NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 3

HIV Testing and rehabilitation after critical illness – post consultation meeting

Minutes of the meeting held on 17 May 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Hugh McIntyre, Keith Lowe, Susannah Solaiman, Julia Thompson, Malcolm Fisk, Ann Nevinson, Rhian Last, Ulrike Harrower, David Pugh, Jim Stephenson, Ben Anderson, Deryn Bishop, Ivan Bennett **Specialist committee members** HIV Testing Robbie Currie, Philippa James, Ann Sullivan, Martin Dadswell, Nicky Connor **Rehabilitation after critical illness** Melanie Gager, Gordon Sturmey, Michele Platt, Carl Waldmann, David McWilliams, Dorothy Wade **NICE staff** Mark Minchin (MM), Jamie Jason (JJ) Melanie Carr (MC), Craig Grime (CG) *[agenda items 5-8]* Ania Wasielewska (AW) Julie Kennedy (JK) *[agenda items 12-17]* **NICE Observers** Terri Irwin, Health Quality Ontario
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Madhavan Krishnaswamy, Eve Scott, Daryl Thompson, Lauren Aylott.

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. The Chair informed the committee of the apologies and reviewed the agenda for the day.	
2. Committee business	**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 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. • Clinical lead for the Pharmacy contraception scheme in Manchester. • Current practice has been paid for services to produce patient group directions for pharmacists to use in providing contraception services (by Manchester City Council). • Provided pharmacist training through the previous Manchester PCT and now the CPPE	

Agenda item	Discussions and decisions	Actions
	(Continuing Pharmacy Postgraduate Education of the University of Manchester). Fee paid. • 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 • Employing organisation receives 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 22 March 2017 and confirmed them as an accurate record.	
3. QSAC updates	MM updated the committee on the NICE conference and recommended sessions that might be of particular interest to committee members. MM outlined plans for the composition of QSAC3 from September 2017.	

HIV testing: encouraging uptake		
4. Recap of prioritisation exercise	MC presented a recap of the areas for quality improvement discussed at the first QSAC meeting for HIV testing. At the first QSAC meeting on 20 January 2017 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:	

	1. Offering and recommending HIV testing in healthcare settings 2. Offering and recommending HIV testing in community settings 3. Increasing opportunities for HIV testing 4. Referral to an HIV specialist The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here	
5. Presentation and discussion of stakeholder feedback and key themes/issues raised	MC presented the committee with a consultation report summarising consultation comments received on the draft quality standard for HIV testing: encouraging uptake. The committee was reminded that the consultation summary report 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. The committee noted the general comments made by stakeholders including opinions on the focus on areas with a high HIV prevalence and the approach to offering an HIV test. Suggestions to extend statements to include testing for other blood borne viruses were acknowledged but it was agreed this is beyond the scope of this quality standard. The committee discussed feedback on the importance of including local authorities as a commissioner and agreed to ensure all statements include all potential commissioners and to emphasise the need for commissioners to work collaboratively to ensure	

	improvements in HIV testing are funded.	
5.1 Discussion and agreement of final statements	The committee discussed each statement in turn and agreed on amendments to statements in view of consultation feedback. **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)
Adults and young people admitted to hospital or who attend an emergency department are offered an HIV test in areas of extremely high HIV prevalence or in areas of high HIV prevalence if they have a blood test.	• Clarify if this is just elective and emergency admissions • Include outpatient settings and indicator conditions • Exclude disclosure of known HIV status from process measure • Additional measure of offer of a test • Amend 'to aid measurability..' text in data source section • Include specific hospital services and departments in descriptor • Emphasise opt-out testing • Processes must be in place for those discharged prior to test result • Amend 'high risk area' to 'high prevalence area' in patient descriptor	The committee agreed: • The statement applies to all admissions and emergency department attendances. • Key improvements in HIV testing in outpatient departments are addressed by statement 3. • Known HIV status should be removed from the process measure. • The statement should continue to use the term "offer" to emphasise patient choice whilst the measures focus on receipt of testing. However, it was agreed that the NICE team would explore the phrase "offer and recommend" in the statement. • The process measure data source section should be amended and the text related to aiding measurability should be removed. • Opt out testing should remain as a possible approach to help improve uptake of HIV testing. This would apply to other relevant statements. • Processes to support or contact people who leave healthcare settings prior to receipt of test results are important components of clinical practice. However, these processes are addressed by good practice guidelines. • The NICE team should re-examine the patient audience descriptor and the use of "high risk area"	**N**

Draft statement 2	Themes raised by stakeholders	Statement revised (Y/N)	
Adults and young people in areas of high or extremely high HIV prevalence are offered an HIV test by their GP when registering or when having a blood test if they have not had an HIV test in the last 12 months.	• A quality statement on screening procedures that are outside GMS contract should not be included • Routine testing for those having a blood test may be a waste of resources due to patient profile • May be difficult to implement at GP registration • Broader statement suggested that clarifies all situations when HIV testing should be offered • May not be feasible to measure offer of a test • Additional measure of uptake of HIV testing at registration • Ensure GP practices are aware of local HIV prevalence and offered support such as training • Emphasise opt-out testing • Add definition of testing to clarify venous sample or POCT	The committee agreed: • The National Screening Committee had provided general advice on the definition of screening. This statement would qualify as case finding. • The statement aligns with NICE guidance. • HIV testing at registration may not be an appropriate measure as some patients are registered at birth. However, the statement will help encourage uptake when moving to new GP practices. • Statements focused on specific actions are preferable for quality improvement purposes. • The statement should continue to use the term “offer” to emphasise patient choice whilst the measures focus on receipt of testing. However, it was agreed that the NICE team would explore the phrase “offer and recommend” in the statement. • An additional measure on uptake at registration should be re-examined by the NICE team. • Opt out testing should remain as a possible approach to help improve uptake of HIV testing. • The statement could list types of test as examples only. The committee discussed the unintended consequences and practicality of promoting annual HIV testing for all people solely based on location rather than individual risk factors. The committee agreed that in practice, healthcare professionals were likely to use clinical judgement to determine if an HIV test should be offered. Options included removing the 12 month timeframe, removing inclusion of blood tests or removing the statement entirely. A confidential vote was taken as to whether this statement progresses as a key area for quality improvement. The majority voted for the statement to remain, however with explicit	**N**

		caveats that clinical judgement should be used.	
Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**

Adults and young people diagnosed with an indicator condition are offered an HIV test.	• May be difficult to measure in primary care
	• Include GUM/sexual health services and outpatient settings
	• Suggested ways to improve implementation including technology, training, opt-out and anonymised testing
	• Support for prioritised list of conditions although may be too long:
	  ○ Include all lymphoma and pneumonia
	  ○ Focus on main conditions commonly missed – pneumocystis, pneumonia, shingles, oral candidiasis and weight loss
	• Clarify if restricted to areas with high prevalence
	• Should not be limited to high prevalence areas
		The committee agreed:
		• The statement applies in all settings in which indicator conditions were diagnosed.
		• Opt out testing should remain as a possible approach to help improve uptake of HIV testing.
		• The definition of the list of indicator conditions should remain unchanged.
		• The statement is not limited to high prevalence areas only.
		• NICE team to explore amending “diagnosed with” to “presenting with”.
			N

Draft statement 4	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults and young people in at-risk groups in areas of high and extremely high HIV prevalence can find information about HIV testing	• Should not be limited to high and extremely high prevalence areas • Replace ‘can find information’ with ‘are provided with information’ • Measure should specify where information should be available • Emphasise funding for self-sampling	The committee agreed: • The statement should be removed because of measurement difficulties.	**Y** **Remove**

services, including self-sampling.	kits needed • Do we need reference to 'chemsex' in definition of 'at-risk groups'?		
Draft statement 5	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults and young people in at-risk groups who test negative for HIV are advised to repeat the test at least annually.	• At least annually' is too long and not specific enough • Should be based on risk behaviour rather than risk group • Will require improvement in recording of at-risk groups • Difficult to collect data on whether people are advised • Outcome should be based on previous service users • Include advice on lifestyle and behaviour change	The committee agreed: • For some groups testing is recommended more frequently than annually however, as written, the statement aligns with the NICE guidance. • NICE team to explore using "recommend" not "advise" • To remove the recall systems from the audience descriptors.	**N**
Draft statement 6	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People identified as at risk of HIV from contact with an adult or young person newly diagnosed with HIV are offered an HIV test.	• Concern wording will lead to misconceptions about potential routes of transmission. Suggested alternative: • *People newly diagnosed with HIV have the opportunity to identify people known to them who may have been exposed and those people are contacted and offered an HIV test* • Clarify if testing children of HIV infected women is included	The committee agreed: • Although notification procedures are now generally undertaken by specialist services, variation still exists across services. • NICE team to clarify inclusion or exclusion of children. • NICE team to emphasise that this statement largely applies in specialist HIV / sexual health services • To amend wording from "in contact" to "may have been exposed"	**Y**

	• Clarify if process measure is based on 'identifiable contacts' • Include routes of transmission in rationale • Consider a specific descriptor for GP setting • Support for 3 month timescale		

6. Resource impact	The committee considered the resource impact information presented for each of the quality improvement areas discussed and were satisfied that none of the areas prioritised for statement development would have a significant impact on resources. The committee concluded that overall increased initial costs would be offset by future financial savings.	
6.1 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.	
6.2 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. The committee questioned whether transgender men were included. NICE team to re-examine inclusion of transgender men. The committee also agreed that the equality statement should acknowledge that people living in low prevalence areas are excluded from some statements.	
7. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the HIV testing quality standard.	

Rehabilitation after critical illness		
8. Committee business	**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 under consideration at the meeting today. The following interests were declared: Specialist committee members Melanie Gager • None. David McWilliams • None. Michele Platt • None. Dorothy Wade • None. Carl Waldmann • Honoraria and travel expenses from ORION • Honoraria and travel expenses from BiO2	
9. Recap of prioritisation exercise	AW presented a recap of the areas for quality improvement discussed at the first QSAC meeting for rehabilitation after critical illness: At the first QSAC meeting on 20 January 2017 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: • Agreeing goals during the critical care stay • Discharge from critical care to ward • Discharge from hospital • Coordination of the rehabilitation care pathway The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here	
10. Presentation and discussion of stakeholder feedback and key themes/issues raised	AW and JK presented the committee with a summary of consultation comments received on rehabilitation after critical illness. The committee was reminded that the report provided prior to the meeting was a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended as an initial basis for discussion. The committee was therefore reminded to refer to the full list of consultation comments provided within the appendices. The committee was informed that the report doesn't include the following types of comments: • 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	
11. 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.** The committee discussed how they could encourage more consultation comments, particularly from patient groups, and it was suggested this was an agenda item for the QSAC away day in July 2017.	AW and JK to highlight this as a potential item with the NICE programme manager for QS.

Draft statement 1	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Adults in critical care who are at risk of physical and non-physical morbidity have short- and medium-term rehabilitation goals agreed within 4 days of being admitted to and before discharge from critical care.	• Support for the statement and the timeframe • Wrong focus - assessment and a co-ordinated plan more important than having rehabilitation goals • Accomplishing goals needs to be monitored and followed-up, not just agreed. • "Psychological morbidity" should be used rather than "non-physical morbidity" - not well understood. • Various suggestions to change definitions of goals • Concerns about malnutrition or weight loss not being included under the definition of risks of morbidity	The committee discussed: • The importance of the assessment being a continual process rather than a singular event. • Changing needs and heterogeneity of the population • If the focus of the statement should be on assessment and having a plan but they concluded that the focus should be goals. Goals would be easier to measure than plans. • The issue of whether there is a need to amend current definitions of short and medium term goals? The committee agreed: • To keep goals as the focus of the statement but clarify that assessment happens first and the goals inform the plan. • To take out the phrase 'short and medium term' goals and refer just to 'goals' • To add information on nutrition within the definitions and cross reference with the guideline. • Capture the message that needs and goals change quickly and they need to be reviewed regularly.	**Y**
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults transferring from critical care to a general ward have a formal handover of their individualised structured rehabilitation	• Further definition/details needed for the formal handover • Handover not sufficient - physical rehabilitation and psychological support also need to be delivered • Concern that there is no mention of nutritional issues in the section on	The committee discussed: • The importance of the handover being used to ensure continuity. The committee agreed: • That rehabilitation continuing without a break following	**Y**

programme.	the required information about the needs of the person • Change word "programme" to "plan" • Concerns about measurability of this statement – currently predominantly verbal communication between therapists	transfer is a key issue. • Contextualising the programme to link with statement 1. • To use recommendation 1.15 from CG50 for measures. • To add allied healthcare professionals to the audience descriptors. • To make improvements to the outcome measures.	
Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults who have been in critical care and are discharged from hospital are given information about what to expect after discharge.	• Hospitals already give this type of information - information not sufficient; someone should go through it with the patients and families • Statement is very broad and does not specify who should provide the information after discharge and what it should contain • Timing - some information required before hospital discharge, information should be given depending on the patient's pathway, understanding, mental status etc. • Type of information • Involving other services at this stage – role for primary care, social care and voluntary sector	The committee discussed: • How the information would be given. • People who are given information should also be spoken with and made aware what they need to do once discharged. The committee agreed: • To expand on the patient outcome measure. • To incorporate the continuity of goals into the rationale. • To make a clear link between statement 3 and statement 1 by ensuring that the information provided is patient specific and reflects the agreed goals. • Review the process measures.	**N**

	• Concerns about measurability of this statement - patients given information in the form of a booklet, not recorded who/when gets the information		
Draft statement 4	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Adults with rehabilitation needs identified from a functional assessment have a review 2 to 3 months after their discharge from critical care.	• Current population too broad - only those having rehab needs at the point of discharge should be brought back to clinic. • Suggestion to change "review" to "further physical/non-physical functional assessment" to emphasise the importance of a full multi-disciplinary assessment for the most high-risk patients at the 2-3 month time point. • Rehabilitation needs' doesn't capture that patients may be experiencing psychological problems • Expected nutritional problems post hospital stay should be included in either physical or non-physical morbidity; • Involving other services at this stage – role for primary care, social care and voluntary sector • Definition of 'functional assessment' - what should be included or what tool is recommended • Greater clarity required on the format of follow-up review	The committee discussed: • Narrowing down the population and differences between 4 days ventilation and 4 days stay in ICU. • Psychological issues are not picked up in 4 days. • GP care is often not sufficient to support this population. The committee agreed: • To narrow down the population to people who have a length of stay in critical care lasting longer than 4 days. • To highlight that everyone who spent time in critical care should be able to self-refer at some point in the future. This is to be included in supporting information.	**Y**

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Nutritional screening on discharge from ICU to the ward	The committee agreed that nutrition and malnutrition should be added to the relevant definitions throughout the document. The committee agreed that there is no need for a separate statement on nutritional screening considering that QS24 already covers nutritional screening and nutrition support.	**N**
Psychological needs/support after critical illness	The committee agreed that psychological needs are already covered within the document and there is no need for a separate statement. It was also highlighted that there were no recommendations within the guideline that such a statement could be based on.	**N**

12. 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.	
13. 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.	
14. Next steps and timescales (part 1 – open session)	AW outlined what will happen following the meeting and key dates for the rehabilitation after critical illness quality standard.	
15. Any other business (part 1 – open session)	No AOBs. **Date of next QSAC3 meeting: 20 September 2017**	