National Institute for Health and Clinical Excellence

Quality Standards Stable Angina Topic Expert Group

Minutes of the scoping workshop held on 12th September at the NICE Manchester office

Attendees	Adam Timmis (AT) – Chair Aidan MacDermott (AMD) Christopher Blauth (CB) Helen O'Leary (HOL) Leonard Jacob (LJ) Maurice Pye (MP) Rob Henderson (RH) Roger Till (RT) Sotiris Antoniou (SA) John Soady (JS) **NICE staff** Craig Grime (CDG) Terence Lacey (TL) Andy McAllister (AMA) Lucy Spiller (LS) – Minutes **Observers** Ben Doak
Apologies	Norma O'Flynn Liz Clark Jonathan Shribman

Agenda item	Discussions and decisions	Actions
1. Introductions and apologies	AT welcomed the attendees and reviewed the agenda for the day.	
2. Quality standard overview	AMA presented the group with an overview of the process for developing NICE quality standards (QS). He reported that the NHS White Paper *Equity and Excellence: Liberating the NHS* and the Health and Social Care Bill emphasise that QS will be very important in the future. AMA advised the group that review groups, including members of the relevant TEGs, will be invited to undertake further work on the quality standard measures in order to develop valid and clearly worded COF indicators. AMA described the next steps in the development of the QS and highlighted key dates in the process. The TEG queried how the QS will link to the COF, public health and social care. The NICE team reported that we are currently unsure of the exact mechanisms for this. The group queried the relationship between the clinical guideline and the QS. AMA said there are similarities but the QS are more measurable. TL added that the QS complement, rather than replace, the clinical guideline. The group queried whether we could make recommendations about commissioning. TL confirmed that the QS can cover commissioning as well as a number of other areas. He also highlighted that the QS are aspirational.	
3. Example of a quality standard	CDG showed the group an example of a QS. CDG emphasised that the statements must be measurable.	

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	The TEG highlighted that the process measures used in the example QS assume data is collected. CDG confirmed this is correct as the QS are aspirational, and therefore if it is possible to collect a certain dataset it can be included in the QS. The group asked for clarification on which sectors the QS apply to. CDG confirmed the QS can apply across primary, secondary care and tertiary care. The group queried what achievement level we would expect for each statement. The NICE team confirmed that we don't set baselines as there is then no incentive for the organisations already achieving those targets to improve. The TEG queried whether we expect patients to look at the QS. The NICE team confirmed we do and also explained that there is a patient information version published alongside each QS. CDG emphasised that each individual statement must have a maximum of two concepts, as any more makes measurement difficult. The TEG queried whether the measures are aspirational as well as the statements and CDG confirmed they are. The TEG queried whether we will be able to address the financial resources required to implement the QS. CDG confirmed the costing and commissioning team are involved in this aspect of the QS.	
4. Quality standards methodology	TL outlined the method used to develop a QS. TS highlighted that the QS are aspirational and not intended to reinforce current practice.	

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	The TEG queried whether private sector organisations can be publication partners. AMA confirmed there are a set of criteria organisations must meet in order to become publication partners and private sector organisations would not meet these criteria. The TEG queried what we can learn from past QS consultations. The NICE team said we tend to receive most comments on definitions and those statements which are difficult to measure. The group queried what an NHS Evidence accredited source is and CDG explained the process. The TEG queried what would happen if the group wanted to make a recommendation on an area which had changed since publication of the guideline, e.g. if new evidence had arisen. CDG confirmed that the Topic Expert Group would be relied upon for highlighting changes in evidence and in those instances NICE would review the evidence. The TEG queried whether the QS can cover tertiary care and CDG confirmed that it can.	
5. Business items • Declarations of interest • Equality impact assessment	AMA ran through the declarations of interest policy. Some group members queried whether they should declare certain interests and AT advised them to record them on their declaration of interest forms. However AT did not feel there were any conflicts of interest. AMA outlined the equality impact assessment and the group said they are unaware of any equality issues at present. AMA outlined the next steps in the development of the QS and highlighted the key dates in the process. The group queried whether a commissioning guide will be	

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	produced. The NICE team confirmed the costing and commissioning team will produce an impact assessment for the QS.	
6. Scoping session- • Areas of care map	The group considered and agreed the proposed scope, with a slight change to the wording.	Insert 'diagnosis' into 'assessment and management'.
	The group agreed the QS should cover diagnosis, as well as management, of stable angina. However they felt there should be members of the guideline development group for CG95, chest pain of recent onset, on the group. The group suggested some members for the NICE team to approach.	NICE team to contact individuals nominated by the group.
	The group agreed the population, exclusion and settings could be the same as in CG126 and CG95.	Combine the population, exclusion and settings used in CG126 and CG95.
	The group considered the areas of care diagram, adapted from the areas identified in CG126. AT led the group through discussion of the key recommendations from the guideline and the group agreed that the draft standard will consider the following areas of care: **1. Information for patients** – overarching the whole care pathway. **2. Secondary prevention** – overarching from 'optimal medical treatment' to 'stable angina not responding to optimal medical treatment or revascularisation'. The group felt it was more appropriate to include secondary prevention as an overarching factor rather than under the 'optimal medical treatment' heading.	CG to include the areas of care listed below in the scope.

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	3. Assessment and diagnosis • Clinical assessment • Diagnostic testing **4. Optimal medical treatment** • Short acting nitrates • Beta blockers/calcium channel blockers • Other anti-anginal drugs **5. Symptoms not satisfactorily controlled with optimal medical treatment** • Coronary angiography • PCI/CABG **6. Symptoms satisfactorily controlled with optimal medical treatment** • Functional or non-invasive anatomical test • Coronary angiography • CABG **7. Stable angina not responding to optimal medical treatment or revascularisation** • Comprehensive re-evaluation • Pain interventions The group decided not to include the following areas of care: **1. Rehabilitation** – the group felt there was insufficient evidence to include a separate statement on rehabilitation. They also felt rehabilitation was inherent within PCI/CABG and this was sufficient.	

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	2. Psychological rehabilitation – the group agreed there was insufficient evidence to include a statement on psychological rehabilitation. **3. Cardiac syndrome x** – the group agreed this should not be included as it is not the same as cardiac syndrome x is not caused by atherosclerosis. It is also very rare and is only normally identified in tertiary care.	
7. Scoping session- Evidence sources, policy drivers and measures	The group discussed which guidelines should be used as primary evidence sources. RH highlighted the smoking cessation wasn't included in CG126 but CDG confirmed we can refer to NICE public health guidance if the group want to include a statement on this subject. The group agreed that the following guidelines should be used as the primary evidence sources: • NICE clinical guideline CG126 (2011) Management of stable angina • NICE clinical guideline CG95 (2010) Chest pain of recent onset The group discussed the National Patient Safety Agency (NPSA) report and highlighted some other potential patient safety issues but did not feel any of these needed to be included in the QS. The group discussed the composition of the group and felt it would be sufficient with the addition of two members from CG95, as outlined above. The group discussed the equality issues and felt they would be covered by the EQIA for CG126 and CG95.	Use the guidelines listed as the primary evidence sources. Use the equality issues identified in CG126 and CG95.
8. Scoping	The NICE team described the stakeholder consultation process	

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session- • Stakeholder consultation • Potential publication partners	and the use of publication partners to help disseminate the QS. The group felt it would be useful to encourage the following organisations to become stakeholders/publication partners: • British Cardiovascular Intervention Society • Society for Cardiothoracic Surgery • Royal Pharmaceutical Society	
9. Next steps and AOB	AT thanked the group and closed the meeting.	