NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 3

HIV testing and Rehabilitation after critical illness – prioritisation meeting

Minutes of the meeting held on 20 January 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Hugh McIntyre (chair), Geeta Kumar, Darryl Thompson, David Pugh, Malcom Fisk, Ann Nevinson, Rhian Last, Ulrike Harrower **Specialist committee members** **HIV** Philippa James, Nicky Connor, Ann Sullivan, Robbie Currie, Martin Dadswell **Rehabilitation after critical illness** Michele Platt, Melanie Gager, Carl Waldmann, David McWilliams, Dorothy Wade, Karen Hoffman, Gordon Sturmey **NICE staff** Mark Minchin (MM), Jamie Jason (JJ), Craig Grime (CG), {1-5} Melanie Carr (MC), {1-5} Ciara Donnelly (CD), {1-5} Kirsty Pitt (KP), {10-12} Julie Kennedy (JK), {10-12}, Adam Storrow (AS), {10-12} **NICE Observers** Gemma Partridge
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Jim Stephenson, Gillian Parker, Eve Scott, Madhavan Krishnaswamy, Susannah Solaiman, Karen Ritchie, Ben Anderson, Lauren Aylott, Keith Lowe, Julia Thompson, Deryn Bishop and Martin Siddorn.

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. 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> <u>Nikki Connor</u> • Lead author on PHE's HIV Testing in England: 2016 Report - submitted in evidence. <u>Robbie Currie</u> • Trustee – National AIDS Manual (NAM) • Co-Chair of the English HIV & Sexual Health Commissioner's Group (EHSHCG) • Consultant – Paul Fraser Associates (Sexual Health) <u>Martin Dadswell</u> • None <u>Philippa James</u> • Practising GP commissioned to provide sexual health services for patients through Manchester City Council and NHS England.	

Agenda item	Discussions and decisions	Actions
	Personal, financial,non-specific interest • Clinical lead for the Pharmacy contraception scheme in Manchester. The practice where Philippa works has been paid for services to produce patient group directions for pharmacists to use in providing contraception services (by Manchester City Council). Philippa has provided pharmacist training through the previous Manchester PCT and now the CPPE (Continuing Pharmacy Postgraduate Education of the University of Manchester). Philippa is paid a sessional fee to provide this training. • Chair of Study Steering Committee – NIHR Funded study "Feasibility of Acceptability of Home Sampling Kits to increase the uptake of HIV testing in Black Africans in the UK – the HAUS Study". • Involved in preliminary discussions with ViiV Healthcare and LGBTF in Manchester to improve HIV testing in General Practice in Manchester. • On the steering group organising a conference on "HIV in General Practice" jointly between BHIVA and RCGP. Ann Sullivan Non-personal, financial, specific • Employing organisation receives/d grant funding to support a number of HIV testing research and implementation studies, and reviewing and HIV testing guidelines, including NIHR, European Commission, Department of Health, Health Foundation, Gilead, British HIV Association, ECDC. • Author of HIV testing papers, member and Secretary elect of BHIVA Executive Committee. • Costs covered (no speakers fees, no commercial companies) to give lectures/presentations – ECDC, WHO, PHE, IUSTI. **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 16 November 2016 and confirmed them as an accurate record.	

Agenda item	Discussions and decisions	Actions
3. QSAC updates	MM gave an update regarding the new QSAC model.	
4 and 4.1 Topic overview and summary of engagement responses	MC presented the topic overview and a summary of responses received during engagement on the topic.	
4.2 Prioritisation of quality improvement areas	The Chair and MC 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.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Healthcare settings a) Specialist sexual health services b) Secondary and emergency care c) GP surgeries	 N Y Y	The committee discussed the different healthcare settings for HIV testing. It was agreed that increasing HIV testing in healthcare settings is important in order to ensure early diagnosis and prevent onward transmission. The committee suggested that it is a priority to increase HIV testing in areas with an extremely high/high HIV prevalence. It is also important to ensure HIV testing is offered when a person has an HIV indicator condition. There was a discussion about whether there should be separate statements for secondary care and GPs. Although it would be possible to combine across settings it was suggested that specific statements for each setting will have more impact.	It was agreed to progress 3 statements. • A statement on increasing HIV testing in secondary care based on recommendation 1.1.7 • A statement on increasing HIV testing in GP surgeries in areas of high and extremely high prevalence based on recommendation 1.1.9 • A statement on increasing testing for people with indicator conditions based on recommendations 1.1.5 and 1.1.8 However, NICE to consider merging the statements on secondary and primary care with indicator conditions.

		The committee discussed the resource impact information presented and were reassured that HIV testing is relatively cheap and has potential to generate cost savings if the costs of late diagnosis can be avoided and if HIV infection can be prevented.	
Community settings a) Community settings b) Point of care testing c) Self-sampling d) Digital and social media	 N N Y N	The committee are keen to increase and promote testing within community settings in order to ensure at risk groups that may not engage with mainstream services are able to access HIV testing. Late diagnosis remains a significant problem in heterosexual people including BME groups. Public Health England are promoting a national self-sampling scheme but not all local authorities are participating. The committee considered the recommendations available and decided that a focus on ensuring that people at risk know how to access self-sampling may encourage commissioners to ensure this is in place for specific communities. No specific resource impact information was available for this area and the committee agreed there would not be a significant resource impact.	It was agreed to progress a statement on ensuring that people in at risk groups and communities are able to access self-sampling based on recommendation 1.2.4
Increasing opportunities for HIV testing a) Regular testing b) Follow-up testing	 Y N	The committee agreed that follow-up testing once past the window period is not a priority area as it is usual practice when a person tests negative but may have been exposed to HIV recently.	It was agreed to progress 2 statements: • A statement on advising people at risk who test negative of the need to have regular testing based

c) Partner notification	Y	There was a concern that regular testing and partner notification operating solely in general practice could have a significant resource impact on GP's. It was agreed that any statement should focus on advising people of the need to have a regular test if they have a high risk of exposure. The committee felt that this is important for specific groups at risk including black Africans. Partner notification was agreed as a priority as evidence suggests it is an effective approach to identifying undiagnosed HIV and is not being undertaken consistently. There are agreed BHIVA / BASHH standards and definitions for partner notification and it was suggested that the quality statement could use a relevant timescale as long as a question is included at consultation.	on recommendation 1.2.6 • A statement on partner notification based on recommendation 1.2.9
Referral to an HIV specialist	N	The committee felt this area was already well established practice and not a priority for quality improvement.	

Additional areas suggested	**Committee rationale**	**Area progressed (Y/N)**
Prisons	Committee agreed this is an important area and has potential to be prioritised for a statement. It was accepted however that it may be covered in the quality standard on the physical health of people in prisons. It was therefore agreed not to include it in the draft QS but the committee will re-visit this at the next meeting.	**N – to re-visit at next meeting**
Testing platforms	It was agreed that this is beyond the remit of this QS.	**N**
Serious incident reporting	It was agreed that this should be considered as an outcome measure to assess the	**N**

	success of interventions to increase testing in healthcare and community settings.	
National awareness campaign	It was agreed that this is outside the remit of quality standards which are focussed on local interventions.	**N**
Collaborative commissioning	It was agreed that quality standards do not focus on the approach to commissioning.	**N**
Integrated sexual health approach	It was agreed that this will be covered in a future quality standard on sexual health across the life course.	**N**

5. Resource impact	The committee were undecided whether there would be a cost impact or overall saving. **ACTION:** NICE team to investigate costs of implicating the standards in more detail and report back at the next meeting.	
5.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on HIV testing. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
5.2 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 were concerned to ensure that the quality standard addresses the needs of BME groups and transgender women. It was agreed that the committee would contribute suggestions as the quality standard was developed.	

6. Next steps and timescales (part 1 – open session)	MC outlined what will happen following the meeting and key dates for the HIV testing quality standard.	
Lunch		
7. 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.	

8. 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.	
9. 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> <u>Melanie Gager</u> • None. <u>Karen Hoffman</u> • None. <u>David McWilliams</u> • None. <u>Michele Platt</u> • None. <u>Dorothy Wade</u> • None.	

	Carl Waldmann • Honoraria and Travel expenses from ORION • Honoraria and Travel expenses from BiO2	
10. Topic overview and summary of engagement responses	KP presented the topic overview and a summary of responses received during engagement on the topic.	
11. Prioritisation of quality improvement areas	The Chair and KP led a discussion in which areas for quality improvement were prioritised. The Chair asked the committee to clarify the key differences between rehabilitation for people in critical care and people in general wards. The committee heard of the unique characteristics that centre around organ support, and the degree of physical and psychological impact that a stay in critical care causes. People that have received care in a critical care setting start rehabilitation at a much lower point, often needing to relearn how to breathe or eat.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
During the critical care stay a) Short clinical assessment b) Early structured rehabilitation	 N Y	The committee felt that the initial assessment is currently being done better than the structured rehabilitation that follows. Therefore it was agreed that a statement in this area should focus on rehabilitation goals. The committee agreed that this should occur as soon as possible, within a maximum of 4 days after admission. They agreed that it is important to highlight physical and non-physical needs, reviewing rehabilitation goals and that the adult and their family/carer should be involved where possible.	NICE team to draft a statement on setting rehabilitation goals, based on the recommendations in CG83 (1.3-1.6). To explore specifying a timescale based on guidelines such as the Intensive Care Society/Faculty of Intensive Care Medicine guidelines.

Discharge from critical care to ward a) Discharge to ward b) Nutrition support	 Y N	The committee highlighted that the step down from the critical care environment to a general ward is a big change for patients. They felt that ward staff need to understand the condition of the patient before they were admitted to critical care and that a handover should capture this information. The committee agreed that handover must involve both the critical care team and the ward team. They agreed that the handover should be structured and that physical and non-physical needs should be discussed. The committee agreed that nutrition support was covered in the quality standard on nutrition support in adults and therefore did not prioritise a statement in this area.	NICE team to draft a statement on structured handover for adults transferring from critical care to a general ward, based on the recommendation in CG50 (1.15).
Discharge from hospital and follow-up a) Follow-up after discharge from hospital b) Provision of information	 Y Y	The committee discussed the follow-up 2-3 months after discharge. They discussed the potential resource impact and whether the statement should focus on a subset of the population, such as adults who had been in critical care for 4 days or more. It was noted that the guideline recommendation is for 'people with rehabilitation needs'. The committee agreed that it was important that there was a way for people to re-access the system if they experience problems after discharge and that the follow-up appointment could provide this opportunity. They also agreed that it was important to highlight physical and non-physical needs at the follow-up appointment. The timing of follow-up was discussed and it was highlighted that some people would experience problems before 2-3 months, but also that 2-3 months after discharge from critical care, some people would still be in	NICE team to draft a statement about follow-up and to explore the timing and potential subset population based on the CG83 guideline and other guidelines such as the Intensive Care Society / Faculty of Intensive Care Medicine guidelines.

		hospital. Again, the committee highlighted that the change from the ward environment to being at home has a big impact on patients and their carers. The committee discussed the importance of the adult's family/carer being involved in the rehabilitation. They agreed that information needs to be provided so the adult and family/carer know what to expect after discharge. The committee felt that this was relevant throughout the pathway, not just on discharge from hospital.	NICE team to draft a statement about providing information to patients to help them understand what to expect when they transfer, and to explore whether it is possible to cover the whole pathway or just discharge from hospital, based on the recommendations in the guideline CG83.
Coordination of rehabilitation pathway	N	The committee discussed having a named person or team to act as a coordinator of an adult's care. However, it was felt that there are now numerous coordinators for different reasons and that it could be confusing. The committee felt that having a coordinator would not solve the issues discussed. Therefore the committee agreed not to prioritise this area.	

Additional areas suggested	**Committee rationale**	**Area progressed (Y/N)**
Care of tracheostomy patients	The specific suggestions raised by stakeholders in relation to care of tracheostomy patients are not directly covered in CG83 but form part of the general principles of care for the guideline.	**N**
Additional therapies	Stakeholder suggestions about additional therapies such as neuromuscular electronic stimulation are not covered in CG83 and were considered out of scope for this quality standard.	**N**

Functional outcomes to assess rehabilitation provision and outcomes	Stakeholders suggested there is a lack of accepted outcome measures to allow evaluation of rehabilitation provision within critical care and throughout the patient's recovery which limits benchmarking and comparison between units. This is outside the scope of this quality standard and underpinning guidance.	**N**
Delirium	Stakeholders suggested delirium is a significant problem to people who are critically ill who can also be adversely effected by the experience for a long time after discharge. It was felt that more could be done to assist patients in intensive care experiencing delirium. This is covered by NICE quality standard 63, Delirium in adults. The committee agreed that this quality standard should reference the delirium quality standard.	**N – NICE team to ensure delirium quality standard is referenced.**
Information for people with sepsis	One stakeholder highlighted that specific information on support for people having survived sepsis should be given as they often experience higher lengths of stay, and increased risks of complications. A separate quality standard referral is in development for sepsis.	**N**
Access to social care advice	Stakeholders commented that patients and their families should have access to social care advice during the rehabilitation pathway. Access to social care advice is not directly covered in development source, CG83 although elements of social care form part of the assessments for patients rehabilitation needs.	**N**
ABCDE bundle	One stakeholder referred to the use of the ABCDE bundle within critical care to support early mobilisation of patients. This is not covered within the source guidance.	**N**

12. Resource impact	The committee was satisfied that the prioritised areas for quality improvement would be achievable by local services, given the resources available.	
12.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on rehabilitation after critical illness. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
12.2 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.	
13. Next steps and timescales	KP outlined what will happen following the meeting and the key dates for the rehabilitation after critical illness quality standard.	

	Date of next committee meeting to discuss rehabilitation after critical illness: 17 May 2017 Date of next QSAC3 meeting: 22 March 2017 • Violence and aggression – post-consultation • Multimorbidity – post-consultation
14. Any other business	No items of AOB were raised.