Quality standards advisory committee 1

Cerebral palsy – (post-consultation) & Mental health of adults in contact with the criminal justice system (prioritisation)

Minutes of the meeting held on 6 July 2017 at the NICE offices in Manchester

Attendees	**Quality standards advisory committee (QSAC) standing members** Bee Wee, Tim Fielding, Phillip Dick, Alyson Whitmarsh, Hugo Van Woerden, Hazel Trender, Ian Reekie, Sunil Gupta, Rhian Last, John Jolly, Ruth Bell, Simon Baudouin, Lauren Aylott, **Specialist committee members** **Cerebral palsy** Charlie Fairhurst, Duncan Walsh, Stephanie Cawker **Mental health of adults in contact with the criminal justice system** Leroy Simpson, Joanne White, Mark Warren, Vikki Baker, Steffan Davies **NICE staff** Nick Baillie, Gavin Flatt, {agenda items 3- 9} Julie Kennedy, {agenda items 3- 9} Eileen Taylor, {agenda items 10-16} Shaun Rowark, {agenda items 10-16} Jamie Jason
Apologies	**Quality standards advisory committee (QSAC) standing members** Gita Bhutani, Nicola Hobbs, Anita Sharma, Tessa Lewis, Zoe Goodacre, Ruth Halliday, Teresa Middleton, **Specialist committee members** **Cerebral palsy** Liz Keenan, Wendy Doyle **Mental health of adults in contact with the criminal justice system** Nick Kosky

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	**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>Standing committee members</u> Rhian Last declared she has a new role as Editor in Chief, Journal of General Practice Nursing. <u>Specialist committee members</u> <u>Charlie Fairhurst</u> • Clinical advisor NGA • Chair NICE Guideline - Cerebral palsy in under 25s (NG62) • Chair NHS England's Clinical Reference Group - Paediatric Neurosciences • Chair RCPCH's Specialist Advisory Committee on Neurodisability Trustee Whizz Kidz <u>Stephanie Cawker</u> • None. <u>Duncan Walsh</u> Duncan is an employee of PACE, a charity that works with children and young people with cerebral palsy and other motor disorders and their families. Duncan's wife works for Sunrise Medical as an Area Sales Manager.	

Agenda item	Discussions and decisions	Actions
	Minutes from the last meeting The committee reviewed the minutes of the last meeting held on 1 June 2017 and confirmed them as an accurate record.	

Cerebral palsy – post consultation meeting		
3. Recap of prioritisation exercise	GF and JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for cerebral palsy: At the first QSAC meeting on 2 March 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: • Multidisciplinary care • Information and support The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here	
4. Presentation and discussion of stakeholder feedback and key themes/issues raised	GF and JK presented the committee with a report summarising consultation comments received on cerebral palsy. 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 GF summarised the significant themes from the stakeholder comments received: • Support for the quality standard in that it accurately reflects key areas for quality improvement. • No particular areas of concern. • Additional areas for quality improvement were suggested. • Clear definitions within statements • Availability of data sources • Resource impact	
5. 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)
Follow-up for children at risk of cerebral palsy **Children with any risk factor for cerebral palsy have an enhanced multidisciplinary clinical and developmental follow-up programme from birth to 2 years.**	• Important area of care. • Timeframe of every 3 months from birth up to the age of 2 years was suggested. • Information sharing not addressed in enhanced clinical and developmental follow up programme. • Orthoptists should be included in MDT team. • Therapy should be tailored to the needs of children at risk. • Information of alternative providers of follow up care should be provided.	The committee felt the most important part of the statement was the follow up and having the right person with the right skills to detect cerebral palsy. It was questioned who would do the follow up, that it might not be the NHS and it could be difficult putting into practice. The committee highlighted potential difficulties with resource impact if the focus remained as 'all risk factors' and felt this may be difficult to achieve due to difficulties identifying a denominator. It was suggested that the statement wording should be changed from 'any' to 'major' risk factors and define major in the definitions' section. The committee agreed that the major risk factors should be defined as pre 28 weeks, neonatal encephalopathy and neonatal sepsis.	**Y**

		The committee agreed to remove the words 'multidisciplinary' and 'programme' from the statement. This will allow for clinical judgement and for bespoke care to be provided that is appropriate for the child and young person who is at risk of cerebral palsy.	
Draft statement 2	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Referral for children with delayed motor milestones **Children with delayed motor milestones are referred to a child development service.**	• Overlap with statement 1. • Need to clarify how the children at risk of cerebral palsy are identified and monitored. • Delayed motor milestones depend on the specific diagnosis making measurement difficult. • MDT team in the child development service should include orthoptists. • Concerns about current availability of services.	The committee agreed to keep this statement with no changes.	**N**
Draft statement 3	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Personal folders for children and young people with cerebral palsy **Children and young people with cerebral palsy have a personal folder.**	• Clarification required over what is included in the personal folder. • Include information outlining the aims of the personal folder • Disordered developmental journeys should be included. • Potential overlap with existing health and social care services support tools.	The committee discussed the feedback from families and felt having a file of the child's history would reduce anxiety and frustration. The committee queried who holds the personal folder and suggested that this should be clarified within the supporting information. To be effective the personal folder would have to be an evolving document – this should be explicitly recognized within the rationale section.	**N**

		The committee discussed that this was an area NHS England are currently looking at. The committee agreed to keep the statement subject to some clarifications within the supporting information.	
Draft statement 4	**Themes raised by stakeholders**	**Committee rationale**	**Statement revised (Y/N)**
Information about specialist teams for children and young people with cerebral palsy **Children and young people with cerebral palsy are given information about how specialist teams will be involved if they are needed to manage comorbidities.**	• Clarity is needed over whether this would apply to all children with cerebral palsy or just those with more complex needs. • Alternative wording suggested due to varying implications for different audiences. • Inconsistent evidence of defined referral pathways. • Responsibility of the local care provider for specialist liaison and care coordination should be highlighted. • Orthoptists should be named within the audience descriptors.	The committee felt it was not clear whether information was to be given when cerebral palsy is diagnosed or on the diagnosis of a comorbidity. It was discussed that the emphasis of this statement was to provide information to families at an early stage. It was highlighted that if the statement included information regarding comorbidity this would be difficult to audit. The committee therefore agreed to revise the statement to focus on providing information and not focus it on comorbidities. It was agreed that information to be provided is specific to cerebral palsy and should be clearly defined within the supporting information. It was highlighted that different time points exists for when information should be given. It was agreed separate measures should be developed for each time point. The committee highlighted that a structural statement on access to specialist services would also be important. However the NICE team noted a structural statement was investigated previously but could not be developed due to the number of different possible care pathways available for cerebral palsy. It was agreed that the team would explore this again.	**Y**

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Support for the family and carers of children with cerebral palsy.	The committee felt there were already 2 of the 4 statements focused in this area.	**N**
Managing urinary dysfunction.	The committee felt that there was already sufficient guidance on this area.	**N**

6. Resource impact	Concerns were raised as to national and regional service provision around statement 1. However it was hoped that, following the suggested amendments, the quality standard would help focus resource use and promote high quality care.	
7. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on cerebral palsy. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
8. 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 noted the following areas. • Language • Transient population • Disability –difference between disability and mental health?	
9. Next steps and timescales	GF outlined what will happen following the meeting and key dates for the cerebral palsy quality standard.	

	Mental health of adults in contact with the criminal justice system – Prioritisation meeting	
10. Welcome,	The Chair welcomed the specialist committee members and asked the quality standards advisory	

introductions and plan for the day (private session)	committee (QSAC) members to introduce themselves.	
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>Vikki Baker</u> • Seconded from a mental health trust to work within the offender Personality Disorder pathway as joint service director at Resettle. <u>Steffan Davies</u> • None <u>Leroy Simpson</u> • None <u>Mark Warren</u> • Previous interim chair of the Royal College of Nursing Criminal Justice Nursing Forum. Term expired end of 2016 <u>Joanne White</u> • None	

13.Topic overview and summary of engagement responses	ET and SR presented the topic overview and a summary of responses received during engagement on the topic.	
14. Prioritisation of quality improvement areas	ET 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 1 & 2	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Initial assessment a) Assessment for specific conditions b) Content of assessment c) Patient involvement and reasonable adjustments **Identification and assessment throughout the care pathway** a) Liaison and diversion b) Identification of support needs c) Comorbidities and physical health	**Y**	Areas 1 and 2 were considered at the same time. The committee discussed the importance of identifying mental health issues in the first instance and it was felt that this is not done well across services. When issues are identified a mental health assessment can take place. The committee noted that the source guidance recommendations tended to focus primarily around prison settings. It was discussed that people in contact with the criminal justice who do not go to prison are often not in the system long enough for guidance on mental health to apply. However, it was felt that mental health identification and assessment is quite consistently done in prisons, and acknowledged that a quality statement focusing on the second stage assessment was already included in the quality standard on physical health for people in prisons. The committee also discussed specific mental health conditions, but did not feel it was a priority to focus on any one condition.	Identification of support needs Content of assessment

		The committee agreed to focus a statement on the content of a comprehensive mental health assessment. The committee discussed focussing this on all people in contact with the criminal justice system. It was noted that this was a broad scope and the NICE team would focus this on a specific action and population.	
Suggested quality improvement area 3	**Prioritised (yes/no)**	**Rationale for prioritisation decision**	**If prioritised, which specific areas to be included?**
Risk assessment and management, and care planning a) Accurate risk assessment and management b) Integrated services and information sharing c) Self-harm and suicide risk in prison d) Specialist teams, pathways and services for mental health	**Y**	The committee noted that suicide prevention will be covered in another quality standard and that risk assessment for these people is done quite consistently in prisons. The committee agreed to focus a statement on developing a mental health care plan. This statement will focus on people who come under the responsibility of the criminal justice system and are accessing services through the system. The committee discussed carrying out risk assessments. It was noted that this seems to be done well however the risk management plans are not always acted upon in court or transport services. The committee discussed there was a gap when transferring between services and agreed to focus on a statement on sharing risk management plans during transitions.	Accurate risk assessment and management. Integrated services and information sharing
Suggested quality improvement area 4	**Prioritised (yes/no)**	**Rationale for prioritisation decision**	**If prioritised, which specific areas to be included?**
Psychological interventions a) Personality disorder	**N**	The committee agreed there are already practices in place for personality disorder and felt this was not a priority area.	

b) Delivery of psychological treatment		Delivery of psychological treatment was also discussed, including therapeutic communities. It was noted that the recommendation to refer people to therapeutic communities was a 'consider' recommendation meaning there is limited evidence to support this at present. In addition it was felt that the resource impact of establishing a therapeutic community would be significant. The committee therefore agreed not to prioritise either area.	
Suggested quality improvement area 5	**Prioritised (yes/no)**	**Rationale for prioritisation decision**	**If prioritised, which specific areas to be included?**
Staff training a) Stakeholders and SCMs highlighted training for key non-clinical professionals as a key area for quality improvement	**Y**	The committee discussed who would undergo the training and what this would focus on. It was discussed whether the purpose of training would be to identify mental health problems. The committee felt that training is important in building and managing relationships which can have significant beneficial effects for both staff and people in contact with the criminal justice system. The committee discussed police training in basic mental health awareness and noted they are often the first line non-clinical staff involved in dealing with people with mental health problems especially in the community. The committee agreed to develop a statement on training. It was noted that this is a broad area and the NICE team would focus the statement to a specific population and aspect of training.	

Additional areas suggested	Committee rationale	Area progressed (Y/N)
Second-stage health assessment	The committee agreed that the timing of when this assessment should take place in prison is already covered by the statement in the quality standard on the physical health of people in prisons.	**N**
Smoke free prisons	The suggestion from a stakeholder was to change the source guidance which is not within the remit of a quality standard.	**N**
Accommodation on release	This area is not covered within the guideline and the committee therefore did not wish to progress this.	**N**
Equality and diversity	Equality and diversity considerations are included in quality statements and equality impact assessments.	**N**
Enabling environments framework	This area is not covered within the guideline and the committee therefore did not wish to progress this.	**N**
Personality disorder service	This area is not covered within the guideline and the committee therefore did not wish to progress this.	**N**
Built environment	This area is not covered within the guideline and the committee therefore did not wish to progress this.	**N**
Forensic outreach	This area is not covered within the guideline and the committee therefore did not wish to progress this.	**N**
Brain injury	This area is not covered within the guideline and the committee therefore did not wish to progress this.	**N**
15. Resource impact	It was noted that the statement on training may have some resource impact locally.	
15.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on Mental health of adults in contact with the criminal justice system. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
15.2 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 noted the following: • People on remand • Veterans	
16. Next steps and timescales (part 1 – open session)	ET outlined what will happen following the meeting and key dates for the Mental health of adults in contact with the criminal justice system quality standard. The committee felt it would be helpful to have a police representative specialist committee member at the next meeting for this topic.	
17. Any other business (part 1 – open session)	No other business. **Date of next meeting for Mental health of adults in contact with the criminal justice system 2 November 2017** **Date of next QSAC 1 meeting: 7 September 2017**	