presenting in other healthcare settings are referred on to a falls prevention service too.<br><br>We therefore suggest adding 'and other health professionals' after 'older people at risk of falling who present to GPs…'. |

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| 5 | Action on Hearing Loss | When older people are undertaking a risk assessment with a healthcare professional, it is very important that the requirements of the Accessible Information Standard10 are being complied with. The Standard provides clear guidance on what providers of health and social care must do under equality law to make their services accessible for people with sensory loss and learning disabilities – including people with hearing loss. We strongly feel there should be a section under this quality statement outlining the guidance and the importance of communicating well and considering the most appropriate forms of information provision, as there is a high chance that the people having a multifactorial risk assessment will have some kind of sensory loss or disability leading to communication needs.<br><br>The following paragraph included in other NICE quality standards (such as the draft quality standard for 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs) could be helpful, as well as the summary below about the Accessible Information Standard:<br><br>Barriers to communication can hinder people's understanding of risk assessments and intervention planning and prevent them from participating as fully as they are able to. For example, learning or cognitive difficulties; physical, sight, speech or hearing difficulties; difficulties with reading, understanding or speaking English. These needs should be taken into account and adjustments made to ensure all older adults identified as being at risk of falling understand the risks and can be involved in making decisions about their care, if they have the capacity to do so. Information should be provided in an accessible format, particularly for people with physical, sensory or learning disabilities and those who do not speak or read English.<br><br>Providers must also ensure compliance with the Accessible Information Standard, which became mandatory on 31st July 2016 and requires all NHS and statutory-funded adult social care providers to have systems in place to identify, record, flag, share and meet communication needs of people with disabilities and sensory loss, which includes providing accessible information, communication support, and creating an environment where good communication can take place. |
| 6 | Action on Hearing Loss | Given the level of unaddressed hearing loss amongst older people, and the link between hearing loss and falls11, assessing hearing loss should be included in the list of common assessment components to ensure as many people as possible identify and address their hearing loss and to mitigate against the negative impact evidence demonstrates it has on someone's ability to avoid falls, maintain mental and physical health and independence12. |

[10] NHS England (2015) Accessible Information Standard, SCCI 1605 https://www.england.nhs.uk/ourwork/patients/accessibleinfo-2/

[11] 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

[12] Evidence on the impacts of unaddressed hearing loss are outlined in more detail in Action on Hearing Loss (2015) Hearing Matters, available at: www.actiononhearingloss.org.uk/hearingmatters

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| 15 | Age UK | While there is recognition that many factors can put people at risk of falling, we believe the impact of frailty should be explicitly highlighted within the definitions of statement 2 as falls can be both an indicator and a consequence of frailty in later life. Frailty is a distinctive state of health related to the ageing process where the body's inbuilt reserves are eroded and people become increasingly vulnerable to physical and emotional setbacks. Around 10 per cent of people aged over 65 currently live with frailty, rising to between a quarter and half of those aged 85 and over. Currently, progressive frailty often remains unnoticed until a crisis happens which necessitates urgent intervention, such as a fall. Older people included in Age UK research often talked about 'turning points' in their ability to do everyday tasks and the impact this had on both their feelings of self-reliance and their quality of life. There was often no response from local services when these turning points occurred and important opportunities to remain active and independent were missed, which increased risks of rapid deterioration in people's health and wellbeing. Recognising frailty using validated tools and greater emphasis on proactively planning care would make a huge difference to a person's long-term outcomes and ability to remain independent, particularly in preventing falls at home or in hospital settings. For people with mild or "pre" frailty simple support such as providing information and advice can often help to delay onset and help engage people with local community support. See for example the Age UK/NHS booklet, A practical Guide to Healthy Ageing (updated October 2015). We would therefore like to suggest adding a point to the definitions on page 16 to include: "identification of frailty". |
| 17 | AGILE (special interest group for Physiotherapists working with Older People – part of the Chartered Society of Physiotherapy | Although the detailed descriptors further into the standard emphasise bone health when considering falls the headline standards do not. To ensure awareness that bone health assessment and management is a key part of falls assessment and management the statements should be amended.<br><br>e.g. Older People at risk of falls should be offered a multifactorial falls risk assessment should read " Older people at risk of falls should be offered a multifactorial falls risk assessment which includes and assessment of fracture risk and bone health. |
| 18 | AGILE (special interest group for Physiotherapists working with Older People – part of the Chartered Society of Physiotherapy | The falls standard should reflect the links between the frailty and falls agendas and no reference is made.<br><br>Older people should be screened for falls and frailty in a joined-up manner using evidence based screening tools and the standard should make this clear to prevent unnecessary duplication and waste of healthcare resource.<br><br>Multifactorial falls risk assessments overlap with recommended content for comprehensive geriatric management of the frail older patient. Providers should ensure that their assessment processes ensure that domains relating to falls and frailty are incorporated in their assessments in a linked manner. |
| 24 | Association of | Ambulance services do currently have established referral pathways to refer patients after a fall for further falls assessments. To |

| ID | Stakeholder | Comments |
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| | ambulance chief executives | be able to collect this data would be very difficult without additional resources or funding for our audit departments-many ambulance services are still paper based. The statements are unclear of the role of ambulance clinicians. |
| 26 | The Professional Affairs Committee of: The British Association of Prosthetists and Orthotists (BAPO) | BAPO feel that the current suggested 'Multifactorial Falls Risk Assessment' should be strengthened to better represent the input of the orthotist. Orthotists are a small but valued and specialised group of AHPs who routinely provide footwear solutions and orthoses to NHS patients with the goal of preventing falls. This task is within the remit of the orthotist as the lead AHP in assessing biomechanical pathology and prescribing appropriate solutions.<br><br>Unsuitable footwear is well recognised as a risk factor for falls and therefore risk assessment should cover this. BAPO suggest that 'review of patient's footwear' should be included with the Multifactorial Falls Risk Assessment.<br><br>The suggested 'Multifactorial Falls Risk Assessment' lists that 'gait, balance, mobility and muscle weakness' should be assessed. All of these factors can be greatly influenced and improved by the provision of lower limb orthoses (such as insoles, ankle-foot-orthoses and knee braces). BAPO feel that current wording could be improved to ensure that patients are assessed for their suitability of orthoses problems with gait, balance, mobility and muscle weakness are noted. Suggested wording: '…assessment of gait, balance, mobility & muscle weakness with identification of appropriate orthoses to tackle individual presentation of the patient'. |
| 27 | British Association of Audiovestibular Physicians (BAAP) | "assessment of gait, balance and mobility..." This should include some attempt at basic assessment of the vestibular system. At the very least, Benign Paroxysmal Positional Vertigo (BPPV) should be positively excluded as it is (a) excessively common in the elderly, (b) a significant cause of imbalance and falls and (c) very easily treated by a one-off, simple physical manoeuvre. The elderly, in particular, may complain of imbalance rather than actual positional vertigo (they may sleep propped up) and a Dix-Hallpike test should be a routine screening test in all potential fallers. |
| 41 | British Geriatrics Society | We believe there is potential for confusion between risk assessment (risk of falling, stratification) and risk factor assessment (part of falls prevention if linked to risk factor modification) and would suggest that Statement 2 should focus on risk assessment/stratification and Statement 3 should cover falls risk factor assessment and modification as a single process. This is implied anyway, as the denominator population is older people who have had 2 or more falls, or who have abnormalities of gait or balance, but could be made explicit as a separate Statement. |
| 42 | British Geriatrics Society | Measuring the number of patients who fall is duplicated and should only be under Statement 3, as falls risk factor assessment without intervention does not reduce falls. |
| 45 | British Society of Audiology (BSA) Balance Interest | A multisystem assessment should include an assessment of vestibular function that goes beyond the consideration of the loosely termed "balance", to include dizziness, vertigo, other similar sensations, and the vestibular system more specifically. BPPV needs to be especially considered, due to its high prevalence in fallers. |

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| | Group (BIG) | |
| 58 | Cardiff and Vale University Health Board | It may not be necessary to complete a falls risk assessment by a healthcare professional, and certainly not only in the setting of a specialist falls service, they could be done by others for example a home hazard check could be done by a third sector partner or public sector provider, and if there is cause for a more in depth assessment once the multifactorial elements are put together, that would be the point where specialist input could be required. An assessment of strength and balance could be carried out by the third sector, or exercise instructors etc. It could be a bit limited to restrict doing these assessments solely to healthcare professionals, especially as this should be a more broad population approach to primary falls prevention so would involve large numbers of older people. |
| 60 | Care & Repair England | As the multifactorial risk assessment includes home hazards there will be a need to ensure that those undertaking this assessment have access to skills and knowledge about how poor and inappropriate housing impacts on falls. Some 1.2 million of households aged 65 or older lived in a home that failed to meet the Decent Homes Standard in 2012. The main reason for homes failing to meet this standard is the presence of a Cat 1 hazard with the two commonest being risk of falls and excess cold.<br><br>It is proposed that the assessment is undertaken by health professionals. We suggest that these professionals should ideally be trained in home hazard assessments and understand who to contact locally for advice on housing interventions that would help to reduce falls risk including repairs and adaptations as well as dealing with day to day hazards.<br><br>We are aware that in many areas this will be done by Occupational Therapists, some of whom have these skills and knowledge, but we welcome the fact that the QS expects a multidisciplinary team to be in place, which we would urge must involve expertise on housing, and will expect quality reviews to assess how comprehensive the risk assessment for falls are. |
| 77 | The Chartered Society of Physiotherapy (CSP) | The statements broadly represent the key areas for quality improvement. However the need for bone health assessment could be given higher priority than it is currently. Whilst bone health is mentioned within the descriptor of multifactorial falls risk assessment, this particular component could be given more prominence in the statement itself. |
| 111 | National Osteoporosis Society | We suggest the following changes to the multifactorial falls risk assessment list on page 16:<br>• Medication review should be listed alongside polypharmacy rather than with cardiovascular assessment.<br>• Where a patient has cardiovascular disorders, more detailed assessment may be needed in falls associated with syncope such as echocardiography, Holter monitoring and tilt testing. Addition of this comment would be helpful.<br>• We would recommend inclusion of assessment for foot disorders.<br>• It is important to consider falls and bone health together when reducing an individual's risk of fracture. We would recommend inclusion of osteoporosis in the multifactorial risk assessment and signposting of individuals for further bone |

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| | | health assessment. |
| 113 | NDR-UK | Nutrition assessment and dietary intervention does not appear to have been considered in either prevention of a fall or treatment after a fall. Frailty is closely linked to inadequate or inappropriate nutrition. This issue should be included with the other 400 risk factors associated with falling. |
| 114 | NDR-UK | Certain dietary measures can reduce the risk of osteoporosis as well as treating it. Thus nutrition assessment should be included. |
| 129 | Newcastle University | This outcome does not measure the QS. The outcome proposed would be better placed in QS3. I suggest it would be better of the outcome was 'number of older people at risk of falling who are offered multifactorial intervention, following a multifactorial assessment' |
| 130 | Newcastle University | Number of falls does not address this QS. Performing a multifactorial assessment would not necessarily lead to a reduction in falls, rather it is the intervention (ie QS3) not the assessment that leads to a reduction in falls.<br>Furthermore, number of falls is not a reliable outcome measure outside of clinical trials. |
| 131 | Newcastle University | You define at risk of falling as 2 or more falls in the past 12 months. Earlier in QS1 introduction you state that people are most at risk of falling after their first fall. Preventing falls is most important after the first fall. I believe you should change the definition to 1 or more falls in the previous year. |
| 132 | Newcastle University | I think it is superfluous to include a list to be included in a risk assessment. This is covered by existing NICE guidance. If you are to leave this in, I suggest that medication review and cardiovascular assessment are separated. You should also include ECG and postural BP. |
| 147 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | The denominator in this outcome measure requires clarification as it states the number of older people presenting to a healthcare professional who were considered to be at risk of falling. The majority of the population aged 65 and over will have at least one risk factor making them 'at risk' of falls therefore clarification of how to measure 'at risk' is needed.<br><br>Additionally, the ability (knowledge and skill) to assess 'at risk' patients will differ between the professionals identified by the quality standard therefore again leading to over referral or under referral in some instances. |
| 148 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | The numerator and denominator within this are ambiguous. If you want to determine the proportion of older people who have a multifactorial falls risk assessment, and this is documented in their patient record, the denominator would be the number of older people presenting to a healthcare professional. By defining the denominator as those being 'considered at risk of falling', either relies on professional judgement that the individual is at risk, or will be as a result of a risk assessment. If the latter, the numerator and denominator will be the same.<br><br>An additional point is that both identification of risk and the process of multifactorial risk assessment (referral and completion) are |

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| | | all documented in the 'patient record' implying that there is central documentation by all professionals identified within the quality statement. As commented above, the limited inter-service data sharing would make this difficult without significant changes to systems. |
| 149 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | See comment 12 above [ID 146]. |
| 150 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | A concern is that 'Healthcare Professionals' is not well defined in this section.<br><br>A recommendation is that for 'Commissioners' that the quality standard stipulates that falls assessments and interventions are evidence based and meet NICE guidelines recommendations. |
| 151 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | A recommendation is that measurement of postural blood pressure is included as a specific assessment rather than being included within the polypharmacy bullet point.<br><br>Would also recommend that medication review is listed separately from cardiovascular examination as these are two separate processes |
| 170 | NHS Improvement | Not all providers will have healthcare professionals with skills and experience in falls prevention readily accessible for in an ED, DSU or OPD |
| 171 | NHS Improvement | Page 14 – what is the proposed data source for falls in older people? |
| 172 | NHS Improvement | Page 15 – could the multifactorial risk assessment be provided in primary care? |
| 173 | NHS Improvement | Page 16 - nursing homes and residential homes are different and should not be used interchangeably. All references to care setting should be explicit as to whether they are nursing or residential homes |
| 180 | Optasia Medical | There is a missing full stop at the end of the paragraph. |
| 181 | Optasia Medical | Where "osteoporosis risk" is listed, we would prefer "fracture risk" using FRAX or QFracture, as per other standards. Fracture is the consequence of the fall, not osteoporosis. |
| 184 | Orders of St John Care Trust | Commissioners need to ensure that Service Providers have sufficient resources to manage referrals as my own experience of this from working within the care home sector is that in some parts of the nation are under resourced. Sometimes it takes many weeks for a referral to be acted upon. |

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| 190 | Parkinson's UK | We agree it is vital that older people, including those with Parkinson's are helped to prevent falling, rather than only dealing with consequences after a fall has taken place.<br><br>Parkinson's UK has developed resources for health and social care professionals at http://www.parkinsons.org.uk/professionals/education-and-training-professionals<br>In particular:<br>Parkinson's care http://www.parkinsons.org.uk/professionals/education-and-training/parkinsons-care-apple-training-academy<br>and<br>Parkinson's disease http://www.parkinsons.org.uk/professionals/education-and-training/parkinsons-disease<br><br>Parkinson's UK recommends that the health and social care professionals conducting these assessments have a knowledge and understanding of Parkinson's to enable them to reduce the risk of falling for people with the condition. |
| 195 | Primary Care Neurology Society | The falls standard should reflect the links between the frailty and falls agendas and no reference is made.<br><br>Older people should be screened for falls and frailty in a joined-up manner using evidence based screening tools and the standard should make this clear to prevent unnecessary duplication and waste of healthcare resource.<br><br>Multifactorial falls risk assessments overlap with recommended content for comprehensive geriatric management of the frail older patient. Providers should ensure that their assessment processes ensure that domains relating to falls and frailty are incorporated in their assessments in a linked manner. |
| 196 | Primary Care Neurology Society | With regard to the assessment and the multifactorial intervention, the multifactorial falls assessment makes no mention of sleep. Sleep or lack of it, can be a significant issue for older people and in particular older people with co-morbidities and this will significantly increase a person's risk of a fall. Therefore, the P-CNS would wish that any risk assessment ask about sleep problems. |
| 220 | Royal College of Physicians | Quality statement<br>Quality statement 1 states 'Older people are asked about falls when they have routine reviews etc ' but does not say what should be done if the answer is yes. It should be made clearer that only those who have had 2 or more falls or have an issue with mobility or walking need an MFFRA. That leaves the question about what to do with those who answer yes but have only had one fall or how a patient should be assessed to 'demonstrate abnormalities of gait or balance'. We suggest a timed up and go test should be mentioned. |
| 221 | Royal College of Physicians | Rationale<br>Under 'Rationale' it states that 'the assessment should be performed by a healthcare professional with skills and experience in falls prevention, often in the setting of a specialist falls service'. As stated above, the numbers would be far too high to be done |

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| | | mostly 'in a specialist falls service'. It is very possible to train those who are seeing the patient (community nurses, therapists, GP practices etc) to perform a good MFFRA without referring to a specialist service. If complex needs are identified, then onward referral to a falls service would be appropriate. If single issues are identified- (eg falling due to poor vision), then referral onwards (eg to optician) would be more appropriate.<br><br>We feel the key components of the MFFRA are appropriate. |
| 222 | Royal College of Physicians | This QS would be measurable and auditable. The National audit of In-patient Falls (NAIF) asked about the presence or absence of an MFFRA, what assessments and interventions the MFFRA documentation included and then which components had actually been carried out on a sample of inpatients in hospital. This audit could be adapted to audit those patients at risk of falling out of hospital. Those services wishing to audit their service locally could adapt the audit tool used in NAIF to answer questions related to QS2. |
| 241 | Royal College of Physicians of Edinburgh | The denominator suggested – the number of older people presenting to a healthcare professional who were considered to be at risk of falling – lacks specificity. The majority of older people are 'at risk of falling' and therefore we would recommend that the QS defines how 'at risk' is to be determined by healthcare professionals so there is a consistent application of this denominator between different bodies. This denominator would also rely on combining data from a broad range of healthcare professionals, some of whom would have varying skills and capacity to make the determination of 'risk'. |
| 242 | Royal College of Physicians of Edinburgh | The numerator and denominator as defined are ambiguous: if determining the proportion who have a multifactorial falls risk assessment, and this is documented in their record, the denominator would be the number of older people presenting to a healthcare professional. Defining the denominator as being those 'considered to be at risk of falling', either relies on a professional 'judgement' that the individual is at risk, or will be a resultant of a risk assessment. If the latter, the numerator and denominator will be the same (ie to determine the denominator as being an older person at risk of falling would require the numerator to be an older person undergoing a multifactorial assessment). |
| 243 | Royal College of Physicians of Edinburgh | See comment 13. Reservations have been expressed over whether it is possible to collect data on the number of falls in older people consistently or accurately without a substantial (and disproportionate) recording resource. |
| 244 | Royal College of Physicians of Edinburgh | We would recommend greater specificity on who is being defined as 'healthcare professionals' in this context, for example, stipulating that the commissioning process requires that falls assessments and interventions are evidence based and meet NICE guidelines. |
| 245 | Royal College of | The College suggests that 'measurement of postural blood pressure' is specifically included rather than within the polypharmacy |

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| | Physicians of Edinburgh | definition. We would also recommend that medication review is defined separately from 'cardiovascular examination' as these are two separate processes. |
| 256 | Royal Pharmaceutical Society | Pharmacists are ideally situated to be involved as part of components of the multifactorial risk assessment, to include:<br>• Identification of falls history, and identification of polypharmacy –use of multiple drugs and drugs that can increase the risk of falls such as drugs that cause postural hypotension and psychoactive drugs.<br>• Identification of chronic conditions that affect mobility or balance.<br><br>These can be identified via conversation, Medication Use reviews or health checks to identify patients at risk of falls. |
| 265 | South Tyneside NHS Foundation Trust | We are fortunate to have MDT led falls services in both localities this Trust serves. The drawback is that the demand far exceeds capacity. Our waiting list was over 6 months for an assessment at one point. With funding and efficiencies becoming tighter each fiscal year, It is doubtful this standard would be achievable or sustainable. This standard also places an inequitable burden on areas of deprivation that also have a higher percentage of older adults. |
| 271 | Syncope Trust And Reflex anoxic Seizures (STARS) | STARS suggests assessment should include:<br>• Consideration whether a fall could have been due to syncope.<br>• Routine reviews should take into consideration that patients vulnerable to episodes of low blood pressure, if inactive for long periods and/or on medication that affect blood pressure, are liable to faints and falls.<br>• Hidden infections such as a bladder infection are commonly found in elderly patients. It is common that during such an illness blood pressure tends to drop causing an individual to fall and perhaps blackout.<br>• Carotid sinus hypersensitivity (CSH) is a common cause of syncope in older adults<br>• Arrhythmias – bradycardia and tachycardia - can produce sudden decrease in blood supply to the brain leading to syncope. |
| 277 | The Whiteley Homes Trust | This statement has appropriate audience descriptors but there may be difficulties if health professionals fail to collaborate effectively. Written guidance and appropriate technology will be crucial to support measureable outcomes. |
| 287 | Yeovil District Hospital NHS Foundation Trust | Is further specific guidance required for "others considered by a clinician to be at risk?" |
| 290 | Yorkshire Ambulance Service | YAS currently has a pathway to refer patients who have fallen to community falls specialists and has been in place for many years. What we are unable to determine is the impact of these referrals on the wider health and social care economy. It would be helpful for standards to be in place that enables data collection that shows the longer term impact of primary interventions. This would help us to determine where interventions are best placed to achieve maximum effect. |

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| 301 | Ferring Pharmaceuticals | The Multifactorial risk assessment mentions urinary incontinence. This should be broadened to include 'frequent night-time voiding (>2 voids per night)' as this will cover both rushing (and falling) to void in the day and night time falls as a result of nocturia/day time falls due to tiredness. Data clearly links escalating number of voids per night to risk of fall. |
| 304 | College of Occupational Therapists | At risk is defined in many ways. Consider level 1 falls screen as per framework for action.<br>http://www.gov.scot/Resource/0045/00459959.pdf<br>http://www.knowledge.scot.nhs.uk/fallsandbonehealth.aspx<br><br>That multifactorial risk assessment could be completed by a variety of people including health, social care, care home staff. See Level 2 framework for action<br>http://www.gov.scot/Resource/0045/00459959.pdf<br>http://www.knowledge.scot.nhs.uk/fallsandbonehealth.aspx |
| 310 | The Royal Society for the Prevention of Accidents | Multifactorial risk assessments are a key aspect of any falls prevention programme but represent the most detailed end of the assessment process and given the pressures on local NHS resources are likely to only be offered to a very limited number of people. This statement, or an additional statement needs to offer an alternative that can be delivered at a more basic level and delivered by a wider range of staff and organisations than NHS professionals that may in turn act as part of the referral process into the more formal falls services and multifactorial assessments. |
| 311 | The Royal Society for the Prevention of Accidents | To define "at risk of falling" as people who have had 2 or more falls in the last 12 months effectively closes the door on this quality standard being used to drive early intervention to prevent falls. Whilst it is acknowledged that this limited definition is an attempt to recognise limited professional resources, this limiting definition means that this quality statement will be ineffective in tackling the underlying causes proactively and seeing a significant reduction in falls in an ageing population. |
| 312 | The Royal Society for the Prevention of Accidents | The measures only indicate the number of people who have had assessments. The number of people presenting to a healthcare professional who were considered to be at a risk of falling is an ineffective denominator as there will, in any given population be a number of people who are not referred or not known to the healthcare professional. Whilst this may be a measure of efficiency in managing patients through the process and hopefully will be of benefit to those patients who receive multifactorial risk assessments and reduce their likelihood of a repeat fall, this will have a limited impact on the high level of falls in the overall over 65s population |
| 322 | AESOP | The key areas for quality improvement are missing information on older people who complete exercise interventions. On page 14 Outcomes – it is recommended that data is collected on the number of older people who are referred to falls prevention exercise and who receive an intervention. However, I recommend that information that information is also collected on the number of older people who COMPLETE the intervention, as we know that retention rates are low. If there continues to be a |

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| | | discrepancy between the number of older people who start a falls prevention exercise intervention and the number of older people who complete a falls prevention exercise intervention, then falls rates will not decrease. |
| **Statement 2: Consultation question 7** | | |
| 35 | British Geriatrics Society | The descriptors are generally well described.<br>Other comments for Statement 2:<br>We feel that medication review should be uncoupled from Cardiovascular assessment and added to the Polypharmacy section below<br>For cardiovascular disorders there should be a comment that more detailed assessment may be needed in falls associated with syncope (e.g. echocardiography, Holter monitoring, Tilt testing)<br>Consideration should be given to add assessment for foot disorders.<br><br>However, we note that this text is taken directly from NICE CG161 item 1.1.2.1. |
| 67 | Carers UK | Housing Associations provide housing for significant numbers of over 65s included supported accommodation. They are an important audience for falls prevention and should be included in the audiences. |
| 108 | National Osteoporosis Society | We think that the audience descriptors adequately describe what statement 2 means for different services providers. |
| 140 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | For statement 2, the audience descriptors do adequately describe what the statement means for different types of service providers that carry out multifactorial falls risk assessments. However, concerns with data collection and outcome measures are included in following points. |
| 161 | NHS England | Yes. It is suggested that the most effective and widely utilized methodology for is a comprehensive geriatric assessment: http://www.bmj.com/content/343/bmj.d6553.long ; http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.1999.tb02988.x/full<br><br>A key difficulty for falls risk identification is that older people poorly recall falls and for those living alone or with cognitive impairment, corroboration may be difficult. This can lead to underestimation of recalled falls events by up to 30% :https://www.researchgate.net/profile/Rob_Morris2/publication/11587628_Epidemiology_of_Falls/links/543d13d50cf20af5cfbfa4a7.pdf It is suggested that for each audience attempts are made to use additional historical information and risk factor identification and corroboration to ensure that falls events are, wherever possible identified to ensure that the at risk population is clearly identified. |

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| 202 | Ramsay Health Care | Yes again I feel the descriptors adequately describe what the statement 2 means. Easy to read |
| 209 | Royal College of General Practitioners | We agree that the audience descriptors adequately describe what the statement means for the different types of service providers that carry out multifactorial falls risk assessments.<br>(JD) |
| 215 | Royal College of Nursing | Do the audience descriptors adequately describe what the statement means for the different types of service providers that carry out multifactorial falls risk assessments? For quality statement 2: we know of good number of delays for patients waiting to be seen in specialist falls services and these have impact on care and falls prevention. It is considered that there does need to be an expansion of falls teams overall. |
| 234 | Royal College of Physicians of Edinburgh | For quality standard 2, the audience descriptors do adequately describe what the statement means for the different types of service providers that carry out multifactorial falls risk assessments. Specific questions and issues relating to the data collection and numerators are included below at comments 14-18. |
| 251 | Royal College of Psychiatrists | Yes, the description is clear and accurate. |
| 298 | Public Health Wales | Yes |
| **Statement 3** | | |
| 7 | Action on Hearing Loss | As above, the prevalence of hearing loss amongst older people, the level of unmet need, and the link between hearing loss and falls means that referrals to audiology, hearing assessment and management should be a common component of multifactorial intervention programmes and should be on this list.<br><br>Hearing loss is independently associated with an increased risk of falls13. For example, a 25 dB hearing loss14 is associated with nearly threefold higher odds of reporting a fall over the preceding year compared with someone with no hearing loss. There is then a 1.4 increase in odds for every 10 dB increase in hearing loss.15 Research suggests that this risk could be reduced by ensuring auditory information is available, for example by wearing hearing aids16. |

[13] 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

[14] Hearing loss is defined by the quietest sound the person is able to hear, measured in decibels.

[15] Lin and Ferrucci (2012) Hearing loss and falls among older adults in the United States. Archives of Internal Medicine 172(4): 369-371

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| | | Hearing aids are the main form of treatment for most people with hearing loss17, but currently approximately two thirds of people who could benefit from hearing aids aren't accessing them 18. More needs to be done to actively promote the importance of identifying and addressing hearing loss and the benefits this has for people with hearing loss and the health and social care system. |
| 8 | Action on Hearing Loss | In line with comments above, having hearing checked should be added to the list of things included in the plan, alongside having eyes checked.<br><br>Many people with hearing loss will not be addressing the problem, and this has a serious impact on their ability to communicate, remain socially active, manage their physical and mental health and remain safe and independent19. |
| 9 | Action on Hearing | We also recommend hearing assessment and intervention being added to the list of successful multifactorial interventions. |

[16] 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

[17] Chisholm 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

[18] Action on Hearing Loss (2011) Hearing Matters

[19]Action on Hearing Loss (2015) Hearing matters, Available at: www.actiononhearingloss.org.uk/hearingmatters; Ringham (2012) Access All Areas. Available at: www.actiononhearingloss.org.uk/accessallareas; Monzani et al (2008) Psychological profile and social behaviour of working adults with mild or moderate hearing loss. Acta Otorhinolaryngologica Italica. 28(2): 61-6; Arlinger (2003) Negative consequences of uncorrected hearing loss – a review. International Journal of Audiology 42(2): 17-20; Gopinath et al (2012) Hearing-impaired adults are at increased risk of experiencing emotional distress and social engagement restrictions five years later. Age and Ageing 41(5): 618–623; Action on Hearing Loss (2013) Joining Up (available at www.actiononhearingloss.org.uk/joiningup; Saito et al (2010) Hearing handicap predicts the development of depressive symptoms after three years in older community-dwelling Japanese. Journal of the American Geriatrics Society 58(1): 93-7; Mulrow et al (1992) Sustained benefits of hearing aids. Journal of Speech & Hearing Research 35(6): 1402-5; National Council on the Aging. (2000) The consequences of untreated hearing loss in older persons. Head & Neck Nursing. 18(1): 12-6; Acar et al (2011) Effects of hearing aids on cognitive functions and depressive signs in elderly people, Archives of Gerontology and Geriatrics, 52(3): 250-2; Lin et al (2011) Hearing loss and incident dementia. Archives of Neurology 68(2): 214-220; Lin et al (2013) Hearing loss and cognitive decline in older adults. Internal Medicine 173(4): 293-299; Gurgel et al (2014) Relationship of hearing loss and dementia: A prospective, population-based study. Otology & Neurotology 35(5): 775-81; Albers et al (2015) At the interface of sensory and motor dysfunctions and Alzheimer's disease. Alzeimer's and Dementia Journal, 11 (1), 70-98; Chia et al (2006) Association between vision and hearing impairments and their combined effects on quality of life. Archives of Ophthalmology 124(10): 1465-70; McKee et al (2011) Perceptions of cardiovascular health in an underserved community of deaf adults using American Sign Language. Disability and Health 4(3): 192-197; Margellos-Anast et al (2006) Cardiovascular disease knowledge among culturally Deaf patients in Chicago. Preventive Medicine 42(3): 235-9; Kakarlapudi et al (2003) The effect of diabetes on sensorineural hearing loss. Otology and Neurotology 24(3): 382-386; Mitchell et al (2009) Relationship of Type 2 diabetes to the prevalence, incidence and progression of age-related hearing loss. Diabetic Medicine 26(5): 483-8; Chasens et al (2010) Reducing a barrier to diabetes education: identifying hearing loss in patients with diabetes. Diabetes Education 36(6): 956-64; Formby et al (1987) Hearing loss among stroke patients. Ear and Hearing 8(6): 326-32; Gopinath et al (2009) Association between age-related hearing loss and stroke in an older population. Stroke 40(4): 1496–1498

| ID | Stakeholder | Comments |
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| | Loss | Recent data shows that across the UK 9 out of 10 people use their hearing aids regularly and 81% people think their hearing aid works better than or as expected 20. Evidence confirms that given good support, follow up and rehabilitation, high levels of hearing aid use and satisfaction can be achieved at low costs21. This support improves people's quality of life, safety and independence22. |
| 16 | Age UK | Older people are more likely to respond positively to preventative and self-care strategies when they are actively engaged in their health. Yet far too few patients are given the opportunity to express their needs, agree priorities and set goals through care and support planning. One third of patients in general practice say they are not fully involved in decisions about their care (Richmond Group of Charities, Vital Signs, 2015). This also applies to falls prevention – older people are more likely to change their behaviour and follow the programme of falls prevention activities if they feel they have had a say in it and can take ownership of it, including the opportunity to choose activities that best suit their needs, abilities and preferences. Engaging them right from the outset in the design of their package of interventions and empowering them to take control of their health and wellbeing is crucial to the success of falls prevention strategies. This requires a real behaviour change among healthcare professionals towards shared decision-making and supporting people to self-manage. As such, we would recommend amending the third quality statement in order to reflect the principle of shared decision-making and shift away from the notion of older people as passive 'recipients' of interventions, as follows: "Older people at risk of falling agree with their practitioners and carry out an individualised multifactorial intervention". |
| 22 | AGILE (special interest group for Physiotherapists working with Older People – part of the Chartered Society of Physiotherapy | These outcomes are too vague and either need removing or further quantification. |

[20] European Hearing Instrument Manufacturers Association (2015). Eutrotrak 2015; Perez E and Edmonds BA, 2012. A Systematic Review of Studies Measuring and Reporting Hearing Aid Usage in Older Adults since 1999: A Descriptive Summary of Measurement Tools. *PLoS ONE* 7 (3), e31831

[21] Abrams et al (2002) A cost utility analysis of adult group audiologic rehabilitation: are the benefits worth the costs? Journal of Rehabilitation Research and Development 39(5): 549-558

[22] Yueh et al (2001) Randomized trial of amplification strategies. Archives of Otolaryngology -- Head & Neck Surgery. 127(10):1197-204; Cacciatore et al (1999) Quality of life determinants and hearing function in an elderly population: Osservatorio Geriatrico Campano Study Group. Gerontology 45:323-323; Mulrow et al (1990) Quality-of-life changes and hearing impairment. A randomized trial. Annals of Internal Medicine. 113(3):188-94; Chisolm 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 the American Academy of Audiology, 18 (2), 151-83; Kochkin (2005)

| ID | Stakeholder | Comments |
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| 28 | British Association of Audiovestibular Physicians (BAAP) | “strength and balance training” could include vestibular rehabilitation, where appropriate, and repositioning manoeuvres (mainly the Epley) in cases of BPPV. |
| 29 | British Association of Audiovestibular Physicians (BAAP) | “...(such as consultant geriatricians, nurses, physiotherapists, occupational therapists)” could be expanded to include access, where appropriate, to Audiology, Audiovestibular Medicine or Ear, Nose and Throat (ENT). |
| 43 | British Geriatrics Society | Whilst feeling of independence and ability to maintain ADLs is important for older people, there is no guidance on how this should be recorded and measured. We think it is unlikely that this information will be readily available and the resource required to collect such data meaningfully is likely to be prohibitive. |
| 46 | British Society of Audiology (BSA) Balance Interest Group (BIG) | The document refers to strength and balance retraining only. This should be extended to include vestibular rehabilitation, positional manoeuvres for BPPV, the possible assessment and treatment of BPPV in primary care at the least, with consideration of referral onto specialist vestibular rehabilitation services. |
| 47 | British Society of Audiology (BSA) Balance Interest Group (BIG) | Healthcare professionals – add Audiology / Audiovestibular Medicine / Ear, Nose and Throat / Physiotherapy. |
| 61 | Care & Repair England | We welcome this proposal for individualised intervention. Whilst the QS states that health professionals must ensure that, following a multifactorial assessment, older people have an appropriate intervention it should also insist that the health professionals work with housing professions locally to ensure that the assessment has identified the optimum solution to make the home environment safe and secure to reduce falls.<br><br>This will require joint working with local bodies such as home improvement agencies, with local authority providers of Disabled Facilities Grant, with housing advice agencies and with housing associations for them to directly provide or facilitate the necessary housing interventions. As well as ‘fixing anything unsafe at home’ (p20) interventions should ensure that the appropriate repairs and adaptations are organised to prevent further falls.<br><br>In terms of resources we would make the point that funding for adaptations from the Better Care Fund and funds for repairs, handyperson and home improvement agency services from local councils and sometimes from the NHS need to be available |

| ID | Stakeholder | Comments |
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| | | and sufficient to meet the demand for housing interventions for fall's prevention work. We would urge health, social care and health commissioners to work collaboratively to ensure that this is the case. |
| 69 | Carers UK | As part of the multifactorial intervention, home hazard assessment and intervention is looked at. This quality standard should address the outcomes of these interventions – Carers UK's research (based on over 5,000 carers) shows that 1 in 5 carers are waiting for adaptations. The data collected will show evidence of people at risk receiving an individualised multifactorial intervention but there is nothing to record which components of the intervention have been carried out and to assess the outcome of the action was taken except on a wider scale.<br><br>This quality statement also requires commissioner to ensure that services are commissioned to enable older people to have a multifactorial intervention. However, unless concrete action is taken as a result of the intervention then it will not be effective. As mentioned, 1 in 5 carers have said they are still waiting for adaptations to be made – ensuring that older people are not at risk of falls requires services to be commissioned that prevent this – i.e. fast tracking adaptations for certain at risk groups. |
| 73 | Central and North West London NHS Foundation Trust (CNWL) | Statement 3 This should not be too hard to measure, but will need joined up services to ensure the individualised plan is delivered effectively. The issue of the person consenting should be considered for example some people who should use a stick refuse to as they feel they will look old or get dependent on it. The individualised plan should cover this by involving the person in writing it.<br>We have quite a lot of falls due to alcohol use in our older person population. This is very difficult to tackle. |
| 78 | The Chartered Society of Physiotherapy (CSP) | Whilst strength and balance training is mentioned as a key part of the multifactorial intervention, it is imperative for this to be delivered at an intensity and frequency that is evidence-based. In order to provide evidence-based exercise classes, it is likely that more investment will be required. Therefore each intervention should be related more explicitly to the evidence base. |
| 81 | IHip Impact Protection Ltd | Multifactorial interventions have been found to have no effect on the numbers of falls in the biggest RCT yet undertaken – in Australia, the 6-PACK trial with 30,000 hospital patients. Balance exercises may also have a negative or disastrous result if the patient suffers from any of the symptoms or disabilities mentioned above. To rule out the use of hip protectors, however, is to refer to evidence that has not been updated since 2004, when modern hip protectors made from highly effective reactive materials were not available. Since 2012 hip protectors have been readily available that provide complete protection to the hips in a fall of whatever severity but are still comfortable enough to ensure complete patient compliance/adherence. They are also very cost effective – See http://www.ncbi.nlm.nih.gov/pubmed?term=24834633 |
| 112 | National Osteoporosis Society | Under individualised multifactorial interventions, a list is given of interventions which are not recommended. We would like to question the following inclusions in this list: |

| ID | Stakeholder | Comments |
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| | | • Vitamin D – There is some evidence that vitamin D reduces falls risk in people living in care homes. The recent report of the Scientific Advisory Group on Nutrition also highlighted evidence that vitamin D maintains muscle strength. We are concerned that the wording used in the draft could create confusion by implying that people should not be given vitamin D supplements. This contradicts the public health advice on vitamin D supplementation for general health. https://www.gov.uk/government/news/phe-publishes-new-advice-on-vitamin-d.<br>• Group exercises – there is good evidence that the FaME programme can reduce falls. Is the document making the point that group exercises need to be appropriately targeted in order to reap benefits? If so, this point should be clearer to avoid confusion. |
| 115 | NDR-UK | Multifactorial intervention should include nutrition is linked to muscle strength. |
| 116 | NDR-UK | Individualised multifactorial interventions – nutrition intervention can maximise the benefits of low intensity exercise, group exercise and brisk walking, and thus should be included in this section. |
| 133 | Newcastle University | I do not understand why you list some of the components of a multifactorial intervention. It implies other elements are less important. I believe this is covered in existing NICE guidance and is beyond the scope of this guidance. |
| 134 | Newcastle University | Outcome A: Number of falls is actually extremely difficult to capture and record. When it is recorded it is hugely unreliable. It will not accurately measure what you want it to measure.<br>Outcome B: Fear of falling will not capture useful data. It is highly prevalent in non-fallers. It would not necessarily be expected to improve following a multifactorial intervention.<br>Outcome C: Feeling of independence in older people. Does this adequately reflect successful falls intervention? No.<br>Outcome D: Does not assess success of a falls service/intervention<br><br>I suggest as a starting point the outcome should be 'number of older people who undergo multifactorial assessment who are offered a multifactorial intervention'. |
| 152 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | A recommendation is that an additional bullet point is added to the current 4 to say:<br>'treatment of postural hypotension if identified through postural blood pressure management' |
| 153 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | This measure is asking for them same information as Process b) in statement 2.<br>The difficulties in measuring this have been discussed in comment 14 above [ID 148]. |

| ID | Stakeholder | Comments |
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| 154 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | The denominator of the number of older people assessed as at risk of falling is again ambiguous as discussed above [ID 148]. |
| 155 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | A question in relation to all 4 of these outcomes is how will these to be measured? This requires further clarity as all 4 would be difficult to collate across all services included in the quality standard. Even a form of sampling would have significant resource implications.<br><br>Outcome b – fear of falling in older people: how will this be collated?<br>Outcome c - how is feeling of independence in older people to be measured?<br>Outcome d – 'Ability of older people to maintain activities of daily living' is non-specific outcome measure.<br><br>However, although the detail hasn't been provided in terms of how these outcomes will be measured, they are in fact important elements for the quality standard to incorporate. Clearer guidelines are required for the measurement of these because at present, with current systems, it would be practically impossible for organisations to measure and report these. Therefore the ability of for reporting bodies to show that the falls services that they commission are meeting quality standards.<br><br>A recommendation for the quality standard would be to simplify the process to ensure that older people are consistently asked about falls. This should then have a supplementary question about whether they have had a falls assessment. If not, the standard should look to measure the proportion of older people who have reported falls, who are then referred for multifactorial risk assessment.<br><br>The standard should also aim to measure falls services' components of a multifactorial intervention in line with the evidence base and NICE guidelines. This would be a useful measure for commissioners to ensure they have the confidence that they are commissioning evidence based interventions. |
| 174 | NHS Improvement | Page 19 – how would you measure the patients' fear of falling? Loss of independence, ability to maintain activities of daily living? |
| 175 | NHS Improvement | The wording of this paragraph concerning vision assessment could be strengthened .As it stands the paragraph mentions vision assessment as a successful component of a multifactorial falls assessment (MFA) but then recommends that referral for correction of visual impairment is not recommended… I think the advice is that this intervention is not recommended as a single intervention but only as part of a MFA. |
| 176 | NHS Improvement | Page 21 - - in regards to the interventions list there is an inference that incontinence programmes and low intensity exercised are linked. What is the difference between low intensity exercise and brisk walking? |

| ID | Stakeholder | Comments |
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| 182 | Optasia Medical | The population of 65+s at risk of a first fracture is likely to be large. We do not believe, therefore, that home hazard assessment and intervention is realistic for this population. These activities would be better suited to over 75s and/or those who have already fallen. Whilst an individual multifactorial intervention is ideal, delivery of the resulting programme would be more achievable in group settings. |
| 191 | Parkinson's UK | We agree with the quality statement that older people at risk of falling should receive an individualised multifactorial intervention. Many people with Parkinson's can be supported to reduce their risk of falls by making simple changes to their lifestyle. If they were given this information early on, it could prevent them falling and injuring themselves. |
| 192 | Parkinson's UK | Health and social care professionals should use resources developed by Parkinson's UK http://www.parkinsons.org.uk/content/falls-and-parkinsons-information-sheet to empower individuals.<br><br>Due to the nature of Parkinson's, Parkinson's UK believe everyone with Parkinson's, regardless of age, who is at risk of falling should be offered a multifactorial intervention. |
| 200 | Primary Care Neurology Society | P-CNS supports AGILE's concern that these outcomes are too vague and either need removing or further quantification. |
| 223 | Royal College of Physicians | 1. This QS is clear and concentrates on the key intervention to reduce falls.<br>2. This QS will require resources to allow it to be implemented in all regions. There is currently not enough provision of exercises to reduce falls in most regions. What provision there is is often too short and not evidence based. |
| 224 | Royal College of Physicians | QS3 is auditable at a national and local level. This is the key part of this quality standard as asking about previous falls and performing an MFFRA are not effective unless it leads to interventions known to reduce falls. |
| 246 | Royal College of Physicians of Edinburgh | We would suggest that an additional component is included with the 4 already defined – 'treatment of postural hypotension if identified through postural blood pressure measurement'. |
| 247 | Royal College of Physicians of Edinburgh | This measure is asking for the same information as Process b) in quality statement 2. The difficulties in measuring this are highlighted in Comment 15 above. |
| 248 | Royal College of Physicians of | The denominator of 'the number of older people assessed as at risk of falling' is ambiguous as highlighted above. |

| ID | Stakeholder | Comments |
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| | Edinburgh | |
| 249 | Royal College of Physicians of Edinburgh | All 4 outcomes described carry significant practical difficulties in collating. A form of sampling could be used by reporting organisations; however this will have significant resource implications to achieve.<br><br>As highlighted in comment 13, measuring the number of falls in older people has no agreed methodology currently. How is 'fear of falling' data to be collated? (outcome b). How is 'feeling of independence' to be determined? (outcome c).<br>'Ability of older people to maintain activities of daily living' is a non-specific outcome measure.<br><br>Whilst all the above outcomes are at face value, worthy parameters to consider for a quality standard, it may be practically impossible for organisations to measure and report these in a meaningful way. Thus, the ability for reporting bodies to show that the falls services that they commission are meeting quality standards are hampered by the difficulties in defining, measuring and consistently providing comparative data between their services and other services elsewhere in the country. A simplification of the process would be to ensure that older people are consistently asked about falls – ie every patient encounter includes a question about whether the older person has fallen. This should have a supplementary question about whether they have had a falls assessment. If not, the standard should seek information on the proportion of older people who have reported falls, who are referred for multifactorial assessment.<br><br>The multifactorial assessment components can be specifically defined as needing to conform to established evidence base for effective assessment. Falls services also need to be able to demonstrate that they provide the components of a multifactorial intervention that are evidence based. Measuring whether this process meets defined standard would be a useful exercise for commissioners to undertake, so they are not commissioning services that lack evidence base, to the exclusion of services which could. |
| 257 | Royal Pharmaceutical Society | Pharmacists in all settings mentioned can be involved in interventions such as medication review with modification or withdrawal to reduce components of fall risk.<br>We recommend that pharmacists are included in the category of healthcare providers in this section. |
| 260 | Sandwell MBC – Public Health (and partners) | It is encouraging to see that recognition has been given to various factors leading to falls and that a multifactorial approach is needed. Statements need to be clear so there is distinction between primary and secondary prevention and to demonstrate that focus is on the wider determinants rather than a reactionary measure. |
| 263 | Society of Teachers of the Alexander | We support the idea of an individualised multi-factorial intervention for older people who are assessed as being at risk of falling. We suggest that the range of available interventions encompassed in such a multifactorial approach should include the option of |

| ID | Stakeholder | Comments |
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| | Technique (STAT) | Alexander Technique lessons, provided by registered Alexander Technique teachers, with the principal aim of improving balance and postural support.<br>There is evidence that Alexander Technique training leads to improved balance, postural support, and movement co-ordination,1−7 and that this intervention therefore has potential in falls prevention.8,9 It has been successfully taught to older adults8,9 and is an acceptable intervention.10 Evidence shows that the skills learned are retained in the long term by those who attend lessons.11 Two major randomised controlled trials demonstrate the effectiveness of Alexander Technique lessons in improving chronic back pain12 and chronic neck pain,13 both of which are common in older people and can contribute to the likelihood of falling. The Alexander Technique is a gentle, self-management approach which can help individuals to develop the ability to co-ordinate themselves quickly and efficiently in any situation thus allowing improved balance and movement.<br>References<br>1. Cacciatore TW, Gurfinkel VS, Horak FB, Cordo PJ & Ames KE. (2011) Increased dynamic regulation of postural tone through Alexander Technique training. Human Movement Science 30, 74–89.<br>2. Cacciatore TW, Gurfinkel VS, Horak FB &Day BL. (2011) Prolonged weight-shift and altered spinal coordination during sit-to-stand in practitioners of the Alexander Technique. Gait & Posture, 34, 496–501.<br>3. Cacciatore TW, Horak FB & Henry SM. (2005) Improvement in automatic postural coordination following Alexander Technique lessons in a person with low back pain. Physical Therapy, 85, 565–78.<br>4. Cacciatore T.W., Mian O.S., Peters A., & Day B.L. (2014) Neuromechanical interference of posture on movement: Evidence from Alexander Technique teachers rising from a chair. Journal of Neurophysiology, 112, 719-729.<br>5. Dennis, R. (1999). Functional reach improvement in normal older women after Alexander Technique instruction. Journals of Gerontology. Series A, Biological Sciences & Medical Science, 54, M8-M11<br>6. O'Neill, M.M, Anderson, D.I., Allen, D.D., Ross, C., & Hamel, K.A. (2015). Effects of Alexander Technique training experience on gait behaviour in older adults. Journal of Bodywork and Movement Therapies, 19, 473-481.<br>7. Hamel K.A., Ross C., Schultz B., O'Neill M. & Anderson D.I. (2016). Older adult Alexander Technique practitioners walk differently than health age-matched controls. Journal of Bodywork and Movement Therapies. Published online.<br>8. Batson, G. & Barker, S. (2008). Feasibility of group delivery of the Alexander Technique on balance in the community-dwelling elderly: Preliminary findings. Activities, Adaptation & Aging, 32(2), 103-119 (video evidence can be seen by following this link https://www.youtube.com/watch?v=lNf5bGRwhZA).<br>9. Gleeson, M., Sherrington, C., Lo S. & Keay, L. (2015). Can the Alexander Technique improve balance and mobility in older adults with visual impairments? A randomized controlled trial. Clinical Rehabilitation 29, 244-260.<br>10. Yardley, L., Dennison, L, Coker, R., Webley, F., Middleton, K., Barnett, J., Beattie, A., Evans, M., Smith, P. & Little, P. (2010). Patients' views of receiving lessons in the Alexander Technique and an exercise prescription for managing back pain in the ATEAM trial. Family Practice, 27, 198-204.<br>11. Stallibrass C, Frank C, Wentworth K. Retention of skills learnt in Alexander Technique lessons: 28 people with idiopathic Parkinson's disease. Journal of Bodywork and Movement Therapies 2005; 9: 150–7.<br>12. Little P., Lewith G., Webley F., Evans M., Beattie A., Middleton K., Barnett J., Ballard K., Oxford F., Smith P., Yardley L., |

| ID | Stakeholder | Comments |
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| | | Hollinghurst S & Sharp D. (2008) Alexander Technique lessons, exercise, and massage (ATEAM) for chronic and recurrent back pain. BMJ 337:a884.<br>13. McPherson H., Tilbrook H., Richmond S., Woodman J., Ballard K., Atkin K., Bland M., Eldred J., Essex H., Hewitt C., Hopton A., Keding A., Lansdown H., Parrott S., Torgerson D., Wehnam A. & Watt I. (2015) Alexander Technique lessons or acupuncture sessions for persons with chronic neck pain: A randomized trial. Annals of Internal Medicine, 163, 653-662. |
| 266 | South Tyneside NHS Foundation Trust | This is already provided through our Community Falls Services in coordination with Care of the Elderly consultants in our hospital and joint working with our GPs. The remaining difficulty is the “home hazard assessment and intervention”. NICE 161 states this be carried out by a qualified individual, but the previous quality standard on falls insists on an OT carrying this out. The consortium of participants of the North East Regional Falls Group has already stated that given the restriction on the previous quality statement, there is absolutely no practical way to comply with this statement. We strongly recommend this be satisfied by the NICE guidance of “qualified individuals”. |
| 272 | Syncope Trust And Reflex anoxic Seizures (STARS) | An individualised multifactorial falls risk assessment should include these additional checks and guidance<br>• Dehydration – syncope can occur if a patient has not drunk enough fluids. Guidance for patient is to drink 2 litres of water daily.<br>• Postprandial hypotension – symptoms may be subtle with a slight dizziness or weakness during or when standing up after eating, leading to a fall. Guide for patient is to avoid large portions and sitting in chair with feet raised following a meal. |
| 273 | The Care Forum | Fear of falling as an outcome is hard to measure as it does not have to be associated with the event of having a fall. Should a close friend or family member have a serious fall, fear can result causing restriction of activities. Also the fear often has to be assessed and derived rather stated directly by patients, meaning experienced practitioners are required to be able to identify it readily. |
| 274 | The Care Forum | Falls are disempowering and as mentioned in the quality standard, they have deep reaching effects on those affected by them. Independence is reliant on many factors, and is difficult for carers as they have the responsibility of others to look after. |
| 278 | The Whiteley Homes Trust | This statement has appropriate audience descriptors but will require timely referral from health professionals to ensure that interventions are effective and outcomes are measurable. |
| 288 | Yeovil District Hospital NHS Foundation Trust | It is outlined that Home hazard assessment is not effective in isolation – this would have implications for our current pathway where social services complete those with no attached rehab need – this would appear to be of limited use. |
| 302 | Ferring | Individualised multifactorial intervention |

| ID | Stakeholder | Comments |
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| | Pharmaceuticals | The risk assessment in statement 2 should cover frequent night time voiding and there should, therefore, be an associated intervention under statement 3: Treatment for frequent night time voiding (nocturnal polyuria). |
| 305 | College of Occupational Therapists | Interventions must within a minimum standard to reduce variation e,g. in time to respond to falls, in length of intensity of exercise provision, home environment assessments are most effective if delivered by an occupational therapist, as this a core part of the profession. The College would suggest that there is a home hazard screen that would then signpost to Occupational Therapy. |
| 313 | The Royal Society for the Prevention of Accidents | Who provides the home hazard assessment and intervention? The quality statement (like the others) is very focused on NHS interventions (falls specialists services, for example who will only ever have the capacity to deal with the very high risk patients who have already fallen, Physios, OTs, consultant geriatricians who are very unlikely to be involved in home hazard assessments, etc.) There are a range of non-medical services who are experienced and trained in this aspect (e.g. Fire Services, Environmental Health, third sector organisations, some housing improvement agencies and care organisations who have had home hazard assessment training. Etc.) The quality statement should highlight the important of involving and commissioning services from the full range of potential partners in reducing falls. |
| **Statement 3: Consultation question 8** | | |
| 36 | British Geriatrics Society | The descriptors are generally well described.<br>Other comments on statement 3:<br>We do not support the view that vitamin D should be down as not recommended. This goes against recent advice that all older people in England and Wales need vitamin D during the winter months. NICE CG161 states that there is insufficient evidence to support the routine use of vitamin D but equally does not specifically advise against.<br>We agree that untargeted group exercises should be not recommended (as in NICE CG161). However, the wording could be made clearer that targeted group exercise is recommended - There is good evidence for falls reduction with the FaME programme, which was delivered as group exercise in the initial randomised trials. |
| 109 | National Osteoporosis Society | We think that the audience descriptors adequately describe what statement 3 means for different services providers. |
| 141 | The Newcastle upon Tyne Hospitals NHS Foundation Trust | For statement 3, the audience descriptors are adequate for the different types of service providers that carry out multifactorial interventions. Again, additional comments are detailed below. |
| 162 | NHS England | For service users and carers it is recommended that this be rephrased to 'discuss with a care professional a plan to reduce the risk of them falling' based on the principle that falls interventions are targeted at risk reduction rather than abolishing risk. There is otherwise a danger of encouraging false expectation from the intervention, which can lead to on-going poor service user |

| ID | Stakeholder | Comments |
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| | | experience and inappropriate re-referral. |
| 203 | Ramsay Health Care | I think all points are described in full and easy to understand. |
| 235 | Royal College of Physicians of Edinburgh | For quality standard 3, the audience descriptors are adequate for the different types of service providers that carry out multifactorial interventions. Additional specific commentary is provided below at comments19-22. |
| 252 | Royal College of Psychiatrists | GP's and primary care health workers should be explicitly stated in this list. |
| 299 | Public Health Wales | Yes |
| **No substantive comments** | | |
| 319 | Department of Health | I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation. |

## *Registered stakeholders who submitted comments at consultation*

| Label used in report | Stakeholder name |
|---|---|
| AACE | Association of Ambulance Chief Executives |
| AESOP | AESOP |
| Age UK | Age UK |
| AGILE | AGILE (special interest group for Physiotherapists working with Older People - part of the Chartered Society of Physiotherapy) |
| AHL | Action on Hearing Loss |
| BAAP | British Association of Audiovestibular Physicians |
| BAPO | The British Association of Prosthetists and Orthotists |
| BGS | British Geriatrics Society |
| BSABIG | British Society of Audiology Balance Interest Group |

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| CNWL | Central and North West London NHS Foundation Trust |
| COT | College of Occupational Therapists |
| CRE | Care & Repair England |
| CSP | The Chartered Society of Physiotherapy |
| CUK | Carers UK |
| CVUHB | Cardiff and Vale University Health Board |
| CWCC | Cheshire West and Chester Council |
| FP | Ferring Pharmaceuticals |
| GST | Guy's and St Thomas' NHS Foundation Trust |
| IIPL | IHip Impact Protection Ltd |
| LC | Lancashire Care NHS Foundation Trust |
| NB | North Bristol NHS Trust |
| NDR | NDR-UK |
| NHSE | NHS England |
| NHSIPS | NHS Improvement: Patient Safety |
| NOS | National Osteoporosis Society |
| NU | Newcastle University |
| NUTH | The Newcastle upon Tyne Hospitals NHS Foundation Trust |
| OM | Optasia Medical |
| OSJCT | Orders of St John Care Trust |
| PCNS | Primary Care Neurology Society |
| PHW | Public Health Wales |
| PUK | Parkinson's UK |
| RCGP | Royal College of General Practitioners |
| RCN | Royal College of Nursing |
| RCP | Royal College of Physicians |

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| RCPE | Royal College of Physicians of Edinburgh |
| RCPsy | Royal College of Psychiatrists |
| RHC | Ramsay Health Care |
| RoSPA | The Royal Society for the Prevention of Accidents |
| RPS | Royal Pharmaceutical Society |
| SMBC | Sandwell MBC - Public Health (and partners) |
| ST | South Tyneside NHS Foundation Trust |
| STARS | Syncope Trust And Reflex anoxic Seizures |
| STAT | Society of Teachers of the Alexander Technique |
| TCF | The Care Forum |
| TWHT | The Whiteley Homes Trust |
| YAS | Yorkshire Ambulance Service |
| YDH | Yeovil District Hospital NHS Foundation Trust |