NICE National Institute for Health and Care Excellence

Quality Standards Topic Expert Group TEG 3

AUGIB

Minutes of the meeting held on 5th April 2013

Meeting held at Manchester

Attendees	Kelvin Palmer (KP), Mimi McCord (MM), Kenneth Halligan (KH), Mark Vaughan (MV), Simon McPherson (SM), Daniel Greer (DG), Markus Hauser (MH) **NICE Attendees** Carl Prescott (CP), Naomi McVey (NM), Terence Lacey (TL), Lisa Nicholls (LN), Andrew Wragg (AW)
Apologies	Carlos Gomez (CG), David Patch (DP), Joseph Varghese (JV), Mark Donnelly (MD), Lynda Greenslade (LG)

Agenda item	Discussions and decisions	Actions
1.Introductions and apologies	KP welcomed the attendees, noted the apologies and reviewed the agenda for the day. The group confirmed that the minutes from the meeting held on 27th November 2012 were an accurate record.	
Declaration of Interest	KP asked the group whether they had any new interests to declare since the last meeting and none were declared.	
2.Review of progress so far and objectives of the day	TL reviewed the progress made on the quality standard (QS) so far. He advised the group that the main objectives of the day were to discuss the results of the consultation and agree the quality statements and associated measures for progression into the final QS. TL reminded the group that the QS should only consist of aspirational statements addressing key areas of quality or variations in care. The group was also reminded that the QS should be as concise as possible and should not include anything that is standard practice. TL reminded the TEG that further changes may be made to the QS following the meeting, subject to discussion with and agreement of the TEG Chair and following Guidance Executive. TL confirmed that the group will have the opportunity to see and comment on the final version of the QS before publication.	
3. Support for commissioners and others using the quality standard	NM outlined the role of the NICE Costing and Commissioning team and advised the group that they will develop a support document for commissioners and other users to accompany the QS. She stated that the purpose of this document is to help commissioners and service providers consider the commissioning implications and potential resource impact of using the QS.	

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	NM advised the group that they may need to provide input during its development. She also told them that they will have the opportunity to comment on the document. NM asked the group to contact her if they have any questions or would like to contribute.	
4. Presentation and discussion of consultation feedback	CP gave a brief overview of the consultation comments received. There were some issues to consider on definitions and populations, however most statements were well received. One area the TEG discussed was the 16-19 age range, which had been suggested by stakeholders to consider for a number of statements. From the consultation feedback it was questioned whether this group had access to a paediatric service. The TEG felt that issues for 16-19 year olds would be the same as for adults and did not feel the 16-19 age range should come under paediatric services. CP advised the group that they would consider each statement and look at the consultation comments. The TEG would then decide whether to progress the statement and modify the statement if necessary. They would also need to consider any equalities issues, resource implications and outcome measurers. The TEG was asked to remember to ensure statements are aspirational and not standard practice.	
5. Presentation, discussion and agreement of	At consultation stakeholders felt that AUGIB was not clearly defined. CP and KP agreed to clarify the definition of AUGIB. It was also suggested at consultation that the introductory definition and context	CP and KP to amend wording of AUGIB in introduction

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final statements	setting was perhaps critical and demotivating for those providing AUGIB services. The TEG felt that whilst the text was accurate the tone could be modified to be less pessimistic. The TEG looked at each of the 10 statements and reviewed each statement based on consultation feedback.	
	Draft QS1: People with acute upper gastrointestinal bleeding are offered a risk assessment using a validated risk score. From the consultation comments the TEG agreed to change 'offered' to receive as this is a more passive intervention than an active treatment. The TEG felt this statement was aspirational, as there is a variation in care across the service. **Revised statement 1: People with acute upper gastrointestinal bleeding receive a risk assessment using a validated risk score.**	CP to amend statement wording
	Draft QS2: People with severe acute upper gastrointestinal bleeding who are haemodynamically unstable are offered endoscopy within 2 hours of resuscitation. The TEG considered the consultation comments, particularly around the 2 hour timeframe. The evidence base for 2 hours was questioned. The TEG agreed that 2 hours had no evidence base, but that it was a pragmatic and realistic translation of the word "immediately" which is used in the underpinning recommendation. Additionally, clarity was requested regarding when the 2 hour timeframe stated. The TEG agreed to include "within 2 hours of optimal resuscitation" in the	CP to define optimal and circulate for TEG comment.

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	statement, and define “optimal” in the definitions section. The TEG felt this was an aspirational statement and decided to clarify the statement with the use of the word “optimal”. **Revised statement 2: People with severe acute upper gastrointestinal bleeding who are haemodynamically unstable are offered endoscopy within 2 hours of optimal resuscitation.**	CP to amend statement wording
	Draft QS3: People with acute upper gastrointestinal bleeding who are haemodynamically stable are offered endoscopy within 24 hours of admission. The TEG felt that 24 hours was a reasonable timeframe. Consultation stakeholders pointed out that not all patients would require endoscopy within 24 hours e.g. some patients with trivial bleeding could be referred for an elective scope. In order to rule out those with trivial bleeding it was clarified that this statement referred to those “admitted to hospital”. ”Admitted to hospital” was added to the statement. **Revised statement 3: People admitted to hospital with acute upper gastrointestinal bleeding and are haemodynamically stable are offered endoscopy within 24 hours of admission**	CP to amend statement wording
	Draft QS4: People with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage are offered combination endoscopic treatments, or a mechanical method.	

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	No significant comments or suggestions from consultation. NICE internal team suggested some amendments to the wording as they felt it was unclear. The TEG agreed with the suggested wording from the internal NICE team and agreed to amend the wording as below. **Revised statement 4: S04 People with non-variceal acute upper gastrointestinal bleeding and stigmata of recent haemorrhage are offered endoscopic treatments (combination or a mechanical method).**	CP to amend statement wording
	Draft QS5: People with non-variceal acute upper gastrointestinal bleeding who are haemodynamically unstable and who re-bleed after endoscopic treatment are offered interventional radiology. The TEG felt a number of the consultation comments for this statement concerned restructuring services rather than clinical care. Since the statement was mostly well received the TEG decided to keep the statement wording, but they decided to modify the patient descriptor as they agreed with the consultation comments that this was unclear. **Revised statement 5: People with non-variceal acute upper gastrointestinal bleeding who are haemodynamically unstable and who re-bleed after endoscopic treatment are offered interventional radiology.**	CP to revise patient descriptor wording

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	Draft QS6: People with suspected or confirmed variceal acute upper gastrointestinal bleeding are offered antibiotic therapy at presentation No specific consultation comments. The TEG considered if it would be possible to define the type and duration of antibiotics, but it was felt that this would vary and so this would not be possible. The TEG retained the wording of the statement. **Agreed statement 6: People with suspected or confirmed variceal acute upper gastrointestinal bleeding are offered antibiotic therapy at presentation**	No change to statement wording
	Draft QS7: People with upper gastrointestinal bleeding from oesophageal varices are offered band ligation No specific comments or suggestions from consultation. The TEG felt this was aspirational and a variation does happen in the service. Statement wording to remain the same. **Agreed statement 7: People with upper gastrointestinal bleeding from oesophageal varices are offered band ligation**	No change to statement wording
	Draft QS8: People with acute upper gastrointestinal bleeding from gastric varices are offered endoscopic injection of N-butyl-2-cyanoacrylate	

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	No significant consultation comments or suggestions. The TEG was happy to keep the wording and felt this was an area for quality improvement. **Agreed statement 8: People with acute upper gastrointestinal bleeding from gastric varices are offered endoscopic injection of N-butyl-2-cyanoacrylate**	No change to statement wording
	Draft QS9: People with uncontrolled acute upper gastrointestinal bleeding from varices are offered transjugular intrahepatic portosystemic shunts (TIPS). Following consultation comments the TEG decided to amend the statement and definitions to clarify that this statement refers to those patients where endoscopy has failed. Statement amended to include 'despite' endoscopic therapy, so it was clear this statement should only be applied when this has failed. The TEG discussed the fact that this statement was based on two recommendations, one of which was a "consider" recommendation. The TEG felt that as there was no alternative to TIPS for this group of patients then it was appropriate within this context to state that TIPS should be "offered". CP to check with DP and the QS technical team to confirm this. Include in definitions to clarify this statement applies if statement 7 and 8 treatment options have not worked.	CP to check guidelines and confer with DP and QS technical team CP to add in definitions to only refer to this statement if 7 and 8 haven't worked. CP to amend

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	Revised statement 9: People with uncontrolled acute upper gastrointestinal bleeding from varices despite endoscopic therapy are offered transjugular intrahepatic portosystemic shunts (TIPS).	statement wording
	Draft QS10: People with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved are advised to continue on low-dose aspirin The TEG was asked to consider the appropriateness of the underpinning clinical guideline recommendation for QS development, as it may be difficult to capture the nuances of this recommendation within a quality statement, particularly as aspirin is a causal factor for bleeding. CP proposed changing the statement to reflect that the risks and benefits of continuing aspirin should be discussed, as outlined in the full clinical guideline. However the TEG felt that this applied mainly to other drugs discussed within that section of the full clinical guideline, and not to aspirin, which should be continued. The TEG also felt that it was clear that this statement only applied to a particular population (those continuing aspirin for secondary prevention). As this population were already taking the drug, had a proven history of cardiovascular events, and as the anti-platelet effects of taking aspirin continue for at least 7 days, the TEG felt this was an important statement that would prevent adverse events and mortality. The TEG felt this signified a change in practice and was important to keep in and keep the wording as it is. They also felt this was safe. The TEG understood the need to be mindful of the BNF.	No change to statement wording

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	Agreed statement 10: People with acute upper gastrointestinal bleeding who take aspirin for secondary prevention of vascular events and in whom haemostasis has been achieved are advised to continue on low-dose aspirin	
8.Summary of meeting and agreement of final statements	CP presented a summary of the revised statements to the TEG. The TEG discussed the other areas for additional statements suggested by stakeholders. It was felt the areas suggested referred to areas of care which were standard practice, or areas which were service focused rather than clinically care focused, therefore none of the suggested areas were progressed.	
9.Equality Impact assessment	The TEG discussed any potential equality issues. It was felt that those who live in a remote/rural setting may have difficultly accessing services, however this should not prevent the QS from outlining the areas the TEG felt were most important for quality improvement	
10.Next steps •Timelines •Final quality standard product •endorsement	AW outlined the next steps, including key dates in the QS development process. The TEG was also informed of the organisations who expressed interest at consultation stage to endorse the standard. The TEG gave some further organisations to approach regarding endorsement: • Association of Upper GI surgeons • British Association for the Study of the Liver • British Society of Haematology • National Blood Service • British Cardiac society	

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	AW briefed the group on the CCGOIS indicators process. They were reminded that they would be invited back to a meeting to discuss these indicators for AUGIB.	
11.AOB	KP thanked the group and closed the meeting.	