NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 1

Renal Replacement Therapy Services – post-consultation meeting
Falls – prioritisation meeting

Minutes of the meeting held on 2nd September 2014 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Bee Wee – Chair (BW), Karen Whitehead (KW), Helen Bromley (HB), Gita Bhutani (GB), Nourieh Hoveyda (NH), Phillip Dick (PD), Lee Beresford (LB) (AM only), Alyson Whitmarsh (AW), Ian Manifold (IM), Juliette Millard (JM), Gavin Maxwell (GM) **Specialist committee members** Renal replacement therapy services - Daljit Hothi (DH), Mumtaz Goolam (MG), Mark Devonald (MD), Angela Beale (AB), Nick Flint (NF), Max Troxler (MT), Adrian Coleman (AC), Gerry Endall (GE) Falls – Vicki Goodwin (VG), Harm Gordjin (HG), John Taylor (JT), Opinder Sahota (OS) **NICE staff** Rachel Neary-Jones (RNJ), Lisa Nicholls (LN) Am only – Sabina Khan (SK), Craig Grime (CG) Pm only – Julie Kennedy (JK), Stephanie Birtles (SB) **Topic expert advisers** Renal replacement therapy services – None Falls – Frances Healey (FH) **NICE observers** Jane Lynn – Pm only Eileen Taylor – Pm only Will Carr – Pm only
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Hasan Chowhan, Jane Worsley, Robyn Noonan, Jennifer Bostock, Arnold Zermansky, Phyliis Dunn **Specialist committee members**

	Renal replacement therapy services – Andrew Lewington

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day (private session)	BW welcomed the attendees and the Quality Standards Advisory Committee (QSAC) members introduced themselves. BW 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)	BW 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** BW 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. BW asked the specialist committee members to declare all interests. The following interests were declared: <u>Standing committee members</u> • None <u>Specialist committee members</u> • None **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 2nd July 2014 and confirmed them as an accurate record.	
4. Topic session – renal replacement therapy services (public session)	The committee then moved on to discuss renal replacement therapy services (RRT).	
4.1 Recap of	SK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for RRT.	

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prioritisation exercise	**At the first QSAC meeting on 3rd April 2014 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:** • Information education and support • Transplantation • Changing treatment modalities • Transport • Vascular access The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: http://www.nice.org.uk/Media/Default/Get-involved/Meetings-In-Public/Quality-Standards-Advisory-Committee/QSAC1/QSAC-1-minutes-3-April-2014.pdf SK reminded committee members that at the previous prioritisation QSAC meeting the published 2011 quality standard on chronic kidney disease (CKD) was discussed. In particular quality statements 11-15 were considered for review and it was agreed to include them in this standard due to their direct overlap with this topic. SK reminded the committee that the CKD statements had been included with the newly written RRT statements for consultation and confirmed that the committee were content with this presentation for the final standard.	
4.2 and 4.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	SK presented the committee with a report summarising consultation comments received on RRT.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. SK asked the committee to consider the different population groups for each statement, as the published CKD quality standard just states 'people'. Young people and children were discussed at the prioritisation QSAC meeting in relation to education programmes so the NICE team would find it useful if the committee could clarify whether the statements should apply to adults, young people, children or all combined.	

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	SK briefly discussed the additional statements raised by stakeholders which would be re-visited at the end of the topic discussion.	
4.4 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 Quality Statement 1: People with CKD requiring renal replacement therapy are supported to receive a pre-emptive kidney transplant before they need dialysis, if they are medically suitable The group discussed the stakeholder feedback on this statement and agreed the following:- • To clarify the meaning of 'support' as it was queried in this statement and felt to be unclear • To remove 'pre-emptive' as this term was queried as this is not always possible for late presenters. The committee also felt antibody removal was important however it was agreed that it should a separate statement if required. The committee discussed stakeholder suggestions that the sufficient list timing of 6 months be increased to 9 months. It was felt that reasonable time is needed to plan for pre-emptive transplantation and these timescales would depend if it was a live donor. It was suggested that the measurement time needs to be looked at and whether the listing timeframe should be increased from 6 to 9 months. NICE team should go back to the source guidance to check this. The committee felt that the statements focus needs to be on preparation for transplant as this is the quality improvement area, although actually receiving the transplant is the desired outcome. It was agreed to progress the statement and to include children, young people and adults in the population. It was agreed to keep this as one statement but address the two areas of those requiring renal replacement therapy and those medically suitable in the definitions section with mention of the 6–9 months separate in the underpinning information if the NICE team can identify a recommendation to support this.	SK to update statement to include adults, young people children if the NICE team can identify a specific recommendation to support this. The terms 'Requiring renal replacement therapy' and 'medically suitable' to be

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		included in the definitions section. The listing 6 month timeframe to be increased to 9 months if NICE team can identify a specific recommendation to support this.
	Draft Quality Statement 2: People with CKD on dialysis are supported to receive a kidney transplant, if they are medically suitable The group discussed the stakeholder feedback on this statement. The committee also questioned the use of 'supported' in the statement wording. They also discussed patients' decision making as clinicians will advise but the decision should take account of the patient's opinion as well as the clinical opinion and risk. Further to this the committee also questioned the word 'receive' and whether this could be realistically achieved as this is about patient choice. The NICE team advised the committee that this wording was from the old CKD quality standard and could be amended. The committee asked whether assessment for medical suitability needs to be considered? Also it was queried whether this would be done annually and should be for all CKD patients? Would a suitable target be 100%? They asked the technical team to clarify this in the definitions'. Patients suitable for transplant but may opt for one were also highlighted. It was discussed whether the emphasis should be on 'offer' or 'assessed' for medically suitable. The committee discussed that offer may be better, as this also implies assessment and patients have the option to decline. It was therefore agreed that the focus of the statement should be on an offer of transplant. The committee discussed the measures and felt the words were misleading. They queried the outcome measure which appeared to be similar to a process measure. The NICE team agreed to look at the measures when re-wording the statement. It was agreed to progress the statement but to change the wording from receive to 'offer' the transplant if medically suitable.	SK to re-draft the statement to say 'offer the transplant' rather than receive. SK to also look at the wording of the measures and specifically the outcome measure.

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	Draft Quality Statement 3: People with established kidney failure start dialysis with a functioning arteriovenous fistula or peritoneal dialysis catheter in situ The group discussed the stakeholder feedback on this statement. The committee felt some work was needed on the wording in terms of the timeliness of catheter insertion, dialysis and peritoneal dialysis access and arteriovenous fistula. It was queried whether 2 weeks prior to dialysis was suitable for catheter insertion as mentioned in the measures. The rationale wording was discussed. It was agreed that dialysis cannot be started without a catheter in place so the wording was not correct. The quality improvement area was agreed to be the planning in advance. It was also felt that the timing needed to remain in the measures as without this the statement was meaningless. The committee also discussed the use of peritoneal versus haemodialysis catheters as one type is not necessarily suitable for all. Within process measure (b) the committee highlighted that a patient listed is not a mark of successful treatment as they could have been on the list for 6 months. The committee also queried how data is collected and whether this is done currently or retrospectively? The NICE team will look at the process measures when re-drafting the statement wording. They also suggested that the Renal Registry could be referenced as a data source for this statement. The committee agreed that this statement should be specific to adults as this procedure is too invasive for young people and children. It was agreed to progress the statement and add 'planning in advance' to the wording and re-draft the measures if necessary.	SK to update the statement wording to include 'and planning in advance' and to redraft the measures if necessary.
	Draft Quality Statement 4: People on long-term dialysis receive the best possible therapy, incorporating regular and frequent application of dialysis and ideally home-based or self-care dialysis	

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	The group discussed the stakeholder feedback on this statement. The committee discussed whether this statement should remain and queried whether home-based or self-care should be the focus? It was agreed home-based dialysis should be the main focus as this should always be aimed for and the quality improvement area is increasing the amount of home based dialysis. It was reported that some patients do not progress from clinical dialysis to home-based dialysis. The committee acknowledged that not all patients would want to dialyse at home therefore it was suggested to include something on patient choice with the term 'offer' to replace 'receive' in the statement. When considering long term dialysis it was queried when is it suitable for an offer for home or self-based dialysis to be made as those who are considered long term may need some form of RRT on a permanent basis for life? So should end stage instead of long term be in the statement wording? It was felt however that this would be inappropriate for children. It was felt that home-based dialysis is not considered appropriate for all patients and there are individual centre variations in facilitation at home so an 'offer' may be difficult. However, it was argued that home-based dialysis should be considered as there shouldn't be a barrier for those who choose to have dialysis at home and the home circumstances shouldn't prevent this. It was agreed to progress the statement and amend the wording to reflect people are offered home-based dialysis and the structure measures should be re-drafted to reflect home-based dialysis. Delete the 'self-care' wording from the statement.	SK to update the statement wording to people being 'offered' home-based dialysis as the main focus and removal of self-care. The structure measures will also need to reflect home-based dialysis.
	Draft Quality Statement 5: People receiving haemodialysis or training for home therapies who are eligible for transport, have access to an effective and efficient transport service The group discussed the stakeholder feedback on this statement. The committee felt transport remains a real concern for renal patients with variation in transport services reported and stressed that irregularities in transport cause real patient distress. It was therefore felt to be a priority statement with transport timing to be the focus to be measured. The committee queried the term 'eligibility' and agreed that this should be defined or removed.	

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	The 30 minute target was discussed and it was felt to be a suitable measure to include for patients arriving 30 minutes prior to an appointment and being collected 30 minutes after an appointment to take it further than the requirements in the national service framework. The committee acknowledged that there were cost implications for this statement but felt that it was still a priority area for quality improvement. Patient choice was raised again with patients importantly having the right to choose where they go for dialysis which shouldn't necessarily be the closest option. The committee were advised to specifically focus on one issue. Any additional information can then be included in the rationale, measures and definitions sections. It was felt that this statement should not include children as they are small population requiring transport. It was agreed to progress the statement and include the recommendation regarding 30 minute transport time. It was also agreed to remove the 'effective and efficient' wording.	SK to update the statement wording to include the 30 minutes timing target for transport services and remove the 'effective and efficient' wording.
	Draft Quality Statement 6: Specialist renal centres have ongoing individualised education programmes for people preparing for or receiving renal replacement therapy and their families or carers The group discussed the stakeholder feedback on this statement. The committee felt this could be a structural issue around measuring renal centres having education programmes. They also discussed that 'individualised' programmes would be difficult to measure and suggested removing this. The committee queried whether 'on-going' is suitable in this statement and agreed to remove it. Patient choice was again highlighted and the consideration that the provision of education programmes differ both on local and national levels.	

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	The committee queried whether a definition of a good programme should be included and whether these programmes require review? What also constitutes achievement and success within these programmes? The committee asked for further clarity around this in the statement and accompanying information, The committee also discussed whether education programmes should be broadened to include self-care and peer support groups? It was agreed to progress the statement as a structural statement but to delete the word 'ongoing'.	SK to delete the word 'ongoing' from the statement.
	Draft Quality Statement 7: People who have a suspected acute rejection episode have a timely transplant kidney biopsy carried out and reported on before treating the episode The group discussed the stakeholder feedback on this statement. The committee discussed the timing of when a biopsy should be carried out in regards to a suspected acute rejection. It was felt that 4 hours wasn't a realistic or practical timeframe however 24 hours was more reasonable. It was however reported that there may be a number of medical reasons why this also may not happen within 24 hours. The 7 day ability to carry out a biopsy and laboratory test results was reported as variable because a histopathologist or pathology technician may not be available over the weekend so biopsy results would have to be delayed. The NICE team reminded the committee that there is a forthcoming quality standard in the library on 7 day working which may address the need for 7 day services. The committee asked for clarity on the word 'timely' and whether this should be 'safely' or whether timely should be defined? It was suggested that the statement should include wording that the biopsy should only be carried if safe to do so. It was highlighted that the focus should be on the biopsy and ensuring that treatment is not delayed whilst waiting for the results. The issue isn't that a biopsy is not being carried out it is that it isn't done within the 24 hour timeframe. It was agreed to progress the statement and include within 24 hours in the statement wording.	SK to update statement wording to include 'within the 24 hour timeframe'.
	Draft Quality Statement 8: People receiving haemodialysis have their vascular access monitored	

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	and maintained in line with local protocols The group discussed the stakeholder feedback on this statement. The committee felt this statement was important however 'in line with local protocol' was queried as being difficult to measure. The committee discussed whether local protocols are based on national guidelines as well as variation in local protocols. It was felt this needed to be more specific. The ability of the multi-disciplinary team to escalate results and identify people who need early intervention was also raised as important. The NICE team highlighted a statement in the Infection Control Quality Standard (61) which is slightly different but could have a slight overlap with this statement on vascular access. The committee felt this statement needed more work on potentially defining surveillance and how regularly this is carried out. It was agreed to progress the statement but to delete 'in line with local protocols' with more focus on systematic observation and advanced surveillance. NICE team to investigate the overlap between this statement and Infection Control Quality Standard (61) on vascular access.	SK to delete 'in line with local protocols' from this statement and develop more focus on systematic observation. NICE team to investigate the overlap between this statement and Infection Control Quality Standard (61) on vascular access.
	Additional areas suggested by stakeholders SK presented the additional areas suggested by stakeholders. It was decided by the committee not to progress these areas any further.	
5. Supporting the quality standard (part 1 – open session)	RNJ presented a summary of the organisations who have expressed an interest in supporting the quality standard and asked the QSAC to consider whether any key organisations were missing. The following organisations were highlighted: • National Kidney Federation • British Association for Paediatric Nephrology • Royal College of Pathologists	

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	• Polycystic Kidney Disease Charity • British Kidney Patient Association RNJ asked the committee to email any suggested organisations they felt were key to NICE.	
6. Next steps and timescales (part 1 – open session)	LN outlined what will happen following the meeting and any key dates for the renal replacement quality standard.	
7. Welcome and code of conduct for members of the public attending the meeting	BW 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.	
8. Committee business (public session)	Declarations of interest BW 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. BW asked the specialist committee members to declare all interests. The following interests were declared: Standing committee members • None Specialist committee members • Harn Gordjin – conducted management training for care homes on falls • Vicki Goodwin – Chair of the British Geriatrics Society committee for bone health and falls • Opinder Sahota –honorarium from Ofsted for talks on osteoporosis Topic Adviser • Frances Healey – occasional expense-paid trips to speak at academic events	
9. Topic expert adviser presentation	FH gave a short presentation on potential priorities from a safety perspective for the NICE falls quality standard. Data was presented from the Royal College of Physicians (2011) report 'Falling standards, broken promises: Report of the National audit of falls and bone health in older people 2010' and the Royal College of Physicians (2012) 'Report of the 2011 inpatient falls pilot audit'.	

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10. Topic session – falls (public session)	The committee then moved on to discuss falls.	
10.1 and 10.2 Topic overview and summary of engagement responses	JK presented the topic overview and a summary of responses received during engagement on the topic.	
5.3 Prioritisation of quality improvement areas	JK led a discussion in which areas for quality improvement were prioritised. The committee discussed the age group and settings for this quality standard. It was agreed that; the quality standard would focus on people aged 65 and older and would cover all settings. JK clarified that for the assessment and prevention of falls during a hospital stay, people aged 50 to 64 years who are admitted to hospital and are judged by a clinician to be at higher risk of falling because of an underlying condition are also covered by the quality standard. The NICE team also advised the committee that two further quality standards would be produced on falls. One on re-enablement after a fall (social care focussed) and one on falls prevention (public health focussed). The QSAC considered the draft areas as outlined in the briefing paper prepared by the NICE team. 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: • **Assessment -** the committee discussed this area in relation to multifactorial falls risk assessment, medication review, visual assessment and assessment and management of bone health. The committee discussed assessment of future risk and whether some elements of multifactorial risk would be picked up under a different population. The patient pathway was also considered and if the person is not an inpatient in hospital. The committee also discussed whether anyone who has a fall and presents in a health or social care setting should be included. Multifactorial assessment was seen as important but it was agreed to focus on key elements in the measures to avoid the statement being too broad. With regards to outcome measures there was discussion about how to make the measures user	

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	friendly and easy to collect. It was queried whether medication review could trigger further assessment and whether this could be potentially picked up within the Quality and Outcomes Framework (QOF) under polypharmacy. The committee felt a statement on multifactorial assessment should be developed to include medication review, visual assessment, bone health and gait, balance and mobility as these were the key elements highlighted by stakeholders. In the measures it was agreed not to choose a specialist for collecting data, it should be able to be done by any member of the team. It was agreed a question would be included in the consultation on whether stakeholders felt that these are the key areas that should be included in the statement on multifactorial assessment. • **Emergency care** - the committee discussed this area in relation to assessment and emergency care following a fall in hospital. The committee raised concerns over excluding community settings. NICE advised that the target population is based on in-patients but a sub-set can be included. Emergency care will include multifactorial and acute assessment. The multifactorial elements is a hospital protocol to be measured which was seen as okay and perhaps 5 elements could be adhered to. The chair highlighted the unsafe retrieval of patients could be an issue. The committee therefore discussed drafting a statement along the lines of protocol priority checks after an in-patient fall. The committee wanted the statement to be patient focused in terms of the post-fall protocol. JK advised that because of the way the recommendations on post-fall protocol are written in the NPSA guidance it would only be possible to develop a structural statement for this area. The group therefore agreed that a statement should be developed on access to investigation and specialist treatment based on recommendation 5 of the NPSA guidance. This statement would be patient focused rather than structural. This was felt to be a priority area for the NICE team to develop a statement on which should be patient focused. • **Intervention** - the committee discussed this area in relation to a multifactorial interventions, individualised care planning, exercise/strength and balance training, home hazard and safety intervention and vitamin D. The committee discussed this element in more detail and it was noted	JK to draft a statement on assessment to include medication review, visual assessment, bone health, gait, balance and mobility and medication review JK to draft a statement on emergency care with a focus on patients JK to draft a 2 statements

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	that there is no recommendations for vitamin D. The issue for consideration discussed was which elements of multifactorial intervention were a priority. It was agreed that vision and medication review was already dealt with in the statement on assessment. Therefore strength and balance training and home hazard assessments were seen as the key areas to be focused on. The committee discussed whether these should be looked at together or separated out. It was felt they were 2 separate priorities and should be drafted as two statements. It was agreed to keep the population the same as previously discussed and not include those who haven't already fallen. The QSAC agreed that the following areas should not be progressed for potential inclusion in the draft quality standard: • **Prevention** – the committee discussed this area in relation to identification of people at risk and encouraging the participation of older people in falls prevention programmes. The population was discussed and whether the focus should be those who are at risk but have never fallen or those who have already fallen and are at risk again. The committee agreed for this quality standard to look at those who have fallen and prevention of future falls. NICE reassured the committee that an additional quality standard on preventing falls would be developed in the future to address this area. **Education and information** - the committee discussed this area in relation to competence of healthcare professionals in falls assessment and prevention and information giving. The committee discussed whether this statement was specific for the quality improvement for falls as quality standards assumed that professionals are adequately trained to deliver them. It was felt that this was sufficient. Giving information to people at risk of falls was also considered but the committee felt it would be covered in the future standard on falls prevention.	on intervention to include home hazard and exercise and strength. These statements will be for older people with recurrent falls. JK to draft a statement on education
11.1 QSAC specialist committee members and stakeholder list (part 1 – open	RNJ asked the QSAC to consider the constituency of specialist committee members on the group and whether any additional specialist members were required. The committee were happy with the constituency.	

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session)	Stakeholder list: The QSAC reviewed the stakeholder list and agreed that the following organisations should be approached to register as stakeholders for Falls • Royal College of General Practitioners • Chartered society of physiotherapists • AGILE • Royal society for the prevention of accidents • College of optometrists • Royal college of Nursing • College of occupational therapists • Osteoporosis society • Royal Pharmaceutical Society	
11.2. Next steps and timescales (part 1 – open session)	LN outlined what will happen following the meeting and any key dates for the falls quality standard.	
12. Committee development session (private session)	Representatives of the press and other members of the public were excluded from this section of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. The committee were presented with a session on the proposed Quality standards revisions process.	
9. Any other business (part 1 – open session)	The following items of AOB were raised: • RNJ highlighted that the terms of reference for the committee had been updated regarding member attendance. The required attendance rate has increased from 50% to 75% which is in line with other committees at NICE that meet monthly. Committee members were reminded that they should not miss more than 2 consecutive meetings and to notify NICE in advance if they have any difficulty with attendance. Date of next meeting for falls: 6th January 2015 Date of next QSAC 1 meeting: 2nd October 2014	