NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 2

1. Oral health in care homes and hospitals – post consultation meeting

2. Liver disease – post consultation meeting

Minutes of the meeting held on 9 March 2017 at the Mercure Hotel in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Michael Rudolf (MR) [Chair], Barry Attwood, Gillian Baird, Julie Clatworthy, Michael Fairbairn, Malcolm Griffiths, Jean Gaffin, Ruth Halliday, Tessa Lewis, Corinne Moocarme, Anita Sharma, Ruth Studley **Specialist committee members** **Oral health in care homes and hospitals [1-9]** Victoria Elliott [1- 9], Mary Tomson [1- 9], Paul Batchelor [1- 9], Margaret Odgen [1- 9] Joanne Charlesworth [1- 9], Elizabeth Kay [1- 9] , Sheila Welsh [1-9] **Liver disease [10 – 17]** Rachel Pryke [10-17], Irene McGill [10-17], Gerri Mortimore 10-17], Andrew Fowell [10-17], Indra van Mourik [10-17] **NICE staff** Nick Baillie (NB), Eileen Taylor (ET) [1- 9], Julie Kennedy (JK) [1- 9], Melanie Carr (MC) [10-17], Nicola Greenway (NG) [10-17], Maroulla Whiteley (MW) [10-17], Joanne Ekeledo **Topic expert advisers** None **NICE Observers** Louise Shires, Mark Minchin [10-17]
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Anjan Ghosh, Guy Bradley-Smith, Robyn Noonan, Ruth Bell and Anita Sharma

	Specialist committee members Andrew Langford

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 Specialist committee members • Elizabeth Kay o Non-executive director for Plymouth Hospitals NHS Trust o Advisor about economic modelling for Wrigley's o Payment from Wrigley's for input to workshops for young dentists and hygienists and therapists o Short term consultancy with British Dental Industry Association exploring engagement of dental students with innovation in industry	

Agenda item	Discussions and decisions	Actions
	○ Trustee of the Oral health Foundation (previously Oral Health Foundation) ○ On editorial board of British Dental Journal ○ Trustee 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 ○ Dental lead on a project for the National Association Primary Care ○ 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 ○ 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 **Minutes from the last meeting**	

Agenda item	Discussions and decisions	Actions
	The Committee reviewed the minutes of the last meeting held on 9 February 2017 and confirmed them as an accurate record.	
4. QSAC updates	Further information about the proposed QSAC Away Day will be provided when available.	
5. Recap of prioritisation exercise	ET and JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for oral health in care homes and hospitals: **At the first QSAC meeting on 10 November 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:** • Oral health assessment – progressed • Mouth care plans – progressed • Daily mouth care – progressed • Access to dental services – not progressed • Oral health promotion – not progressed • Training – 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-QS10025/documents/minutes **Note:** The committee was informed that a statement had initially been included on training following the prioritisation meeting but this was subsequently removed at an early stage in the process, following internal review, as it was felt that it overlapped with the CQC fundamental standards.	**5. Recap of prioritisation exercise**
5.2 and 5.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	ET and JK presented the committee with a report summarising consultation comments received on oral health in care homes and hospitals. 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:	**5.2 and 5.3 Presentation and discussion of stakeholder feedback and key themes/issues raised**

Agenda item	Discussions and decisions	Actions
	• 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 • 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)
1. Adults who move into a care home have their mouth care needs assessed on admission.	• Care home staff training • Assessment / definition of assessment • Staff roles • Equality considerations • Data collection • Resource impact	The committee discussed timing of the assessment and where this could occur. There was a discussion about this happening in hospital prior to discharge to a care home. However, it was agreed that building more into assessment undertaken in hospital could potentially delay discharge. The committee agreed that having 1 week as the maximum timescale for undertaking the assessment in care homes is a pragmatic interpretation of 'on admission'. The committee discussed stakeholder concerns about the oral health assessment tool that is highlighted in the quality standard as a tool care homes should consider using. Specialist committee members highlighted that assessment of mouth care needs and oral health assessment are very different things. The tool is actually used to assess mouth care needs but is called an oral health assessment. It was agreed that stakeholders' concerns were based on the name of the tool rather than its content. The tool is appropriate for the	**N**

		assessment of mouth care needs by care home staff who have been trained to use it. Specialist members felt that care homes would find it beneficial for the tool to be highlighted in the quality standard. Committee agreed to keep the statement wording unchanged and the oral health assessment tool as an example of the type of tool which can be used. It was also agreed that it should be made explicit in the supporting information for the statement that this is different to the assessment that a dentist would undertake.	
2. Adults living in care homes have their mouth care needs recorded in their personal care plan.	• Care plan accessibility / completion • Recording of mouth care needs • Teeth / dentures • Records and audits • Data collection • Resource impact	Committee discussed mouth care plans and how often they are reviewed. Timescales for review are not defined in NG48. Specialist members advised that the Care Quality Commission recommend that mouth care plans should be reviewed monthly. The committee felt this was appropriate and addressed the concerns raised by stakeholders. It was agreed that there was no need for timing to be included in the wording of the final statement. Committee agreed to keep the statement wording unchanged and highlight the importance of regular reviews in the audience descriptors.	**N**
3. Adults living in care homes are supported to clean their teeth twice a day or to carry out daily care for their dentures.	• Addition to statement – at least twice a day? • Teeth / dentures • Staff training – care resistant behaviour / support residents • Exclusions? • Mental Capacity Act • Equalities • Measures / data collection • Resource impact	Committee discussed the need to include 'and/or' in the wording of the statement to include people who have a combination of natural teeth and dentures. It was agreed that changing the statement wording to say 'and' rather than 'or' would ensure that the statement included this population. Committee discussed how support would be recorded, and how the statement would be measured. It was felt that the current measures are too specific and exclusive. NICE team to reconsider the measures and look at merging these into one broader measure that is more inclusive.	**Y – NICE team to amend statement to include people with a combination of natural teeth and dentures**

		The committee suggested that the measures should say 'supported' in line with the statement wording and that this could be defined. This would enable the measures to capture a wider population. NICE team to add a definition of 'support' using NICE guideline recommendation NG 48 1.3.1. Committee discussed equality issues and agreed to include that people have the right to refuse mouth care and should not be forced to receive it. This also needs to note that repeated refusal should not be ignored. Committee discussed the oral health impact profile. It was recognised that it is not suitable for all care home residents as it is a relatively simple measure that does not cover people with cognitive impairment. Given the proportion of care home residents with cognitive impairment it was questioned if it is a useful data source. However, it was agreed that people with cognitive impairment could be addressed using local data collection so it is appropriate to retain the oral impact profile. Committee discussed the suggestion to amend the statement wording to 'at least twice a day' but felt this was not necessary.	
4 (Placeholder) Supporting daily mouth care in hospitals.	• Statement welcomed • General and condition specific guidance needed • Oral care training • 'Provision of mouth care' • Mouth product provision • Data collection • Resource impact	No current guideline recommendations to support statement. The statement will remain a placeholder. NICE team to re-word the statement. Change the statement wording 'to support people in hospital to clean teeth and/or dentures daily' in keeping with the statement for care home residents. The rationale should confirm that this is also essential for hydration/nutrition. NICE team to align the rationale with statement 3.	**Y – NICE team to amend statement to align with statement 3.**
Consultation question 5: The committee identified	• Shared arrangements • Full skill mix of dental team	Committee discussed these areas. No further action was possible as none of the areas raised had relevant guideline recommendations to support a statement.	**N**

variability in access to dental services for adults in care homes. Is there a specific, measurable action that will improve access to dental services for adults in care homes?	• Record care home visits • Transport to dental practices • Named dental practitioner • Service user involvement • Dental appointment following admission • Care home staff awareness		

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Tooth brushing with fluoride toothpaste and denture care twice a day for people in hospital.	The committee agreed that this is covered by the placeholder statement.	**N**
Oral health in food, drink and nutrition policies.	It was agreed that this area is not specific enough to base a quality statement on.	**N**
Training for care home staff to carry out an oral health assessment.	This was previously progressed and was removed from the quality standard as it overlaps with the CQC fundamental standards. The committee agreed that training should be emphasised in the audience descriptors for the relevant statements.	**N**
People should be supported to have regular dental check-ups and follow up	The committee agreed not to progress a statement on this area as it was discussed at the prioritisation meeting and it was agreed that it was not possible to develop a measurable statement that would have an impact on access to dental services.	**N**

6. Resource impact	Committee identified two areas: Training costs for care home staff. However it was noted that online training packages are available meaning the cost would not be significant. Cost savings may be realised by preventing complex dental problems but this is not quantifiable.	

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 in care homes and hospitals. It was agreed that the committee would contribute suggestions as the quality standard was developed.	
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.	
9. 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 in care homes and hospitals quality standard. The Chair thanked the specialist committee members for their input into the development of this quality standard.	
10. 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.	
11. 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 under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: • Andrew Fowell – received standard meeting sponsorship (travel, accommodation and meeting registration) for attendance at the EASL International Liver Conference in April 2016 from Gilead Sciences Ltd. Has accepted standard meeting sponsorship (travel, accommodation and meeting registration) for attendance at the BASL annual meeting in September 2016 from Abbvie Ltd. • Rachel Pryke – member of Lancet commission in liver disease and NICE NAFLD GDG. NICE fellowship 2015-2018. Attendance at EASO 'train the trainers' obesity conference. Founded primary care obesity training ltd in 2016 to run obesity training courses for primary care. This company has no links to industry. The training materials were developed in conjunction with WHO Europe, for which reimbursement was received in 2015-16. Participated in an advisory board meeting for a NAFLD new product evaluation.	
12. Recap of prioritisation exercise	NG and MC presented a recap of the areas for quality improvement discussed at the first QSAC meeting for liver disease:	**12. Recap of prioritisation exercise**

	At the first QSAC meeting on 13 October 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: • Identification of liver disease in primary care – not progressed • Assessing the progression of liver disease – progressed • Management and support (excluding cirrhosis) – progressed • Management of cirrhosis - 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-QS10029/documents/minutes	
12.2 and 12.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	NG and MC presented the committee with a report summarising consultation comments received on liver disease. 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 • General comments on role and purpose of quality standards • Requests to change NICE templates The committee noted the general comments made by stakeholders including specific concerns about resource impact, a focus mainly on adult disease, and not enough emphasis on alcohol as a cause of liver disease; it was agreed to discuss these issues in relation to each statement. It was noted that a number of suggestions for additional statements had been made and these would be given full consideration by the committee. The committee noted suggestions to include other causes of liver disease including autoimmune, metabolic and genetic but confirmed that they cannot be included at this	**12.2 and 12.3 Presentation and discussion of stakeholder feedback and key themes/issues raised**

	stage as no relevant guidance is available.	
12.4 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.**	**12.4 Discussion and agreement of final statements**

Draft statement	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
1. Adults, young people and children newly diagnosed with non-alcoholic fatty liver disease are given healthy lifestyle advice.	• Important to highlight impact of lifestyle on the liver • Will not add to current clinical practice • Should go beyond simple one-off advice • Extend population to include other types of liver disease • Rationale overstates benefits of healthy lifestyle advice • Amend definition of healthy lifestyle advice • Add measure of success of healthy lifestyle advice	The committee accepted that based on the recommendations available in the source guidance the statement cannot focus on referral to structured lifestyle support as suggested by stakeholders. It was agreed, however, that the statement is still useful because it raises awareness of the impact of lifestyle on liver disease. Committee discussed the use of 'heathy lifestyle' in the statement. It was agreed to specifically mention in the statement itself that this includes physical activity, diet and alcohol use, rather than only pointing this out within the definition. Committee felt 'newly diagnosed' required further definition.	**Y - NICE team to amend statement wording to make it clear what is included in healthy lifestyle advice and include a definition of 'newly diagnosed'.**
2. Adults, young people and children with non-alcoholic fatty liver disease are offered regular testing for advanced liver fibrosis.	• Concern about potential resource impact • Needs to be clearer that ELF is 'consider' • Should reflect variability in local access to testing and different approach in paediatric hepatology • Include transient elastography scores in measures to define low risk • Clearer that definition of advanced liver fibrosis is derived from biopsy • Mixed opinions on including or excluding children	The committee discussed the tests used to diagnose NALFD and acknowledged that there is current variation in practice in different areas and a different approach in paediatric hepatology. It was explained to the committee that the ELF test is beneficial because it can be used in primary care to identify people at risk of developing more serious liver disease, and stratify those that do, and do not, need further investigation. The committee expressed concerns around how this statement would be implemented in primary care, as currently the ELF test is not commissioned in all areas of the country.	**Y – NICE team to decide if the statement should be developmental, remove the word 'regular' and emphasise the need for a change in the pathway.**

		The committee acknowledged that there would be resource implications when implementing this statement due to the potential size of the population but felt it was still a key area for quality improvement and agreed to progress the statement. It was agreed to focus the statement on performing an initial test and remove 'regular' from the statement The committee asked the NICE team to consider if the statement needs to be developmental pending further information on the resource impact. The need for a change in the pathway should also be emphasised. The committee agreed children should be included in the statement as they may not be looked after by a hepatologist.	
3. Adults and young people with risk factors for cirrhosis are offered non-invasive testing for cirrhosis.	• Developmental due to concerns about potential resource impact • Should harmful drinkers be included? • Improve/broaden definition of risk factors for cirrhosis • More flexible definition of non-invasive testing • Measure availability of non-invasive testing • Broaden focus of equality and diversity consideration	The committee discussed the potential resource impact of the statement which was highlighted to be significant. Committee discussed the population groups to be included in the statement. It was agreed that harmful drinkers should be included due to the importance of alcohol misuse as a cause of liver disease and to reflect stakeholders' comments about raising the profile of alcohol as a cause of liver disease The committee considered the suggestion that repeat testing for cirrhosis should be included but agreed the priority should be to focus on the initial test. The committee decided to retain the statement as a developmental statement and retain the definition of risk factors for cirrhosis in line with the guideline.	**Y – NICE team to identify the statement as developmental.**
4. Adults and young people with cirrhosis who do not have hepatitis B are offered 6-monthly	• Accepted by clinicians but concern it may not improve mortality and may not be cost-effective	The committee discussed the wording of the statement in relation to people with hepatitis B and agreed to revise the statement to ensure they are included.	**Y – NICE team to revise the wording to include people with hepatitis B**

ultrasound surveillance for hepatocellular carcinoma.	• Significant investment in radiology and recall systems but earlier diagnosis may lead to savings • Misleading to exclude people with hepatitis B • Statement should not specify ultrasound	The committee considered the resource impact of surveillance and felt that as 62% of hospitals were already achieving the statement, many services would already have the necessary systems in place which may reduce this overall impact.	
5. Adults and young people with cirrhosis who have medium to large oesophageal varices are offered endoscopic variceal band ligation for the primary prevention of bleeding.	• Not widely accepted by clinicians • Query if associated with improved mortality • Increased pressure on endoscopy departments • Emphasise patient choice and shared decision making	The committee agreed not to progress this statement as it was not widely supported by clinicians and stakeholders at consultation.	**Statement not progressed**

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
Lowering the risk in those at risk of liver disease	Not progressed - overlaps with existing QS for obesity & alcohol –use disorders	**N**
Early identification of alcohol related liver disease	Not progressed – recommendations in CG100 are based on liver function tests which are unreliable. This population is now covered in statement 3 of this QS.	**N**
Retesting for cirrhosis in those at risk	Not progressed - agreed to focus on initial test as priority for quality improvement in statement 3	**N**
Surveillance for oesophageal varices in people with cirrhosis	Not progressed – not seen as a priority	**N**
Referral to tertiary care for monitoring of complications for people with cirrhosis at risk	Not progressed – unable to measure 'people at risk of complications'	**N**

Prophylactic antibiotics for people with cirrhosis and acute upper gastrointestinal bleeding	Progressed - Committee agreed this was an area for quality improvement and asked the NICE team to check if this area is sufficiently different to the statement in QS38 and if so develop as a statement on 'managing complications of cirrhosis'	**Y – NICE to develop statement if possible and consult with key stakeholders**
Albumin and antibiotic prescription for people with cirrhosis and ascites diagnosed with spontaneous bacterial peritonitis	Not progressed - considered at first meeting and not prioritised.	**N**
People with NAFLD are assessed and treated for other metabolic conditions	Not progressed – No guidance available on which to base a quality statement	**N**
Full hepatitis screen for all people with persistently raised liver function tests	Not progressed - No guidance available on which to base a quality statement	**N**
Testing and treatment for hepatitis B and C and testing and vaccination for family and contacts	Not progressed – covered by hepatitis B QS or within remit for hepatitis C referral	**N**
Monitoring hepatitis C sustained virologic response rates for people with cirrhosis	Not progressed - No guidance available on which to base a quality statement	**N**
Diagnostic paracentesis for people admitted to hospital with ascites due to cirrhosis	Not progressed – No guidance available on which to base a quality statement	**N**
People admitted with decompensated liver disease are seen by a specialist within 24 hours	Not progressed - No guidance available on which to base a quality statement	**N**

13. Resource impact	The committee re-considered the resource impact information for each statement and agreed to develop 2 statements as developmental to address concerns raised by stakeholders.	

14. Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on liver disease. It was agreed that the committee would contribute suggestions as the quality standard was developed.	

15. 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.	
16. Next steps and timescales (part 1 – open session)	NICE team outlined what will happen following the meeting and key dates for the liver disease quality standard. . The Chair thanked the specialist committee members for their input into the development of this quality standard.	
17. Any other business (part 1 – open session)	The following items of AOB were raised: • The Chair thanked those standing members who were moving to other QSAC committees as part of the QSAC restructuring and for whom this was their last attendance at QSAC 2. **Date of next QSAC2 meeting: Thursday 8 June 2017**	