Tuberculosis

Consultation on draft quality standard – deadline for comments 5pm on 09/08/16 **email:** QSconsultations@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Does this draft quality standard accurately reflect the key areas for quality improvement? If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted. 2. [Insert any specific questions about the quality standard from the Developer, or delete if not needed]
Organisation name – stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	**British HIV Association (BHIVA)**
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	**None**
Name of commentator person completing form:	Dr Marc Lipman

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NICE National Institute for Health and Care Excellence

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Supporting the quality standard - Would your organisation like to express an interest in formally supporting this quality standard? More information.		[**Answer Yes or No**]	
Type		[office use only]	
Comment number	**Section**	**Statement number**	**Comments** Insert each comment in a new row. Do not paste other tables into this table because your comments could get lost – type directly into this table.
Example 1	Statement 1 (measure)		This statement may be hard to measure because…
1	Introduction: Questions for consultation, Q1, page 7		An area that is missing from the quality standards is that of obtaining samples to confirm the suspected TB diagnosis. This is touched upon in sections of Quality standard 2, but only mentions pulmonary TB. It is important to ensure that anyone who is thought to have active TB (and hence is likely to start treatment for TB) should have appropriate sampling and diagnostic tests performed. Clinical examples of this would include lymphadenopathy or pleural effusions; with specimens being sent for microbiological diagnosis. This is important as it will help to improve the current relatively low rate of microbiological confirmation, provide information on drug resistance patterns, reduce the number of people started on treatment perhaps unnecessarily and hence decrease the number of adverse events associated with drug therapy.
2	Introduction: Questions for consultation, Q2, page 7		Local data capture is likely to be very patchy across sites. For some areas this should be relatively easy e.g. anything which involves lab information as this is usually electronically stored (though from personal experience it can be incredibly difficult to extract negative results routinely from systems, for example if one wanted to check that the relevant samples had been sent and were culture negative). For other data measures (e.g. abnormal chest radiographs requiring rapid patient review by TB services, new systems will have to be introduced to flag up and record information on the images in the first place).
3	Introduction: Questions for consultation, Q4, page 7		Extra resource is likely to be needed for the introduction of Quality standards 2 (use of NAAT in primary samples), 4 (DOT in underserved), and 5 (accommodation for homeless). Some of the costs in 2 might be offset by moving away from performing AFB smears on samples and replacing this with NAAT. However, consideration needs to be then given to technical issues (is NAAT adequate if the sample is pus and contains potential amplification inhibitors?) and what are

			the public health implications of a positive NAAT in terms of isolation and de-isolation on treatment?
4	Introduction: Questions for consultation, Q5, page 7	Quality statement 1	There is an argument for offering latent TB testing to children aged <18. It is not clear from the statement whether they are or aren't included. They are generally at an increased risk of progression to active TB compared to adults, have longer to live with latent TB and in a country with a relatively low risk of local transmission, effectively treating previous infection acquired abroad is likely to be a useful means of reducing active TB at a personal and public health level.
5	Introduction: Questions for consultation, Q6, pages 7 and 12	Quality statement 2	Not clear why NAAT has been selected for people aged <15. There is less pulmonary disease – so are you implying that you would be seeking to diagnose/confirm more extra-pulmonary TB?
6	Introduction: Questions for consultation, Q6, pages 7 and 13	Quality statement 2	Not clear why HIV infected population has been specifically selected. Also, not sure what the measurements in the numerator and denominator will indicate as "primary specimen" is a very broad concept (e.g. does this include urine, bone marrow and blood? – which are often cultured in suspected HIV/TB). The denominator may need some rewording as it is assumed that you are interested in patients with active TB who have HIV, rather than e.g. latent TB requiring treatment.
7	Quality statement 2 and others, page 13	General comment	One of the measures selected for local data collection is "the proportion of with pulmonary TB starting treatment within 2 months of symptom onset". We would be interested to know how this timeframe was chosen. Is there good evidence that it is a useful measure of transmission risk to others? (presumed reason for choosing this measure)
8	Quality statement 3, page 19	Assessment	Rapid review in a TB service may require a greater flexibility in working practice for TB nurses and teams, in particular in smaller services which do not run as a service separate service from e.g. general respiratory specialist nursing for airways disease.
9	Quality statement 4, page 23	Under-served groups	It is surprising that migrants aren't classified as an under-served group, given potential issues of access, stigma, associated co-morbidities e.g. HIV, Hepatitis B or C. If one were to do so, then the issue of paternalism may arise if you are suggesting that DOT is routinely offered. A difficult issue but one that needs to be acknowledged more transparently.
10	Introduction: Questions for consultation, Q7, pages 7 and 25	Homelessness	The issue arises of what happens once anti-TB treatment is completed? Is there a mechanism to ensure that there is long term accommodation in place? The costs associated with housing during treatment could be offset by local groups (e.g. the footprint of the TB control boards) undertaking cost-sharing across a region and working in partnership with local housing organisations.
11	Introduction: Questions for consultation, Q9, pages 8 and 25	Cohort review	Suggest that the Multidisc TB teams do more than "take part" – perhaps "are responsible for", as the ownership may encourage more involvement? Also the issue of what is the aim of cohort review appears relevant. It should be a vehicle that ensures high-quality care is delivered to an individual, though mainly it serves to check that the public health duties associated with TB are being adequately performed. This needs to be done in a setting which is more than just a single service reviewing its own data. Hence there is something about the network of TB services (that are contributing to local cohort review) which might be also within the statement.
12	Quality	Cohort review	Does there need to be a definition of a Multidisciplinary TB team? It is not terribly clear exactly what this is. It is within

	statement 6, page 29		NICE guidance but perhaps could be spelt out again - with the aim of encouraging buy in. This would also enable local teams to be clear re what they need to do to achieve effective MDT working and cohort review.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include section number of the text each comment is about e.g. introduction; quality statement 1; quality statement 2 (measure).
- If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor).
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons).We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance and quality standards that we have produced on topics related to this quality standard by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.