Falls in older people: prevention

Consultation on draft NICE quality standard (QS10011)

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The National Institute for Health and Care Excellence (NICE) is currently developing a quality standard on falls prevention among older people, which is due to be published in January 2017. As part of this, stakeholders have been invited to comment on the draft quality standard, including the key areas for improvement that have been shortlisted (available online here). Age UK welcomes this quality standard as a positive contribution to preventing falls and reducing the fear of falling in later life.

Key points and recommendations

Age UK's detailed comments can be seen in the NICE proforma below. Key points from our response include:

- Asking NICE to 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;
- Highlighting the importance of communicating falls prevention messages in a way that resonates with older people's lives and ensures they engage with risk-reduction strategies;
- Explicitly highlighting the impact of frailty on older people's risk of falling as falls can be both an indicator and a consequence of frailty in later life;
- Recognising that older people are more likely to follow falls prevention programmes if they have had a say in the design of their package through shared decision-making.

Age UK's comments

Comment number	Section	Statement number	Comments Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
1	General		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.
2	General		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).
3	Statement 1 (Quality statement and Rationale)	1	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 […]"*
4	Statement 2 (Definitions)	2	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".*
5	Statement 3 (Quality statement)	3	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".*