NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 2

Head and neck cancer – post consultation meeting

Oral health promotion in care homes and hospitals – prioritisation meeting

Minutes of the meeting held on Thursday 10th November 2016 at the NICE offices in Manchester

Attendees	**Standing quality standards advisory committee (QSAC) members** Michael Rudolf (MR) [Chair], Barry Atwood, Gillian Baird, Ruth Bell, Guy Bradley-Smith, Jean Gaffin, Anjan Ghosh, Ruth Halliday, Tessa Lewis, Corinne Moocarme, Robyn Noonan [agenda items 1-6], Anita Sharma, Amanda Smith, Ruth Studley **Specialist committee members** Head and neck cancer – Malcolm Babb, Cyrus Kerawala, Laurence Newman, Sarah Orr, Martin Robinson, Wai Lup Wong Oral health promotion in care homes - Paul Batchelor, Joanne Charlesworth, Victoria Elliott, Elizabeth Kay, Margaret Ogden, Mary Tomson, Sheila Welsh **NICE staff** Nick Baillie (NB), Julie Kennedy (JK), Eileen Taylor (ET) [agenda items 1-6], Kirsty Pitt (KP) [agenda items 7-11], Ian Mather (IM) [agenda items 7-11] **Topic expert advisers** None
Apologies	**Standing quality standards advisory committee (QSAC) members** Julie Clatworthy, Michael Fairbairn, Malcolm Griffiths

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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: Standing committee members • None to declare Specialist committee members • Sarah Orr is a committee member of the British Association of Head and Neck Oncology Nurses and a committee member of the Cancer Nursing Partnership. She also declared that she is a member of the Cancer52 steering group looking at MDT and received an honorarium for writing an article in the British Journal of Community Nursing. • Wai Lup Wong declared that he is a PET CT clinical guardian at NHS England and PET CT clinical reference group chair at NHS England. • Cyrus Kerawala has undertaken work to implement recommendations on sentinel lymph node biopsy. • Malcolm Babb is the President of the National Association of Laryngectomee Clubs, which is a registered charity providing information and support to patients and clinicians. **Minutes from the last meeting** The committee reviewed the minutes of the last meeting held on 13th October 2016 and confirmed them as an accurate record.	

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Agenda item	Discussions and decisions	Actions
4. QSAC updates	NB advised that the team planned to send an update on the 2017/18 programme to the QSACs via email during the week commencing 14th November 2016.	NICE team to update all QSACs on the 2017/18 programme.
5. Recap of prioritisation exercise	ET presented a recap of the areas for quality improvement discussed at the first QSAC meeting for head and neck cancer: **At the first QSAC meeting on 14th July 2016 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:** • Investigation - progressed • Treatment of early disease - progressed • Optimising rehabilitation and function - progressed • Information and support – not progressed The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: https://www.nice.org.uk/guidance/GID-QS10018/documents/minutes	
5.2 and 5.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	ET presented the committee with a report summarising consultation comments received on head and neck cancer. 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. These included the following types of comment: • Relating to source guidance recommendations • Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation advice	**5.2 and 5.3 Presentation and discussion of stakeholder feedback and key themes/issues raised**

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Agenda item	Discussions and decisions	Actions
	• General comments on role and purpose of quality standards • Requests to change NICE templates	
5.4 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.**	**5.4 Discussion and agreement of final statements**

Draft statement	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with cancer of the upper aerodigestive tract have their need for enteral nutrition assessed at diagnosis.	• Is the statement already being achieved? • Suggestion to reword the statement to specify 'oral nutrition support and enteral tube feeding assessed' • Suggestion to reword the rationale to include detail on risk of malnutrition • Statement will be difficult to achieve as posts needed are often unfilled	The committee agreed this is still an area for quality improvement. One of the reasons for variation in care is a lack of dietetics staff. Stakeholder comments saying it will be difficult to achieve the statement support the assertion that this is not happening in current practice and is therefore an area for quality improvement. The aim of the statement is to ensure tube feeding requirements will be assessed prior to commencement of treatment. It was agreed the current wording reflects this intention. The committee considered whether adding a definition of 'enteral' could make this clearer. The committee agreed the statement would be improved if the wording was changed to say 'People with cancer of the upper aerodigestive tract have their nutritional status, including the need for possible prophylactic tube feeding, assessed at diagnosis.' This would clarify the intent of the statement.	Y – NICE team to update statement wording.
People with advanced stage cancer of the upper aerodigestive tract are offered	• Should the statement be changed to say have/receive rather than offer?	The committee discussed the issue of why the groups specified in the definition are not included in the statement wording. They agreed it would not be a concise statement if this detail was included. However, it was agreed that changing	Y – NICE team to update statement wording.

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systemic staging using fluorodeoxyglucose positron emission tomography (FDG PET)-CT.		the statement wording to say 'specific advanced stage cancer' would make the population clearer. The committee discussed the issues surrounding data collection for this statement. The information is available but is difficult to obtain. This makes measurability a challenge. Some work is being done around quality dashboards to improve data collection in this area. Local services can also do their own audits. Providers are reimbursed on a per scan basis so could include this information in the data collection. Following this discussion the committee agreed the current measures are appropriate.	
People with early stage oral cavity cancer are offered sentinel lymph node biopsy (SLNB).	• Concerns around evidence base for SLNB • Disagreement regarding SLNB being a low morbidity procedure • Elective neck dissection is the gold standard • Suggestion to add 'unless cervical access is required at the same time' to the statement as per the guideline recommendation	The specialist committee members highlighted a possible misunderstanding amongst stakeholders about what SLNB is. It is a biopsy, which is investigation, not treatment. Some stakeholder comments seem to consider it as treatment. The committee felt that stakeholders may have misinterpreted the statement to mean that everyone with T1/T2 cancer should have SLNB. It should actually be a choice between this or, if neck access is needed at the same time, elective neck dissection. Specialist members pointed out that the stakeholder comments about morbidity is contrary to the evidence used to develop the NICE guideline and to the experience of specialist committee members working in centres that currently deliver SLNB. Neck dissection has high morbidity and very few people have it without any morbidity at all. It was felt that the stakeholder comments about morbidity may have been underpinned by multifactorial issues. Specialist committee members advised that there are very few RCTs for head and neck cancer. The paper cited by stakeholders as describing elective neck dissection as the gold	Y – NICE team to update statement wording.

		standard of care did not consider SLNB as an alternative method of assessing neck node involvement. The committee agreed to amend the statement to include the wording 'as an alternative to elective neck dissection unless they need cervical access' as per the recommendation. This makes it clear that other surgical management can happen at the same time if required. The committee acknowledged the concerns raised by stakeholders about data collection and resource impact but agreed these issues are acknowledged in the quality standard because the statement is developmental.	
People with cancers of the upper aerodigestive tract that have similar outcomes from surgery or radiotherapy are given a choice of these treatment options.	• The statement limits patient choice • People with T3 laryngeal cancer should not be included • Treatments may be superceded so should the statement specify surgery/radiotherapy? It could be a generic statement about offering treatment options with similar outcomes.	The committee discussed the comment that people with T3 laryngeal cancer should not be included. The evidence supports its inclusion. However, the T3 group is different from the others included in the statement as this is advanced disease and concomitant radiotherapy may also be used as part of treatment. The committee agreed that this statement goes further than the statement about choice in the patient experience quality standard. Choice isn't currently being made available as centres usually only offer what they have traditionally provided. Patients are currently guided by the surgeon or oncologist. Concerns were raised by stakeholders about measurement but the committee agreed this information could be collected. The NICE team agreed to reword the statement so that it does not specify surgery or radiotherapy alone so that it is appropriate to include the T3 group.	Y – NICE team to update statement wording.

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Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Thyroid cancer	The guidelines do not contain anything that can be developed as a quality statement for this area. Thyroid cancer is dealt with by a different MDT so it is not appropriate to include it in this quality standard. The NICE team agreed to make the NICE guidelines team aware there is a need for guidance in this area.	**N**
Early diagnosis and referral	The committee agreed that there is currently a lack of strong evidence to base a statement on this area.	**N**
Independent peer advocacy support	Agreed not to take this forward as the stakeholder that raised the issue suggested the existing recommendation is not sufficient to drive up quality improvement.	**N**
HIV testing	This area was discussed at the first meeting and was not prioritised.	**N**

5.5. Resource impact	There was not considered to be a resource impact for statements 1, 2 and 4. It is acknowledged that there would be a resource impact in setting up a SLNB service (statement 3) which is one of the reasons this is a developmental statement.	
5.6. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on head and neck cancer. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
5.7. 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. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the head and neck cancer quality standard. The Chair thanked the specialist committee members for their input into the development of this quality standard.	

7. 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.	

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<td>8. Committee business (public session)</td>
<td>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:

Standing committee members
• Jean Gaffin – recently trained as an expert by experience with the Care Quality Commission
Specialist committee members
• Elizabeth Kay
  ○ Non-executive director for Plymouth Hospitals NHS Trust
  ○ Advisor about economic modelling for Wrigley's
  ○ Payment from Wrigley's for input to workshops for young dentists and hygienists and therapists
  ○ Short term consultancy with British Dental Industry Association exploring engagement of dental students with innovation in industry
  ○ Trustee of British Dental Health Foundation
  ○ On editorial board of British Dental Health Foundation
  ○ Contracted to Healthcare Learning Company to assist with oral health programme
  ○ Has conducted research in oral health and made related statements
• Paul Batchelor
  ○ Involved with the Department of Health in Ireland in development of a new dental contract
  ○ Chair of Faculty of General Dental Practice guidance on dementia-friendly dental practice, developed with Alzheimer's Society
  ○ Advisor to British Dental Association on England NHS dental contract reform.
• Mary Tomson
  ○ Author of two recently published papers linked to topic[1,2]
• Joanne Charlesworth
  ○ Oral health promotion manager for Sheffield Community and Special Care Dentistry. Involved in the Residential Oral Care Sheffield Programme – cited as a NICE shared learning example.
• Margaret Ogden</td>
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[1] Watson F, Tomson MAH, Morris, AJ, Taylor-Weetman K, Wilson KI. West Midlands Care Home Dental Survey 2011: Part 1. Results of questionnaire to care home managers. Br Dent J 2015; 219(7): 343-346.
[2] Tomson MAH, Watson F, Morris, AJ, Taylor-Weetman K, Wilson K. West Midlands Care Home Dental Survey 2011: Part 2. Results of clinical survey of care home residents. Br Dent J 2015; 219(7): 349-353.

	○ Lay member on Manchester School of Dentistry's Oversight and Management Committee on triage ○ Involved with developing NICE quick guide on improving oral health for adults in care homes • Sheila Welsh ○ Member of Scotland's National Older People's Oral Health Improvement Group ○ Programme Manager for Caring for Smiles – NHS Scotland's oral health education and support programme for care homes ○ Member of Scottish Oral Health Research Collaborative- Public Health of four university dental schools ○ Co-author on Cochrane Systematic review ○ Author of journal articles on oral health in care homes	
9.0 and 9.1 Topic overview and summary of engagement responses	KP presented the topic overview and a summary of responses received during engagement on the topic.	
9.2 Prioritisation of quality improvement areas	The Chair and KP 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?**
Oral health assessment	Yes	Initial assessment The committee discussed the importance of having an assessment of mouth care needs included as part of the assessment that happens on admission. It was agreed that this was a priority area. The completion of the assessment tool could be used to measure achievement. Regular assessment	**Assessment on admission to a care home.**

		The committee discussed regular assessment and agreed that it too is important. However, the guideline does not state a time period for doing regular assessments. The committee acknowledged that the clinical judgement involved means it was not possible to specify a timescale in the guideline. This creates issues in terms of measurability meaning it is not appropriate to develop a statement for this area.	
Mouth care plans	Yes	The committee advised that recording and updating mouth care plans is a priority area. More specifically it is about people's mouth care needs. It is important to update this when things change. The NICE team will emphasise the importance of acting on changes in the rationale for the statement. Having dental passports was not prioritised as there are no recommendations to support a statement on this area.	**Recording and updating mouth care plans.**
Daily mouth care	Yes	The committee agreed that brushing teeth twice a day is not always currently happening in hospitals or care homes. However, it was acknowledged that not all people in hospitals and care homes who are unable to brush their own teeth want to have their teeth brushed for them. Providing support for mouth care needs is often overlooked by staff and some staff do not have the confidence to deal with oral health. The committee agreed that brushing natural teeth twice a day with fluoride toothpaste is very important, as is providing daily oral care for full or partial dentures. The committee therefore agreed that there should be a statement on supporting daily mouth care for people in care homes, and also stressed the	**Daily mouth care supported by staff.**

		importance of applying this statement to people in hospitals. The NICE team agreed to explore including both settings in the statement but advised that it may have to be a separate placeholder statement due to the lack of specific guidance for oral health in hospitals. Mouth care champions were discussed and felt to be important but this area was not prioritised as there are no recommendations to support it.	
Access to dental services	No	There are issues with access for regular dental appointments and for emergency appointments. The committee agreed that variation in size of care homes means having a separate dental facility is not realistic. The NICE team agreed to allude to this as a priority area but the committee could not agree on a statement that they felt would have an impact on access to dental services. The committee did not feel that governance of visiting dental providers was a priority area.	
Oral health promotion	No	The committee discussed oral health promotion activities and policies. The specialist committee members advised that not all areas have oral health promotion services so it would be difficult to progress a statement on oral health promotion that would apply nationally.	

Additional areas suggested	**Committee rationale**	**Area progressed (Y/N)**

Training	Training is not normally covered directly in quality statements as staff being appropriately trained is an underpinning concept of all quality standards. However, the committee agreed that training is a key area for this topic and is one of the areas that is most likely to have an impact on quality of care. Training staff on how to undertake oral health assessments, respond to oral health needs, and brush teeth were highlighted as areas for improvement. The NICE team agreed to explore developing a statement in this area and to ask a question at consultation about affordability and achievability.	**Y**
Triple aim framework	Underpinning concept to be considered throughout development.	**N**
Person-centred care	Underpinning concept to be considered throughout development.	**N**
Links with Care Quality Commission	CQC inspectors look for evidence of how providers are using quality standards to improve the care they offer. This is used to inform the award of good and outstanding ratings.	**N**
Joint strategic needs assessments	Joint strategic needs assessments are addressed by a separate quality standard (in development) on oral health promotion in the community.	**N**
Appropriate equipment	It is not within the remit of quality standards to address this issue.	**N**
Clinical interventions	This issue is outside of the scope of this quality standard.	**N**
Free dental check-ups for over 60s	This is not within the remit of NICE.	**N**
Gaining consent	This is not within the remit of NICE.	**N**

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9.3. Resource impact	The committee were satisfied that the statements progressed would be achievable by local services given the resources required to deliver them.	
9.4 Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on oral health promotion in care homes and hospitals. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
9.5 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.	
9.6 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 there is appropriate specialist representation on the group.	
9.7. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on oral health promotion in care homes and hospitals. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
9.8 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.	
10. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the oral health promotion in care homes and hospitals quality standard. The Chair thanked the specialist committee members for their input into the development of this quality standard.	
11. Any other business (part 1 – open session)	The following items of AOB were raised: • None **Date of next meeting for oral health promotion in care homes and hospitals: 9th March 2017** **Date of next QSAC 2 meeting: 9th February 2017**	