NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 1

Sepsis / Transition between inpatient mental health settings and community or care home settings – prioritisation meeting

Minutes of the meeting held on Thursday 5 January 2017 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Dr Gita Bhutani (Chair), Dr Ivan Benett, Dr Ian Manifold, Mr Phillip Dick, Mr Gavin Maxwell, Dr Arnold Zermansky, Ms Alyson Whitmarsh, Ms Amanda De La Motte, Ms Teresa Middleton, Mr Ian Reekie, Mr Sunil Gupta **Specialist committee members** **Sepsis**- Dr Alison Tavare, Ms Catherine White, Mr Suman Shrestha, Ms Enitan Carrol, Dr John Butler, Professor Richard Beale, **Transition between inpatient mental health settings and community or care home settings -** Dr Shawn Mitchell, Mrs Ginny Beacham **NICE staff** Mr Nick Baillie (NB), Ms Stephanie Birtles (SB) [agenda items 1-7], Mr Shaun Rowark (SR) [agenda items 1-7], Mrs Alison Tariq (AT) [agenda items 7-11], Ms Kirsty Pitt (KP) [agenda items 7-11], Miss Jamie Jason (JJ) **NICE Observers** Ms Johanna Hulme [agenda items 1-6], Ms Simran Chawla.
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Dr Bee Wee, Dr Helen Bromley, Ms Jane Worsley, Ms Phyllis Dunn, Dr Hugo van Woerden, Ms Hazel Trender, Dr Steve Hajioff **Specialist committee members** **Transition between inpatient mental health settings and community or care home settings** Mrs Dawn Talbot, Ms Sarah Matthews, Ms Helen Van Ristell

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>Sepsis</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	

Agenda item	Discussions and decisions	Actions
	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.	

Agenda item	Discussions and decisions	Actions
	John Butler • 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. **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 3 November 2016 and confirmed them as an accurate record.	
4 and 4.1 Topic overview and summary of engagement responses	SB and SR presented the topic overview and a summary of responses received during engagement on the topic.	
4.2 Prioritisation of quality improvement areas	The Chair and SR led a discussion in which areas for quality improvement were prioritised. The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. The outcome of discussions is detailed below.	

Suggested quality improvement area	Prioritised (yes/no)	Rationale for prioritisation decision	If prioritised, which specific areas to be included?
Identifying people with suspected sepsis a) Early identification b) Face-to-face assessment	 Yes No	The committee discussed the guideline recommending structured observations to identify sepsis, but it was noted that not everywhere actually undertakes a full set of structured observations and the aim of this statement should be to reduce national variation. The committee discussed the difficulties in defining a denominator population for this statement. However they also raised the importance in doing so given that identification of suspected sepsis is the point of entry to the healthcare system. The NICE team agreed to consider the population and the possibility of retrospective measures in more detail when drafting the quality statement. Face to face appointments are implicit in the early identification of sepsis. The committee agreed not to progress this as a quality statement of its own at this time, but would try to highlight the importance of this in the statement on early identification.	Early identification of people with suspected sepsis using NICE NG51 – Recommendation 1.1.7
Managing suspected sepsis outside acute hospital settings	No	The committee discussed what procedures in place prior to treatment in acute care setting. It was suggested that when a person is severely ill with sepsis primary care will appropriately refer on to acute care settings as recommended by the guidance. Identifying these people would be identified in a statement on identification as previously discussed. The committee also discussed the importance of safety netting for people who are at low risk of illness from suspected sepsis. This would be addressed in a statement on information and support to be discussed.	

Managing and treating suspected sepsis in acute hospital settings a) Use of intravenous fluid b) Senior clinician review	 Yes Yes	The committee discussed the specific issues in the management and treatment of suspected sepsis, in this case the timely use of intravenous fluid. Discussions were had about pre alerting hospitals prior to arrival of patients with suspected sepsis where possible but it was reflected that different areas have their own systems in place so this process should not be mandated. The committee noted that senior clinician review can be in many settings but it is important that the clinician undertaking the review is senior enough to ensure the things that need to be done (such as appropriate antibiotic prescribing) following the review. The committee stated that interventions should be 1 hour for high risk patients in accordance with the guidance for both of these statements.	People with suspected sepsis (1 or more high risk criteria) have IV within 1 hour using NICE NG51 Recommendation 1.6.2, 1.6.17 and 1.6.32 Review by senior clinician within 1 hour based on NICE NG51 Recommendation 1.6.1 and 1.6.31
Antibiotic treatment in people with suspected sepsis Antibiotic treatment in people with suspected sepsis	Yes	The committee discussed the red/amber/green decision making process in hospitals for categorising patients with suspected sepsis and explained who can and should make the decision about treatment for each patient. The committee also discussed what giving antibiotics “within 1 hour” meant in practicality. The committee agreed this was making sure that a whole dose of antibiotics was delivered within 1 hour. All discussions were in the context of the NICE quality standard and guideline on antimicrobial stewardship.	People with suspected sepsis have antibiotic treatment within 1 hour as described in NG51 recommendations 1.7.2 and 1.7.3.

Finding the source of infection in people with suspected sepsis	No	The committee discussed the importance of finding the source of infection in treating sepsis, for ensuring no relapses or recurrence of the illness. However whilst important, the committee felt this was not a key area for quality improvement, and noted the difficulty of defining a population relevant to a quality statement. This area was not progressed. The committee discussed that although clearly important there would be difficulty in drafting a measurable statement about determining the source of sepsis.	No action.
Information and support	Yes	The committee discussed how information provision specifically around safety netting would be useful if it came from a trusted source and provided reliable consistent information. Issues were raised about the diversity of where people with sepsis may present. It was agreed to focus on NG51 recommendations 1.5.3 and 1.11.5 which describe providing information about symptoms and accessing medical care for people with suspected sepsis.	Safety netting for people with suspected sepsis, who do not have any high or moderate to high risk criteria and people who have been assessed for sepsis but have been discharged without a diagnosis of sepsis, including NG51 recommendations 1.5.3 and 1.11.5.

Additional areas suggested	**Committee rationale**	**Area progressed (Y/N)**
Antimicrobial stewardship	The committee agreed that this area has been addressed by the quality standard on antimicrobial stewardship and therefore should not be progressed.	**N**
Infection prevention and control	The committee agreed that this area has been addressed by the quality standard on infection prevention and control and therefore should not be progressed.	**N**

National registry of sepsis	The committee acknowledged that while this is an important area, in order to know the true prevalence of sepsis, it is not within the remit of quality standards to mandate the use of national registries, therefore it should not be progressed.	**N**
Neonatal sepsis	The committee acknowledged that this population would be covered by this quality standard. However they agreed that no specific statements were required in this this area as it has been addressed by the quality standard on neonatal infection.	**N**
Procalcitonin testing	The committee felt that because NICE has already recommended that further research and data collection is needed to show the impact of adding procalcitonin testing to standard clinical practice as part of its diagnostic guidance this area should not be progressed.	**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**
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**
Training and education	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**

5. Resource impact	The committee considered general resource impact all quality improvement areas. It was not felt that any areas would have a significant resource impact.	
5.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on sepsis. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
5.2 Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
6. QSAC specialist committee members (part 1 – open session)	NB asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required. **Specialist members**: It was agreed that additional specialist members were not required].	

7. Next steps and timescales (part 1 – open session)	NB outlined what will happen following the meeting and key dates for the sepsis quality standard.	
Lunch		
8. 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.	
9. 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.	
10. 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>Standing committee members</u> • None declared <u>Specialist committee members</u> Shawn Mitchell • Employed full time by St Andrew's Healthcare, an independent provider of mental health services - almost all placements funded by the NHS. Ginny Beacham • None declared	

11. QSAC Updates	None.	
12. Topic overview and summary of engagement responses	KP and AT presented the topic overview and a summary of responses received during engagement on the topic.	
13. Prioritisation of quality improvement areas	The Chair and KP led a discussion in which areas for quality improvement were prioritised.	

Suggested quality improvement area	**Prioritised (yes/no)**	**Rationale for prioritisation decision**	**If prioritised, which specific areas to be included?**
Hospital admission a) Planning for hospital admission b) On admission c) Out-of-area	a) No b) Yes c) Yes	a) The committee discussed that many hospital admissions would be as an emergency and that planning is more difficult for this group. It was agreed not to prioritise this area. b) Although access to an Independent Mental Health Advocate is already a requirement for people admitted under the Mental Health Act, the committee agreed it was important that everyone admitted should have access to advocacy services. The committee discussed the need for the offer to be formalised rather than just signposting. The committee also discussed the value of peer support workers as an alternative arrangement for advocates but felt that this type of advocacy was not appropriate in this context.	Two statements prioritised. **Advocacy** Access to advocacy for people admitted to an inpatient mental health setting, based on NG53 recommendation 1.3.4. **Out-of-area admissions** Reviewing out-of-area placements at least every 3 months, based on NG53 recommendation 1.3.11.

admissions		c) The committee discussed the difficulties in continuity of care associated with out-of-area admissions. The committee agreed it was important that named practitioners from the ward and from the person's home area work together to coordinate out-of-area placements.	
Hospital discharge a) Discharge planning b) Psychoeducation c) Communication on discharge	a) No b) No c) Yes	a) The committee agreed that this area could be combined with communication on discharge. b) The committee agreed that psychoeducation was important, particularly for people with bipolar disorder or schizophrenia, but that it was not specific to times of transition. Therefore it was not prioritised for statement development. c) The committee discussed the importance of starting discharge planning early and involving people in their own plan. It was agreed that sending the care plan to people involved in someone's care within 24 hours of discharge would improve continuity of care. It was felt that this would be achievable if the care plan was developed throughout a person's hospital stay. It was highlighted that the agencies who are involved in a person's future care should be identified within the care plan. The committee highlighted that the statement should include the importance of the person's involvement in care	**Communication on discharge** Sending a copy of a person's latest care plan to everyone involved in their care within 24 hours of discharge, based on NG53 recommendations 1.5.20 and 1.6.3. Ensure cross- reference to statement 8, QS 24.

		planning and cross-reference statement 8 in QS14	
Follow-up support a) Named coordinator b) Timing of follow-up c) Continuing therapy	 a) No b) Yes c) No	 a) This area was not considered a priority area for quality improvement. b) The committee discussed the importance of follow-up for everyone who is discharged from an inpatient mental health setting. They agreed that it was important to highlight that follow-up should occur within 48 hours for people who have been identified at risk of suicide, but that everyone should still be followed up within 7 days of discharge. The committee highlighted that the follow-up appointment shouldn't be 'offered' as it shouldn't rely on the person to make an appointment. The committee also discussed how arrangements for follow-up appointments were made and the links to discharge planning. c) This area was not covered in the development source (NG53) and was therefore not prioritised for statement development.	**Follow-up of at risk group** Follow-up within 48 hours of discharge for people at high risk of suicide, based on NG53 recommendation 1.6.8. **Follow-up** Follow-up within 7 days of discharge for everyone discharged from an inpatient mental health setting, based on NG53 recommendation 1.6.7.
Support for families, parents and carers a) Sharing information with families, parents and carers	a) No	a) The committee discussed these two areas together. It was agreed that while involvement of families, parents and carers is clearly important, it would be difficult to measure. The committee were also aware of nationwide initiatives to	No statements prioritised.

		improve involvement, as well as the requirement in the Care Act to provide carers' assessments in some circumstances. The committee agreed that involvement of families, parents and carers could be highlighted in other statements, such as the statement about discharge plans.	
b) Carers' assessments	b) No	b) As above.	

Additional areas suggested	Committee rationale	Area progressed (Y/N)
National database of community mental health teams	This area is not contained in the development source (NG53) and is beyond the remit of quality standards.	**N**
Addressing the needs of black and minority ethnic groups	The committee agreed that all minority groups and equality issues should be considered throughout the development of all statements. It was also noted that there is a separate quality standard referral on promoting health in black and minority ethnic groups that will be developed in the future.	**N**

14. Resource impact	The committee considered general resource impact all quality improvement areas. It was not felt that any areas would have a significant resource impact.
14.1 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on transition between inpatient mental health settings and community or care home settings. It was agreed that the committee would contribute suggestions as the quality standard was developed.
14.2 Equality and	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked

diversity	the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed.
15. QSAC specialist committee members	NB asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required. **Specialist members**: It was agreed that additional specialist members would be helpful – particularly a representative from acute care or a crisis team and ensuring the lay perspective is well represented.
16. Next steps and timescales	KP outlined what will happen following the meeting and the key dates for the transition between inpatient mental health settings and community or care home settings quality standard.
17. Any other business	The following items of AOB were raised: • None raised Date of next meeting for transition between inpatient mental health settings and community or care home settings: 4 May 2017. Date of next QSAC 1 meeting: 2 February 2017. • Physical health of people in prisons – prioritisation meeting.