NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 1

Learning Disabilities: Managing mental health problems post-consultation meeting

Tuberculosis post-consultation meeting

Minutes of the meeting held on 6 October 2016 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Bee Wee (Chair), Ivan Benett, Gita Bhutani, Phillip Dick , Phyllis Dunn, Sunil Gupta, Steve Hajioff, Ian Manifold, Gavin Maxwell, Hugo van Woerden (until 2.45), Ian Reekie, Arnold Zermansky **Specialist committee members** Learning Disabilities: managing mental health problems: Umesh Chauhan, Richard Hastings, Sharon Jeffreys, Ian Rogers, John Taylor Tuberculosis: Sarah Anderson, Francis Drobniewski, Gerry Davies, Joe Hall, Mango Hoto **NICE staff** Mark Minchin (MM), Stephanie Birtles (SB) Sabina Keane (SK) [agenda items 1-6], Julie Kennedy (JK) [agenda items 7-11], Helen Vahramian (HV) **NICE Observers** Eileen Taylor [agenda items 1-6]
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members:** Helen Bromley, Amanda De La Motte , Peter Jenks, Teresa Middleton, Alyson Whitmarsh, Jane Worsley **Specialist committee members** Learning disabilities: Regi Alexander, Tuberculosis: Sue Collinson, Christine Bell,

NICE National Institute for Health and Care Excellence

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day (private session)	The Chair welcomed the attendees and the Quality Standards Advisory Committee (QSAC) members introduced themselves. 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: <u>Specialist committee members</u> **Richard Hastings** • Member of Learning Disability Mental Health NICE Guideline committee • Member of Learning Disability Challenging Behaviour Service Models NICE Guideline committee • Advisor to charities and social enterprises: Royal Mencap Society, Sibs, Cerebra, Ambitious about Autism, Brain in Hand, Positive Behavioural Solutions Ltd • Funding for mental health research relating to learning disability/autism to my department from: NIHR HTA, NISCHR in Wales, NIHR RfPB, Autistica, Baily Thomas Charitable Fund, Australian Research Council • Member of the *Skills for Health* Learning Disabilities Core Skills Education and Training Framework Steering Group	

Agenda item	Discussions and decisions	Actions
	• Member of the NHS England Midlands and East Regional Transforming Care Board • Member of the Learning Disability Transforming Care Service Model Reference Group (NHS England, Local Government Association, ADASS) **Sharon Jeffreys** • Member of NICE Guideline Development Group (GDG) Mental Health /LD 2014-2016 • Member of NICE GDG LD& Challenging behaviour service model **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on Thursday 1 September 2016 and confirmed them as an accurate record.	
4. QSAC updates	MM provided an update to the committee on the following: • Changes to the 2017/18 QS work programme – Email to all members – Likely to be some changes to the QSACs • NICE accreditation programme – Now closed for new applicants – Continued maintenance • NICE Fellows and Scholars 2017 intake – Recruitment open until 4th November – NICE website for background	
5. Recap of prioritisation exercise	SB and SK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for Learning disabilities:managing mental health problems: **At the first QSAC meeting on 2 June 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:** • An annual health check based on NICE draft guideline recommendation 1.7.3 in mental health	

Agenda item	Discussions and decisions	Actions
	problems in people with learning disabilities. • Assessment based on NICE draft guideline recommendation 1.6.1 in mental health problems in people with learning disabilities. • Pharmaceutical interventions based on NICE draft guideline recommendation 1.9.7 in mental health problems in people with learning disabilities. • Psychological interventions based on NICE draft guideline recommendation 1.9.9 based on mental health problems in people with learning disabilities. • Organising effective care based on NICE draft guideline recommendation 1.2.8 in mental health problems in people with learning disabilities. NICE draft guideline The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here:	
5.1 and 5.2 Presentation and discussion of stakeholder feedback and key themes/issues raised	SB and SK presented the committee with a report summarising the consultation comments received on learning disabilities: managing mental health problems. The committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and provides a 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 in 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	

Agenda item	Discussions and decisions	Actions
	• Requests to change NICE templates	
5.3 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 statement 1	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with learning disabilities are offered an annual health check that includes a review of mental health problems.	This statement needs to be aligned with NHS England's standard template for annual health checks. Query raised on GPs' expertise to assess mental health during this health check. Query raised on the population as the stated starting age for health checks is 14 years. Need for follow up offer if the health check is initially refused. Concern raised on ensuring this health check data is collected and shared, especially if learning disability and mental health services do not share the same clinical records. A number of additional areas were suggested to be included in the health check In line with quality statement 1 of Learning disabilities: challenging behaviour quality standard (QS101) - could we also call this	The relationship between this quality standard and the NHS England statement should be clarified with regard to age range. This should focus on 14 years and older ie young people and adults. There are recognised problems in capturing the target population group on GP learning disability registers, because of under-registration and also inclusion of out of scope patients such as those with autism and ADHD, rather than a learning disability. This will affect performance measurement. On the question of who should carry out the annual check, it should be the GP located in primary care. On the issue of capacity, care was needed to ensure that the presence of a third person at the check, such as parent, friend or care worker was appropriate. The process measure should be the number of patients offered (as opposed to received) an annual health check over the previous 12 months.	Approved as drafted subject to the NICE Quality Standards team clarifying the age range population and the focus on primary care setting.

	annual health check a comprehensive health assessment? Mixed stakeholder opinion was received. Annual health check was preferred to raise its profile however comprehensive health assessment was supported as it implies physical and mental health similarities and demonstrates progress above existing annual health checks.		

Draft statement 2	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with learning disabilities and identified mental health needs have a mental health assessment conducted by a professional with expertise in mental health problems in people with learning disabilities.	Definitional queries on this mental health assessment were:- • its timing and trigger • who would be conducting this and the specific expertise needed • its focus on 'identified mental health needs' which will exclude suspected and milder mental health needs. How will these needs be initially identified? • what the formal assessment questionnaire entails. Concern raised on the feasibility of joint working between learning disability and mental health services and the pool of expertise needed. Concern raised on the overlap between statements 1 and 2 with a suggestion to combine.	There are difficulties in identifying people who have emerging, suspected or potential mental health problems (rather than those who have LD **and** mental health problems) where early intervention would be beneficial. There is evidence of under-treatment within this population group. They are more likely to have mental health problems than the general population but these are less likely to be picked up. This would be improved by making a correct onward referral or treating in situ, depending on context. Effective preliminary assessment by healthcare professionals who have sufficient knowledge of mental health difficulties within this cohort to make correct onward referral was key.	Further consideration by the Quality Standards team in consultation with the specialist committee members. The focus should be that a **mental health assessment is carried out by someone with mental health and LD expertise.** The statement should ideally remain patient-centered in its focus, but if necessary, redrafted as a structural statement.

Draft statement 3	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with learning disabilities and a serious mental illness have a key worker.	Suggestion to add 'long-term mental health illness' to the statement wording. Serious mental illness definition needs to include people with complex learning difficulties. Resource impact of the key worker's responsibilities was raised. **Consultation question 6 comments** What term would you use in your setting to describe this role? Key worker? Care or case coordinator? Please detail your answer. Mixed stakeholder opinion was received. Key worker was viewed as a residential care and education term which may create misinterpretation. Other suggestions included case holder, named worker and Care Programme Approach (CPA) co-ordinator.	The provision, accessibility and role of key workers is highly variable. It is common for this patient group to have multiple contacts with different parts of social care and health care systems. A named key worker was therefore suggested. Service navigation, gap bridging, advocacy and being a single central point of contact, are critical aspects of the role. The key worker needs to be accessible patients who cannot easily seek help on their own behalf and empowered to work across services. A clearer definition of the key worker term adding to NG54 recommendation 1.2.8 was suggested.	Approved subject to further definition of the named key worker by the NICE Quality Standards team.

Draft statement 4	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with learning disabilities who are taking antipsychotic drugs long-term and are not experiencing psychotic symptoms have their prescriptions reduced	Concern raised that the current statement wording stating reduction or discontinuation in prescriptions is prescriptive. Concern raised on the statement stating 'not experiencing psychotic symptoms' as this is often reliant on observations.	Psychotropic drugs can have major irreversible adverse effects when used long-term. It is common for people with learning disabilities to be inappropriately prescribed these drugs long-term. In such cases, where appropriate, a reduction or discontinuation, is required. When the antipsychotic drugs are appropriately prescribed for a diagnosed mental health problem, emphasis should be	Approved subject to amendment of the statement by the NICE Quality Standards Team to change focus specifically on people with learning disabilities who are

or discontinued.	For long-term antipsychotic drug use an official diagnosis of serious mental illness is needed. Suggestion to acknowledge that antipsychotic drugs are used to prevent psychotic symptoms. Suggestion to include inappropriate prescribing of antidepressants within this statement. In order to reduce antipsychotic drugs a local approach with pharmacy, community learning disabilities and carer involvement may be needed. **Consultation question 7 comments** on defining the timeframe of long-term antipsychotic drugs? Mixed stakeholder opinion received:- • any time after 3 months as medication effects could be measured and reviewed • 6 months • the timeframe would depend on the diagnosis and presentation of the symptoms against a treatment review on effectiveness.	placed on having an annual documentation of the reason(s) for continuing the prescription if it is not reduced or discontinued.	taking antipsychotic drugs having annual documented reason(s) for continuing the prescription if it is not reduced or discontinued.

Draft statement 5	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Health and social care provider organisations	Generally supported for using a 'whole person' approach	This is a structural statement focused on parents and carers training.	The NICE quality standards team to

provide parent training programmes for parents and carers of children with learning disabilities	This statement could require additional resources but if effective it would have a longer term saving in reducing long-term mental health problems. More detail needed on the outcome quality of relationship between carer and person being cared for This may be difficult to locally collect. Concerns raised on these parent training programmes were:- • what these specifically entail • the link between mental health problems and quality of parenting. Parental training should be offered sensitively • the facilities and parental commitment required to attend these sessions • providing generic training programmes when specialised work is needed for children with spectrum conditions or attachment difficulties	There was a discussion on the specific psychological intervention of parent training programme due to the current limited evidence to support the 'consider; recommendations 1.9.8 and 1.9.9. Also an overlap was reported with other quality standards that might pick up a proportion of this group (e.g. QS101 Challenging behaviour and QS59 on Antisocial behavior and conduct disorders in children and young people). This would need to be checked by the NICE Quality Standards Team, possibly with a view to including cross referencing.	consult further with the specialist committee members on possible ways to develop this statement based on the overlap with other quality standards.

Additional statements suggested	**Committee rationale**	**Statement progressed (Y/N)**
Psychological interventions	Out of scope	**N**
Care and treatment review or 'Blue Light' meeting	Out of scope	**N**

Physical activity and access to exercise and sport	Out of scope	**N**
Joint working between learning disability services and secondary mental health teams-Green Light Toolkit (NDTi, 2013)	Out of scope	**N**
Attachment-trauma population	Out of scope	**N**
Hearing loss	Out of scope	**N**

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 learning disability: managing mental health problems. 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. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
6. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the learning disability: managing mental health problems 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:	

	Specialist committee members • Gerry Davies - academic co-ordinator of the PreDiCT-TB consortium, a public-private partnership funded by the European Union Innovative Medicines Initiative and the European Federation of Pharmaceutical Industries and Associations. • Francis Drobniewski - Employee (part-time), Director, National TB Lab. – Received grant to develop and implement a co-ordinated EU network of TB reference laboratories. – UK NIHR Health Technology Assessment and Innovate UK grants new TB diagnostic. Systematic review and economic analysis modern TB diagnostics. – Received unrestricted educational grant to develop and deliver short training course on clinical TB and MDRTB to medical doctors internationally – Received EU FP7 grant PANNET; research relating to MDRTB diagnosis and management. – Received Grant NIHR Imperial –PHE develop joint research between Imperial and PHE on drug resistant organisms including TB. – Founder, Donor and Director of small consulting-training company providing training and supporting research – Travel funded in connection with lectures and seminars on diagnosis and management of MDRTB disease at meetings organised by the Chinese Centers for Disease Control, Peking Medical College, Institute and Fondation Biomerieux and the European Society for Clinical Microbiology and Infectious Disease.	
9. Recap of prioritisation exercise	JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for tuberculosis (TB): At the first QSAC meeting on 5 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: • latent TB screening for new entrants and to align it with the collaborative TB strategy for England where possible. • molecular testing for patients referred to a TB MDT and access to sputum testing and/or chest X-ray. • enhanced case management and directly observed therapy for under-served groups. • use of cohort reviews in TB services. • provision of accommodation during treatment of active TB. The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here.	
9.1 and 9.2 Presentation and discussion of stakeholder feedback and key themes/issues raised	SB and JK presented the committee with a report summarising consultation comments received on TB. 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	
9.3 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.**	

NICE National Institute for Health and Care Excellence

Draft statement 1	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People, who have arrived in the country within the past 5 years, from countries with a high incidence of TB, are tested for latent TB infection when they first present to healthcare services.	Concerns about the practicalities of involving various healthcare professionals Suggestion to focus on people registering with a primary care provider Definition of 'countries with a high incidence of TB' makes it unachievable Focus the population on people aged 16 to 35 years in line with the national strategy Focus on people aged 0 to 65 years as latent TB treatment is not offered to people over 65 years Be more explicit about including children Without clear evidence an age range should not be specified	The difficulties of identifying, tracking and consequently measuring the uptake of this population are recognised. It is unlikely that country of recent residence is coded to any significant extent within primary care information systems. However, the Home Office issues travel cards to asylum seekers that record their country of origin. For pragmatic reasons the GP surgery is the most suitable focus of responsibility as it is the most likely place for locating high risk individuals because the majority of new arrivals register with a GP. The age group covered by the quality statement should be specified to ensure that high risk individuals are the focus. An age range is not specified in the NICE guideline on TB but is specified in the Latent TB Testing and Treatment for Migrants: A practical guide for commissioners and practitioners document which supports the National TB strategy. The rationale for the 16 to 35 years age range is that the highest burden of TB disease and the largest proportion of new entrants from high incidence countries are aged between 16 and 35 years.	Approved subject to specification of 16 to 35 years age range, and focus of responsibility on GP surgeries.

Draft statement 2	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People who are referred to a TB service, who meet specific criteria, have rapid diagnostic NAATs for the M. tuberculosis complex	Statement should be more specific about the population Concerns that definitions make measurement difficult Impact of whole genome sequencing on use	Although performance measurement and in particular improvements in mortality will be challenging, the 4 population groups specified in the draft statement definitions are appropriate. The committee agreed that the definitions would remain the same but the process measure for the group for whom rapid information about mycobacterial species would alter the person's care would be removed from the process	Approved subject to refinement of process and outcome measures

on primary specimens.	of NAATs in the future Audit of laboratory provision of TB microbiology coordinated by PHE (Colindale) planned for autumn **Consultation question 6:** Should the statement focus on a specific group? • No clear requirement to focus on specific groups further • Suspected pulmonary TB but this may be hard to achieve • Difficult to identify when rapid information about mycobacterial species would alter the person's care	measures. Whilst the facilities for carrying out these tests are well established in the UK, it is recognised that there are costing issues. The committee considered changing the term 'rapid' to 'same day' but concluded that 'rapid diagnostic NAATs' is an adequate and pragmatic definition.	

Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People who have imaging features suggestive of active TB are assessed within 1 working day by the TB service.	Timescale is not achievable or necessary Concerns that this restricts rapid assessment of suspected TB to those with radiology imaging features 'Imaging features suggestive of active tuberculosis' should be changed to 'active pulmonary tuberculosis' Clearer definition of what 'assessment' means	The key purpose of this statement is to limit the risk of spread within to the general population and therefore each potential case should be assessed quickly and case management started. Radiology services are the starting point where a visual assessment of potentially active TB should initiate a referral to a local TB service. The actions necessary to fulfill the statement encompassed decision makers separate organisations; • the radiologist in making a rapid referral on initial assessment	Approved in principle subject to the clarification of who would begin the assessment and where and refinement of the measures.

		• ability of the receiving TB service to see the patient quickly • the propensity of the patient to receiving treatment • the nature of the referral and the communication between the two organisations. Time is of the essence. Further clarity is needed as to which actions come within the timescale and whether 1 working day would be achievable nationally. The standard must be capable of being applied in all parts of the country. There are wide variations in conditions outside major urban centres that could impede rapid processing. Not all hospitals have a radiology service. It is not uncommon for radiologists to report back to the referring GP, which would extend the referral time. Although overall incidence of TB is higher in urban than rural areas, there are significant pockets of multi-drug resistance among agricultural workers because of antibiotic exposure in animal husbandry. The committee agreed that it was important to retain the timescale of 1 working day. However, in recognition of the practical difficulties some services would face to implement this they agreed to amend the statement to show that the assessment does not have to be started by a member of the TB service e.g. it could be done by a respiratory physician. They also agreed that the assessment could be started by telephone if face to face contact is not possible within the timescale. The proportion of people with pulmonary TB starting treatment within two months of symptom onset should be redefined as an outcome rather than a performance measure.	

Draft statement 4	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with TB from under-served groups are offered directly observed therapy (DOT) as part of enhanced case management	Focussing on the under-served group is too narrow The decision to provide DOT is for the TB team not the patient Clarification is needed regarding what the measures mean	Under-served groups are by their nature poorly recorded and difficult to identify. However the guideline recommendation lists 9 groups, which could be unduly complex for a single statement within the Quality Standard. The term **under-served** described a broadly coherent and understood grouping. Consider further refinement of the denominator to; • patients where adherence to therapy has or is likely to be a problem; • patients who have active TB There was a suggestion to split the process measures into the groups defined as under-served in order to improve measurability. The committee questioned whether including the phrase 'enhanced case management' (ECM) in the statement was necessary. While members felt it is important to highlight ECM it was agreed that including it in the statement wording did not add anything and removing it would make it more concise and focused.	Approved subject to removal of the phrase 'enhanced case management' from the statement and refinement of the measures.

Draft statement 5	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with active TB who are homeless are offered accommodation for the duration of their treatment.	This is desirable to help avoid people with TB spending long periods in hospital Need to specify who holds the legal responsibility to offer accommodation or it is unlikely to happen The definition of homelessness is broad	The definition of homelessness needed some clarification. As currently drafted it is unclear whether it includes encompasses homelessness and those beyond the normal welfare safety net. The statement is achievable but the issue will be identifying the provider. This could variously be the local authority; a CCG or for those without recourse to public funds such as asylum	Approved subject to refinement of the definition of homelessness

	making measurement difficult **Consultation question 7:** on whether this statement be achievable by local services given the potential resource impact of providing accommodation. • Difficult due to resource impact but essential • Achievable by most services given the relatively low volume of people the statement is concerned with • The statement would not be achievable. Suggest that priority is given to those who have infectious TB and are occupying an acute hospital bed even though fit for discharge • Are homeless people likely to comply with this? **Consultation question 8:** on how the respondent would describe suitable living accommodation for people with active TB. • A safe, secure, self-contained single room environment per person or family • Accommodation should be located within a reasonable distance of the relevant TB clinic • Could include shared areas once the infectious period has passed • Security of accommodation i.e. tenure for duration of TB treatment	seekers, the Home Office. The overall aim of the statement is to ensure adherence to treatment. Therefore there must be provision for housing people during the course of their treatment.	

NICE National Institute for Health and Care Excellence

Draft statement 6	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Multidisciplinary TB teams take part in cohort review at least quarterly	Concerns that quarterly review is not appropriate for all services Difficulties with measurement were highlighted Focus on ensuring all notified TB cases are discussed at cohort review State a minimum of 5 close contacts within the process measure	There was much support for the underlying principle of cohort and peer review as drivers for improving the quality of TB control treatment. However, the committee recognised that the identification of data fields and provision of nationally integrated information systems to support data collection and analysis would be problematic. The new TB Control Boards are beginning to put similar measures in place in their standing meetings. The committee therefore questioned whether this is an area for quality improvement if cohort review is already being rolled out. It nevertheless welcomed emerging quality improvement practices in this area.	**Not progressed**

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Contact tracing/active case finding	Considered in context of the other statements	**N**
Delayed diagnosis of TB when it has not been suspected	Too broad	**N**
Obtaining samples to confirm suspected TB	Not sufficiently defined	**N**
Routine testing of specimens for treatment resistance.	Not sufficiently defined	**N**
Case finding for TB in HIV positive people	There is a case for identifying HIV positive people as a distinct sub-group within the population covered by Quality Statement 1. Many also fall within the definition of people	**Y**

	who have arrived in the country within the last 5 years. This group is very high risk for TB and includes children. It is covered in guideline recommendations 1.2.1.3 and 1.2.4.2. As it is more identifiable and measurable than the larger group, it would provide a focus for measuring the quality of delivery. The committee discussed including this group within statement 1 but agreed that it would not be feasible and agreed to have a separate statement on latent TB testing for people with HIV. The technical team agreed to explore having a statement on both testing and treatment for this group.	

9.4 Resource Impact	In relation to statement 1 the recording of country of origin codes within general practice is patchy. There is £10m NHS special funding to encourage this among 59 CCGs, but there will be a resource impact as it rolls out more widely. However, there will be longer term cost savings though the benefits of rapid diagnostics.	
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 TB. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
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.	
10. Next steps and timescales	The NICE team outlined what will happen following the meeting and key dates for the TB quality standard.	
11. Any other business (part 1 – open session)	The following items of AOB were raised: • None raised **Date of next QSAC 1 meeting: Thursday 3 November 2016 - Haematological malignancies and menopause**	