Quality Standards Advisory Committee 4

Osteoporosis– prioritisation meeting
Falls prevention – post-consultation meeting

Minutes of the meeting held on Wednesday 28th September 2016 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Damien Longson (DL) [Chair], Alison Allam, Moyra Amess, Simon Baudouin, Jane Bradshaw, James Crick, Allison Duggal, Nadim Fazlani, Nicola Hobbs, Jane Ingham, John Jolly, Annette Marshall, Jane Putsey, Mathew Sewell, Michael Varrow, David Weaver **Specialist committee members** Osteoporosis – Terry Aspray, Juliet Compston, Frances Dockery, Sheila Ruddick, David Stephens, Angela Thornhill Falls prevention - Raymond Jankowski, Margaret Ogden, Cameron Swift, Victoria Welsh **NICE staff** Nick Baillie (NB), Tony Smith (TS), Stacy Wilkinson (SW) [agenda items 1-6], Paul Daly (PD) [agenda items 7-11], Lisa Nicholls (LN), Nicola Bodey (NB) [agenda items 1-6], Adam Storrow (AS), [agenda items 7-11] **NICE observer** Helen Vahramian
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Zoe Goodacre, Tim Fielding, Asma Khalil, Derek Cruickshank

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.	

Agenda item	Discussions and decisions	Actions
(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 topics under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> • Terry Aspray – has received travelling expenses and some speaker feed for non-promotional lectures and teaching materials produced on vitamin D, metabolic bone disease and osteoporosis, from Pulse magazine, Leicester University, OnTrac medics, Mark Allen Group, British Menopause Society, Royal College of Obstetricians and Gynaecologists and Bone Research Society. Has published on the topic of osteoporosis, bone health and fractures. • Juliet Compston – Advisory Board Gilead – development of new antiretroviral drug tenofovir alafenamide 2015-2016. Chair of the osteoporosis guideline development group. • Sheila Ruddick – funded attendance at National osteoporosis conference in November 2015 by Eli Lilly. **Minutes from the last meeting** The Committee reviewed the minutes of the last meeting held on 27th July 2016 and confirmed them as an accurate record.	
4. QSAC updates	NB updated the committee on the status of the hip fracture quality standard. The draft quality standard went out for a second consultation to check it reflected the key areas. It was agreed there was no reason not to progress the quality standard as drafted. The committee was reminded that an email has been circulated to members about changes to the quality	

Agenda item	Discussions and decisions	Actions
	standards programme for 2017/18. Committee members were invited to contact NB with any queries. The committee was informed that the NICE accreditation programme has been closed to new applications. Guideline producers who are currently accredited will remain accredited.	
5 and 5.1 Topic overview and summary of engagement responses	SW and TS presented the topic overview and a summary of responses received during engagement on the topic.	
5.2 Prioritisation of quality improvement areas	The Chair and SW led a discussion in which areas for quality improvement were prioritised. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below.	

Area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Who to assess for fragility fracture	Yes	The committee discussed Fracture Liaison Services (FLS) to identify people for assessment. This was not prioritised because there are no guideline recommendations to support a quality statement. The committee discussed the groups of people to consider for fragility fracture risk assessment, including people who have had a previous fragility fracture, people who have had a fracture but not a recorded fragility fracture, and people not known to have had a fracture. The committee felt that the priority is preventing fractures in all people who are at risk (both primary and secondary prevention), and agreed there is variation in the current approach to identifying people at risk. All at-risk groups need to be identified and then have a risk assessment.	NICE to consider the feasibility of drafting a statement on: Identification and assessment of people who are at risk of fragility fracture

How to assess for fragility fracture risk	No	The committee discussed access to DXA scans and waiting times, noting variation in length of waiting time and local availability of DXA scanners. In the absence of a guideline recommendation about the timescale between referral and provision of DXA scans, and noting that DXA scans may not be needed for people at low risk of fragility fracture, the committee agreed this was not an area to prioritise within the quality standard.	The committee agreed not to progress this area.
Management for people at risk of fragility fracture	Yes	The committee agreed not to prioritise lifestyle (exercise) advice in the absence of strong guideline recommendations relating to fragility fracture risk. The committee discussed drug treatment for people with osteoporosis or assessed as at risk of fragility fracture, noting that access to some treatments for specific groups is covered by NICE technology appraisals. The committee agreed that there were some key areas for quality improvement relating to the use of drug treatment that should be covered by the quality standard. First, the initiation of drug treatment for adults at higher risk of fragility fracture; the committee felt that treatment initiation within a certain timeframe following diagnosis was an important area, but acknowledged that there might not be recommendations to support this in the wording of a quality statement. Secondly, the committee discussed the importance of follow up and side effects of treatment. They felt that there is a high drop-out rate of people taking drugs and that effective follow up to review adherence and side effects would support adherence or allow alternative treatments to be considered. In addition, the committee agreed that	NICE to consider the feasibility of drafting statements on: 1) Initiation of drug treatment 2) Follow up to review adherence and side effects of drugs 3) Long-term follow-up of people taking drugs for osteoporosis

		long-term follow up to check whether people should continue or stop treatment is also important (and a recommendation in the recently published NICE guideline on multimorbidity makes reference to this).	

Additional areas suggested	Committee rationale	Area progressed (Y/N)
1. Quality of bone density reporting	No recommendations in the guidance	The additional suggested areas were not progressed by the committee.
2. Screening for coeliac disease	Outside the remit of this QS referral	
3. Access to treatments for vertebral compression fractures	Treatment options are covered in NICE TA279.	
4. Patient information	Covered by QS15: Patient experience in adult NHS services	
5. Falls: assessing risk and prevention	In the scope of falls prevention QS, under development	
6. Indicators and implementation support	Not suitable for statement development	

5.3 Resource impact	Resource impact was discussed under each area for consideration. The actions for the NICE team were agreed on the basis that the potential quality statements were considered to be achievable in terms of the resources required to deliver them. For example: • Increased identification and assessment of people at risk of fragility fracture could increase additional clinical time and have an associated cost, but would reduce the number of fractures, avoid preventable mortality and have a cost saving long-term. • There is no resource impact work available for follow up as it was not covered by NICE guideline CG146, but there is potential for additional clinical time and costs associated with that.	
5.4 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on osteoporosis. It was agreed that the Committee would contribute suggestions as the quality standard was developed.	
5.5 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. The committee raised vitamin D deficiency in the Asian population, but agreed this issue is separate from the osteoporosis context, as all people with osteoporosis need to have sufficient vitamin D levels. It was agreed that the Committee would contribute suggestions as the quality standard was developed.	
5.6 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 the constituency was suitable.	
6. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the osteoporosis quality standard.	
7. Welcome and	The Chair welcomed the public observers and reminded them of the code of conduct that they were	

code of conduct for members of the public attending the meeting (public session)	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: <u>Specialist committee members</u> • Raymond Jankowski – was on the original falls guideline CG16. Wife is the National Lead for immunisation at Public Health England. • Victoria Welsh – holds an NIHR Doctoral Research Fellowship (DRF2011/04/147) and is employed to complete this at the Arthritis Research UK Primary Care Centre, Keele University. PhD is entitles 'Pain and falls in older people'. It was noted that Harm Gordijn was unable to attend the meeting due to last minute circumstances. As a result of this and being unable to contribute to the quality standard, he submitted his resignation from the committee.	
9. Recap of prioritisation exercise	PD and TS presented a recap of the areas for quality improvement discussed at the first QSAC meeting for falls prevention: **At the first QSAC meeting on 25th May 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:** • Identification of cases: Statement on routinely asking older people about falls (based on recommendation 1.1.1.1) • Multifactorial risk assessment: Statement based on recommendation 1.1.2.1 • Multifactorial interventions: Statement on tailored multifactorial interventions based on multifactorial risk assessments The following areas were also discussed but not prioritised by committee:	

	• Falls programmes • Information giving The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: https://www.nice.org.uk/guidance/GID-QS10011/documents/minutes	
9.1 and 9.2 Presentation and discussion of stakeholder feedback and key themes/issues raised	PD and TS presented the committee with a report summarising consultation comments received on falls prevention. 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 included 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	
9.3 Discussion and agreement of final statements	The Committee discussed each statement in turn, discussed if changes were needed, and agreed any changes needed to statements. **These statements are not final and may change as a result of the editorial and validation processes.**	

Draft statement 1	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Older people are asked about falls when they have	• Should the main action of the statement do more than ask about falls, e.g. probe	The committee asked who should be asking the question and social care staff should be aware of this.	Yes. Consider amending statement

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	other matters (such as balance, strength); include observations; or include screening tests? • How often should practitioners ask older people about falls? • Which practitioners / services should ask older people about falls? • Measurability: statement considered measurable, but there are challenges • Queries made about hospital related terms used	Define falls in the rationale. Committee discussed the advantages and disadvantages of widening and narrowing the scope of the statement in terms of who should ask older people about falls. The consensus view was that the statement should apply to health and social care practitioners. Implementation of the statement was recognised as being more challenging in community and social care settings. A lack of integrated, standardised information systems operating across organisations means that measurement may have to be based on case record review in some community and social care settings. Committee considered that the term 'ask about falls' in the draft statement makes the action wider than a single question asking if someone has fallen. Members wanted the NICE team to explore how the statement could probe balance, whilst remaining underpinned by the guideline recommendation and not narrowing the scope of who could perform the action, e.g. observations of balance and gait require a trained healthcare professional. Such a change would ensure the statement captures people at risk of falling who have not yet fallen (as well as past fallers), and allow for careful framing of questions about falls (use of the word 'fall' can be problematic as some people do not want to be classified as a faller). Members were clear that practitioners should not be asking at every single contact about falls. A sensible, pragmatic balance is needed and opportunities should be taken to ask questions as part of regular assessments, reviews, health checks, and events such as annual flu vaccinations. Members queried whether some specific phrases in the rationale of the statement were consistent with the statement wording. Committee were also advised of the problems associated with some of the terms used in relation to hospitals in the statement.	wording to address balance. Review and amend audience descriptors, measures, and definitions to ensure that the statement: • Probes balance • Includes case record review as a way of collecting data • Considers the way that people are asked about falls Review use of the terms 'at risk of falling' and 'have fallen' in rationale to ensure they align with the statement. Review use of phrases relating to admission to / attendance at hospital.

Draft statement 2	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Older people at risk of falling are offered a multifactorial falls risk assessment	• Identification of the target population • Components of a multifactorial risk assessment (MFRA) • What practitioners and services should carry out MFRA? • Audience descriptors generally considered appropriate (response to consultation question)	Members recognised that the target population for this statement is different to statement 1, and this is necessary as it is determined by the underpinning guideline recommendation. Specialist members explained that identifying the target population involves getting the story behind falls that have occurred, using clinical judgment and taking observations of balance and gait. Following discussion of stakeholder comments, members were satisfied with the components of MFRA listed in the draft statement. These are illustrative in any case, and taken form the source guidance. Committee noted that the statement says that MFRA should be performed by healthcare professional with skills and experience in falls prevention, often in the setting of a specialist falls service. This mirrors the source guideline, and does not mean that MFRA can only take place in the setting of a specialist falls service. Members described how MFRA could be undertaken by healthcare professionals with the necessary skills and knowledge in other settings with appropriate clinical governance. In addition, MFRA often involves a multidisciplinary approach with different professionals performing different components, but being coordinated and pulled together by a professional with falls expertise.	Yes. Statement wording to be retained. Audience descriptors and other sections to be reviewed in light of committee discussion.

Draft statement 3	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Older people assessed as at risk of falling receive an individualised multifactorial intervention	• Components of multifactorial intervention • Reference to interventions that are 'not recommended' • Who should perform interventions?	The committee discussed reducing the long definition in interventions and keeping the introductory sentience and linking it to the guideline. By delivering by competent clinicians in context of specialist falls service you build in clinical governance. As it's currently written it stands up to scrutiny based on stakeholder comments. Do the multifactorial interventions need including? It's individualised so	Yes. NICE team to review use of word 'receive' in statement wording in light of consistency rules and procedures. Formatting and positioning of

	• Audience descriptors generally considered appropriate (response to consultation question)	no need to specify. Update part in statement of recommended and not recommended interventions and make clearer in wording. Agree rather than receive the multifactorial intervention. Or are offered? Receive is an audit measure however. Is it the offer or receipt of intervention? Recommendation mentions people considered but wanted something more. Review the use of the word 'receive'. Need something more robust and is measurable and auditable. Committee discussed the advantages and disadvantages of listing components of multifactorial interventions in the statement. Members recognised that the components of multifactorial intervention will vary as they are individualised and based on the results of the MFRA. Committee concluded that the components in the statement are illustrative, evidence based and stand up to scrutiny based on stakeholder comments. The positioning and formatting of the text describing the components within the statement should be reviewed and made consistent, though. Members discussed whether the term 'receive' within the statement should be replaced with 'offer' to be consistent with other quality standards, and also other alternatives making reference to agreeing the interventions (such as 'agree and receive'). 'Receive' has the advantage of ensuring that interventions are actually happening, and is auditable. 'Offer' and 'agree' reflect discussion, choice and ownership. Committee recognised that NICE has consistency rules and procedures that govern the use of these terms and asked the NICE team to review the wording accordingly.	components of multifactorial interventions to be reviewed and made consistent.
Additional statements suggested	**Committee rationale**		**Statement progressed (Y/N)**
1. Health promotion initiative	No guideline recommendations or evidence to progress a statement based on this suggestion.		The additional suggested statements were not progressed by the committee.
2. Self-	The suggested statement focused on self-management through provision of information and advice, and		

management	reablement. Reablement is covered by a NICE guideline that is in production and could be the subject of a future quality standard. Provision of information and advice this was discussed at the first committee meeting but was not prioritised as a key area for quality improvement.	

9.4 Resource impact	A summary of stakeholder comments on resource impact was presented to committee, and matters with potential resource impact were raised for each of the draft statements. Members discussed potential resource impacts and the achievability of the statements, including potential cost savings. Specialist committee members informed committee of significant potential cost savings from reducing hospital admissions and bed days; and that the time between investment in falls prevention services and the cost savings being realised was generally short (could be within 12 months). Studies were also referenced of implementation in different areas (such as Nottingham) to demonstrate that the actions are achievable. Overall, committee was satisfied that the statements would be achievable given the net resources required.	
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 falls prevention. It was agreed that the Committee would contribute suggestions as the quality standard was developed. The committee suggested amending the last bullet in the draft statement to read “mortality in older people resulting from falls and underlying causes”.	
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. One member suggested that people who over-use alcohol as a consideration as they may be more likely to experience falls.	
10. 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.	
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 30th November 2016, care of dying adults in the last days of life and vaccine uptake in under 19's**	