NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 4

Falls prevention – prioritisation meeting
Hip fracture (update) – post consultation meeting

Minutes of the meeting held on Wednesday 25th May 2016 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Damien Longson (DL) [Chair], Allison Allam, Moyra Amess, Derek Cruickshank, Allison Duggal, Nadim Fazlani, Tim Fielding, Zoe Goodacre, Nicola Hobbs-Brake, Jane Ingham, John Jolly, Asma Khalil, Annette Marshall, Jane Putsey, Michael Varrow **Specialist committee members** Falls prevention – Harm Gordijn, Raymond Jankowski, Margaret Odgen, Cameron Swift, Victoria Welsh Hip fracture (update) – Freja Evans-Swogger, Tim Chesser, Cameron Swift, Iain Moppett, Ruth Halliday, Jan Wright, Antony Johansen **NICE staff** Nick Baillie (NBa), Tony Smith (TS) [agenda items 1-6], Paul Daly (PD) [agenda items 1-6], Lisa Nicholls, Karyo Angeloudis (KA) [agenda items 7-11], Julie Kennedy (JK) [agenda items 7-11], Nicola Bodey (NBo) [agenda items 7-14] **NICE Observers** Falls prevention - Martin Domanski
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Jane Bradshaw, Alaster Rutherford, David Weaver

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day	The Chair welcomed the attendees and the Quality Standards Advisory Committee (QSAC) members introduced themselves.	

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(private session)	The Chair informed the Committee of the apologies and reviewed the agenda for the day.	
2. Welcome and code of conduct for members of the public attending the meeting (public session)	The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow. It was stressed that they were not able to contribute to the meeting but were there to observe only. They were also reminded that the Committee is independent and advisory therefore the discussions and decisions made today may change following final validation by NICE's guidance executive.	
3. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: Standing committee members • Jane Ingham – role on national falls audit Specialist committee members • Harm Gordijn – owns a training company on the management of falls aimed at care homes. Also trains health hand social care professionals on how to prevent falls in older people and how to develop a falls strategy • Raymond Jankowski – wife is the National Lead for immunisation at Public Health England • Victoria Welsh – holds an NIHR Doctoral Research Fellowship and is employed to complete this at the Arthritis Research Primary Care Centre. PhD is entitled pain and falls in older people. **Minutes from the last meeting** The Committee reviewed the minutes of the last meeting held on 27th April 2016 and confirmed them as an accurate record.	
4. QSAC updates	NB updated the committee on some web statistics available for people accessing quality standards on the NICE website. The committee were also advised of a new way of searching for quality statements. This is in BETA format on the website and the NICE team encouraged the committee to test this out and send in any comments.	

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5 and 5.1 Topic overview and summary of engagement responses	PD and TS presented the topic overview and a summary of responses received during engagement on the topic.	
5.2 Prioritisation areas for committee discussion	The committee was asked to consider the pathway diagram relating to falls prevention from NICE guideline CG161, and to suggest the parts of the pathway that should be prioritised as quality improvement areas within the quality standard. The committee noted the potential value of the quality standard in enabling action in primary care, and supporting partnerships between primary healthcare, social care and specialist falls services. The committee noted that falls are a syndrome or symptom relating to ageing, and a signal for other healthcare issues. The importance of acting on assessed risk was emphasised. From a consideration of the pathway, it was agreed that identification of older people at risk of a first fall, multifactorial risk assessment and multifactorial interventions would be prioritised for discussion as potential areas for quality standards. Other stakeholder suggestions, as set out in the committee briefing paper, would then be considered.	
5.3 Prioritised area – identification of cases and multifactorial risk assessment	The committee discussed the suggested quality improvement areas of identification of cases and multifactorial risk assessment together. The NICE team summarised stakeholder comments and current practice in this area of care. It was noted that the NICE clinical knowledge summary sets out a stepwise approach to identification, assessment and referral. While the NICE recommendation on identification of at-risk older people emphasises the role of healthcare professionals, the committee felt this could be undertaken by other care workers who visit older people at home, with appropriate linkages to primary healthcare teams. The NICE team was asked to draft a quality statement based on recommendation 1.1.1.1 from NICE guideline CG161, to cover routinely asking older people about falls. The NICE team was asked to include a broader range of care professionals within the scope of the statement. In terms of measures, NICE was asked to consider separate measures for different care settings (general practice, emergency departments, outpatients and inpatients). The committee agreed that acting on concerns about the risk of falls, by undertaking multifactorial risk	**NICE team to draft a quality statement based on recommendation 1.1.1.1 from NICE guideline CG161, to cover routinely asking older people about falls.** **NICE team to draft a second quality statement**

Agenda item	Discussions and decisions	Actions
	assessment, was a key quality improvement area. While assessments in primary care do happen, this if often fragmented manner, with components of multifactorial assessment not pulled together and not recorded. Specialist services should be used as part of the assessment where necessary. The committee heard specialist opinion that this action was achievable without an additional cost impact. The NICE team was therefore asked to draft a second quality statement based on recommendation 1.1.2.1 on providing multifactorial risk assessment for people around whom there are concerns.	**based on recommendation 1.1.2.1 on providing multifactorial risk assessment for people around whom there are concerns.**
5.3 Prioritised area – multifactorial interventions	The committee agreed that the provision of multifactorial interventions, to take responsibility for outcome where a specific risk factor is identified, was a key area for quality improvement. The committee noted numerous recommendations in NICE guideline CG161 about potential interventions (recommendations 1.1.3 to 1.1.8), and interventions that are not recommended because of lack of evidence (1.1.12). The committee agreed that rather than focus on specific interventions the priority should be to ensure the provision of a range of multifactorial interventions, tailored to a person's risk factors that together will reduce the risk of falls. The NICE team was asked to draft a statement about tailored multifactorial interventions based on the multifactorial risk assessments.	**NICE team to draft a statement about tailored multifactorial interventions based on the multifactorial risk assessments.**
5.3 Other potential quality improvement areas:	The NICE team summarised other quality improvement areas, suggested by stakeholders and set out in the committee's briefing paper. Falls prevention programmes were discussed in terms of patient empowerment. It was suggested that compliance could be improved through the emphasis of positive aspects of improved strength, balance and wellbeing rather than in terms of the prevention of falls. Overall, the committee felt that the NICE guideline recommendations about falls prevention programmes were set out in terms of service delivery, and could be addressed as aspects of other quality statements (equality considerations and audience descriptors). Regarding information giving, the committee noted the quality standard on patient experience in adult NHS services, and did not feel a specific statement relating to falls prevention should be prioritised.	

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Agenda item	Discussions and decisions	Actions
6.4 Resource impact	No specific resource impacts were identified at this stage for each of the areas prioritised. Resource impact will continue to be considered throughout the development of the quality standard.	
6.5 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on falls prevention. It was agreed that the Committee would contribute suggestions as the quality standard was developed.	
6.6 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the Committee to consider any relevant issues. It was agreed that the Committee would contribute suggestions as the quality standard was developed. The committee asked the NICE team to note that older people who are not routinely in contact with care services (for example, the homeless, those not registered with GPs and some members of traveller communities) may miss out on routine checks.	
6.7 QSAC specialist committee members (part 1 – open session)	NB asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required. **Specialist members**: It was agreed that no further specialist were required.	
6. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the falls prevention quality standard.	
7. Welcome and code of conduct for members of the public attending the meeting (public session)	The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow. It was stressed that they were not able to contribute to the meeting but were there to observe only. They were also reminded that the Committee is independent and advisory therefore the discussions and decisions made today may change following final validation by NICE's guidance executive.	
8. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared:	

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	Standing committee members • Jane Ingham – CEO of HQIP and commissions patient outcomes Specialist committee members • Tim Chesser – board member of the falls fragility fractures audit project. Is CERO of BOA trauma group. Was on the NICE guideline on hip fracture. Editorial board journal of the orthopaedic trauma inquiry. Institutional support all major orthopaedic companies. Design contract for pelvic reconstruction plate. Pain speaker fees and expenses from Stryker and JRI. On Acumed advisory board. • Ruth Halliday - independent research consultant, since July 2015 and has provided services to JRI Ltd regarding a research project reviewing a total hip replacement implant for elective total hip replacements. • Antony Johansen - clinical lead for the National Hip Fracture Database, run within the Clinical effectiveness Evaluation Unit at the RCP in London. Responsible for delivering Audit against standards defined by QS16 to commissioners - NHS England and NHS Wales through HQIP • Iain Moppett – researcher in peri-operative care of patients with hip fracture, Grants form National Institute of Academic Anaesthesia and NIHR. Member of BOA peer review group providing peer review to trusts with outlier hip fracture mortality. Author of documents to support informed consent.	
9. Recap of prioritisation exercise	KA and JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for hip fracture (update): **At the first QSAC meeting on 27th January 2016 the QSAC agreed that the following areas for quality improvement should be progressed for further consideration by the NICE team for potential inclusion in the draft quality standard:** • Analgesia • Surgery • Mobilisation strategies post-surgery • Multidisciplinary management The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: https://www.nice.org.uk/Media/Default/Get-involved/Meetings-In-Public/Quality-Standards-Advisory-	

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	Committee/QSAC4/qsac4-minutes-jan-16.pdf	
9.2 and 9.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	KA and JK presented the Committee with a report summarising consultation comments received on hip fracture (update). The Committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended to provide an initial basis for discussion. The Committee was therefore reminded to also refer to the full list of consultation comments provided throughout the meeting. The Committee was informed that comments which may result in changes to the quality standard had been highlighted in the summary report. Those comments which suggested changes which were outside of the process, were not included in the summary but had been included within the full list of comments, which was within the appendix. These included the following types of comment: • Relating to source guidance recommendations • Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation advice • General comments on role and purpose of quality standards • Requests to change NICE templates	
9.4 Discussion and agreement of final statements	The Committee discussed each statement in turn and agreed upon a revised set. **These statements are not final and may change as a result of the editorial and validation processes.**	
	Draft Quality Statement 1: Adults presenting with hip fracture receive prompt pain management that is based on an assessment of their pain The committee discussed the draft statement, taking into consideration stakeholder comments received at consultation. The committee discussed removing the specific measures on paracetamol as this is already happening in practice. The suggestion to include nerve blocks was also discussed but it was noted that the guidance only says to consider them and there is no strong evidence. The committee highlighted analgesia as important but is difficult to measure.	

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	The committee felt there was a limit to the evidence base for this statement. Pain assessment was discussed, as well as regular review of analgesia. It was agreed that although analgesia is important this statement did not add to patient care in its current form. This is because the existing measures would not lead to quality improvement and it isn't possible to add measures on nerve blocks due to the evidence base. The committee therefore agreed it should be removed from the quality standard. NICE team not to progress this statement.	**NICE team to remove draft statement 1**
	Draft Quality Statement 2: Adults with hip fracture have surgery on the day of, or the day after, admission under the supervision of senior surgeons and anaesthetists The committee discussed the wording senior surgeons and anaesthetists and whether this was necessary or whether the word competent could be used. It was agreed that using the term senior rather than competent would ensure that the statement was measurable. It was noted that a senior surgeon would be needed due to the frailty of hip fracture patients. Planned trauma list was discussed and whether this could be included in the statement definitions or measures. The committee felt strongly about the inclusion of planned trauma list as it ensures the appropriate team members input during hip fracture surgery. The committee discussed the issue that there is data to suggest that the majority of hip fracture surgeries occur between 8am and 8pm. However, specialist members explained that this does not mean the surgery is done on a planned trauma list. A planned list has specific people with relevant competencies and specialists advised that a significant number of hip fractures still do not happen on this type of list. NICE team to update the statement to include planned trauma list in the statement and define it in the definitions. Staff supervision will be included in the definition of planned trauma list.	**NICE team to amend statement to include planned trauma lists in the statement wording and to move staff supervision to the measures and definitions.**
	Draft Quality Statement 3: Adults with displaced intracapsular hip fracture receive cemented arthroplasty, and those who are assessed as clinically eligible are offered a total hip replacement The committee discussed that only half the population is being included in this statement.	

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	The committee discussed offering all patients surgery in line with the guidance – CG124. The committee agreed the whole surgical pathway should be followed. Total hip fracture eligibility was felt to be 'too woolly'. Some SCMs felt the need to include contraindications to cemented arthroplasty. The committee questioned which type of hip fracture surgery is the priority area asking the specialists which surgery isn't being done consistently. The specialists advised there is a need for improvement in all types of hip fracture surgery and they therefore felt they couldn't specify one particular type of surgery. NICE to extend the scope of the statement to include other types of hip fracture surgery.	**NICE to NICE to extend the scope of the statement to include other types of hip fracture surgery**
	Draft Quality Statement 4: Adults with hip fracture start daily mobilisation on the day after surgery The committee discussed this statement and highlighted that mobilisation just suggests walking and other aspects needs looking at. Rehabilitation was suggested as wording but the guidance doesn't say this so the statement will retain the word mobilisation to align with the source guidance. The NICE team agreed to strengthen the definitions to ensure it is clear that mobilisation involves more than just walking. Specialists advised that timing should be no later than day after surgery. The committee discussed continued daily mobilisation should be done on the day after surgery and continuously until discharge. The committee discussed the issue that mobilisation should be led by a physiotherapist. It was agreed this wouldn't be added to the statement and confirmed it is included in the rationale and definitions sections. Measurability was discussed. Although mobilisation doesn't just apply to hip fracture this was noted as a key area for hip fracture patients who need to be mobilised as soon as possible after surgery. NICE team to update the statement to say adults with hip fracture start daily mobilisation no later than the day after surgery until discharge. The specialist committee members questioned the accuracy of the figure of an average 8.5 hours of physiotherapist time per patient that is presented in the resource impact section of the quality standard.	**NICE team to draft statement to say adults with hip fracture start daily mobilisation no later than day after surgery until discharge.** **NICE team to update the**

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	The NICE team advised that this figure will be removed as well as the data on who receives it.	**resource impact section.**
	Draft Quality Statement 5: Adults with hip fracture are offered a formal orthogeriatric-led Hip Fracture Programme when admitted to hospital The committee discussed the statement on hip fracture programme and highlighted that it is not offered. There is one and it's in place for the patient to receive appropriate care. The committee asked to amend the wording to say 'cared for within' rather than 'offered' The committee discussed that the clinical governance and service governance approach across all stages of the pathway was a key area missing from the statement. The committee felt this should be statement 1 in the order of quality statements as it sets the scene for the rest of the standard. The measures need to be used to look at the specific aspects within the hip fracture programme. The committee suggested measures on: rapid optimisation of fitness to surgery, orthogeriatric assessment. This is potentially a service based statement but NICE will explore this further to make it more person centred. It will focus on hip fracture programme and focus on clinical and governance aspect. NICE team to re-draft the statement to say clinical and service governance responsibility for all stages of the pathway of care and rehabilitation, including community.	**NICE team to order statements so this is statement 1 of the quality standard.** **NICE team to re-draft the statement to say clinical and service governance responsibility for all stages of the pathway of care and rehabilitation, including community.**
	Additional areas suggested by stakeholders There were 2 additional areas suggested for improvement: 1. Bone assessment and secondary prevention 2. Rehabilitation after discharge The bone assessment and secondary prevention had no recommendations to support this and it was agreed that the statement on hip fracture programme covered rehabilitation after discharge.	
9.5 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on hip fracture (update). It was agreed that the Committee	

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	would contribute suggestions as the quality standard was developed. The committee mentioned mortality rates within 120 days, 30 day mortality and re-admission rates within 30 days.	
9.6 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the Committee to consider any relevant issues. It was agreed that the Committee would contribute suggestions as the quality standard was developed. The committee highlighted early supported discharge withheld from people admitted from care or nursing homes because of their living environment. Concern over discrimination for this group.	
10. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the hip fracture (update) quality standard.	
11. Any other business (part 2 – Private session)	The following items of AOB were raised: • None The Chair thanked the specialist committee members for their input into the development of this quality standard. **Date of next QSAC 4 meeting:** Wednesday 29th June 2016 – vaccine uptake in under 19s	