NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 1

Transition between inpatient mental health settings and community and care homes and Sepsis – post consultation meeting

Minutes of the meeting held on 4 May 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Bee Wee (chair), Helen Bromley, Gita Bhutani, Gavin Maxwell, Alyson Whitmarsh, Hugo Van Woerden, Teresa Middleton, Ian Reekie, Sunil Gupta **Specialist committee members** *Transitions Mental health* Shawn Mitchell, Ginny Beacham, Sarah Matthews, Sandra Bilsborrow, Neeraj Berry *Sepsis* Suman Shrestha, Enitan Carrol, John Butler, Richard Beale **NICE staff** Nick Baillie [NB], *Items 5-9* Michelle Gilberthorpe [MG], Julie Kennedy [JK] *Items 8-11* Shaun Rowark [SR], Julie Kennedy [JK], *Notes* Jamie Jason [JJ]
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Jane Worsley, Phillip Dick, Arnold Zermansky, Amanda De La Motte, Hazel Trender, Ivan Bennett, Steve Hajioff, **Specialist committee members** Sepsis - Catherine White, Alison Tavare

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> <u>Shawn Mitchell</u> Shawn is employed full time by St Andrew's Healthcare, an independent provider of mental health services, almost all placements funded by the NHS. <u>Ginny Beacham</u> None to declare. <u>Sarah Matthews</u> None to declare. <u>Sandra Bilsborrow</u> None to declare.	

Agenda item	Discussions and decisions	Actions
	Neeraj Berry None to declare. **Minutes from the last meeting** The Committee reviewed the minutes of the last meeting held on 05 January 2017 and confirmed them as an accurate record.	
4. QSAC updates	NB noted that this was the last QSAC 1 meeting and thanked members for their ongoing contributions.	

Transition between inpatient mental health settings and community and care homes		
5. Recap of prioritisation exercise	MG and JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for Transition between inpatient mental health settings and community and care homes. **At the first QSAC meeting on 5 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:** • Hospital admission • Hospital discharge • Follow up support • Support for families, parents and carers The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here	
6. Presentation and discussion of stakeholder feedback and key	MG presented the Committee with a consultation report summarising consultation comments received on the draft quality standard for transition between inpatient mental health settings and community and care homes.	

themes/issues raised	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. MG further explained revisions that had taken place to statements between the prioritisation meeting and consultation; these were made in view of feedback from the QSAC Chair and SCMs, and further quality assurance. Consultation questions were asked about specific statements to gather feedback on how statements could be measured and support quality improvement.	
6.1 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)
People admitted to an inpatient mental health setting have access to advocacy services.	• Reference potential transition from social care. • Clarify roles of parent, carer and advocate. • Reference range of advocacy	The committee discussed the following: The Committee agreed that the statement applies to people transitioning to and from an inpatient mental health setting from a range of settings.	**Y**

	approaches, including non-statutory in view of reduction/removal of funding. • Signposting should meet needs of different people. • Children, young people and families require information at different points, not just on admission. • Hospital admission protocols unlikely to evidence promotion of advocacy services on admission.	The committee agreed that the statement should specify and define independent advocacy. It was also agreed to strengthen wording in the rationale around the ongoing need for access to advocacy throughout the person's stay in an inpatient setting. The Committee agreed that both process measures should consider proportions of people, and include a denominator, rather than measure a number. It was noted measure B may be more appropriate as an outcome. **Action: add 'independent' before advocacy in the statement wording. Review measures and strengthen reference to offering advocacy throughout stay.**	
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People admitted to inpatient mental health settings outside the area in which they live have regular reviews of their placement.	• Services providing social care to the person (prior to admission, or post-discharge) should be included in reviews. • Face-to-face reviews preferable, as safeguarding disclosures less likely to be made over skype/telephone. • Financial implications in developing expert capacity in each locality for the range of mental health services, but potential for premature discharge from placements if insufficient expert capacity.	It was noted that there was little feedback from stakeholders in response to the consultation question on an appropriate timescale. The Committee discussed the difference between 'contact' and 'review', and agreed that 3 monthly reviews of placements are appropriate for people accessing specialist mental health services, whereas 72 hour/weekly follow-up is important for acute care. The Committee considered splitting populations in the measures to apply different timescales for follow-up for people accessing acute care and people accessing specialist mental health services. The Committee also considered making a distinction between adults and children. The term 'out of area specialist placements' may be used. The committee agreed to progress a statement on follow-up for people accessing specialist mental health services outside the	**Y**

		area in which reviews take place at least every 3 months **Action: amend statement to focus on people accessing specialist mental health care out of area, and use 3 month timeframe specified in the NICE guideline.**	
Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People discharged from an inpatient mental health setting have their care plan sent to everyone identified in the plan as involved in their ongoing care within 24 hours.	• Difficult to implement if admission lasts less than 7 days (many people), but this group most at risk of suicide. • Care plans should be received by those involved in ongoing care at earliest opportunity. • Social care providers should be involved in care planning. • Suggestions for inclusions in care plan definition. • Should measure involvement of people in developing their care plan, but it is not always appropriate to be involved / have plan shared.	The committee agreed that the statement should apply to everyone discharged from an inpatient mental health setting, regardless of the length of stay. . The Committee acknowledged that it may not always be appropriate for people to be fully involved in developing their care plan, or to receive a copy. However, the Committee agreed that the aspiration is for everyone to be included in developing their care plan and agreed that specific exclusions should not be stipulated. Consideration could be given to clarification in the definitions section. The Committee discussed involvement of social care providers and considered that this is already standard practice. The Committee considered that supporting information statement should be more person-centred and there should be more involvement of families / carers The Committee agreed to progress the statement as it is with amendments to the supporting information. **Action: Make amendments to the supporting information to include patients admitted for less than 7 days; consider including a sentence in the definitions section to highlight that it might not always be appropriate for people to be**	**N**

		fully involved in developing their care plan, or to receive a copy.	
Draft statement 4	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People discharged from an inpatient mental health setting are followed up within 48 hours if a risk of suicide has been identified.	• National Confidential Inquiry into Suicide and Homicide by People with Mental Illness and the Health Select Committee recommend 48-72 hour follow up for everyone discharged from an inpatient mental health setting. • Suggestion of groups of people who might be at a higher risk of suicide: people who live alone, people who have alcohol or drug problems, and males aged between 50-64. • People with complex mental health disorders or personality disorder often receive inappropriate follow up for severe distress when there is an apparent suicide risk. • Drug & alcohol teams often do not have capacity to "pick people up" within 48 hours. People discharged from a mental health setting following treatment from a drug and alcohol team should receive follow-up care from the same team in the community. • Children, young people and families require a single point of contact that they can contact by phone, text or email. • Equality and diversity considerations	The Committee noted that there was little feedback from consultation about how the "at risk" population requiring follow-up within 48 hours would be identified. The Committee considered feedback that 7 days is not an aspirational timeframe for follow-up but highlighted that there is variation in practice in terms of achieving follow-up within this timescale. The Committee acknowledged difficulty in defining the population requiring 48 hour follow-up. It was agreed that people who are identified as at moderate to high risk of suicide are the target population for 48 hour follow-up. There are various validated tools that could be used to define risk. It was agreed that decisions about risk should take risk on admission into account, rather than solely risk at discharge and once back in a community setting. Follow up within 48 hours over the weekend was also discussed. The Committee discussed format of follow-up and suggested that recommendations within the guideline are based on incidence of suicide rather than evidence of effectiveness of specific methods of follow-up. It was agreed that follow up method should be in accordance with modes of communication identified in the person's care plan. It was agreed that a "mental health professional" should follow-up, as the team following-up might differ according to need, The Committee agreed that 7 day follow-up should be one of the components of the care plan, stipulated in statement 3. The Committee suggested that there should be a cross	**N**

	section should be reworded, so it does not appear to suggest that prevention of homelessness is solely to support ease of follow-up.	reference to NICE guidance on suicide. The committee agreed to progress a statement on 48 hour follow-up for people at moderate to high risk of suicide.. The committee agreed that a separate statement on follow-up within 7 days would not be progressed, but 7 day follow-up for the remainder of people discharged from an inpatient mental health setting should continue to be a reference in the rationale section. **Action: Retain statement on 48 hour follow up and state that population is those at moderate/high risk; Add a reference to the format of follow-up being in line with mode of communication identified in the person's care plan; Add 7 day follow up to the definitions section of statement 3 on care planning; Review equality and diversity considerations section.**	

Additional statements suggested	**Committee rationale**	**Statement progressed (Y/N)**
Reintegration to education or vocation.	This area is covered on the discharge plan.	**N**
Contact with addictions teams if addictions disorder identified.	This area is covered on the discharge plan.	**N**
Communication between primary care team/GP practice and mental health team before and during admission, including 24 hour access to key mental health worker to	Variation in contact with primary care on admission important but not appropriate for a statement.	**N**

discuss urgent problems.		
Support requirements of people with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition (particularly NHS England's programme of care and treatment reviews).	There are related quality standards for learning disabilities: identifying and managing mental health problems QS142, January 2017; Learning disabilities: challenging behaviour QS101, October 2015 and Autism QS51, January 2014	**N**

7. 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. However, it was agreed that there would be a resource impact regarding provision of advocacy in view of discontinuation of funding, and it should therefore be highlighted that there is a range of advocacy services. The committee agreed there would be a resource impact for follow up of people with a moderate to high risk of suicide within 48 hours, however improving follow-up should reduce other costs in terms of increased length of stay, or potential readmissions.	
8. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on Transition between inpatient mental health settings and community and care homes. It was agreed that the Committee would contribute suggestions as the quality standard was developed. The committee discussed how it may be difficult to measure experience. The committee agreed that "delayed transfers" should be changed to "delayed discharge", as transfers were out of scope of the quality standard.	
9. 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 (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the Transition between inpatient mental health settings and community and care homes quality standard.	
Sepsis		
11. 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.	
12. 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>Alison Tavaré</u> Personal Financial: • West of England AHSN GP clinical advisor • Author of 'Sepsis in Adults' for Health England • Joint Director of AJT Medical Ltd Personal non-financial • Author of RCGP "NICE: Sepsis guidance' In press • Alison has given various non-remunerated talks on sepsis and NEWS/ structured sets of observations • Alison has attended a UK Sepsis Trust reception at the Houses of Parliament	

	• Alison has reviewed the UK Sepsis Trust tool kits Non-personal Financial • Alison's husband Prof Jeremy Tavaré is Director of Research Health at the University of Bristol and holds grants from the Wellcome Trust, Medical Research Council, Engineering and Physical Sciences Research Council and DiabetesUK. He is Chair of the Medical Research Council's Non-clinical Fellowships and Training Panel. <u>Catherine White</u> • Volunteer (Trustee and Information Manager) with ICUsteps charity. <u>Enitan Carrol</u> • Enitan received an MRC Confidence in Concept award in 2014 on identifying biomarkers of sepsis using peptide arrays with a company called Avacta Life Sciences. • July 2015: Enitan received a Knowledge Transfer Partnership with Avacta from Innovate UK. The Knowledge Transfer Partnership (KTP) scheme allows UK Universities to help UK Industry by utilising knowledge which exists within the University. The scheme is partly funded by the Business itself (~33%) with the remainder being funded by government grants. The academic's institution receives financial remuneration for this, to be used for any academic purpose on any project. • Enitan was invited to join the Scientific Advisory Board of BioFire Diagnostics, a wholly owned subsidiary of Biomerieux. BioFire Diagnostics specialise in molecular diagnostics for pathogen detection. All payments will be made directly to my institution and not to myself. • Enitan has filed patent for a panel of meningitis biomarkers through the University of Liverpool. <u>John Butler</u> • John sat on the Sepsis Guideline Development group which developed the NICE guideline	

	NG51. This was published in July 2016. • John is a member of the UK Sepsis group. Suman Shrestha • Suman provides consultancy services to LiDCO Ltd on training and education for nurses • Suman participated on focus group meetings regarding products developed by BARD Ltd., Intersurgical Ltd. and Aerogen Ltd. Richard Beele • None.	
13. Recap of prioritisation exercise	SR and JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for Sepsis. **At the first QSAC meeting on 5 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:** • Identifying people with suspected sepsis • Managing suspected sepsis outside acute hospital settings • Antibiotic treatment in people with suspected sepsis • Information and support The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here	
14. Presentation and	SR and JK presented the committee with a report summarising consultation comments received on sepsis.	

discussion of stakeholder feedback and key themes/issues raised	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	
15. 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 suspected sepsis are assessed to stratify risk of severe illness or death using a structured set of observations	• Difficulties in implementation • Use of early warning scores e.g. NEWS • Separate populations by age • Difficult to record observations outside of ED • Additional observations could be recorded	The committee discussed: • GPs see a lot of patients with suspected illness but only a small percentage will have sepsis. The observation will lie with the experience of the clinician, and risk stratification only takes place once the clinician thinks that a person may have sepsis. • Measuring blood pressure is required for risk	**N**

		stratification. Stakeholders highlighted that the equipment to measure blood pressure in children under 12 is not always available outside of acute settings. If there was a chance of suspected sepsis the committee agreed the child should be sent where their blood pressure can be measured as part of assessment and risk stratification for sepsis. . • Not all people in primary care have a face to face appointment, and therefore it may be difficult to record the required physiological observations. The committee were reminded that people with suspected sepsis should be seen in a face to face setting. • People with high risk sepsis should be referred as a medical emergency, however this was out of the scope of the statement, as it focused on initial identification. **The committee agreed that the statement did not need to change, but that additional clarifying information could be provided through the definitions.**	
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People with suspected sepsis in acute hospital settings and at least 1 criteria indicating high risk of severe illness or death are reviewed by a senior clinical decision-	• Potentially significant resource impact • Definition of senior clinician • Availability of senior clinicians within an hour • Focus on subpopulation who receive review • Consultant review • When does 1 hour start?	The committee discussed: • The statement needs to reflect that the timeframe to be reviewed by a senior clinician starts when risk stratification in statement 1 has identified that someone is high risk. • Whether there needs to be a separate statement about	**Y**

maker within 1 hour of risk being identified		the senior decision maker, or given that it focuses on the same population as draft statement 3, these 2 statements could be combined, which would make it clearer. The two aspects could be measured separately. • Whether additional healthcare professionals could be defined as 'senior decision maker' but it was agreed that the definitions used in the guidelines needed to be used. • That the stakeholders may have misinterpreted the purpose of the senior clinical decision maker. They are required to review those most at risk, and make a decision about whether it is sepsis. Other clinicians may have started antibiotics, which should be delivered within 1 hour of risk stratification. **Action: combine draft statements 2&3. Clarify that the 1 hour timeframe begins when risk has been stratified.**	
Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People with suspected sepsis in acute hospital settings and at least 1 criteria indicating high risk of severe illness or death have antibiotic treatment within 1 hour of risk being identified	• Goes against antimicrobial stewardship • Too many people identified at risk • Define appropriate antibiotics • Include taking of blood cultures and review of antibiotics • Be clear that takes place after senior review? • Can primary care deliver IV antibiotics?	The committee discussed: • The statement needs to reflect that the treatment of antibiotics is relating to the delivery of the first dose not the full course. • Adding a definition to the appropriate type of antibiotics.	**Y**

	• When does 1 hour start?	• Whether the statement should explicitly reference the NICE quality standard on antimicrobial stewardship. • There are two activities that happen in an hour, could the statement be combined with draft statement 2? **Action: combine statements 2&3. Say have IV antibiotic treatment delivered. Specify that it is first dose not course. Add definition of antibiotics to clarify appropriateness issue. Amend statement wording to say 'at least one of the high risk criteria'. Include detail of antimicrobial stewardship quality standard.**	
Draft statement 4	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People with suspected sepsis in acute hospital settings, at least 1 criteria indicating high risk of severe illness or death, and with lactate over 2 mmol/litre, have an intravenous fluid bolus within 1 hour of risk being identified.	• Change from lactate threshold of 2 mmol/litre e.g. 4 mmol/litre • Define type and volume of fluid • Recording lactate may not be possible within 1 hour • Reliable measure in children? • Change outcome measures • When does 1 hour start?	The committee discussed: • Having a different statement about consultant review for people who have failed to respond within 1 hour of antibiotics or IV fluids?. • Whether there was a variation in practice in this area? It was noted there was room for improvement. • Whether to change the lactate threshold to above 4 mmol/litre to focus on those who are sickest. • The high risk group should also include people with hypotension. The subgroup that benefit are patients that are hypotensive or have high lactate.	**Y**

		• Change of focus to anyone with suspected sepsis at high risk and with lactate over 2 mmol/litre. or suspected sepsis and hypotensive based on recs 1.6.2 & 1.6.3. These are the groups that will benefit most. • Evidence in children is not as strong. Should we exclude children on this basis? Kept in as there are recommendations for this population. **Action: additional population of people who have suspected sepsis and hypotension.**	
Draft statement 5	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
People who have been seen by a healthcare professional and assessed as at low risk of sepsis are given information about symptoms to monitor and how to access medical care.	• Is safety netting specific to sepsis • Define low risk • Applicable to all settings	**The committee discussed:** • There is a need for this specific group. The confusion from stakeholders is which people this will be. The low risk group suggest a larger group than the statement intends, as it will not be everyone who attends, but people who were suspected of sepsis, risk stratified, and who were found not to be at high or moderate risk at the time. • The cohort of people could be those with infection. However this would still be a large group, around 30% of GP consultations.. • A primary care read code would need creating to measure this. The committee agreed to retain the statement but focus on a	**N**

		smaller population. **Action: explore narrowing the population for the statement. Amend outcome measure**. Consultant review proposed for inclusion as a separate and additional statement based on consultation comments from draft statement 2. Statement on alerting consultant for people who fail to respond to treatment. Recommendation 1.6.7 plus for the relevant recommendations for specific age groups. Clarified that it's about alerting the consultant to attend, as no time frame is available for how quickly an attendance should take place. The alert should be within be 1 hour after the initial treatment. **Action: add new statement on alerting consultants to attend.**	

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Sepsis six.	The committee acknowledged that the guidance does not reference any specific tools given the wide variation of what is used in different regions for different populations. Therefore it should not be progressed.	**N**
Sepsis "champion"	The committee agreed that as no NICE or NICE accredited guidance covers this improvement area it should not be progressed.	**N**
Training workshops.	The committee agreed that it is not within the remit of quality standards to include improvement areas on training and education as there is implicit within quality standards that all healthcare professionals involved in patient care are appropriately trained.	**N**

Post-sepsis syndrome.	The committee agreed that as no NICE or NICE accredited guidance covers this improvement area it should not be progressed.	**N**
High risk population (neutropenic sepsis and sepsis in pregnancy).	The committee acknowledged that this population would be covered as an at risk group in this quality standard. However they agreed that no specific statements were required in these areas.	**N**
Blood cultures.	The committee agreed that making additions to the statement on delivering antibiotics will address this area. No specific statement were needed on taking blood cultures.	**N**
Review of antibiotics. .	The committee agreed that making additions to the statement on delivering antibiotics will address this area. No specific statement were needed on reviewing antibiotics.	**N**
Source of infection	The committee were reminded that they did not progress this area at the prioritisation stage. The committee felt that finding the source of infection is part of the role of the senior clinical decision maker, and therefore this would be covered in the statement on senior review.	**N**
Phenotype and genotype testing.	The committee agreed that as no NICE or NICE accredited guidance covers this improvement area it should not be progressed.	**N**

16. 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 also highlighted that a new report on the cost of sepsis, may help to demonstrate cost savings associated with this quality standard.	
17. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on Sepsis. It was agreed that the Committee would contribute suggestions as the quality standard was developed.	
18. 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.	
19. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the Sepsis quality standard.	
20. Any other business (part 1 – open session)	No other business. **Date of next QSAC1 meeting: 1 June 2017**	