National Institute for Health and Care Excellence

Quality Standards Advisory Committee 3 meeting
Date: Wednesday 19 June 2019
Location: NICE office, Level 1a City Tower, Piccadilly Plaza, Manchester, M1 4BT

Morning session: Suicide prevention – review of stakeholder feedback

Afternoon session: Intrapartum care: women with existing medical conditions or obstetric complications and their babies – prioritisation of quality improvement areas

Minutes: Draft

Attendees

Quality standards Advisory Committee 3 members:
Hugh McIntyre (Chair), Jim Stephenson (Vice Chair), Ivan Benett (left at 12.00), Amanda De La Motte, Carolyn Chew-Graham, Christine Camacho, Keith Lowe, Phil Taverner, David Pugh, Deryn Bishop, Nadim Fazlani, Julia Thompson

Specialist committee members:

Morning session – TOPIC: Suicide prevention
Amy Beck, Andy Chapman, Stephen Habgood, Navneet Kapur, Vikki Levick

Afternoon session – TOPIC: Intrapartum care: women with existing medical conditions or obstetric complications and their babies
Mandish Dhanjal, Sarah Fishburn, Manjiri Khare, Felicity Plaat, Helen Smith, Rebecca Whybrow

NICE staff
Nick Baillie (NB), Melanie Carr (MC){4-8}, Julie Kennedy (JK){4-8}, Rachel Gick (RG){12-15}, Alison Tariq (AT){12-15}, Jamie Jason (notes)

NICE observers
Chris Bird, Shatha Abdullah Almuhaideb, Rebecca Fletcher

Apologies
Jane Dalton, Ann Nevinson, Darryl Thompson, Malcolm Fisk, Madhavan Krishnaswamy,
Helen Garnham specialist member for suicide prevention

1. Welcome, introductions objectives of the meeting

The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to review stakeholder comments on the suicide prevention quality standard.

The Chair confirmed there were no public observers.

2. Confirmation of matter under discussion and declarations of interest

The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the morning session was suicide prevention specifically:

- Multi-agency suicide prevention partnerships
- Reducing access to methods of suicide
- Media reporting
- Involving family or carers
- Supporting people bereaved or affected by a suspected suicide

The Chair asked standing QSAC members to declare verbally any interests that have arisen since the last meeting and all interests specifically related to the matters under discussion during the morning session. The Chair asked the specialist committee members to verbally declare all interests.

3. Minutes from the last meeting

The committee reviewed the minutes of the last QSAC meeting held on 15 May 2019 and confirmed them as an accurate record.

4. Recap of prioritisation meeting and discussion of stakeholder feedback

MC provided a recap of the areas for quality improvement prioritised at the first QSAC meeting for potential inclusion in the suicide prevention draft quality standard.

MC summarised the significant themes from the stakeholder comments received on the suicide prevention draft quality standard and referred the committee to the full set of stakeholder comments provided in the papers.

5. Discussion and agreement of amendments required to quality standard

Draft statement 1: Multi-agency suicide prevention partnerships have a core group of representatives and clear governance and accountability structures

The committee discussed the geographical footprint for suicide prevention partnerships and agreed that as structures are currently changing, with sustainability and transformation partnerships and the development of integrated care systems, it is important to ensure that the quality standard can fit with these future structures.

Although the committee agreed that the word 'partnerships' reflects the importance of organisations working together it was agreed that we should be consistent with the terminology used by Public Health England and so may need to change to 'groups'.

There was a concern that the wording and definition of 'core group' in the statement is problematic because local partnerships may be organised differently. The committee agreed that the key issue is to ensure that there is a strategic group that sets and oversees the strategic direction with other wider groups focussed on implementation. It is important to acknowledge that local partnership structures will vary.

The committee agreed that people with lived experience should be involved in the partnership, but it may not be appropriate to share confidential real-time surveillance information with them.

The committee discussed stakeholder suggestions that employers and education should be included in the partnership. It was agreed that they should be included.

The committee confirmed that partnerships in residential detention and custodial settings cannot be a sub-group of the community partnership but there should be clear links.

It was agreed that self-harm is an appropriate outcome for suicide prevention and is used as a proxy measure internationally.

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team:

- NICE team to align the wording for 'multi-agency suicide prevention partnerships' with Public Health England guidance.

- NICE team to revise the statement to focus on a strategic group with a wider implementation group.
- NICE team to include employers and education in the partnership.

Draft statement 2: Multi-agency suicide prevention partnerships reduce access to methods of suicide based on local intelligence

The committee discussed the wording and agreed that 'intelligence' could be changed to data or information.

The committee agreed that the rationale should make it clear that local information should inform the priorities for the local partnership including hotspots and availability of methods.

It was suggested that it would be helpful to highlight that some population groups are at higher risk such as people with physical health problems who are able to access prescribed drugs. It is important to highlight that improved information sharing between healthcare professionals in different settings is needed.

The committee were informed that there has been a recent change in the standard of proof required for a coroner to decide that a death was by suicide. This may increase the number of deaths by suicide and may also have an impact on the coroner's willingness to share real time data.

The committee confirmed that the intent for the descriptor for people in the community is not to highlight specific hotspots and therefore it can be retained if it can be worded appropriately.

The committee discussed whether it is possible to prevent opportunities for suicide in new developments such as car parks. Although the guideline did not cover this, the committee asked NICE to consider adding information to the audience descriptors on including suicide prevention when planning and designing new developments rather than taking action retrospectively.

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team:

- NICE team to explore changing the phrase 'local intelligence' in the statement.
- NICE team to strengthen the rationale and descriptors to clarify the role of local information.
- NICE team to explore if the wording for the descriptor for people in the community needs to be revised.
- NICE team to add information in the descriptors on the importance of information sharing for people with physical health problems.
- NICE team to look at including future planning and design in the descriptors.

Draft statement 3: Multi-agency suicide prevention partnerships have a local media plan that identifies how they will encourage journalists and editors to follow best practice in suicide reporting

The committee agreed that the statement should highlight the importance of partnerships working with the Samaritans and other partners to improve local media.

There was agreement to change the wording in the statement to 'best practice when reporting about suicide and suicidal behaviour.'

It was noted that signposting to support and stories of hopeful recovery could be added to the definition of best practice if it can be referenced in the national guidance referred to.

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team:

- NICE team to amend statement wording to include reporting on suicidal behavior.
- NICE team to explore adding signposting/hopeful narrative to definition of best practice.
- NICE team to add importance of working with the Samaritans and other key partners to descriptors.

Draft statement 4: People with active suicidal thoughts or plans are asked if they would like their family or carers to be involved in their care and are made aware of the limits of confidentiality

The consensus statement is nationally well regarded, and the committee agreed that it is helpful to reference it in the quality standard as there are misconceptions among healthcare professionals.

The committee agreed that it would be helpful to strengthen the wording 'are asked' to make it clear that it should be an ongoing dialogue. The focus of the statement should be on encouraging a collaborative approach that involves family and carers in suicide prevention if it is appropriate.

The committee agreed that the statement should apply to statutory services rather than the voluntary sector who may have a different approach to confidentiality.

The committee suggested that it would be better to remove the term 'active' from the statement and to focus on when a person presents to a service with suicidal thoughts and plans. It was suggested that it may be helpful to add information about mental capacity to the rationale to clarify that the statement would not apply if someone did not have capacity. The committee noted that there is an upcoming quality standard on decision-making and mental capacity

The committee agreed that friends should be included. Not all people have family, particularly in custodial settings.

The committee noted that there is a safeguarding requirement for children but were unsure if this has any implications for this statement. NICE will need to check.

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team:

- NICE team to explore changing the wording of 'active' and 'are asked' in the statement.
- NICE team to include friends.
- NICE team to make it clear that the statement only applies to statutory organisations.
- NICE team to add information on mental capacity to rationale.
- NICE team to seek external advice on any specific considerations for children.

Draft statement 5: People bereaved or affected by a suspected suicide are given information and offered tailored support

The committee discussed the term suspected suicide. It was suggested that this criminalises suicide and NICE was asked to consider changing the wording to 'evident'. It was agreed that NICE should reflect the wording used in Public Health England guidance.

The committee discussed the focus of the statement and agreed that 'given information' is quite narrow and passive. It would be better to focus on taking every opportunity to actively signpost people to support and making sure they know how to access it. It is important to clarify that tailored

support should be provided by someone who is competent. It was agreed that currently people are not getting the support they need until long after the incident.

The committee agreed it will be difficult to pin down the population. It was suggested that the Public Health England guidance may be helpful in providing a definition, however.

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team:

- NICE team to check the terminology used by Public Health England.
- NICE team to consider rewording ‘given information’.

6. **Additional quality improvement areas suggested by stakeholders at consultation**

The following areas were not progressed for inclusion in the final quality standard as the committee agreed that they were not a priority in relation to the five quality improvement areas already included:

- Public awareness of suicide and how to prevent it- It was agreed that there is already work going on around this.
- Risk assessment and sharing information between mental health, primary and secondary care – It was agreed that the risk assessment approach is flawed.
- Access to support including crisis support services, intensive community support and support from employers- These issues are covered by the quality standard on self-harm.
- Training and skills – would not be include as a separate statement in a quality standard.

7. Resource impact and overarching outcomes

The committee considered the resource impact of the quality standard. It was noted that stakeholders did not make many comments about resource impact and it was suggested that the statements are achievable providing partners work together. The committee were concerned that postvention support will require investment. Given the economic impact of suicide, however, overall suicide prevention will be cost saving.

The committee discussed the overarching outcomes presented in the draft quality standard.

- calls to crisis response services
- suicide-related emergency service calls
- rate of self-harm in the community
- hospital attendances and admissions for self-harm
- suicide rate.

It was suggested that emergency service calls should be removed as it is not clear whether it should increase or reduce. The committee asked if it would be possible to include an outcome to measure the profile of suicide prevention and whether people are talking about it.

MC requested that the committee submit any further suggestions to the NICE team relating to the overarching outcomes of the quality standard when it is sent to them for review.

8. Equality and Diversity

The committee agreed the following groups should be included in the equality and diversity considerations:

- Age
- Gender reassignment
- Pregnancy and maternity
- Religion or belief
- Marriage and civil partnership

- Disability
- Sex
- Race
- Sexual orientation

It was agreed that the committee would continue to contribute suggestions as the quality standard was developed.

9. Close of the morning session

The specialist committee members for the suicide prevention quality standard left and the specialist committee members for the Intrapartum care: women with existing medical conditions or obstetric complications and their babies quality standard joined.

10. Welcome, introductions and objectives of the afternoon

The Chair welcomed the intrapartum care: women with existing medical conditions or obstetric complications and their babies specialist committee members and QSAC members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the afternoon, which was to prioritise areas for quality improvement for the Intrapartum care: women with existing medical conditions or obstetric complications and their babies draft quality standard.

The Chair confirmed there were no public observers.

11. Confirmation of matter under discussion and declarations of interest

The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the afternoon session was intrapartum care: women with existing medical conditions or obstetric complications and their babies specifically:

- Information and care planning
- Existing medical conditions
- Obstetric complications – 1
- Obstetric complications – 2

The Chair asked both standing and specialist QSAC members to declare verbally all interests specifically related to the matters under discussion during the afternoon session.

12. Prioritisation of quality improvement areas – committee decisions

RG provided a summary of responses received during the intrapartum care: women with existing medical conditions or obstetric complications and their babies topic engagement, referred the committee to the full set of stakeholder comments provided in the papers and the committee then discussed each of the areas in turn. The committee discussed the comments received from stakeholders and specialist committee members at topic engagement **(in bold text below)**.

Information and care planning

a) **Information provision – Not prioritised.**
b) **Multidisciplinary (MDT) care planning – Prioritised.**

The committee discussed information and care planning.

The committee considered that there are 2 main populations to consider: women with existing medical conditions and women who develop complications during birth. Some women may present in labour without a birth plan.

There is also a group of women who are at higher risk of adverse outcomes who choose not to access care due to language barriers, mental health issues and social challenges. This population is covered by a separate guideline (CCG110), and these factors should be referenced in the equality and diversity section. The committee also clarified that while topic engagement comments covered a wide range of pregnancy-related issues, this quality standard covers intrapartum care, which is the area covered by the main development source (NG121). Other aspects of maternity care are covered by other guidelines and quality standards.

The committee considered how intrapartum care was planned: usually, intrapartum care is planned in midwifery, with referral to obstetric care if needed. The midwife typically develops a plan and decides the place of birth. Women determined to be at risk of adverse outcomes discuss their intrapartum care and have the plan documented.

The committee agreed that ensuring multidisciplinary care planning for women with existing conditions is important in preparing an individualised care plan and that a statement should be developed for this area. The committee felt that aspects of information provision could be highlighted as an aspect of shared decision-making.

- **Action:** NICE team to draft a statement on specialist expertise in MDTs composition in relation to women with existing conditions.
- **Action:** NICE team to draft a statement on individualised care planning which includes information as an aspect of the woman's involvement.

Existing medical conditions

a) Heart disease – Prioritised
b) Bleeding disorders - Not prioritised
c) Arteriovenous malformation of the brain - Not prioritised
d) Kidney disease - Not prioritised
e) Obesity – Not prioritised

The committee discussed existing medical conditions.

The committee agreed that heart disease was the most important area of those suggested, based on high mortality rates and other factors (long-term condition and increasing prevalence).

Specialist committee members highlighted that there is variation in the care offered: clinicians may automatically offer a caesarean section. Expertise in cardiology was identified as being crucial to performing a risk assessment so that women receive treatment reflecting their level of risk – some woman can have standard intrapartum care if they are categorised as 'low risk'; those at higher risk need different care. However, a cardiologist who is a specialist in the condition during pregnancy is not always involved in the MDT. It was agreed a statement should be developed for this aspect of care.

The committee discussed women with obesity. It was acknowledged that obesity is a significant issue, but the committee concluded that this was not a priority area for this quality standard, as it is a potentially modifiable factor.

The committee considered maternal mental health, as suicide is currently among the leading causes of maternal mortality, but it was noted that this area of care is covered by a separate guideline.

Involving a haematologist and anaesthesiologist in care planning for women on anticoagulation therapy was considered as a possible statement. The committee though agreed that developing a statement on such a broad area could reduce the quality standard's impact.

- **Action:** NICE team to draft a statement on risk assessment for women with heart disease being carried out in an MDT which involves a cardiologist with expertise of the condition in pregnancy.

Obstetric complications – 1

a) **Breech presentation – Not prioritised**
b) **Previous caesarean section – Prioritised**
c) **Fetal monitoring (cardiotocography)- Not prioritised**

The committee discussed the first group of obstetric complications.

The committee agreed that the most important population/area of care is women with a previous caesarean section; this population represents the greatest proportion of obstetric complications (around 20%). Women who have a breech birth at term represent a far smaller proportion (around 3%). Additionally, uncertainty around the evidence that influences current practice for breech presentation was highlighted during the committee's discussion.

The committee agreed that it is very important to offer woman a choice of birth mode by giving information that would support her making an informed decision between a vaginal birth or an emergency caesarean section.

The committee agreed that 'overuse' of certain procedures would be unsuitable for statement development, due to inconsistency in how 'appropriate use' could be defined, and limited current practice.

- **Action:** NICE team to draft a statement on providing the correct information to women who have had a previous caesarean section to support their making an informed choice.

Obstetric complications – 2

a) **Sepsis – Prioritised**
b) **Abnormal placentation – Not prioritised**
c) **Obstetric injuries - Not prioritised**
d) **Thrombosis and embolism - Not prioritised**
e) **Cardiopulmonary resuscitation - Not prioritised**

The committee discussed the second group of obstetric complications.

The committee agreed that sepsis was the main area for improvement; sepsis is a cause of maternal and neonatal morbidity. Recognition, responding quickly and escalating care to the appropriate specialists were identified as specific aspects for statement development.

It was noted that the Royal College of Obstetricians and Gynaecologists have updated their guidance on sepsis, and that this is due to be published shortly.

The committee discussed that care relating to abnormal invasive placentation (AIP), which is becoming more common, and can result in death and serious morbidity, could be improved. It was suggested that AIP could be referenced in the statement on previous caesarean section. It was also noted that NHS England is developing a specialist commissioning specification for regional centres for assessment and management of AIP (consultant responses are currently being analysed).

- **Action:** NICE team to develop a statement on the early recognition of sepsis, drawing on the sepsis guideline, or population-specific recommendations in NG121.

13. **Additional quality improvement areas suggested by stakeholders at topic engagement**

The following areas were not progressed for inclusion in the draft quality standard. RG referred the committee the reasons given in the briefing paper; some areas are beyond the scope of a quality standard/this topic:

- **Audit and review cycles for sepsis**: audits and suggested methods of data collection are not the focus of quality statements; they focus on actions demonstrating high quality care or support.
- **Caesarean section:** not covered by the source guideline.
- **Contraception:** discussion about this forms part of antenatal care, rather than intrapartum care directly.

- **Neurological conditions:** there are no supporting recommendations in the source guidance for multidisciplinary care-planning for women with epilepsy ; screening for Gorlin syndrome is beyond the scope of this quality standard.
- **People's experience:** suggestions relating to continuity of care and reasonable adjustment of care for women with disabilities is covered by the patient experience quality standard.
- **Primary evidence:** it is beyond the scope of a quality standard to examine primary evidence.
- **Risk factors:** supporting women to stop smoking in pregnancy is covered by an existing quality standard - smoking: supporting people to stop (QS32).
- **Social and emotional aspects of care:** this is not a quality improvement area
- **Tariff for intrapartum care;** the suggestion also related to including postnatal care in the tariff; this suggestion is beyond the scope of the standard.
- **Training and development:** quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. Training may be referenced in audience descriptors.

The committee discussed contraception. It was noted that women often become pregnant again very quickly after giving birth. The committee asked whether contraception could be added to the first statement under care planning.

It was agreed that the NICE team will explore referencing the antenatal, postnatal, mental health and obesity quality standards within this quality standard.

14. Resource impact and overarching outcomes

The committee considered the resource impact of the quality standard.

Changes to the MDT may have cost implications. However, overall, the quality standard was felt to have a neutral to cost-saving impact.

The committee confirmed the overarching outcomes are those presented in the draft quality standard.

- Maternal mortality.
- Maternal morbidity.
- Maternal admission to a high-dependency unit or intensive therapy unit.
- Women’s experience of maternity services.
- Harm-free care – women’s perception of safety.
- Neonatal mortality.
- Neonatal morbidity.
- Admission of full-term babies to neonatal care.
- Births resulting in a neonatal unit admission.

The committee suggested replacing HDU/ICT unit to ‘critical care unit’.

The committee suggesting adding impact on maternal mental health as an outcome.

RG requested that the committee submit any further suggestions to the NICE team relating to the overarching outcomes of the quality standard when it is sent to them for review.

15. Equality and diversity

The committee agreed the following groups should be included in the equality and diversity considerations:

- Age
- Gender reassignment
- Pregnancy and maternity
- Religion or belief
- Marriage and civil partnership
- Disability
- Sex

- Race
- Sexual orientation

The committee discussed the higher mortality rates among women in ‘hard to reach’ groups, and that risk of adverse outcomes is higher among some ethnic groups, which affects indirect maternal mortality rates (that is, mortality due to existing medical conditions). It was felt that by addressing care fpr medical conditions more prevalent in these groups the standard would advance equalities among these groups.

The committee agreed that language considerations would be referenced in the statement about women’s involvement in MDT meetings.

The committee asked the NICE team to check whether travellers are considered an ethnic group.

It was agreed that the committee would continue to contribute suggestions as the quality standard was developed.

16. <u>Any other business</u>
None.

Close of meeting