NICE National Institute for Health and Care Excellence

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

**Consultation on draft guideline – deadline for comments 5pm on 28/11/2024** **email: fallsupdate@nice.org.uk**

**Checklist for submitting comments**

- Use this comments form and submit it as a **Word document (not a PDF)**.
- **Do not submit further attachments** such as research articles, or supplementary files. We return comments forms that have attachments without reading them. You may resubmit the form without attachments, but it must be received by the deadline. You are welcome to include links to research articles or provide references to them
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **document name, page number and line number** of the text each comment is about.
- Combine all comments from your organisation into 1 response form. **We cannot accept more than 1 comments form from each organisation**.
- **Do not** paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; **do not** cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public with underlining and highlighting. Also, ensure you state in your email to NICE, and in the row below, that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

**Note:** We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate. Where comments contain confidential information, we will redact the relevant text, or may redact the entire comment as appropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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| | **Please read the checklist above before submitting comments. We cannot accept forms that are not filled in correctly.**<br>We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment.<br>In addition to your comments below on our guideline documents, we would like to hear your views on these questions. **Please include your answers to these questions with your comments in the table below.**<br>1. Would it be challenging to implement of any of the draft recommendations? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives.<br>2. Would implementation of any of the draft recommendations have significant cost implications?<br>3. What would be the feasibility, and likely impact on the wider health and social care system, of fully implementing recommendation 1.3.5 related to offering home hazard assessments carried out by an occupational therapist?<br><br>See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting. |
| **Organisation name** (if you are responding as an individual rather than a registered stakeholder please specify). | Royal College of General Practitioners |
| **Disclosure** (please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry). | No disclosures |
| **Confidential comments** (Do any of your comments contain confidential information?) | No |

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| **Name of person completing form** | Michael Mulholland/Adrian Hayter |

| **Comment number** | **Document** [e.g. guideline, evidence review A, B, C etc., methods, EIA] | **Page number** **'General'** for comments on whole document | **Line number** **'General'** for comments on whole document | **Comments**<br>• Insert each comment in a new row.<br>• Do not paste other tables into this table, because your comments could get lost – type directly into this table.<br>• Include section or recommendation number in this column. |
|---|---|---|---|---|
| Example | Guideline | 016 | 045 | Rec 1.3.4 – We are concerned that this recommendation may imply that …….. |
| Example | Guideline | 017 | 023 | Question 1: This recommendation will be a challenging change in practice because …… |
| Example | Guideline | 037 | 016 | This rationale states that… |
| Example | Evidence review C | 057 | 032 | There is evidence that … |
| Example | Evidence review C | 063 | 012 | CONFIDENTIAL: Our unpublished study has shown that [X] is more effective than [Y] |
| Example | Methods | 034 | 010 | The inclusion criteria … |
| Example | Algorithm | General | General | The algorithm seems to imply that … |
| Example | EIA | 010 | 002 | We agree with the barriers to access listed, and would also like to add …. |
| 1 | Guideline | 5 | 4 | This looks like a specialist-based intervention rather than a GP-led intervention. Do we want falls to be only a specialist service? Rec1.1.3 *Offer comprehensive falls assessment and management for people who 4 have fallen in the past year….*We fully support the need for falls assessments but there is a risk that this leads to knee jerk falls referrals without optimising general practice interventions / quick wins. Eg, GP should do BP & check medication as a minimum, ideally a fuller assessment.<br>This is particularly important as a person with falls may go onto a long waiting list. Falls services are run by MDT with variable medical input so risks missing important brief interventions. |
| 2 | Guideline | 5 | 16 | We are concerned that this misses their medications and blood pressure. |

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| 3 | Guideline | 5 | 24 | We question if readers have the energy to understand/remember what this recommendation is suggesting i.e. who the population is? |
| 4 | Guideline | 7 | 1 | An examination of carotids and physical activity (a bit different from mobility) could be included. Additionally, we recommended putting medication review first along with including a link to a trusted resource on medicines implicated in falls such as National Falls Prevention Coordination Group. Lastly, when moving from GP to GP extended role frailty, it was curious that falls clinics largely don't include a physical assessment for underlying/optimising medical conditions. This seems an important part of minimising the risk of falls. Where should that fit within the falls assessment pathway? |
| 5 | Guideline | 7 | 13-24 | The recommendation to offer a comprehensive falls assessment that includes assessments of mobility, gait, cognitive function, and cardiovascular status requires time, skilled professionals, and coordination. GPs and community healthcare providers could struggle with the added workload of these comprehensive assessments, particularly in areas already facing workforce shortages. Older patients who require multi-specialist input might experience delays. To address the shortage of time and resources, general practices could implement streamlined pathways where screening is done by healthcare assistants or nurses, with referrals to specialists only for those identified as high risk. Training programs could focus on enabling more staff to conduct simple assessments of mobility, cognition, and cardiovascular function. |
| 6 | Guideline | 9 | 4-8 | We believe that national campaigns or the integration of vitamin D promotion into routine consultations, such as during annual reviews or flu clinics, could increase adherence. |
| 7 | Guideline | 9 | 10-23 | We are concerned that the recommendation to "offer a home hazard assessment and intervention, carried out by an occupational therapist, using a validated tool" could present logistical challenges. These assessments require the involvement of trained OTs, which could strain local health systems where there are existing staff shortages or long waiting times for assessments. Access to OTs can be limited particularly in rural settings, where the availability of home visit services is already constrained. This challenge can result in delayed interventions, increasing the risk of falls before assessments can be completed. Implementing a program of home hazard assessments would likely require expanded OT services, including recruitment, training, and possibly contracting private OTs to meet demand. This would be more feasible in urban centres where OTs are more readily available, but rural and underserved areas may face delays due to workforce shortages. Given that the numbers would be too great and to not solely make this the job of the OT, it may be helpful to train non-specialist staff, such as community nurses or healthcare assistants, to perform basic hazard checks while waiting for OT assessment, or explore telehealth options for preliminary assessments. |

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| 8 | Guideline | 8 | 13 | Conducting a structured medication review, especially for patients on psychotropic medicines, may require input from pharmacists, GPs, and potentially specialists. This can significantly increase consultation times and potentially result in the need for more frequent reviews if medications are adjusted. |
| 9 | Guideline | 10 | 4-5 | We believe access to CBT can be limited, especially in areas with long waiting lists for psychological services. We recommend developing self-help CBT resources tailored for people with a fear of falling. |
| 10 | Guideline | 10 | 20-28 | Offering tailored falls prevention exercise programs that include individualised strength and balance exercises, as well as regular reviews, requires the availability of trained professionals to deliver these programs. Local health and community care providers, especially those in areas with a lack of resources for regular follow-up. Patients with mobility issues or those who lack access to community centres offering such programs might face barriers. To reduce the resource burden, community care services could consider group-based exercise programs or virtual programs, which might be more scalable than individual in-person programs. The use of existing social prescribing networks or volunteer-based services could also alleviate the pressure on healthcare providers. |
| 11 | Guideline | General | N/A | We believe that the falls assessment should be implemented by a multiprofessional team and include someone who is a prescriber and able to make changes to medication and do a SMR. The challenge however is that falls teams may not have a prescriber as part of their team.<br>Multidisciplinary proactive community teams could do this, and comprehensive assessments are needed - Holistic, individualised assessment by an appropriate multiprofessional team. |
| | | | | |

Insert extra rows as needed

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