National Institute for Health and Clinical Excellence

Nutrition support in adults
Quality Standard Consultation Comments Table
4th July- 1st August 2012

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
001	NHS Commissioning Board Authority	General	General	1	It is disappointing that there is very little evidence of patient safety being embodied in the quality statements or measures.	The TEG reviewed this comment and agreed that patient safety was a key issue and felt that the whole of the standard was based around patient safety issues. Reference to patient safety has been strengthened
002	The association of anaesthetists of great Britain and Ireland	General	General	2	The AAGBI have no comments	Thank you for your comment
003	Royal College of Anaesthetists	General	General	3	In general the quality standards for nutrition support in adults presented in the draft document are welcome and non-contentious. Although the general principles apply to all categories of those at risk from malnutrition, special considerations apply to the provision of appropriate nutritional support for critically ill patients. For example in critically ill patients who do not tolerate enteral nutrition, attempts to "provide their complete nutritional requirements" (draft quality statement 3) via the parenteral route in the early stages of their illness have been associated with worse outcomes. It is recognised, however that these quality standards are not intended to address specific issues related to this category of patients.	Thank you for your comment. These were considered and changes have been made to statement 2 (previously 3). The TEG recognise that there will be clinical exceptions where the action described in the statement will not be appropriate.
003	Royal College of	General	General	4	From the point of view of an intensive care specialist	The topic expert group prioritised

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	Anaesthetists				key issues that are mentioned in the briefing document but, I am sure for good reasons, receive less emphasis, or are omitted altogether from the draft quality standard include: 1. Incorrect positioning or misplacement of enteral feeding tubes continues to be a cause of avoidable morbidity and even mortality. 2. At least in hospitalised patients it often proves impossible to provide nutritional requirements by the enteral route as a result of, for example gastric stasis and interruptions to feeding for procedures It is important, therefore that patients' nutritional and hydration status is continuously monitored.. 3. The importance of improved training and education, for example with regard to fluid balance and electrolyte disturbances might be given more prominence 4. As well as a nutrition steering group, coordinated care of individual patients receiving nutritional support by a multidisciplinary team that includes a nutritionist, is in our view an important standard. 5. The importance of documentation and effective communication between health care professionals perhaps deserves more emphasis	the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements.
005	Dorset County Council	General	General	5	Would it be appropriate to mention the NACC/ ECCA document How to comply with CQC's Outcome 5: Meeting Nutritional Needs. It's relevant to all social care settings.	Thank you for this suggestion. The evidence sources and other support documents included in the quality standard are those used by the TEG and the NICE quality systems and

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						indicators team to inform the quality statements. Only those specifically relevant to the development of the quality standard are included.
005	Dorset County Council	General	General Comments / definitions	6	Should it also mention dehydration I think it would be useful if MUST was mentioned and then seen as the main validated tool for malnutrition I also feel that the standard does need to mention peoples personal choices – they may not wish to be screened, also the importance of them being involved in decisions. Also should mention their personal likes and dislikes – care needs to be dignified and be person centred, meal times should be an enjoyable experience not a chore! Where care homes are mentioned should it be care and nursing homes. It may not be possible but would also be helpful if sheltered housing, day centres and domiciliary care were specifically mentioned otherwise they will assume it isn't for them.	Thank you for this suggestion. The TEG agreed and the intention is that malnutrition includes dehydration. The intention for all quality statements is that they are person centred. A number of the issues you raise are covered in the previously published Patient Experience quality standard. The definition of settings has been expanded to take into account the settings you referred to.
006	British Association for Parenteral and Enteral Nutrition (BAPEN)	General	General / Implementation	7	We suggest some key elements for the expert group to consider in ensuring the implementation of the quality standards (i) getting the right key messages to the national commissioning board, (ii) setting the right policy and system levers (iii) local commissioning groups working in partnership with / seeking advice from an expert nutrition group at a local level so that appropriate CQUINS etc can be developed, both nationally and locally. This requires the development of appropriate nutrition outcomes (currently a piece of work being considered by the MTF and the NHS III – which would be important to align to these NICE Quality Standards) and appropriate systems to	NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk

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					measure outcomes (e.g. the NHS Safety Thermometer or other systems currently in use for national reporting). This will then support commissioning of good nutritional care with the option to commission for continual improvements in outcomes over time.	
009	Sheffield Teaching Hospitals	General	General	10	I think you need to be clear about what you mean by 'nutrition support'.	Thank you for your comment. A definition has been more clearly identified in the document
009	Sheffield Teaching Hospitals	General	General	11	Screening tools only indicate at risk they are not diagnostic tools of malnutrition.	Thank you. The TEG acknowledged this comment and the wording for this section was reviewed to ensure it is accurate
009	Sheffield Teaching Hospitals	General	General	12	Patient Outcome for all the standards will be maintenance or improvement in nutritional status, the difficulty will be in collecting and collating such data.	Yes, the TEG agreed that this was one of the key outcomes for the whole standard. The outcomes stated under each statement are those that the TEG agreed had a direct causal relationship with the action described in the statement. Measurement is a key factor in agreeing what outcomes to include.
009	Sheffield Teaching Hospitals	General	General	13	Overall easy to read with a few points about regarding definitions and clarity over terms.	Thank you for your comment. This was fed back to the TEG
009	Sheffield Teaching Hospitals	General	General	14	The final version would benefit from having measurement tools for the outcomes to enable consistency in measurement and therefore benchmarking.	NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard

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						means to them, both available from www.nice.org.uk
009	Sheffield Teaching Hospitals	General	General	15	Cannot stress enough the importance of IT systems being in place to capture and collate data….and systems that are shared between organisations to enable effective transfer of care.	Thank you for your comment. The TEG agreed that "documentation" is a key issue and have enhanced the importance of this and communication between settings in statement 3
009	Sheffield Teaching Hospitals	General	General	16	Organisational level outcomes could be- prescribing of oral nutritional supplements; admission avoidance data relating to artificial nutrition care; IT systems in place to support transfer of care/sharing of nutritional care information.	Thank you for your comments. The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity.
012	County Durham and Darlington Foundation Trust	General	General	17	Is it nutrition support or nutritional support – both are used	Thank you for your comments. This has been made consistent throughout the document.
012	County Durham and Darlington Foundation Trust	General	General	18	As stated above these standards need to clarify what is meant by nutritional support, artificial nutrition is clarified latterly but these standards should cover all aspects of nutritional support, as they currently stand it feels very much as though ONS is not covered.	Thank you for your comment. This has been defined in the final standard.
016	NHS Central Lancashire (on behalf of the Lancashire	General	General	19	A general comment in relation to implementation of these standards is the implications on prioritisation, resource and training.	Thank you for your comment. NICE has produced a support document to help commissioners and others

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	Malnutrition Steering Group)					consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk
018	Leeds Community Healthcare NHS Trust (Nutrition Governance Group and Nutrition & Dietetics Department)	General	General	20	Leeds Community Healthcare NHS Trust Nutrition Governance Group and Nutrition & Dietetics Department welcomes the opportunity to comment and to give a practical community perspective on these proposed quality standards for nutritional support in adults. We welcome the simplification of the briefing paper to the 6 draft quality statements. Our understanding is that the quality statements are intended to be aspirational but achievable. It seems that consideration needs to be given to applying these standards in practice especially given the wide variety of settings, conditions and people that nutrition support encompasses. The links with health and social care colleagues is invaluable but if they are required to be compliant with these standards training would need addressing. Recognition of HPC registered dietitians' expert role in this. Within screening there needs to be some consideration to quantity and quality of food and fluid as well as weight and weight loss (in practice staff really struggle to work out % weight loss). It's challenging to make nutrition support standards objective when the area is subjective with so many	Thank you for your comment. The TEG agreed that training was a key issue and reference has been made to this in the introductory text for the standard. A measure has also been included for statement 1 concerning staff training. With regard to what should be included in screening, the statement isn't prescriptive about what local services should use, but recognises the need for any tool to have been validated which should help to provide a more accurate and consistent measure.

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					influencing factors.	
020	Royal College of Psychiatrists	General	General	21	It is pleasing to see that in the document (section 5) people with Learning Disabilities are specifically mentioned but there doesn't seem to be anything more specific relating to this group who can present with specific nutritional challenges. It may be worth adding under the section on screening that anyone undertaking the screening process in this group should be suitably experienced enough to be aware of syndrome-related issues such as people with PKU or the restricted diet sometimes associated with people with autism. Screening tools used by a person not familiar with certain groups may not always pick up important data this of course could be true for other groups of people also).	Thank you for your comment. The TEG agreed that it is essential that any local systems for conducting screening need to be appropriate for all people, with no exceptions and this is referenced in the equality and diversity considerations for statement 1.
025	British Specialist Nutrition Association (BSNA)	General	General	22	The BSNA supports the introduction of a NICE Quality Standard for Nutrition Support in Adults and recognises its importance in helping to drive consistent and quality care. Our members have reviewed the Standard on the basis that ultimately, through the provision of Commissioning Outcomes Framework Indicators drawn from it, it will enable Commissioners, Providers and Healthcare Professionals (HCPs) to review performance and make meaningful comparisons in terms of nutrition support, e.g. between Clinical Commissioning Groups (CCGs) across the country. In order to do this, we understand that the Quality Standard needs to meaningful, useful, feasible and measurable. Furthermore we recognise the	Thank you for your comment.

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					importance of the Quality Standard in being accessible and understood to non-nutritional experts.	
025	British Specialist Nutrition Association (BSNA)	General	General	23	Where reference is made to NICE Clinical Guideline 32 (CG32), it would be helpful for the reader if all relevant text from CG32 is included within the Quality Standard to ensure one clear, unambiguous point of reference. In the current draft Quality Standard, the recommendations from the Clinical Guideline are included in places, but in others the reader is directed to refer to the relevant section.	Thank you for your comment. Actual text from the relevant clinical guideline is only included in the QS document to inform definitions where needed. A hyperlink to the clinical guideline is available in the document.
026	Royal College of Speech and Language Therapists	General	General	24	We welcome this document, which has a good evidence base behind it.	Thank you for your comment.
026	Royal College of Speech and Language Therapists	General	General	25	We recommend a 'description of what the quality statement means for each audience' in each statement – we suggest that 'people' come before the other audiences.	Thank you for your comment. The current order of audience descriptors is standard across quality standards. A separate user version of the quality standard will also be published.
026	Royal College of Speech and Language Therapists	General	General	26	Use of the term 'artificial' to refer to non-oral nutrition - can a less evocative term be used in the place of 'artificial'	Thank you for your comment. The term artificial is used to be consistent with the clinical guideline and was accepted by the TEG as frequently used in practice.
026	Royal College of Speech and Language Therapists	General	General	27	There is little referring to hydration. Is this a deliberate omission? Can more be added?	Thank you for your comment. Hydration / dehydration is included in the definition of malnutrition
026	Royal College of Speech and Language Therapists	General	General	28	There is nothing explicit about capacity and choice. Can this be included?	Thank you for your comment. Quality standards are intended to be person centred and patient choice is

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						implicit throughout the standard.
026	Royal College of Speech and Language Therapists	General	General	29	It is not that clear why some CG32 statements (recommendation sections) have been referenced under certain questions.	The recommendations from CG32 that are referenced are those that were used to inform the statements during the development process.
026	Royal College of Speech and Language Therapists	General	General	30	Where "treatment" is the term used this must be clearly stated to include careful hand feeding. There is increasing evidence that in populations such as those with dementia tube feedings do NOT help (e.g. no nutritional benefit and increased risk of aspiration) and that small snacks/meals either provided by finger foods around the care home/ward and careful feeding one to one (not 1 carer to 6 patients) will optimise nutritional intake and decrease the associated risks of choking, aspiration, requirements for sedation because of challenging behaviour etc.	Thank you for your comments. The TEG agreed and amendments were made to the definition of nutrition support to include help with eating and dietary advice.
026	Royal College of Speech and Language Therapists	General	General	31	My concern over the DQ measures is that the numerator/denominator business only works for those you identify. The big problem is those who are NOT identified!!! Not really those who we know have a problem. Statement 1 has a sensible denominator "*the number of people in a care setting*".	Thank you for your comment. The TEG acknowledged the wider community level issues of people not being identified who are malnourished. The purpose of this standard is about making best use of opportunities within care settings to identify people who are at risk of malnutrition. The wider public health issue of people in the community being malnourished is outside the scope of this standard.
029	The British Dietetic Association	General	General	32	The BDA support the introduction of a Quality Standard on Nutrition and recognise its importance in	Thank you for your comments.

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					helping to drive consistent and quality care. We have reviewed the standard on the basis that ultimately, through the provision of Commissioning Outcomes Framework Indicators drawn from it, it will enable Commissioners, Providers and Healthcare Professionals (HCPs) to review performance and make meaningful comparisons e.g. between CCGs across the country in terms of nutrition support. In order to do this, we understand that the quality standard needs to meaningful, useful, feasible and measurable. Furthermore we recognise the importance of the Quality Standard in being accessible and understood to non-nutritional experts. It would help the reader if all relevant sections from CG32 are included within the Quality Standard to ensure one clear, unambiguous point of reference	Actual text from the relevant clinical guideline is only included in the QS document to inform definitions where needed. A hyperlink to the clinical guideline is available in the document
029	The British Dietetic Association	General	General	33	A general comment in relation to implementation of these standards is the implications on prioritisation, resource and training.	Thank you for your comment. NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk
029	The British Dietetic Association	General	General	34	The opportunities for influencing nutritional assessment across health and social care in the new PH system should be reflected in the standards.	Thank you for your comment. The remit of this quality standard is the health and social car sector. Evidence was not reviewed

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						concerning the wider implications for public health.
029	The British Dietetic Association	General	General	35	A first statement would be useful that focuses on the provision of services to enable access to appropriate food choices e.g. community care staff helping with meals, community cohesion to support elderly neighbours, community day centres/cooking clubs etc. to prevent loss of interest in food, maintenance of adequate food intakes. This upstream approach would have the greatest impact on preventing malnutrition.	Thank you for your comment. The TEG recognises the importance of preventing malnutrition in the first instance. However the scope of this standard was concerned with identifying the risk of malnutrition / malnutrition and relevant care / support where people are malnourished or at increased risk of malnutrition.
029	The British Dietetic Association	General	General	36	The process for implementation of these standards needs to be considered and the importance of the need for health and social care to work closely together. A joint outcome measure across both sectors will need to be considered.	Thank you for your comment. NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk
011	Alzheimer's Society	General	Related NICE quality standards	37	Alzheimer's Society suggest that the NICE quality standard on dementia should be included as a related NICE quality standard. There are 800,000 people with dementia in the UK and one quarter of hospital beds are occupied by people with dementia. People with dementia are at particular risk of malnourishment and dehydration, as explained above. The two quality standards are thus highly relevant to each other.	Thank you for your comment. The TEG and NICE recognise that this quality standard is cross cutting and potentially has relevance to a number of other quality standards. The intention is that this standard will be referenced in related standards.
008	Motor Neurone	General	General	38	Overall we support the contents of the draft quality	Thank you for your comments. The

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	Disease Association				standard as far as it currently goes. We feel, however, that in order to meet the needs of people with motor neurone disease (MND) some of the content needs to be slightly expanded. Often this will entail making explicit things that are already implicit, and otherwise clarifying points so that their meaning cannot be lost or their significance overlooked. In particular it needs to place greater emphasis at certain points on the need for timeliness and for anticipatory assessment. Without this expansion we are not confident that it will provide adequate guidance to healthcare professionals or commissioners, particularly in respect of dealing with the effects of swallowing difficulties arising from MND.	TEG recognised that for some patient groups, there are additional challenges in relation to supporting nutritional intake. This standard provides general principles of high quality nutrition support care, accepting that for some patient groups additional support and intervention will be required.
013	Abbott Nutrition, Abbott Laboratories Ltd.	General	General	39	Abbott Nutrition recognises the importance of a NICE Quality Standard on Nutrition Support in Adults and welcomes its introduction in order to help drive consistent and quality nutritional care across all health and social care settings.	Thank you for your comment.
013	Abbott Nutrition, Abbott Laboratories Ltd.	General	General	40	It would be helpful for the target audience if all relevant text from Clinical Guideline 32 (CG32) could be included within the Quality Standard to ensure an unequivocal point of reference. In the current draft this is inconsistent – the recommendations are included in some places, but the reader is directed to the relevant section of CG32 in others.	Actual text from the relevant clinical guideline is only included in the QS document to inform definitions where needed. A hyperlink to the clinical guideline is available in the document
013	Abbott Nutrition, Abbott Laboratories Ltd.	General	General	41	We recommend the inclusion of a glossary to define key terms, such as 'nutrition support', 'malnutrition', etc. We suggest that these could be taken from CG32.	Within the final quality standard, abbreviations and key terms are defined within the definitions section of each quality statement. Overarching definitions are provided

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						within the introductory sections.
014	Nutricia Ltd	General	General	42	We support the introduction of a Quality Standard on Nutrition and recognise its importance in helping to drive consistent and quality care. We have reviewed the standard on the basis that ultimately, through the provision of Commissioning Outcomes Framework Indicators drawn from it, it will enable Commissioners, Providers and Healthcare Professionals (HCPs) to review performance and make meaningful comparisons e.g. between CCGs across the country in terms of nutrition support. In order to do this, we understand that the quality standard needs to meaningful, useful, feasible and measurable. Furthermore we recognise the importance of the Quality Standard in being accessible and understood to non-nutritional experts.	Thank you for your comment.
014	Nutricia Ltd	General	General	43	Throughout the document, reference is made to NICE CG32. In some places, the recommendations from the clinical guideline are included, other times the reader is directed to look up the relevant section. It would be helpful for the reader if all relevant sections from CG32 are included within the Quality Standard to ensure one clear, unambiguous point of reference.	Actual text from the relevant clinical guideline is only included in the QS document to inform definitions where needed. A hyperlink to the clinical guideline is available in the document
015	Malnutrition Task Force (Malnutrition action group)	Introductio n	Introduction	44	All comments below are collated from members of the Malnutrition Task Force (MTF), an independent group of experts across Health, Social Care and Local Government, who have united to address the problem of avoidable and preventable malnutrition in older people. The MTF experts include representatives from BAPEN, RCN, BGS, RCGP, Public Health, Medicines	Thank you for your comments. Each point is responded to below.

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					Management, Local Authority, Commissioning (CCG), Anchor Trust, Community Meal Providers, Age UK, WRVS, Carers UK, Dietitians, Providers, International Longevity Centre, Nutricia Ltd (Observer Status), Apetito Ltd (Observer Status). We support the introduction of a Quality Standard on Nutrition and recognise its importance in helping to drive consistent and quality care. We have reviewed the standard on the basis that ultimately, through the provision of Commissioning Outcomes Framework Indicators drawn from it, it will enable Commissioners, Providers and Healthcare Professionals (HCPs) to review performance and make meaningful comparisons e.g. between CCGs across the country in terms of nutrition support. In order to do this, we understand that the quality standard needs to meaningful, useful, feasible and measurable. Furthermore we recognise the importance of the Quality Standard in being accessible and understood to non-nutritional experts. • The introduction must make it clear that the focus is on malnutrition related to poor intake rather than risks from malnutrition due to their being overweight. • It needs to be clear throughout the document that good nutritional care includes ensuring adequate hydration. • We suggest two additional bullet points – Preventing hospital admission and Shortening	• This has been clarified. • This has been clarified • This has been referenced as a linked outcome in the rationale

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					hospital stays • Throughout the document, reference is made to NICE CG32. In some places, the recommendations from the clinical guideline are included, other times the reader is directed to look up the relevant section. It would be helpful for the reader if all relevant sections from CG32 are included within the Quality Standard to ensure one clear, unambiguous point of reference. • The relevance of this Quality Standard beyond the period of the NHS Outcomes Framework 2012/2013 and Social Care Outcome Framework 2011/2012 should be explicitly clear especially as their timeframes will be almost complete by the time these QS are launched. Commissioners and providers will then understand that nutrition will be an important element in all future health and social outcome frameworks. • We welcome the reference to the NHS and Adult Social Care Outcomes Frameworks but suggest additional linkage to the Public Health Outcomes framework, as nutrition is relevant to all three.	section of the relevant statement. • Actual text from the relevant clinical guideline is only included in the QS document to inform definitions where needed. A hyperlink to the clinical guideline is available in the document • Thank you for your comment. The quality standard contributes to the outcomes described in the NHS and social care outcomes framework, but they are not interdependent products. • Thank you for your comment. The TEG recognise the importance nutrition has on wider public health. However, that is outside the scope of this specific quality standard.
005	Dorset County Council	Introductio n	paragraph 3.	45	Feel it should cover, adults(18 years and older) in hospital, **care and nursing homes** and the community	Thank you, this is the intention and has been clarified.
012	County Durham and	Introductio		46	Should this be referenced?	The key evidence sources for this

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	Darlington Foundation Trust	n				standard are referenced in the document.
009	Sheffield Teaching Hospitals	Question 1	Question 1	47	Percentage of patients screened. The incidence of malnutrition will not tell us that people are screened whereas the incidence by risk rating will give a wider picture of the process happening.	The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Question 1	Question 1	48	The primary focus of Quality Statements 1 and 2 is on process i.e. screening and documentation of results / care plans. The key consideration is how these actions translate into appropriate treatment and review (Quality Statements 3 and 5). These are therefore the areas where clear outcome measures should be provided which consider the effectiveness of the nutritional intervention. Ideally any outcome measures should be patient focussed. Examples could include: • The impact on hospital admissions and readmissions e.g. the number of people admitted to hospital identified at high risk of malnutrition over a set period of time – the goal would be for this figure to reduce as the Quality Standard becomes embedded in care. • The effect of malnutrition on length of stay and the number of patients at medium / high	Thank you for your comment. The QS as a whole aims to describe high quality care across the care pathway. It is expected to improve care for people needing nutrition support. Outcome measures are stated where the topic expert group felt these were appropriate, which include patient and carer-reported outcomes. In addition to this, each statement is now followed by a rationale section which provides a brief explanation for why the statement is important with some reference to the outcomes that the action referred to in the statement has a potential causal link to. This now includes reference to length of stay and speed of recovery. Whilst

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					risk of malnutrition on discharge from hospital. • Other relevant outcome measures could be developed to capture quality of life or patient experience measures. As stated under Quality Statement 4, a measure of effective training could be to reduce unnecessary A&E visits or hospitalisations over a 12 month period due to problems related to artificial nutrition support.	good nutrition support can have a direct impact on these outcomes, there are a number of other factors that impact also. The TEG were therefore concerned about suggesting a strong, direct causal link to these outcomes.
014	Nutricia Ltd	Question 1	Question 1	49	Quality Standards 1 and 2, primarily relate to process; it is the link of these Statements to appropriate treatment and review (Statements 3 and 5) where clear outcome measures should be provided. At a local level if goals are set, the most obvious outcome measure would be to assess the effectiveness of nutrition support in meeting those goals. However in order to make performance comparisons across the country we suggest inclusion of healthcare outcomes that will have a significant impact on both the patient/individual and on healthcare costs. We suggest inclusion of outcome measures to assess effectiveness in the community and within hospital settings. Some examples of how these could be translated into indicators are shown also: Community – impact on hospital admissions and readmissions: - Number of people admitted to hospital	Thank you for your comment. The QS as a whole aims to describe high quality care across the care pathway. It is expected to improve care for people needing nutrition support. Outcome measures are stated where the topic expert group felt these were appropriate, which include patient and carer-reported outcomes. In addition to this, each statement is now followed by a rationale section which provides a brief explanation for why the statement is important with some reference to the outcomes that the action referred to in the statement has a potential causal link to. This now includes reference to length of stay and speed of recovery. Whilst good nutrition support can have a direct impact on these outcomes,

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					identified at high risk of malnutrition (over 12m* period) - Number of times individuals at high risk of malnutrition are readmitted to hospital over a 12m period (*12m period identified to allow for seasonal variation). Hospital: impact on length of stay and malnutrition on discharge: - Average length of stay in hospital for people identified at high risk of malnutrition on admission - Number of people discharged from hospital identified at high risk of malnutrition (over 12m period) Depending on definitions, usage of validated screening tool these indicators may be clarified as 'at risk' or 'at high risk'. Other relevant outcomes could be developed in respect of Quality of Life measures and Patient Experience Measures.	there are a number of other factors that impact also. The TEG were therefore concerned about suggesting a strong, direct causal link to these outcomes
015	Malnutrition Task Force (Malnutrition action group)	Question 1	Question 1	50	Quality Standards 1 and 2 primarily relate to process; it is the link of these Statements to appropriate treatment and review (Statements 3 and 5) where clear outcome measures should be provided.	Thank you for your comment. The QS as a whole aims to describe high quality care across the care pathway. It is expected to improve care for people needing nutrition

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					• **Screening:** people in all care settings are screened within 24 hrs, where appropriate. By identifying those at risk resources can be targeted and through monitoring improvement measured • **A standard around documentation:** universal documents used across all care settings would be excellent, delivering consistency of approach towards individuals nutritional needs • **Nutritional Status:** An outcome around individuals being able to maintain or improve their nutritional status, although it must be recognized that with ongoing illness or injury, this is not always possible. • **Numbers of avoidable malnutrition** • **Training**: although difficult to define, training being offered to all, early recognition of issues relating to artificial nutrition support, earlier intervention to resolve issues is important and an outcome to measure this would be excellent. • **Monitoring and Review**: an outcome to provide a clear indication of the review process and measuring it – e.g. 1wk, 1 month, 3 months. Clear goals set. Who does review? Individual's nutritional status is maintained or improved, improvement in individual related health care issues (though we do appreciate where malnutrition is a consequence of disease this outcome may be inappropriate).	support. Outcome measures are stated where the topic expert group felt these were appropriate, which include patient and carer-reported outcomes. In addition to this, each statement is now followed by a rationale section which provides a brief explanation for why the statement is important with some reference to the outcomes that the action referred to in the statement has a potential causal link to. This now includes reference to length of stay and speed of recovery. Whilst good nutrition support can have a direct impact on these outcomes, there are a number of other factors that impact also. The TEG were therefore concerned about suggesting a strong, direct causal link to these outcomes.

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					• A good outcome may be independence maintained at home – though we appreciate that for individuals with disease related malnutrition, where the underlying disease is the cause of the malnutrition, this will not always be possible. **General comments** At a local level if goals are set, the most obvious outcome measure would be to assess the effectiveness of nutrition support in meeting those goals, though these are very difficult to measure. It is also important that the wording of statement 3 and any associated outcome measure recognizes that meeting a sick or injured patient's nutritional needs cannot or should not always be achieved e.g. it may be considered clinically more reasonable to underfeed a patient for a period rather than use invasive and risky intravenous nutrition In order to make performance comparisons across the country we suggest consideration is given to inclusion of healthcare outcomes that will have a significant impact on both the patient/individual and on healthcare costs. We suggest inclusion of outcome measures to assess effectiveness in the community and within hospital settings. Some examples of how these could be translated into indicators are: **Community** – impact on hospital admissions and readmissions:	

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					- Number of people admitted to hospital identified at high risk of malnutrition (over 12m* period) - Number of times individuals at high risk of malnutrition are readmitted to hospital over a 12m period (*12m period identified to allow for seasonal variation). **Hospital:** impact on length of stay and malnutrition on discharge: - Average length of stay in hospital for people identified at high risk of malnutrition on admission - Number of people discharged from hospital identified at high risk of malnutrition (over 12m period) Depending on definitions, usage of validated screening tool these indicators may be clarified as 'at risk' or 'at high risk'. Other relevant outcomes could be developed in respect of Quality of Life measures and Patient Experience Measures. For Quality Statement 4, as stated previously, an outcome measure of effective training of patients and carers would be to reduce unnecessary hospital visits/A&E visits due to problems with artificial nutrition.	

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					E.g. an outcome indicator could be: 'Number of emergency hospital admissions over 12m due to problems with artificial nutrition'.	
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Question 1	Question 1	51	Ease of measurement needs to be considered – can metrics be set against all of the proposed outcomes?	Thank you for your comment. The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity.
017	Bassetlaw Health Partnership	Question 1	Question 1	52	Dieticians would be best placed to answer this	Thank you for your comment. Dieticians have been involved in the TEG and also given opportunities to feed into the consultation process.
018	Leeds Community Healthcare NHS Trust (Nutrition Governance Group and Nutrition & Dietetics Department	Question 1	Question 1	***53***	***Statement 1*** - Whilst the draft quality measures are mainly data performance and monitoring, need also to consider health & wellbeing outcomes eg through mealtime observation audits and service users experiences e.g. in hospitals, care home, in own home of community meal on wheels service or domically care service provider etc. With the draft quality measures being very weighed to data number performance monitoring, collection of this gathering of numbers screened needs to be achievable for social workers, in appropriate social care settings. It could be considered inappropriate in hospices where weighing as part of a screening tool is often	Thank you for your comment. The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity. The focus of statement 1 is consistent with the recommendations contained in the

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					inappropriate. Is it within the role, scope and knowledge and skill set of a social worker to complete a nutrition screen? Is the proposed gathering of numbers screened workable or achievable within social care. There may be issues over the vague use of screening where there is clinical concern, in practice this means it will be frequently missed as so subjective, would suggest routine screening for high risk groups at regular intervals e.g. at >75 health check and annual where concern recognised. ***Statement 2*** – Audit of documentation to evidence completion not just of screening but goals of treatment documented at key stages of care see statement above. ***Statement 3*** -Support the aspirational role of healthcare professionals to recognise malnutrition risk which leads to further assessment. In practice within a community setting this will have an impact on district nursing and other specialist nursing services in using validated screening tools appropriate to this setting. The assessment of BMI in service users own home and where people are infirm or physically disabled is challenging and not supported by evidence for older adults. Could we suggest use of BMI or percentage body weight for use in practice? We can't see where it says leading to screening leading to assessment, it looks like the assessment section has gone? How is the performance monitoring of this achievable for the homeless, refugees, malnourished alcoholics, long stay mental health units, prison or appropriate in	evidence source for this quality standard which is NICE clinical guideline 32.

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					hospices where weighing as part of a screening tool is often inappropriate ***Statement 4*** – Data from HEF contractor (help desk reports of problems) /EF nurse reports, admissions to A&E would support statement 4. ***Statement 5***- Documentation audits could be used as evidence to support the healthcare outcome of this statement, but considering our recent experience is this realistic in practice? We would suggest that those reviewing nutrition as well as screening for malnutrition should be trained. ***Statement 6***- Nutritional care overseen by a nutrition steering group could help overcome the barriers of measuring outcomes, including audits, by supporting this as an organisation 'must do' reporting issue.	
025	British Specialist Nutrition Association (BSNA)	Question 1	Question 1	54	Quality Statements 1 and 2 primarily relate to process; it is the link of these Statements to appropriate treatment and review (Statements 3 and 5) where clear outcome measures should be provided. At a local level if goals are set, the most obvious outcome measure would be to assess the effectiveness of nutrition support in meeting those goals. However, in order to make performance comparisons across the country, we suggest inclusion of healthcare outcomes that will have a significant impact on both the patient/individual and on healthcare costs. We suggest inclusion of outcome measures to assess effectiveness in the community and within hospital settings. Some examples of how these could be translated into indicators are: Community: impact on hospital admissions and	Thank you for your comment. The QS as a whole aims to describe high quality care across the care pathway. It is expected to improve care for people needing nutrition support. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement. In addition to this, each statement is now followed by a rationale section which provides a brief explanation for why the statement is important with some reference to the outcomes that the

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					readmissions: - Number of people admitted to hospital identified at high risk of malnutrition (over 12m* period) - Number of times individuals at high risk of malnutrition are readmitted to hospital over a 12m period (*12m period identified to allow for seasonal variation). Hospital: impact on length of stay and malnutrition on discharge: Average length of stay in hospital for people identified at high risk of malnutrition on admission - Number of people discharged from hospital identified at high risk of malnutrition (over 12m period) Depending on definitions and usage of validated screening tool, these indicators may be clarified as 'at risk' or 'at high risk'. Other relevant outcomes could be developed in respect of Quality of Life measures and Patient Experience Measures.	action referred to in the statement has a potential causal link to.
025	British Specialist Nutrition Association (BSNA)	Question 1	Question 1	55	As stated previously, for Quality Statement 4, an outcome measure of effective training of patients and carers would be to reduce unnecessary hospital visits/A&E visits due to problems with artificial nutrition. An example outcome indicator could be: 'Number of emergency hospital admissions over 12m due to problems with artificial nutrition'.	Thank you for your comment. The QS as a whole aims to describe high quality care across the care pathway. It is expected to improve care for people needing nutrition support. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement. In addition to this, each statement is now followed by a rationale section which provides a

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						brief explanation for why the statement is important with some reference to the outcomes that the action referred to in the statement has a potential causal link to.
026	Royal College of Speech and Language Therapists	Question 1	Question 1	56	Can you suggest any appropriate healthcare outcomes for each individual quality statement? Fim score, Northwick Park Therapy Dependency Scale (NPTDS). Could incorporate qualitative outcomes in training QS through pre/post questionnaires, self-rating confidence scales. Goal setting to be SMART.	Thank you for your comment. The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity.
029	The British Dietetic Association	Question 1	Question 1	57	Healthcare Outcomes; % weight change, Body Mass Index, skin integrity, functional status, hospital admissions, Malnutrition risk (score / grade of risk dependent on type of screening tool used). Ease of measurement needs to be considered – can metrics be set against all of the proposed outcomes?	Thank you for your comment. The QS as a whole aims to describe high quality care across the care pathway. It is expected to improve care for people needing nutrition support. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement. In addition to this, each statement is now followed by a rationale section which provides a brief explanation for why the statement is important with some reference to the outcomes that the

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						action referred to in the statement has a potential causal link to.
009	Sheffield Teaching Hospitals	Question 2	Question 2	58	Consent regarding artificial nutrition and the adequate amount of information provided to progress with these routes…particularly in those were a long term gastrostomy tube is concerned. Standards of care for those on artificial nutrition where outcomes of infection rates, preventable complications and admission avoidance could be used. Patient experience measures on the process of care as well as the patient reported outcome measures….may be required at different levels, so for example at CCG level the rates of death relating to malnutrition, admission avoidance rates due to nutritional treatment/home tube feeding care, whereas in an individual case the reduction in pressure sores, or the gaining of weight post surgery, therefore difficult to determine what is appropriate to describe in the quality standards.	Thank you for your comment. The QS as a whole aims to describe high quality care across the care pathway. It is expected to improve care for people needing nutrition support. Outcome measures are stated where the topic expert group felt these were appropriate, measureable and specifically attributable to the action stated in the statement. In addition to this, each statement is now followed by a rationale section which provides a brief explanation for why the statement is important with some reference to the outcomes that the action referred to in the statement has a potential causal link to.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Question 2	Question 2	59	The Quality Standard is comprehensive in that it covers the complete care cycle from identification of malnutrition risk, through to goal setting, training and review. Further guidance could perhaps be given on how the Quality Standard should be embedded across Health Care, Social Care and Public Health settings. As mentioned previously, it would also be helpful to include the relevant sections from CG32 within this document.	NICE has produced a support document to help commissioners and others consider the commissioning implications and potential resource impact of this quality standard and patient information to explain to patients and carers what the quality standard means to them, both available from www.nice.org.uk

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					There is perhaps also a need to ensure that the focus of the Quality Standard is on the individual patient to ensure they receive the nutrition support that they require based on their level of risk and personal circumstances.	The intention of the quality standard is that it is person centred. It is recognised and expected that clinicians and care staff provide personalised care.
014	Nutricia Ltd	Question 2	Question 2	60	The Quality Standard covers the key tenets of good nutritional support – from screening, goal setting, to appropriate nutritional intervention, training and review. Areas where further clarity may be required or where the Quality Standard could give further guidance would be on the following – although we note that comments made in the Overview may address some of these points: - Ensuring incorporation of nutrition support into existing Quality Standards for long term and other relevant conditions and diseases. - Building on NICE CG32 to ensure clear for target stakeholders as to how to determine what type of nutrition support is required dependent on screening results and other factors (e.g. ability to swallow safely, social factors etc) - Reference to factors out of scope of nutritional support, but which are important to prevent individuals becoming at risk of malnutrition (e.g. access and quality to good nutrition within hospital and care home settings)	Thank you for your comments. These have been considered by the TEG. The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective

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						care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
015	Malnutrition Task Force (Malnutrition action group)	Question 2	Question 2	61	• Although the Quality Standards cover the key tenets of good nutritional support in relation to screening, goal setting, and appropriate nutritional intervention, reference to training is confined to that of training individuals who need nutrition support and their carers rather than training of all health professionals who look after them. We believe this is a serious omission and that a QS on professional training in nutritional care is needed. An associated outcome measure would then be the % of health professionals in any care setting who have received training within the last 3 years. Such training would have to be appropriate to roles and care settings and should include the causes of malnutrition, the importance of nutritional screening and care, methods of support and care pathways, complications of nutrition support etc. • It may be appropriate to include a QS specifically related to preventing avoidable malnutrition although it could be argued that this is implicit within the existing draft QS. • Delivering artificial nutrition support via enteral tubes or intravenous routes can cause	Thank you for your comments. These have been considered by the TEG. The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective

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					serious even fatal complications and we believe that a QS designed to ensure that these are minimized is needed. An obvious outcome measure would be catheter related sepsis rates (CRS) in patients on intravenous nutrition using a measure that ensured appropriate tests for CRS were made whenever patients on IVN developed a fever of uncertain origin. • Areas where further clarity may be required or where the Quality Standard could give further guidance would be on the following – although we note that comments made in the overview may address some of these points: - Ensuring incorporation of nutrition support into existing Quality Standards for long term and other relevant conditions and diseases. - Building on NICE CG32 to ensure clarity for target stakeholders as to how to determine the type of nutrition support required depending upon screening results and other factors (e.g. ability to swallow safely, social factors, care setting etc) - Reference to factors out of the scope of nutritional support, but which are important to prevent individuals becoming at risk of malnutrition (e.g. access and quality to good nutrition within hospital and care home	care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.

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					settings)	
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Question 2	Question 2	62	The standard does not go far enough in addressing areas of care in the community. Given that the majority of cases of malnutrition occur in the community, this needs to be more strongly reflected in the quality standards.	Thank you for your comment. The TEG recognised and discussed areas of care in the community. This has been further emphasised in the statements.
017	Bassetlaw Health Partnership	Question 2	Question 2	63	Do the standards include health care in prisons?	The standard does not exclude health care in prisons.
018	Leeds Community Healthcare NHS Trust (Nutrition Governance Group and Nutrition & Dietetics Department	Question 2	Question 2	***64***	***Statement 1, 2, 3,5*** - Whilst these quality statements range from recognition, treatment and review at planned intervals, has the TEG considered a specific statement on nutrition training to ensure all have the nutrition knowledge and skills to support these statements within the remit and scope of their role? Is it within the role, scope and knowledge and skill set of a social worker to complete a nutrition screen? Is their role not recognition of key questions within a single assessment process on access to food, fluid and nutritional support and the outcome of the healthcare professional's identification of those who are malnourished or at risk? These quality statements do not reflect the access to HPC registered dietitians for nutritional assessment, education and training of others. ***Statement 4*** – We agree with statement 4 however feel it could be strengthened by including that 'expert' has appropriate working knowledge and understanding of local practices ,policies and procedures.	Thank you for your comment. The TEG agreed that training and expertise of staff is key in delivering the quality improvement the standard is intended to achieve. This is specifically referenced in the introductory text in the quality standard document.
025	British Specialist Nutrition Association	Question 2	Question 2	65	The Quality Standard covers the key tenets of good nutritional support – from screening and goal setting,	Thank you for your comments. These have been considered by the

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	(BSNA)				to appropriate nutritional intervention, training and review. Areas where further clarity may be required or where the Quality Standard could give further guidance would be on the following: - Ensuring incorporation of nutrition support into existing Quality Standards for long term and other relevant conditions and diseases; - Building on NICE CG32 to ensure it is clear to target stakeholders as to how to determine what type of nutrition support is required dependent on screening results and other factors (e.g. ability to swallow safely, social factors etc.); - Reference to factors out of scope of nutritional support, but which are important to prevent individuals becoming at risk of malnutrition (e.g. access and quality to good nutrition within hospital and care home settings).	TEG. The nutrition support quality standard is a cross cutting standard that will have relevance to any condition and care setting based standard in the future. The TEG felt that long term care is sufficiently covered within the statements as they stand. Long term care is referenced in statement 3 concerning documentation and communication, and statement 4 about long term tube feeding. These other areas are outside the scope of this quality standard.
026	Royal College of Speech and Language Therapists	Question 2	Question 2	66	What important areas of care, if any, are not covered by the quality standard? At screening stage there should be thought given to diagnosis of dysphagia and links with appropriate onward referrals to SLT or other relevant professionals. Care pathways could be clearer. Under review QS Advanced Planning should be considered.	Thank you for your comments. These have been considered by the TEG. The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is

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						potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.
028	Baxter Healthcare	Question 2	Question 2	67	Is there is an opportunity in this document to promote patient education and empowerment in nutritional care? Is there also an opportunity to ensure that there are robust measures in place for seamless care between hospital stay and the community and that this is planned prior to discharge? Is it within the scope of this document to specify that treatment options for nutritional support are only to be determined by healthcare professionals with demonstrated appropriate therapy expertise?	Thank you for your comment. The TEG reviewed your comments and felt confident that these issues have been addressed through the content of the quality standard.

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029	The British Dietetic Association	Question 2	Question 2	68	The standard does not go far enough in addressing areas of care in the community. Given that the majority of cases of malnutrition occur in the community, this needs to be more strongly reflected in the quality standards.	Thank you for your comment. The TEG recognised and discussed areas of care in the community. This has been further emphasised in the statements.
001	NHS Commissioning Board Authority	Question 2	Question 2	69	What important areas of care, if any, are not covered by the quality standard? The quality standard does not identify the importance of implementation of the nutrition support goals and treatment.	Thank you for your comments. The TEG agreed the importance of implementation of nutrition support goals. The goals are referenced in 2 statements around documentation / communication in St 3 (previously 2) and review of the goals in St 5.
014	Nutricia Ltd	Questio n 3	Question 3	70	Statements 1-5 incorporate all the tenets of good nutritional support as stated earlier, however are only meaningful if they link together (e.g. screening which is not linked to an action has minimal value). The focus should be on the individual/patient and in ensuring that they receive the nutrition support that they require based on their level of risk and circumstances. Statement 6 may be less important provided that Commissioners and Providers can access nutritional expertise if required.	Thank you for your comment. The QS as a whole aims to describe high quality person centred care across the care pathway, with each statement being interrelated to the others. Individual circumstances should always be considered when providing care. Statement 6 has not been progressed in the final quality standard.
015	Malnutrition Task Force (Malnutrition action group)	Question 3	Question 3	71	• QS 1 – without screening people who can benefit from interventions cannot be identified. Screening is essential to identify there is a problem. Using this as a baseline it is possible to monitor the effectiveness of any identified nutritional support	Thank you for your comment. The QS as a whole aims to describe high quality person centred care across the care pathway, with each statement being interrelated to the others. Individual circumstances

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					• Recording (and implementing) the appropriate treatment plan which then follows the individual (between care settings) This said, we actually believe Statement 1; 2; 3; 4; and 5 to be important and that an additional QS related to training of professional staff on the importance of nutrition etc. is essential: Statements 1&2 are vital to identify individuals at risk and therefore plan interventions and continuity of care. Statement 3 is important- because it ensures that consideration is given of an individual's complete nutritional requirements, and which can only be overseen by a health professional. Statements 4 and 5 are also key because it is important that people have an understanding of their nutritional support, particularly if via enteral feeding etc, and that regular reviews are carried out by a suitably qualified health professional. Statements 1-5 incorporate all the tenets of good nutritional support as stated earlier. They are, however, only meaningful if they link together (e.g. screening which is not linked to an action has minimal value). The focus should be on the individual/patient and in ensuring that they receive the nutrition support that they require based on their level of risk and circumstances. Although statement 6 could be considered less	should always be considered when providing care. Statement 6 has not been progressed in the final quality standard.

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					important if Commissioners and Providers could access nutritional expertise whenever required, experience suggests that the hospitals that have made the greatest improvements in nutritional care are those with a fully functioning nutrition steering committee and nutrition support team. This permits development of nutrition policies and practices within a multidisciplinary context, embedded in clinical governance systems. QS 6 can therefore arguably make the biggest contribution to ending fragmented, inconsistent low quality nutritional care.	
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Question 3	Question 3	72	We would consider screening the most important quality statement as effective screening would allow for earlier identification and intervention improving quality of care and reducing costs associated with malnutrition.	Thank you for your comments. These were considered by the TEG
017	Bassetlaw Health Partnership	Question 3	Question 3	73	Statement 1 : essential to identify all those at risk. Statements 2 and 5 : are part of the same process, care plans should always be reviewed as part of good clinical practice.	Thank you for your comments. These were considered by the TEG
018	Leeds Community Healthcare NHS Trust (Nutrition Governance Group and Nutrition & Dietetics Department	Question 3	Question 3	74	All 6 draft quality statements are important the capture as they give an overview of nutritional care. The exception is nutrition training to ensure workforce has the knowledge and skills to achieve this. Training needs to be more explicit within the quality statements.	Thank you for your comment. The TEG agreed that training and expertise of staff is key in delivering the quality improvement the standard is intended to achieve. This is specifically referenced in the introductory text in the quality standard document
022	South West London and St George's Mental Health Trust	Question 3	Question 3	75	I think the most important quality statement is the q on assessment; it is the foundation of treating malnutrition	Thank you for your comments. These were considered by the TEG

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025	British Specialist Nutrition Association (BSNA)	Question 3	Question 3	76	As previously stated, Quality Statements 1-5 incorporate all the tenets of good nutritional support, however they are only meaningful if they link together (e.g. screening which is not linked to an action has minimal value). The focus should be on the individual/patient and in ensuring that they receive the nutrition support that they require based on their level of risk and circumstances. Statement 6 may be less important provided that Commissioners and Providers can access nutritional expertise if required.	Thank you for your comment. The QS as a whole aims to describe high quality person centred care across the care pathway, with each statement being interrelated to the others. Individual circumstances should always be considered when providing care. Statement 6 has not been progressed in the final quality standard
026	Royal College of Speech and Language Therapists	Question 3	Question 3	77	What, in your opinion, are the most important quality statements and why? All very valid QS, in particular QS 1, 3 & 4. Recognition is key to all five, as without this the rest of the steps would not apply.	Thank you for your comments. These were considered by the TEG
028	Baxter Healthcare	Question 3	Question 3	78	We believe all of the standards are important and that each one is interdependent.	Thank you for your comments. These were considered by the TEG
029	The British Dietetic Association	Question 3	Question 3	79	We would consider screening the most important quality statement as effective screening would allow for earlier identification and intervention improving quality of care and reducing costs associated with malnutrition.	Thank you for your comments. These were considered by the TEG
001	NHS Commissioning Board Authority	Question 3		80	What, in your opinion, are the most important quality statements and why? Quality standard 1 – highlights the importance of recognition in order to gain understanding of the	Thank you for your comments. These were considered by the TEG

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					extent of the issue. Quality standard 4 – Recognises the potential risk of harm associated with artificial nutrition. Quality standard 5 – ensures appropriate management for people receiving nutritional support and of resources.	
014	Nutricia Ltd	Question 4	Question 4	81	This question has been addressed in detail against each of the individual statements	Thank you for your comment.
015	Malnutrition Task Force (Malnutrition action group)	Question 4	Question 4	82	There was a diverse range of views in response to this question. • No. Validated screening tool should be standard across all agencies to ensure consistency of results and limits the risk of variances and misinterpretation – some members of the MTF asked if it is possible to adopt 'MUST' across the board to ensure consistency? We would welcome this if it is possible, especially given that this is the tool of choice for the majority of organisations. • One respondent did not feel that statement 6 is appropriate, and that it would be very challenging to implement across health and social care, particularly social care where there may be a number of local providers of care homes and home care services. It may therefore be more appropriate to state that	Thank you for your comments. Each one is responded to in turn below • The TEG make reference to 'MUST' as an example. However, this is not the only screening tool available and there isn't an evidence base that shows that 'MUST' is the most effective screening tool available. Therefore it would be inappropriate to recommend this tool alone. • Statement 6 has not been progressed in the final quality standard

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					commissioners should seek commissioning advice from a local nutrition steering group. • Others felt that Statement 6 is important and is certainly achievable. NHS Midlands and East are setting up a nutrition steering committee to span the whole region (acute and community) suggesting that it is achievable where areas have strong clinical leadership. This SHA is also providing an intense support team for organisations who want to improve nutritional care (to achieve their aim of eliminating grade 2, 3 and 4 pressure ulcers by December 2012). Whilst this is a particularly ambitious aim, we urge NICE to recognise what is achievable in Healthcare (demonstrated by the reductions in infection, progress towards delivery of 95% harm free care by December 2012) and to set the ambition for nutrition at an appropriate aspirational (but achievable) level. • We would like to add that the MTF and NHS III are currently working to together to develop measures for malnutrition and would like to propose that the NHS Safety Thermometer should include a measure(s) relating to nutrition & hydration	• Statement 6 has not been progressed in the final quality standard • Thank you for this information.
018	Leeds Community Healthcare NHS Trust	Question 4	Question 4	83	see comments above under section 1 statement 1	Thank you.

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	(Nutrition Governance Group and Nutrition & Dietetics Department					
025	British Specialist Nutrition Association (BSNA)	Question 4	Question 4	84	This question has been addressed in detail against each of the individual statements	Thank you.
026	Royal College of Speech and Language Therapists	Question 4	Question 4	85	Are any of the proposed quality measures inappropriate and, if so, can you identify suitable alternatives? We did consider if QS2 Documentation could be incorporated into another standard. If this remains then more thought may need to be considered as to wider access issues e.g. access to care plans in a community domiciliary setting. Can this information be centralised?	Thank you for this comment. The TEG recognised the challenge of documentation and communication particularly concerning community settings. NICE has produced a support document to help in local implementation of the guideline. This includes potential models of care that could be used.
029	The British Dietetic Association	Question 4	Question 4	86	This is included in comments above. All quality measures are appropriate and appear to cover all aspects of managing malnutrition appropriately.	
001	NHS Commissioning Board Authority	Question 4	Question 4	87	Are any of the proposed quality measures inappropriate and, if so, can you identify suitable alternatives? Non are inappropriate but they do not reflect that nutrition and hydration impact on patient safety.	The TEG reviewed this comment and agreed that patient safety was a key issue and felt that the whole of the standard was based around patient safety issues. Reference to patient safety has been strengthened
013	Abbott Nutrition, Abbott Laboratories Ltd.	Question 5	Question 5	88	We do not believe that we are able to comment on the feasibility of establishing nutrition steering committees in any healthcare setting, but consider that the ability of any locality to establish a nutrition steering committee in the community will vary depending on workforce capacity and capability.	Thank you for your comment. Statement 6 has not been progressed in the final quality standard.

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					We believe that local Commissioners and Providers should have the flexibility to determine how best to deliver quality nutritional care, taking into consideration the available expertise in nutrition and the need to integrate nutritional care across Health Care, social care and Public Health.	
013	Abbott Nutrition, Abbot Laboratories Ltd	Question 5	Question 5	89	We do not have the expertise to comment on the feasibility of establishing nutrition steering committees. However our thoughts are that the role of a Quality Standard should be to describe what good quality care should look like, with local commissioners and providers having the flexibility to determine how best to deliver that quality care. The situation may therefore be different across the country. Most importantly expertise in nutrition should be available locally if needed and there should be integration across health, social care and public health, through Health and Wellbeing Boards, to ensure a joined up approach.	Thank you for your comment. Statement 6 has not been progressed in the final quality standard.
018	Leeds Community Healthcare NHS Trust (Nutrition Governance Group and Nutrition & Dietetics Department	Question 5	Question 5	90	Leeds Community Healthcare NHS Trust have a Nutrition Governance Group not a committee. At present this does not link operationally or strategically to adult social care or clinical commissioning groups. The chair, the Head of the Dietetic Service and a registered dietitan does have links however via other routes to clinical commissioning groups. For enteral feeding, in Leeds, effective working/operational/ contract monitoring/ groups are established to achieve the same as a committee with both acute and community working collaboratively to ensure	Thank you for your comment. Statement 6 has not been progressed in the final quality standard.

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					seamless care pathways.	
020	Royal College of Psychiatrists	Question 5	Question 5	91	The question is whether nutrition support committees/groups can be established in community settings. It should be noted that most mental health patients with nutritional support needs are likely to be in community settings, and mental health services do need some way of ensuring that they can access the appropriate nutritional support for them. However a committee may not answer the need adequately. It would be better to have as a quality standard that there were appropriate 'networks' in the community and a clear 'pathway' for patients requiring nutritional support.	Thank you for your comment. Statement 6 has not been progressed in the final quality standard.
022	South West London and St George's Mental Health Trust	Question 5	Question 5	92	I have worked in a Nutrition & Dietetic department in the community and can see no barriers to establishing a nutrition steering group.	Thank you for your comment. Statement 6 has not been progressed in the final quality standard.
025	British Specialist Nutrition Association (BSNA)	Question 5	Question 5	93	We do not have the expertise to comment on the feasibility of establishing nutrition steering committees. However our thoughts are that the role of a Quality Standard should be to describe what good quality care should look like, with local Commissioners and Providers having the flexibility to determine how best to deliver that quality care. The situation may therefore be different across the country. Most importantly, expertise in nutrition should be available locally if needed and there should be integration across health, social care and public health, through Health and Wellbeing Boards, to ensure a joined up approach.	Thank you for your comment. Statement 6 has not been progressed in the final quality standard.
028	Baxter Healthcare	Question 5	Question 5	94	We would strongly support the establishment of	Thank you for your comment.

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					nutrition steering groups in the community as we believe that they would support continuity of high quality care in the community.	Statement 6 has not been progressed in the final quality standard.
017	Bassetlaw Health Partnership	Section 1	Section 1	95	Should be targeted at 'vulnerable' adults, (e.g. long term conditions, palliative care, those with mental health issues who may neglect their self care and others who are potentially at risk / clinical concern) not all adults. Some may only access community health services once and be otherwise fit and well. To screen everyone would be time consuming and costly and would not add value to the patient contact. In BHP we use MUST as the screening tool, which works well and can be carried out by all grades of staff (including support staff). Who will carry out the screening of people admitted to care homes? Care home staff? How will consultant quality of screening and following through be answered? It will be important that this information is transferred with patients when they move between care providers. For instance patients might be screened (statement1) and have this documented in a care plan (statement 2) and might even have a treatment plan (statement 3) and then get transferred from acute hospital to community or a care home. Will all this be transferred with them when we know that currently transfer information isn't always 100% reliable? With regard to all statements there will probably be training needs – e.g. in care homes.	Thank you for your comment. The TEG have provided additional clarity to the situations within which screening is appropriate. St 3 (previously 2) has been strengthened with specific reference to communication of nutrition status between settings in writing.
019	Hywel Dda Health	Section 1	Section 1	96	'Good Nutrition support services are crucial in treating	Thank you for your comments. These

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
	Board				a number of conditions' – vague statement needs further clarity. Good Nutrition support services are not only essential for treating malnutrition and its associated conditions but also in Preventing malnutrition. The importance of NS as part of the wider care package is an important statement - there needs to be further emphasis on this particularly for those with complex conditions – reference to the fact that the cause of malnutrition can be complex and multifactorial (including social, psychological, physiological factors) The introduction highlights who the document covers but should include that this also includes patients with mental health needs/learning disabilities/Transition to adult services from Paediatrics. The section that highlights that the draft 'describes markers of high quality, cost effective care.. etc' - Is this the overall aim of the document, if so this should be highlighted with the bullet points below this forming a summary of the objectives. There should be a bullet point here also focusing on 'Promoting the patient/carer involvement in their nutritional care plan – focusing on self management particularly if looking at measuring outcomes. Also suggest bullet point on promoting seamless service delivery and transition of care across acute/community and mental health settings. The following measures could be used as a framework: preventing people dying prematurely from malnutrition, enhancing quality of life, aiding recovery, experiencing treatment in a safe	have been considered by the TEG and the introductory and over sections have been reviewed and amended.

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					environment, safeguarding vulnerable adults.	
025	British Specialist Nutrition Association (BSNA)	Section 1	Section 1	97	We welcome the reference to the NHS Outcomes Framework and Adult Social Care Outcomes Framework and would recommend a reference and link also to the Public Health Outcomes Framework; nutrition is relevant to all three Frameworks. We recommend that reference is made to the importance and relevance of this Quality Standard beyond the cited time period of the NHS Outcomes Framework 2012/2013 and Social Care Outcome Framework 2011/2012.	• Thank you for your comment. The quality standard contributes to the outcomes described in the NHS and social care outcomes framework, but they are not interdependent products. • Thank you for your comment. The TEG recognise the importance nutrition has on wider public health. However, that is outside the scope of this specific quality standard.
029	The British Dietetic Association	Section 1	Section 1	98	In addition to the reference to the NHS and Adult Social Care Outcomes Framework we would recommend a link to the Public Health Outcomes framework, as nutrition including malnutrition and nutrition support is relevant to all 3 Frameworks	Thank you for your comment. The TEG recognise the importance nutrition has on wider public health. However, that is outside the scope of this specific quality standard.
001	NHS Commissioning Board Authority	Section 1	Introduction	99	It would have been helpful to have a definition of 'nutrition support' – are you including fluid management/hydration within your definition of nutrition.	Thank you for your comment. This definition has been clarified.
001	NHS Commissioning Board Authority	Section 1	Introduction	100	The introduction identifies that the draft quality standards will contribute to 'protecting them from	The TEG reviewed this comment and agreed that patient safety was a key

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					avoidable harm' which is commended. However, the patient safety aspects are not embedded in the quality measures or in the descriptions of what it means for each audience.	issue and felt that the whole of the standard was based around patient safety issues. Reference to patient safety has been strengthened
006	British Association for Parenteral and Enteral Nutrition (BAPEN)	Section 1	Introduction	101	• It would be helpful if you could please add a comment to make it explicit that nutrition will also make a significant contribution to all areas of health and social care in future outcomes frameworks too – commissioners and providers need to fully understand that nutrition is important every year (not just in the years of the outcomes frameworks quoted – which will almost appear dated by the launch of these standards) • We agree it is important to include reference back to the NHS and Adult Social Care Outcomes Framework and would recommend a link also to the Public Health Outcomes framework, as nutrition is relevant to all three Frameworks.	Thank you for your comment. The quality standard contributes to the outcomes described in the NHS and social care outcomes framework, but they are not interdependent products. The TEG recognise the importance nutrition has on wider public health. However, that is outside the scope of this specific quality standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Section 1	Introduction (page 2)	102	We recommend adding a reference link to the Public Health Outcomes Framework, in addition to the NHS Outcomes Framework and Adult Social Care Outcomes Framework, since nutrition is relevant across all of these.	Thank you for your comment. The TEG recognise the importance nutrition has on wider public health. However, that is outside the scope of this specific quality standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Section 1	Introduction (page 2)	103	We recommend that reference is made to the importance and relevance of this Quality Standard beyond the time period of the NHS Outcomes Framework 2012/2013 and Social Care Outcome Framework 2011/2012 as cited.	Thank you for your comment. The quality standard contributes to the outcomes described in the NHS and social care outcomes framework, but they are not interdependent products.
014	Nutricia Ltd	Section 1		104	We welcome the reference back to the NHS and Adult	Thank you for your comment. The

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					Social Care Outcomes Framework and would recommend a link also to the Public Health Outcomes framework, as nutrition is relevant to all three Frameworks.	TEG recognise the importance nutrition has on wider public health. However, that is outside the scope of this specific quality standard.
014	Nutricia Ltd	Section 1		105	We would recommend that reference is made to the importance and relevance of this Quality Standard beyond the time period of the NHS Outcomes Framework 2012/2013 and Social Care Outcome Framework 2011/2012 as cited.	Thank you for your comment. The quality standard contributes to the outcomes described in the NHS and social care outcomes framework, but they are not interdependent products.
017	Bassetlaw Health Partnership	Section 2	Section 2	106	Agree	Thank you.
019	Hywel Dda Health Board	Section 2	Section 2	107	Within the overview section it states that 'it is important that nutritional status is clearly documented in care plans' This needs further emphasis on the importance of the quality of information gathered through effective communication between the community to acute and vice versa (i.e. from admission through to transfer of care and all stages in between) Communication here is extremely important as well as the quality of documentation. Within this section there also needs to be some reference to prevention. These quality standards as well as promoting the importance of treating malnutrition should be used to highlight and raise awareness of the risks associated with malnutrition across all age groups as evidenced by BAPEN (Nutrition Screening data) and to strengthen services to promote high quality care. Draft quality statements – 1. comment needs to	Thank you for your comments. Training and expertise of staff has been referenced as an inherent requirement to enable quality improvement in the introductory text. St 3 (previously 2) has been strengthened with specific reference to communication of nutrition status between settings in writing St 2 (previously 3) has been reviewed and the wording amended. St 6 has not been progressed in the final quality standard. With regard to patient involvement

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					clearly state that people should be screened by those that have been trained to undertake nutritional screening. Need to elaborate that this should be the case across all care settings – Day centres/voluntary agencies/ residential/mental Health and Learning Disabilities etc. 2. – Reference here to the importance of communication and ensuring that goals are communicated and Nutrition is included on handover as an integral part of care planning. 3 – Statement three should say 'Aim to meet Nutritional Requirements' rather than provide complete requirements. 6 – Suggest that this states 'People access nutritional care the quality of which is reviewed within a governance framework by a nutrition steering group that encompasses acute/community and mental health services. Should there also be a point on - involving the patient in the nutritional care plan.. I.e. People identified as requiring NS should be involved in their own nutritional care plan where appropriate and be involved in setting their own goals which should be facilitated, monitored and supported. Malnutrition care plan to document screening results and nutrition support goals, to communicate this between services: Suggest including local Risk Assessment as to mechanism and safety of sharing personal information.	in care planning. This quality standard should be used in conjunction with the Patient experience in the NHS quality standard available at www.nice.org.uk . This make specific reference to patient involvement in care planning.
025	British Specialist Nutrition Association	Section 2	Section 2	108	We recommend the inclusion of a clear definition of what is meant by the term 'nutritional support'.	Thank you for this comment. This definition has been clarified in the

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	(BSNA)					document.
029	The British Dietetic Association	Section 2	Section 2	109	It would be helpful to include a definition of what is meant by the term 'nutrition support' within the overview.	Thank you for this comment. This definition has been clarified in the document.
009	Sheffield Teaching Hospitals	Section 2	Overview	110	Creating an integrated approach where care plans / information is communicated between services needs GPs to be on board to work as effectively as possible. As well as adequate IT systems.	Thank you for your comment. The TEG recognise the importance of all local service providers being involved and engaged in the nutrition care pathway. Reference is made in the over section of the document suggesting the need for local leadership to so support implementation of the quality standard and to provide co-ordination of the care pathway across partners. This could include IT systems.
015	Malnutrition Task Force (Malnutrition action group)	Section 2	overview	111	We recommend inclusion of a clear definition of what is meant by the term 'nutrition support' within the overview.	Thank you. This has been clarified in the document.
004	National Nurses Nutrition Group (NNNG)	Section 2	page 3	*112*	*Comment to add to the first sentence*: The nutrition support should be provided in an appropriate form with the lowest level of risk to the patient	Thank you this was reviewed by the TEG as part of the general review of the introductory text.
014	Nutricia Ltd	Section 2		113	We recommend the inclusion of a clear definition of what is meant by the term 'nutrition support' within the overview.	Thank you this has been clarified in the document.
006	British Association for Parenteral and Enteral Nutrition (BAPEN)	Section 2, question 4	Section 2, question 4	114	It is important and is certainly achievable. NHS Midlands and East are setting up a nutrition steering committee that will span the whole of the region (acute and community) so it is achievable where areas have strong clinical leadership. This SHA is also	Thank you for your comment. State 6 has not been progressed in the final version of the quality standard.

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					providing an intense support team for organisations who want to improve nutritional care (to achieve their aim of eliminating grade 2,3 and 4 pressure ulcers by December 2012). Whilst this is a particularly ambitious aim, we urge NICE to recognise what is achievable in Healthcare (demonstrated by the reductions in infection, progress towards delivery of 95% harm free care by December 2012) and to set the ambition for nutrition at an appropriate aspirational (but achievable) level.	
017	Bassetlaw Health Partnership	Section 3	Section 3	115	Reference should be made about appropriate fluid intake in the overview in Section 2, not just in this statement	The definition of malnutrition has been clarified, to be explicit about the inclusion of dehydration under this term.
017	Bassetlaw Health Partnership	Section 4	Section 4	116	No reference to managing situations where patients are non-compliant with their care plan.	Thank you for your comment. This was received by the TEG. This was not identified by the TEG as a priority for inclusion in the quality standard.
019	Hywel Dda Health Board	Section 4	Section 4	117	The quality standards need to be elaborated upon to provide further guidance. How will these quality standards be monitored? Within these quality standards there is very little on ethics of feeding/decision making in relation to Nutritional support or in fact Risk – as highlighted e.g. within NPSA guidance.	Thank you for your comment. We expect that further advice about how quality standards should be used and monitored by the NHS will come from the NHS Commissioning Board. The TEG recognise the importance of managing risk. The TEG were content that the inclusion of a statement concerning the review of any nutrition support should contribute towards management of

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						risk and ethics in providing nutritional support.
017	Bassetlaw Health Partnership	Section 5	Section 5	118	Agree, review mechanisms and frequency will need to be flexible as appropriate to client group.	Thank you for your comment
017	Bassetlaw Health Partnership	Section 6	Section 6	119	Time limited, smaller divisional Nutrition Steering Groups would be useful initially to ensure standards are put in place as appropriate to care setting but would be too costly and time consuming to sustain. Suggest post implementation standards are monitored through usual internal clinical governance mechanisms. Commissioners need to be aware that implementation of some elements of the standards will have cost implications.	Thank you for your comment. A costing and commissioning report will be published alongside the standard that will consider some potential cost implications to implementing the standard, available at www.nice.org.uk . Statement 6 concerning nutrition steering groups has not been progressed in the final quality standard.
022	South West London and St George's Mental Health Trust	Statement 1	Statement 1	120	a) …..people in appropriate care settings should read ……people in all care settings Description of what the quality statement means for each audience/people: Malnutrition isn't just '(to see if they are getting all the nutrients they need)' it is also about calories/energy which aren't nutrients. Could we include …(to see if people are getting enough to eat and all the nutrients they need) however, no nutrition tool alone will screen for people meeting their nutrient requirements, that's for clinical assessment/judgment	Thank you for your comment. This point has been clarified in the final quality standard audience descriptor.
022	South West London	Statement 1	Statement 1	121	First bulletpoint: screening where there is clinical	Thank you for your comment. The

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	and St George's Mental Health Trust				concern for outpatients is vague and in practice doesn't get done very often. Please could we consider 'at least annually with the physical health check?'	TEG have provide some clarification concerning when screening should occur, with a definition of clinical concern. The TEG considered adding further detail to when screening should take place. The suggested occasions are consistent with those stated in the NICE clinical guideline.
028	Baxter Healthcare	Statement 1		122	In the "process" statement would NICE consider adding that screening needs to be performed using validated and regularly maintained equipment (for example weighing scales, tape measures etc.).	Thank you for your comment. A measure has been added to this statement concerning availability of suitably calibrated equipment to carry out screening.
028	Baxter Healthcare	Statement 1		123	We believe that there is a gap in the care pathway at this point of the document as it does not specify the actions expected on identification of high or medium risk patients. For example "Evidence should be available that all high risk patients have a timely referral to a nutrition support team. For patients at moderate risk evidence should be available that they have suitable nutritional support and ongoing monitoring."	Thank you for your comments. The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the

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						scope of the quality standard), or already covered by existing statements.
030	Ministry of Defence (Defence Medical Services – HQ Surgeon General)	Statement 1	Screening. Definitions	*124*	*People in care homes should be screened on admission and when there is a clinical concern'* As I would regard the Defence Medical Rehabilitation Centre (Headley Court) as some what of a rehab/remedial facility and not a hospital or care home, I would like to add that the screening should be performed on the admission to the unit and monthly thereafter. This then meets the NICE guidelines Nutrition Support in Adults (Feb 2006) where Table 1 states that the Anthropometric measures should be performed at the very least, monthly. *'People in care homes/medium to long stay rehabilitation centres should be screened on admission, monthly and when there is a clinical concern'*	Thank you for your comment. The definition of settings included in St 1 has been expanded and includes all care settings which would include the rehab/medical facility you refer to.
001	NHS Commissioning Board Authority	Statement 1	Audience descriptor	125	Service provides – should not only ensure systems are in place but also that the appropriate equipment is available to offer screening for malnutrition Commissioners – should ensure that they commission services that have appropriate equipment as well as use a validated screening tool	Thank your comment. An additional measure has been included for St 1 concerning the availability of suitably calibrated equipment to enable accurate screening.
001	NHS Commissioning Board Authority	Statement 1	Equality and diversity	126	Given the results of the BAPEN Nutrition Screen Week survey I would suggest that the words 'it is appropriate for' are removed. All people should have the right to a nutritional screen. No screening tool can be used without the right equipment – even if that is a tape measure.	Thank you for your comment. This has been reviewed and amended.

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004	National Nurses Nutrition Group (NNNG)	Statement 1	Page 5	*127*	*Comment about quality statement 1*: using a validated screening tool appropriate to their condition and care environment	Thank you for your comment. This was considered by the TEG. This statement is concerned with service providers using a standard validated tool for all people in contact with the service. The chosen screening tool should be valid to be used in a number of different circumstances. It is important to emphasise that the statement is concerning with identified of risk rather than an actual diagnosis of malnutrition.
004	National Nurses Nutrition Group (NNNG)	Statement 1	Recognition-screening descriptions page 5	*128*	*Comment on point 4, sub-headed People*: should this read ....people are offered screening for malnutrition? Instead of ...people are offered checks for malnutrition?	Thank you for your comment. A user / carer version of the statement does sometimes have different wording if felt that the term used in the actual statement could be provided in more lay terms.
004	National Nurses Nutrition Group (NNNG)	Statement 1	Recognition-screening definitions-screening page 6	*129*	*Comment on last sentence of 1st paragraph under the Screening sub-heading*: MUST screening tool does not suit all patient groups therefore need to avoid being prescriptive in the document. There needs to be consistency in terminology and suggest keeping it as a validated screening tool.	Thank you for your comment . 'MUST' is used as an example of a validated tool. However, the standard does not recommend any specific screening tool.
006	British Association for Parenteral and Enteral Nutrition (BAPEN)	Statement 1		130	Will this need some sort of benchmarking - what about areas that produce unexpectedly low results for example?? Doesn't say anything about what it means in terms of	Thank you for your comment. The NHS Commissioning board will decide how quality standards are used and whether local areas /

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					training, although it does refer to this in the quality measure	service will be benchmarked. The need for staff to have relevant experience and training is included in the introductory text as a key basis for all quality standards
009	Sheffield Teaching Hospitals	Statement 1		*131*	*People are offered checks for malnutrition (to see if they are getting all the nutrients they need) etc.* the tools e.g. MUST do not assess this, the screening tools will not determine how much nutrition someone needs or the amount they are taking. This statement would require a full dietetic assessment usually performed by a registered Dietitian which would be therefore unrealistic to offer in relation to screening. All the 'tools' do is give an indication of risk of malnutrition.	Thank you for this comment. The audience descriptor for this statement has been amended accordingly.
009	Sheffield Teaching Hospitals	Statement 1		**132**	Training is important but it is the change in practice and sustaining that change which is important - also making sure that equipment is present and works i.e. all in all it empowers staff/carers	Thank your comment. An additional measure has been included for St 1 concerning the availability of suitably calibrated equipment to enable accurate screening.
009	Sheffield Teaching Hospitals	Statement 1		133	tools such as MUST that a reasonable number of "screeners" can master and apply in a reasonably short time, is only an indication that something may be wrong as it only shows changes in weight - which is probably a reasonable indicator of poor nutrition but is unlikely to identify quite a number of cases of other nutritional deficiencies. Using weight and height as an indicator is only as good as the tools used for measuring and the people doing the measuring. Widening the scope of people screened would	Thank you for your comment. The difficulty in identifying people who may be malnourished is a key factor in why statement 1 has been included in the standard. A number of settings and situations have been suggested as appropriate times to conduct screening. However we recognise the for certain populations not accessing health care services in

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					increase this inaccuracy and probably lead to complacency that needs are being met when in fact it is only the start of the process. Outcomes would be a much larger proportion of the population having been accessed by a health professional or carer which may uncover other concerns. As always this would be unlikely to access the homeless itinerant and under 65s who are in marginalised situations.	general. However this issue is outside the scope of this quality standard.
009	Sheffield Teaching Hospitals	Statement 1		134	The requirement to screen for risk of malnutrition needs to be in the QOF to progress primary care screening.	Thank you for comments. The quality standard will be reviewed for the development of potential indicators for both the Quality Outcomes Framework and the Commissioning Outcomes Framework. For the Commissioning Outcomes Framework this will involve testing of potential indicators and full public consultation.
011	Alzheimer's Society	Statement 1	General	135	There are 800,000 people with dementia in the UK. People with dementia are significant users of health and care services: one quarter of hospital beds are occupied by people with dementia, and two thirds of people in care homes have a form of dementia. There is clear evidence that people with dementia are at risk of malnutrition. Thus it is vital that the quality standard for nutrition support in adults meets the needs of people with dementia. Alzheimer's Society's Counting the Cost report (2009)	Thank you for your comments. The TEG have not specifically referred to certain at risks groups in relation to screening. However, clear descriptions of the settings and situations where screening should be conducted are included. This includes reference to re-screening at appropriate periods, particularly for those in residential care.

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					was based on a survey of 1,291 carers of people with dementia, 657 nursing staff and 479 nurse managers. The report found that 47% of carers perceived that being in hospital had a significant negative effect on the physical health of people with dementia that wasn't a direct result of the condition. Dehydration and malnutrition were key manifestations of this. 77% of carers said that they were dissatisfied with the overall quality of dementia care provided. The person with dementia not being helped to eat or drink was a key area of dissatisfaction. Counting the Cost (2009) also found that 86% of nurse managers reported that people with dementia either always or sometimes have a longer stay in hospital than people without dementia admitted with the same medical condition. This places huge financial strain on the NHS: Alzheimer's Society (2009) estimated that over £80 million a year could be stayed if people with dementia were supported to leave hospital one week sooner. Evidence submitted to the APPG on Dementia (2011) suggested that improving nutritional care was one way of improving the quality of care of people with dementia, but also reducing complications and lengths of stay in hospital. The Royal College of Psychiatrists audit of dementia care in hospitals (2011) found that nutritional assessment was being undertaken for 70% of patients nationally, but there was wide variation across hospitals, from 3% to 100%. This is clearly	

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					unacceptable; without nutritional screening and appropriate nutritional support a person with dementia may become dehydrated, malnourished, more agitated and lose weight . Screening for malnutrition and the risk of malnutrition is a vital part of overarching efforts to improve dementia care, as prioritised in the Prime Minister's Challenge on Dementia (2012). The NICE quality standard must reflect this.	
012	County Durham and Darlington Foundation Trust	Statement 1		136	Appropriate care settings rather than all care settings – then standardised throughout the statement. The statement currently states all and appropriate care settings.	Thank you for this comment. This issue has been clarified.
012	County Durham and Darlington Foundation Trust	Statement 1	draft quality measure - outcome	137	Should it be looking at the number of people screened as well as the incidence of malnutrition? There may be low incidence but if for instance only 10% of the appropriate population was screened this doesn't tell us much. This is mentioned in the process but should it not also be an outcome?	Thank you for your comment. The measures have been review and amended accordingly.
012	County Durham and Darlington Foundation Trust	Statement 1	Description; People	138	Why is this part in lay terms? If a lay person has access to the document should it not all be written in a more person centred way rather than the last statement for each description. I would have thought that the term screen is well understood as it is commonly used for other services e.g. bowel cancer screening/ breast cancer screening. This comment is relevant for each of the draft statements i.e. why is this the only part of the document in lay terms?	Thank you for your comment. As far as possible the lay / patient version of the statement is consistent with that in the full document. However, at times a decision is made to amend the wording to present the statement in lay terms.
012	County Durham and Darlington Foundation	Statement 1	Description; People	139	Is there a tool proven to work that will check if an individual is getting all the nutrients they need? That	Thank you for your comment. This issues has been clarified in the final

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	Trust				is more of an assessment than a screen – the screening process would highlight anyone who would then need the full assessment?	version of the standard.
012	County Durham and Darlington Foundation Trust	Statement 1	Definitions	140	Is prolonged intercurrent illness the same as long term condition? Should there be examples of groups/diagnosis associated with malnutrition e.g. COPD, heart failure, Parkinsons Disease, cancer	Thank you for your comment. The TEG didn't decide to focus on any specific conditions as the scope of the standard is concerned with general nutrition support for anyone at risk.
012	County Durham and Darlington Foundation Trust	Statement 1	Definitions	141	People in care homes should be screened monthly not just where there is clinical concern – there is a risk of missing and not treating many residents at risk of malnutrition if just done when there is clinical concern. The majority of homes now screen on a monthly basis as a matter of course and this client group are a high risk group for being at risk of under nutrition.	Thank you for your comment. A measure has been included concerning re-screening in the final quality standard.
012	County Durham and Darlington Foundation Trust	Statement 1		142	What about social care settings other than care homes – e.g. domiciliary carers	Thank you for your comment. This standard includes social care settings and additional details have been included in the definition section.
		Statement 1	Recognition – Screening. Draft Measure	143	In order to support consistency, and in the future, comparisons between the performance of different CCGs, it would be helpful for the Denominator to be defined with more specific and rigid parameters. As written it refers to 'all people in a care setting', which is later defined as 'any care setting where there is a clinical concern about any risk of malnutrition'. Thus different Commissioners and Providers may report on this differently.	Thank you for your comment. The measures have been reviewed and amended by the TEG.
014	Nutricia Ltd	Statement	Recognition -	144	Query: As this quality statement is focused only on	Thank you for your comment. Yes

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
		1	Screening Draft Measure		process (i.e. whether or not screening takes place), is it possible to put forward an outcome measure? Or is the intent here merely to state that data would be available on the incidence rates of malnutrition?	your description is correct.
014	Nutricia Ltd	Statement 1	Recognition - Screening Draft Measure	145	We support the intent to gather incidence data for malnutrition, however in order to do this, further provision needs to be made for a feasible, practical and consistent way to record and analyse local data recorded. If incidence rather than prevalence data are recorded, provision must be made to do this on a continual basis over time.	Thank you for your comment. At this stage local areas will decide how they wish to record information such as this. This may be reviewed by the NHS Commissioning board to formalise data collection.
014	Nutricia Ltd	Statement 1	Recognition – Screening General	146	Reference is made through Quality Statement 1 to the use of 'a validated screening tool', thus giving target stakeholders flexibility in how they will screen and record malnutrition. However this flexibility will make translation of the Standard into meaningful COF indicators challenging. In particular, if different tools are used, comparisons of data across different care settings and between CCGs would be less meaningful. We would advocate the expert panel to put forward just one screening tool. Our understanding is that MUST is the most widely used tool.	Thank you for your comment. The TEG make reference to 'MUST' as an example. However, this is not the only screening tool available and there isn't an evidence base that shows that 'MUST' is the most effective screening tool available. Therefore it would be inappropriate to recommend this tool alone. The quality standard will be reviewed for the development of potential indicators for both the Quality Outcomes Framework and the Commissioning Outcomes Framework. For the Commissioning Outcomes Framework this will involve testing of potential indicators and full public consultation. Issues such as the one described here will be part of any

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
						review.
014	Nutricia Ltd	Statement 1	Recognition-Screening. Definitions: Settings	147	The standard provides very clear direction on who and how frequently people should be screened within the hospital setting. In the free-living community the suggestions made are less directive. In order to support Commissioners and Providers, we advocate the inclusion of more specific guidance as to what is best practice as a minimum (in addition to screening when the clinical concerns are outlined) for example: - Screening should be performed as part of routine health checks (including unpaid carers health check), mandated in over 65s and 70s checks and when flu/pneumonia injections are given - As part of key checks for people with chronic conditions (COPD, Dementia, Stroke, Cancer, wounds) - On discharge from hospital into community Further guidance or resource should also be given as to the frequency for screening within the community.	Thank you for your comment. Further detail has been added to the settings following review by the TEG.
015	Malnutrition Task Force (Malnutrition action group)	Statement 1		148	• Re: 'Description of the what the quality statement means for each audience' – [Para re:] 'People' – the suggested screening method will not reveal whether people 'are getting all the nutrients they need', only whether they are getting enough energy • The process will not guarantee the outcome; the numerator needs to be amended to read 'The number of people in the denominator who are screened and found to be malnourished or at risk from malnutrition	Thank you for your comments. The measures and definitions for this statement have been reviewed by the TEG and amended in the final quality standard.

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					using a validated screening tool' • Training in the correct use of the screening tool would be a key issue (Structure) • Screening in community – it is important to consider how those who don't go to GP, have health checks, flu jabs etc. could be identified • Currently adherence to policy in screening people in social care is linked to audit of care records. This is a process carried out in the location but not all social care providers undertake such audits or reviews. However, the Care Quality Commission do already sample care records during compliance reviews and they include screening for malnutrition in those reviews. • In order to support consistency, and in the future, comparisons between the performance of different CCGs, it would be helpful for the Denominator to be defined with more specific and rigid parameters. As written it refers to 'all people in a care setting', which is later defined as 'any care setting where there is a clinical concern about any risk of malnutrition'. Thus different Commissioners and Providers may report on this differently. • **Query:** As this quality statement is focused only on process (i.e. whether or not screening takes place), is it possible to put forward an outcome measure? Or is the intent here merely to state that data would be available	

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					on the incidence rates of malnutrition? • We support the intent to gather incidence data for malnutrition but in order to do this, further provision needs to be made for a feasible, practical and consistent way to record and analyse local data recorded. If incidence rather than prevalence data are recorded, provision must be made to do this on a continual basis over time. • Reference is made through Quality Statement 1 to the use of 'a validated screening tool', thus giving target stakeholders flexibility in how they will screen and record malnutrition. However this flexibility will make translation of the Standard into meaningful COF indicators challenging. In particular, if different tools are used, comparisons of data across different care settings and between CCGs would be less meaningful. We would advocate the expert panel to put forward just one screening tool. • The standard provides very clear direction on who and how frequently people should be screened within the hospital setting. In the free-living community the suggestions made are less directive. In order to support Commissioners and Providers, we advocate the inclusion of more specific guidance as to what is best practice as a minimum (in addition to screening when the clinical concerns are outlined) for example:	

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					- Screening should be performed as part of routine health checks, mandated in over 65s and 70s checks and when flu injections are given - As part of key checks for people with chronic conditions (COPD, Dementia, Stroke, Cancer, wounds) - On discharge from hospital into community • Further guidance or resource should also be given as to the frequency for screening within the community. • Should be strengthened to include addressing malnutrition in the community • This quality statement should also contribute to the public health outcomes framework domain 2 (diet) • Structure: b) should include domiciliary care workers too • Data source -process I) local data collection - should include commissioners lhwb boards and primary care - focus is totally on in pt care settings	
028	Baxter Healthcare	Statement 1	Measure	149	We welcome this Standard which promotes regular screening for all patients in each care setting. However, we would like to suggest that an addition point c) is added to the "Structure" section to ensure that screening is carried out to a protocol. Would NICE consider adding point c) Evidence of local arrangements that a screening protocol is in place and maintained which ensures screening is carried out and	Thank you for your comment. The way in which local service implement the statements is left up to local commissioners and providers to agree. NICE publish a costing and commissioning guide alongside the quality standard that will support implementation.

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					repeated at regular intervals as clinically appropriate.	
028	Baxter Healthcare	Statement 1	definitions	150	In the first bullet point under "settings", we agree that all hospital in patients and out patients should be screened (on admission or at their first clinic appointment). Would NICE consider making this definition more explicit for patients undergoing major surgery by adding that patients need to be regularly screened prior to and following major surgery until completely discharged from the service.	Thank you for your comment. The TEG reviewed what was included under the heading settings and did make some amendments to provide more detail and clarify where they felt it was needed.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 1	Draft Quality Measure (page 5)	**151**	**Structure:** What is meant by 'appropriate' care settings? Suggest that 'appropriate' be reworded to provide greater clarity. The draft quality statement reads 'all care settings', which we suggest using consistently.	Thank you for your comment. This term has now been removed with more detail added to the definition section.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 1	Draft Quality Measure (page 5)	**152**	**Structure:** Reference is made to the use of 'a validated screening tool'. We suggest that the Expert Panel proposes just one screening tool, for example the 'Malnutrition Universal Screening Tool', as this will help to standardise the screening process and additionally how malnutrition is documented within care plans. Standardisation would also support the translation of the Standard into meaningful COF indicators and would better enable comparison of data across different health and social care settings, and between CCGs.	Thank you for your comment. The TEG make reference to 'MUST' as an example. However, this is not the only screening tool available and there isn't an evidence base that shows that 'MUST' is the most effective screening tool available. Therefore it would be inappropriate to recommend this tool alone
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 1	Draft Quality Measure (page 5)	**153**	**Outcome:** We support the intent to gather incidence data on malnutrition, but suggest that this requires clarification as the incidence of malnutrition cannot be established for the population as a whole, only within the population screened. If incidence data are to be recorded (rather than prevalence), provision should	The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard.

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					also be made to enable the ongoing collection of these data over time. We would additionally suggest that to achieve this outcome, adequate provision needs to be made to enable data collection and analysis in a consistent manner. In the longer-term, it would be helpful for the outcome to be linked to improvements in the number of people being screened within a population, and to a decrease in the incidence of malnutrition (as a consequence of effective nutrition care plans being implemented in a timely manner).	The measures have been revised for the final quality standard to improve clarity.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 1	Description of what… (page 5)	**154**	**People:** We suggest that screening will not necessarily tell individuals whether they are receiving 'all the nutrients they need' and that this description should be revised accordingly e.g. they should be routinely screened for malnutrition risk.	Thank you for this comment. This issue has been clarified in the final standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 1	Draft Quality Measure (page 5)	**155**	**Process:** There is a need to be consistent with language and it would be helpful if the denominator could be described in more specific terms. The Quality Statement refers to 'people in all care settings', but this is later defined as in 'any' or in 'a' care setting. Commissioners and Providers may interpret and report on this differently, so to avoid confusion and support consistency we suggest this be revised. This could better enable direct comparisons between the performance of different CCGs in the future.	Thank you for your comment. The language has been clarified and is now consistent throughout.
029	The British Dietetic Association	Statement 1	Draft Quality Measure	156	There appears to be some inconsistency regarding settings e.g. mentions 'all people in a care setting',	Thank you for your comment. The language has been clarified and is

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					latterly refers to 'any care setting where there is a clinical concern about any risk of malnutrition'. Draft quality measure process suggestive of an opt out opportunity to carry out nutritional screening within all care settings.	now consistent throughout
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 1	Definitions (page 6)	**157**	**Settings:** The Draft Quality Standard provides very clear direction on who should be screened and how frequently people should be screened within the hospital setting, but it is less directive on screening in the community and care home settings. Whilst we appreciate that this is in alignment with the recommendations in CG32, in order to support best practice, we advocate the inclusion of more specific guidance regarding for these care settings. For example, while we support routine screening on admission to care homes (3rd bullet point), the terminology 'when there is clinical concern' is open to interpretation. We suggest that this be revised to 'screening should be repeated weekly' (as for hospital in-patients). Appropriate and timely identification of nutritionally 'at risk' individuals in care homes (and subsequent care plan development) would also help the CQC to meet their target for nutrition and hydration.	Thank you for your comment. Further detail has been included in the definitions section concerning settings. The TEG have to ensure that as far as possible the definitions and additional information included in the quality standard is based on the best available evidence and be careful not to suggest actions where the evidence base hasn't been reviewed.
004	National Nurses Nutrition Group (NNNG)	Statement 1	Recognition-screening definitions-settings page 6	*158*	*Comment on 1st bullet point under settings*: screening should be repeated weekly for inpatients or if conditional changes occur within this period and done when there is clinical concern for outpatients. *Comment on 3rd bullet point under settings*: screening	Thank you for your comment. Further detail has been included in the definitions section concerning settings. The TEG have to ensure that as far as possible the definitions and additional information included

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					in care homes should be on admission then monthly thereafter or when there is clinical concern	in the quality standard is based on the best available evidence and be careful not to suggest actions where the evidence base hasn't been reviewed.
029	The British Dietetic Association	Statement 1	Draft Quality Measure	159	This statement is focused only on a specific process around whether or not screening takes place. Would it be helpful to incorporate an outcome measure here?	Thank you for your comment. Outcome measures are stated where the topic expert group felt these were appropriate, which include patient and carer-reported outcomes.
029	The British Dietetic Association	Statement 1	Draft Quality Measure	160	Nationally and locally the incidence of malnutrition will be of benefit in relation to size of problem and resources to treat, however given there is variation in methods further provision needs to be made for a feasible, practical and consistent way to record and analyse data recorded. Also is it helpful to measure incidence or prevalence or both and according to sub-categories or does this over complicate matters?	Thank you for your comments. The way in which data will be collected and measured nationally and locally is outside of the remit of this quality standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 1	Description of what… (page 5)	**161**	**Service providers:** Suggest that this statement is strengthened by replacing 'to *offer* screening' with 'to *undertake* screening'.	The quality standard uses 'offer' in the wording of the headline statements to support patient choice. Often, 'received' is used in the measures in order to assist with measurability, audit and reporting. Reflecting choice will be particularly important when measuring achievement against statements using the quality measures.
029	The British Dietetic	Statement	Draft Quality	162	Reference is made to the use of 'a validated screening	Thank you for your comment. The

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	Association	1	Measure General		tool', in clinical practice and amongst the dietetic profession it is apparent that some screening tools have not been tested for "validity" i.e. reproducibility, inter-rata reliability. Whilst a degree of flexibility may be welcomed this may result in variation in screening and recording malnutrition. Have the expert group considered the impact and how one might overcome the potential variability if different tools are used. A recent survey of nationally based tools in the community (Holdoway, 2012) suggested 'MUST' was the most frequently referenced in GP / community guidelines, could 'NICE' be bold and recommend just one validated universal tool or otherwise provide a clearer indication on validity of tools.	TEG make reference to 'MUST' as an example. However, this is not the only screening tool available and there isn't an evidence base that shows that 'MUST' is the most effective screening tool available. Therefore it would be inappropriate to recommend this tool alone. A definition of "validated" has been included in the statement.
029	The British Dietetic Association	Statement 1	Definitions: Settings	163	The standard provides very clear direction on who and how frequently people should be screened in the hospital / secondary care setting. In the community the suggestions are more vague. For commissioners / providers to act appropriately is it possible to give more specific guidance on screening in the community for example, taking into account the "high risk" groups, would it be best practice to perform screening including frequency e.g. older people, those with chronic conditions such as COPD particularly in acute exacerbations, cancer within and after treatment, dementia, those who have had a CVA, those with pressure ulcers, plus those recently discharged from hospital. When should screening be repeated in the	Thank you for your comment. Further detail has been included in the definitions section concerning settings. A measure has been included

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					community? For community settings, a suggested frequency for re-screening should be included e.g. monthly for care home residents (and patients living in their own home when it is highlighted that they are at risk). Would it be useful to add a comment around "as per local/national guideline agreement"? This should refer to a wider range of care settings, for example community services visiting patients at home, and local authority care services. Given that the prevalence of malnutrition is highest in the community, screening in the listed care settings is a missed opportunity in relation to early identification of the problem. Add 'validated screening tools' to definitions. Not all screening tools in use are validated.	referring to re-screening and additional information included in the definitions section. A definition of validated has been included in the final standard.
029	The British Dietetic Association	Statement 1	Description	164	Would be useful to allocate a timeframe for screening. Would be useful to add a comment around "as per local/national guideline agreement". People – "using a tool that is proven to work" - consider changing to .a validated screening tool.	Thank you for your comments. The measures have been reviewed and amended where deemed necessary.
012	County Durham and	Statement		165	Rather than screened for malnutrition & risk of	Thank you for your comment. This

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	Darlington Foundation Trust	1			malnutrition – just screened for risk of malnutrition. This would need to be standardised throughout the document	has been amended in the final quality standard.
012	County Durham and Darlington Foundation Trust	Statement 1		166	Should it read a validated nutrition screening tool rather than a validated screening tool – this would need to be standardised throughout the document.	Thank you for your comment. This has been clarified in the final document.
012	County Durham and Darlington Foundation Trust	Statement 1		167	Would it be helpful to give an example of a screening tool	An example is included in the definitions section of the quality standard.
005	Dorset County Council	Statement 1	definitions	168	Settings = People in care/ nursing homes. I feel that this should be completed for all residents a minimum of monthly. Knowing care homes they need the guidance to be prescriptive. Monthly is expected by CQC.	Thank you for this comment. A measure has been added concerning re-screening.
008	Motor Neurone Disease Association	Statement 1		169	In the clinical guideline on nutrition, 'malnutrition' is defined as: "a state in which a deficiency of nutrients such as energy, protein, vitamins and minerals causes measurable adverse effects on body composition, function or clinical outcome." For the purposes of this quality standard, and quality statement 1 in particular, we urge that a wider view of malnutrition be taken, so that screening is undertaken for factors that may give rise to malnutrition, or to the need for enteral or parenteral nutrition in order to prevent malnutrition occurring. This approach is implicit within the concept of 'risk of malnutrition' but should be drawn out more directly. It should be specified that screening and assessments should consider a person's changing nutritional needs	Thank you for your comments. The TEG have not specifically referred to certain at risks groups in relation to screening. However, clear descriptions of the settings and situations where screening should be conducted are included. The statement specifically refers to the use of a validated screening tool. This should be effective in identifying risk of malnutrition in a broad sense.

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					over the course of an illness. The definition of 'clinical concern' should include consideration of a known illness that may affect a person's ability to take nutrition on board, for instance by causing dysphagia. The MND Association's clinical guideline on nutrition states with reference to screening: "A combination of body composition measures (dietary histories, BMI, biochemical tests, anthropometry) is recommended to achieve accurate assessment of nutritional status."	
010	University Hospital North Staffordshire NHS Trust	Statement 1	Outcome	170	Could add numbers/percentage of health and social care workers trained to use validated screening tool	A measure is included concerning rates of staff training.
010	University Hospital North Staffordshire NHS Trust	Statement 1	Outcome	171	Could look at percentage of people who have been rescreened at the appropriate interval	Thank you for your comment. A measure has been included concerning re-screening rates.
010	University Hospital North Staffordshire NHS Trust	Statement 1	Definitions /settings	172	People in care homes should be screened on admission and when there is clinical concern. It is suggested that there is some guidance provided for rescreening, such as monthly , quarterly or six monthly depending on the care home setting.	Thank you for your comment. Additional details have been included concerning re-screening in the statement definitions.
026	Royal College of Speech and Language Therapists	Statement 1	Page 6	173	"Clinical concern" also need to include something about social isolation due to depression, grief etc. Common in older people. Linked to reduced intake and swallow problems (see Ekberg et al 2002, Social and psychological burden of dysphagia: its impact on diagnosis and treatment.)	Thank you for your comment. The definition used concerning clinical concern has been taken from the NICE clinical guideline 32. These are examples of clinical concern is not an exhaustive list.
026	Royal College of Speech and Language	Statement 1		174	Healthcare outcomes? Initially this would be in prevention i.e. that more "at risk" people were	Thank you for your comments. This is the intention of statement 1 and is

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	Therapists				identified and so steps could be taken to ensure that they don't get (more) malnourished?	reflected in the rationale section of the statement.
027	British Pharmaceutical Nutrition Group	Statement 1		175	Re:Q1 Quality statement does not require an intervention therefore a health outcome cannot be associated with this statement	Thank you for this comment. The TEG agreed with this point.
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Statement 1		176	This should refer to a wider range of care settings, for example community services visiting patients at home, and local authority care services. Given that the prevalence of malnutrition is highest in the community, screening in the listed care settings is a missed opportunity in relation to early identification of the problem.	Thank you for your comment. Further detail has been added to the definition of "settings", recognising the importance of screening within community based services.
019	Hywel Dda Health Board	Statement 1		179	Agree that numbers of patients screened needs to be captured in all 'care settings' - need to elaborate on this however to include reference e.g. to voluntary sector / day care / residential / Mental Health and EMI etc. Numbers of patients screened can be captured but also suggest need to capture numbers trained on identifying and treating malnutrition as well as the training delivered (i.e. levels of training differ and dependant on skills i.e. training may focus on awareness i.e. prevention or screening therefore need to break this down to capture true outcomes. Section on what the quality statement means for the audience and 'people' – vague, should we be looking here at the patients experience / involvement in their own nutritional care plan (if appropriate) as well as quality indicators that show an improvement in nutritional status highlighted through a reduction in nutritional risk.	Thank you for your comment. Further detail has been added to the definition of "settings", recognising the importance of screening within community based services. A measure is included concerning training rates amongst health and social care staff in conducting screening with a validated tool. The TEG have reviewed the other comments and reviewed and amended the measures where appropriate.

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					Within the section on 'Settings' and Definitions – Feel there needs to be some further emphasis on the range of settings here i.e. Pre-assessment / out-patient clinics / care settings / Day care and Residential / Mental Health and Learning Disabilities etc. Considerations – Need to include here that Consent to screening and for some client groups 'weighing' is very important e.g. in Palliative care. Under screening it should state that screening should be complete a minimum of weekly rather than 'weekly' or in accordance with the outcome of the screening? Day care settings should be included i.e. chemotherapy units. Incidence Rate can be monitored by BAPEN Screening week – this could be included in NICE as a nationwide recommendation. A template could be included in the NICE documentation with a list of changes/signs to look for indicating risk and actual malnutrition, i.e. make the NICE documentation more user-friendly to enable printing off a sheet for individual patient use. There is no mention of self- screening tools that could be sued in outpatient settings while patients are waiting to see consultants. Examples of low risk options could be included here.	
023	South West Yorkshire Partnership NHS Foundation Trust	Statement 1		180	Before I start my comments I would like to say that I fully endorse the nutrition support quality statements and therefore my comments are not intended to be criticisms of all the hard work which has gone into developing these.	Thank you for your comments. The details included in the definitions section are consistent with the content of the NICE clinical guideline 32. The TEG did discuss the issue of

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					I worked closely with the Yorkshire region when we were developing the first nutrition support CQUINs. I am also the Trust lead for the current local nutrition support CQUIN so I have considerable experience in data collection processes for the targets. I am assuming that these quality standards may eventually be used as local targets or indeed become CQUINs themselves. Therefore most of my comments relate to the practicalities of data collection. However, I do also have one or two clinical concerns. Concern: *'Screening should be **repeated weekly** for inpatients'.* I think that screening should only be repeated weekly for those identified to be at high risk. Weekly screening for those found to be at low risk is probably a waste of resources and unnecessarily intrusive to patients. I suggest that those **not** at risk should only be rescreened if there are nutritional concerns (as stated in the GP section). This is especially relevant in mental health settings.	re-screening and the relevant timeframe. The timeframe included in the definitions was deemed to be the most appropriate.
023	South West Yorkshire Partnership NHS Foundation Trust	Statement 1		181	The frequency of the repeating of screening should depend on the setting.	Thank you for your comment. The TEG did discuss the issue of re-screening and the relevant timeframe. The timeframe included in the definitions was deemed to be the most appropriate
024	Nottinghamshire Healthcare NHS Trust	Statement 1	description of the quality statements	182	People: Is the idea to have patient friendly language as I don't think the statement for malnutrition: 'to see if they are getting all the nutrients they need' is correct: a screening tool is not designed to assess all	Thank you for your comment. The wording has been reviewed and clarified in the final quality standard.

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					nutrients, more an assessment of protein energy status. I am also not sure the phrase 'proven' to work is correct, it is a validated tool.	
024	Nottinghamshire Healthcare NHS Trust	Statement 1	Definitions	183	Bullet point number one should be split into 2 separate point . Screening for hospital inpatients Screening outpatients Although this is the outline provided by NICE re screening there needs to be much clearer guidance on screening in outpatients: does this mean any outpatient with any health discipline? Consideration needs to be given with regards to the infrastructure needed to support patients at risk if screened in this setting and how this can be audited	Thank you for your comments. The TEG have reviewed the definitions section of the statement and made amendments where required.
024	Nottinghamshire Healthcare NHS Trust	Statement 1	Equality and Diversity	184	Although the MUST tool can be used in a variety of population groups, at present there is no differing cut off for BMI for different ethnic groups taking into consideration differing body composition	Thank you for your comment. Where possible, any screening or intervention should made reasonable adjustments to take into consideration any differences seen amongst different populations.
024	Nottinghamshire Healthcare NHS Trust	Statement 1	Definitions	185	Comment about quality statement 1 – definitions, People in care homes should be screen on admission and when there is clinical concern. Should this not be done on a routine basis, eg fortnightly or monthly I would be concerned that people would be missed.	Thank you for your comment. A process measure has been included concerning re-screening.
024	Nottinghamshire Healthcare NHS Trust	Statement 1	People	186	In section regarding – People ; in statement re malnutrition, screening tool not designed to assess clients intake of 'all' nutrients as this implies in the	Thank you for your comment. The wording for this audience descriptor has been reviewed and amended.

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					sentence 'see if they are getting all the nutrients they need' Would suggest possible change in wording?	
024	Nottinghamshire Healthcare NHS Trust	Statement 1	Definitions	187	Point 1 : Could point be separate for hospital in patients and outpatients regarding screening Point 3 : Should there be recommendation regarding frequency screening should be undertaken?	Thank you for your comment. Frequency of screening / re-screening was discussed by the TEG and a measure and some additional detail included under the statement.
025	British Specialist Nutrition Association (BSNA)	Statement 1	Measure: Process	188	In order to support consistency, and in the future, comparisons, between the performance of different CCGs, it would be helpful for the Denominator to be defined with more specific and rigid parameters. As drafted currently, the Quality Standard refers to 'people in all care settings', which is later defined as 'any care setting where there is a clinical concern about any risk of malnutrition'. This could result in different Commissioners and Providers reporting on this differently.	Thank you for your comments. This has been clarified and it consistent within the document.
025	British Specialist Nutrition Association (BSNA)	Statement 1	Screening measure	189	As this Quality Statement is focussed only on process (i.e. whether or not screening takes place), is it possible to put forward an outcome measure? Or is the intent here merely to state that data would be available on the incidence rates of malnutrition? We support the intent to gather incidence data for malnutrition, however in order to do this, further provision needs to be made for a feasible, practical and consistent way to record and analyse local data recorded. If incidence rather than prevalence data are recorded, provision must be made to do this on a continual basis over time.	Thank you for your comments. Yes the intent of the statement is that the process happens. The way in which local data is gathered and monitored is outside the remit of this quality standard.

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					General- Reference is made to the use of 'a validated screening tool', which provides flexibility for target stakeholders as to how they will screen and record malnutrition. However, this flexibility will make translation of the Standard into meaningful COF indicators challenging. In particular, if different tools are used, comparisons of data across different care settings and between CCGs would be less meaningful. We would advocate the expert panel to put forward just one screening tool. Our understanding is that the Malnutrition Universal Screening Tool ('MUST') is the most widely used tool.	Thank you for your comment. The TEG make reference to 'MUST' as an example. However, this is not the only screening tool available and there isn't an evidence base that shows that 'MUST' is the most effective screening tool available. Therefore it would be inappropriate to recommend this tool alone. A definition of "validated" has been included in the statement
025	British Specialist Nutrition Association (BSNA)	Statement 1	People	190	We suggest that screening will not necessarily tell individuals whether they are receiving 'all the nutrients they need' and that this description should be revised accordingly e.g. they should be routinely screened for malnutrition risk.	Thank you for your comment. This has been reviewed and amended accordingly.
025	British Specialist Nutrition Association (BSNA)	Statement 1	Definitions settings	191	The draft Quality Standard provides very clear direction on who should be screened and how frequently people should be screened within the hospital setting. It is less directive however, on screening in the free-living community setting. In order to support Commissioners and Providers, we advocate the inclusion of more specific guidance as to what is best practice as a minimum (in addition to screening when the clinical concerns are outlined), for example: - Screening should be performed as part of routine health checks, mandated in over 65s and 70s checks and when flu injections are given; - As part of key checks for people with chronic	Thank you for your comment. Further detail has been included in the definitions section concerning settings. The TEG have to ensure that as far as possible the definitions and additional information included in the quality standard is based on the best available evidence and be careful not to suggest actions where the evidence base hasn't been reviewed.

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					conditions (chronic obstructive pulmonary disease (COPD), dementia, stroke, cancer, chronic renal failure, wounds); - On discharge from hospital into the community. We recommend that further guidance or resource should also be given as to the frequency for screening within the community.	
009	Sheffield Teaching Hospitals	Statement 2	Question 3 and 4	193	Probably standard 2 is the most important because it would be likely to improve outcomes for patients as it makes it much more likely that any needs identified will be met - but of course this can't take place without an effective screening programme. Quality 5 would be better rolled into quality 2 by adding that the care plans should be regularly reviewed by a health care professional or suitably trained carer. Statement 5 seems very wordy and complicated and could lead to misinterpretation.	Thank you for your comment
027	British Pharmaceutical Nutrition Group	Statement 2	Question 4	194	STATEMENT 2 requires additional demands regarding treatment plan, interventions and review	Thank you for your comment.
027	British Pharmaceutical Nutrition Group	Statement 2	General	195	No reference made to transfer of information/screening results/nutritional care plans between clinical settings	Thank you for your comment. This statement (now St 3) has been amended to refer to communication of results and nutrition support goals being communicated in writing between settings.
001	NHS Commissioning Board Authority	Statement 2	Data Source	196	The Essence of Care has a section on care planning	Thank you for your comment.
006	British Association for Parenteral and Enteral Nutrition (BAPEN)	Statement 2		197	Is it worth giving examples on nutrition support goals here? Is this going to be for a general audience?	Thank you for your comment. This standard has been revised following comments and no longer refers to

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					To be consistent do you also need an outcome measure and state that this should be >95% (or number agreed with commissioners). Also should there be a definition of what you mean by key stages of their care - for example within 24 hours of admission for hospital inpatients?	key stages of care. The achievement rate for all quality statements is 100% attainment.
009	Sheffield Teaching Hospitals	Statement 2		198	This is just a screen! It needs to be followed by a full assessment, looking at the problems then problem solving by looking at options, having SMART plans which support the goal - why not have a goal for a MUST of 0, 1 or 2 and more! Food first - and I know there is little evidence except most of us have managed to grow and have our nutritional needs met by food alone!! - needs higher profile	The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline

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						recommendations continue to be implemented.
009	Sheffield Teaching Hospitals	Statement 2		199	Once people are screened a fuller assessment is required to determine nutritional goals, as the majority of screening tools do not determine individual nutritional problems. Once identified at risk the nutritional problems of the individual should be identified and the nutritional care plan developed to address these-this is missing from statement 2.	The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The quality standard contains key markers of clinical and cost effective care across a care pathway. It remains important that other evidence-based guideline recommendations continue to be implemented.

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009	Sheffield Teaching Hospitals	Statement 2		200	So many screeners would be unable to formulate an effective care plan and would be unable to identify nutritional needs other than calories from the screen to put in the care plan. Some standard care plans could be written but again these would be unlikely to lead to all nutritional needs being safely met - thus leading to risk because of false confidence in their effectiveness.	Thank you for your comment. One of the measures for statement 1 refers to training in using a screening tool. It is anticipated that this would include training as to when to refer someone to more specialist services if risk of malnutrition is identified.
009	Sheffield Teaching Hospitals	Statement 2		*201*	*Commissioners should ensure etc.* and that information on nutritional care is shared between healthcare professionals involved in the care of the individual…i.e. electronically!	Thank you for this comment. The statement has been amended to emphasise the importance of communicating in writing someone's nutrition support requirements when transferring between settings
011	Alzheimer's Society	Statement 2	General	202	Alzheimer's Society supports this proposal to ensure that a person's screening results and nutrition support goals are clearly documented in their care plan. Recording and communicating nutritional needs is a key way of preventing malnutrition and dehydration. A copy of the care plan should also be made available to either the person with dementia, and/or their carer, as appropriate. This will allow the person with dementia and their carer to be involved with their nutritional care. On a person's discharge from hospital, whether to another care setting or the person's own home it must also be ensured that any care staff or other individuals involved in their care (such as family	Thank you for this comment. The statement has been amended to emphasise the importance of communicating in writing someone's nutrition support requirements when transferring between settings

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					members) after discharge are aware of nutritional needs or support with nutrition that is needed, so that the persons wellbeing can be maintained within their own home. Alzheimer's Society believes that the care plan should stipulate how much help the person needs with eating and drinking. Lack of help with eating and drinking was one of the biggest areas of dissatisfaction for carers identified in our Counting the Cost (2009) report, with 68% of respondents being dissatisfied with this area of care. For example, one carer told us: *' My mother is in the later stages of Alzheimer's and needs help and encouragement to eat and drink, this help was lacking on the ward and often her food/drink was taken away uneaten or with very little eaten'.* The Royal College of Psychiatrists (2011) have found that while 96% of hospitals had assessment procedures in place that included assessment of a person with dementia's nutritional status, only 74% had systems to ensure that staffing levels were sufficient at mealtimes to aid people with dementia to eat and choose food, if necessary. NICE should consider whether this could be included within the quality standard.	
012	County Durham and Darlington Foundation Trust	Statement 2	Draft quality measure	203	Is there an outcome for this measure? Such as % of people identified at risk of undernutrition with an appropriate care plan	Thank you for your comment. The TEG have reviewed the measures and made amendments where appropriate.

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012	County Durham and Darlington Foundation Trust	Statement 2	Description; service providers	204	Should there be a statement about ensuring that nutritional screening and support goals are transferred across care settings e.g. between wards/ acute to community and acute to community	Thank you for this comment. The statement has been amended to emphasise the importance of communicating in writing someone's nutrition support requirements when transferring between settings
012	County Durham and Darlington Foundation Trust	Statement 2	Description; People	205	See statement above in statement 1.	Thank you for your comment.
012	County Durham and Darlington Foundation Trust	Statement 2	Definitions; Goals	206	The aim and *treatment* of any nutritional support care is documented in the care plan.	Thank you for your comment.
012	County Durham and Darlington Foundation Trust	Statement 2	Definitions; Key stages	207	Another example of transfer of care is community to acute which is often overlooked.	Thank you for your comment. This was taken into account by the TEG
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 2	Documentation of results and nutrition goals.	208	We believe that this standard is critical in supporting best practice as we recognise that screening alone will not lead to a reduction in malnutrition nor to improvements in the nutritional care delivered. We suggest that it could be helpful to provide recommendations on how to ensure continuity of nutritional care as individuals move between different health and social care settings.	Thank you for this comment. The statement has been amended to emphasise the importance of communicating in writing someone's nutrition support requirements when transferring between settings
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 2	Documentation of results and nutrition goals. Draft Quality Measure (page 8)	**209**	**Outcome:** No indication of an appropriate outcome measure is currently provided. This may be appropriate as this Quality Statement is process focussed.	Thank you for your comment. Yes this is a process based statement.

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013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 2	Documentation of results and nutrition goals. Draft Quality Measure (page 8)	**210**	**People:** Comments as previously. We suggest that screening will not necessarily tell individuals whether they are receiving 'all the nutrients they need' and that this description should be revised accordingly e.g. they should be routinely screened for malnutrition risk.	Thank you for your comment. This wording has been reviewed and amended.
014	Nutricia Ltd	Statement 2	Documentation of results and nutrition goals	211	This is an essential standard as we recognise that screening results in themselves do not drive best practice, they must be linked to a relevant goal for the individual. It would be helpful for guidance to give recommendations on how to ensure continuity of care and documentation of the goals with the patient as they move between different care settings. Consideration should be given to how this could be achieved (e.g. 'nutrition passport'?)	Thank you for this comment. The statement has been amended to emphasise the importance of communicating in writing someone's nutrition support requirements when transferring between settings
014	Nutricia Ltd	Statement 2	Definitions	212	Key Stages: we recommend that transitioning from paediatric to adult services is explicit within these examples.	See above comment
015	Malnutrition Task Force (Malnutrition action group)	Statement 2		213	The BAPEN 'MUST' screening tool would not identify the nutrients people need. This would need to be carried out by a registered dietitian as part of a detailed nutritional assessment This is an essential standard as we recognise that screening results in themselves do not drive best practice, they must be linked to a relevant goal for the individual. It would be helpful for guidance to give recommendations on how to ensure continuity of care	Thank you for this comment. The statement has been amended to emphasise the importance of communicating, in writing, someone's nutrition support requirements when transferring between settings.

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					and documentation of the goals with the patient as they move between different care settings. Consideration should be given to how this could be achieved (e.g. 'nutrition passport'?)	
028	Baxter Healthcare	Statement 2	statement	214	The inclusion of screening results and nutritional support goals in care planning documentation is welcomed. Would it be possible to clarify that the care plan referred to is a long term multi-professional care plan that is shared across all care settings.	Thank you for your comment. The definitions section of the statement has been reviewed as a result of changes to the wording of the statement.
029	The British Dietetic Association	Statement 2	Measure	215	An Outcome is needed for quality measure – Incidence rates of malnutrition actually recorded.	Thank you for your comment. The measures have been reviewed and amended as a result of changes made to the wording of the quality statement.
029	The British Dietetic Association	Statement 2	Documentation of results and nutrition goals	216	This is an essential standard as in clinical practice it is frequently observed that screening does not result in actions in those at risk, it is essential that screening is linked to a management plan / relevant goal / outcome. Also how do practitioners, community professionals, providers, ensure continuity of care, goal setting over time and when moving between care settings. Possible solutions should be considered / provided, would a patient held record help to facilitate this? (as is done for some chronic diseases at present) BMI should be recorded along with the MUST score. Query as to whether there is a read code for a MUST score to support with monitoring? Also consideration should be given to how this data will be reviewed.	Thank you for this comment. The statement has been amended to emphasise the importance of communicating, in writing, someone's nutrition support requirements when transferring between settings. The way in which activity will be monitored and reviewed is outside the remit of this quality standard.

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					Bearing in mind the 3 dimensions of quality referred to in the introduction which include risk, and the specific discussion around Dysphagia it is surprising that there is no reference to Dysphagia within the body of the document.	The TEG did discuss specific conditions, and were happy that the standard was relevant to all areas where risk of malnutrition is increased.
005	Dorset County Council	Statement 2	Description - People	217	I don't believe MUST checks whether or not people are having the right nutrients but purely their risk of malnutrition. This is repeated elsewhere.	Thank you for your comment. This issue has been reviewed and clarified.
008	Motor Neurone Disease Association	Statement 2		218	Reference to malnutrition screening results under 'Description of what the quality statement means for each audience' should explicitly refer, additionally, to screening for risk of malnutrition. This is no doubt intended to be implicit, as this formulation has been used in the sections above; it should however be made explicit to avoid ambiguity. This reference to risk is vital in respect of MND, where the often rapid progression of the disease means that timely and sometimes anticipatory interventions are needed: if the intervention comes too late, the individual's condition may have changed again before it is provided, so they will be unable to benefit from it. In the specific case of a gastrostomy (PEG or RIG), it is often recommended that the individual has it fitted before it is required, as the progression of the disease can lead to respiratory weakness or other problems that make the operation unsafe by the time dysphagia has become a serious problem. The important of this	Thank you for your comments. The TEG recognise that this standard does not cover some key issues for certain conditions. This standard should be used alongside more specialist guidelines / recommendations for conditions where more specific care is required.

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					aspect of assessment will become particularly clear in relation to quality statement 3, dealing with treatment,	
010	University Hospital North Staffordshire NHS Trust	Statement 2		219	Include evidence of rescreening at the appropriate interval	Thank you for your comment. A measure has been included concerning re-screening in statement 1.
026	Royal College of Speech and Language Therapists	Statement 2		220	It is unclear how the NICE CG 32 statements 1.9.1/2/5 relate to documentation. CG32 section 1.9 is about "Supporting patients in the community". The documentation stuff is in Appendix D of CG32.	Thank you for your comment. The TEG agreed that good documentation is implicit in these recommendations.
026	Royal College of Speech and Language Therapists	Statement 2		221	Healthcare outcomes? As for QS 1 initially this would be in prevention i.e. that more "at risk" people were identified and so steps could be taken to ensure that they don't get (more) malnourished?	Thank you for your comment. This was taken into account by the TEG when reviewing the measures.
027	British Pharmaceutical Nutrition Group	Statement 2		222	Re: Q1 Quality statement requires only documentation of a care plan it does not require intervention therefore a health outcome cannot be associated with this statement	Thank you for your comment.
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Statement 2		223	BMI should be recorded along with the MUST score. Query as to whether there is a read code for a MUST score to support with monitoring? Also consideration should be given to how this data will be reviewed.	Thank you for your comment. The way in which activity will be monitored and reviewed is outside the remit of this quality standard.
019	Hywel Dda Health Board	Statement 2		225	Within Draft quality statement – need to include people should have their screening results documented but specifically their 'nutritional score' and outcome. Should there be reference here to the fact that goals should be patient centred (Reference to NICE Clinical Guideline 138 – Patient experience)	Thank you for your comment. The wording of this statement has been amended to include documentation of results. It is inherent across the quality standard that patient centred care is provided.

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023	South West Yorkshire Partnership NHS Foundation Trust	Statement 2		226	Concern: *All people who are screened for malnutrition or the risk of malnutrition* ***have their screening results and nutritional support goals (where applicable), documented in their care plan*** *at key stages of their care.* I have concerns regarding the separation of nutrition screening from care planning as they should all constitute one process. Many nutrition screening tools have a nutrition action plan as part of the tool so are therefore 'care plans' in themselves. Screening tools are also usually embedded within the patient records it doesn't make sense for staff to then transfer the score to elsewhere in the notes in another 'care plan'. This is duplication and could lead to error. Presence of the completed screening tool in the notes should constitute '*documented in the care plan'* and would make data collection for audit far easier. Screening tools which also contain nutrition care planning guidelines should constitute '*nutritional goals documented in care plan'* Concern 2: I have concerns as to how data will be collected from **care plans**. If screening scores and nutrition goals are to be documented separately in care plans, this would be extremely difficult to audit electronically, since care plans in electronic records are 'free text'. This	Thank you for your comment. Statement 2 (now statement 3) has been amended following comments and now focuses on documentation in general and communication of screening results and goals, in writing, between settings. Thank you for your comment concerning data collection. It is accepted that for some statements within the quality standard, the IT

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					would necessitate manual audits which are inefficient and outdated in the era of electronic patient records. Additionally I am unsure as to which care plan the statement refers to. Patients often have a number of care plans – often a care plan for each different profession. If they are at high risk and have been referred to the dietitian then they will have a dietetic care plan. If they are at medium risk they will have a nursing care plan. Again this will complicate the data collection if it unclear which care plan should be audited. I'm also not sure of how you would collect data for 'key stages of their care'. How would the auditor know what these key stages were?	infrastructure is not in place to conduct electronic audits and case note review would be required.
024	Nottinghamshire Healthcare NHS Trust	Statement 2		227	What is the outcome?	This is primarily a process statement. Outcome measures are stated where the topic expert group felt these were appropriate and where there was evidence that the action described in the statement was associated with a specific outcome.
024	Nottinghamshire Healthcare NHS Trust	Statement 2	Data source	228	It refers to data collection a) and b) what does b) relate to?	Thank you for your comment. This has been clarified.
024	Nottinghamshire Healthcare NHS Trust	Statement 2	Definitions	229	'where applicable': should this also include that for some patients nutrition support may not be an appropriate intervention and in these cases it should be clearly documented why	Thank you for this comment. It is anticipated that clinical decisions such as this would be documented in someone's care plan.
024	Nottinghamshire Healthcare NHS Trust	Statement 2	Definitions	230	Should 'Key Stages' include 'change in clinical condition'	Thank you for your comment. The reference to key stages of care has

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						now been removed from the statement.
024	Nottinghamshire Healthcare NHS Trust	Statement 2	Definitions	231	Comment about quality statement 2- definitions- Key stages. Also need to included that the information can come from primary care into secondary care, that it is a 2 way process.	Thank you for your comment. The reference to key stages of care has now been removed from the statement.
024	Nottinghamshire Healthcare NHS Trust	Statement 2	Data Source	232	Regarding Data Source: suggest clarity needed regarding 'local data collection' – clarity required regarding this in relation to stated 'structure, process and outcome'	Examples of existing national data collection which may be relevant, in part at least, to the quality measure are referenced where appropriate. It is expected that local data sources and audits where appropriate will be considered in order to measure the quality statements in full.
024	Nottinghamshire Healthcare NHS Trust	Statement 2	Definitions	233	In 'where applicable' section – if nutrition support input is not appropriate - would need to document why	Thank you for this comment. It is anticipated that clinical decisions such as this would continue to be documented in someone's care plan
025	British Specialist Nutrition Association (BSNA)	Statement 2	General	234	This is an essential Statement as we recognise that screening results in themselves do not drive best practice, they must be linked to a relevant nutrition support goal for each individual. It would be helpful to provide recommendations on how to ensure continuity of care and documentation of the goals with the patient as they move between different care settings. Consideration should be given to how this could be achieved (e.g. 'nutrition passport').	Thank you for this comment. The statement has been amended to emphasise the importance of communicating, in writing, someone's nutrition support requirements when transferring between settings.
025	British Specialist Nutrition Association (BSNA)	Statement 2	Definitions: key stages	235	We suggest that another example of a key stage of care is the transfer from paediatric to adult care.	Thank you for your comment. The reference to key stages of care has now been removed from the

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						statement.
001	NHS Commissioning Board Authority	Statement 3		236	Please consider including something about the appropriate care setting in the statement. This should be threaded throughout the measures, descriptors and equality and diversity sections.	Thank you for your comment. This was considered by the TEG when reviewing the wording of the statements.
001	NHS Commissioning Board Authority	Statement 3	Definitions	237	The first mention of 'fluid'. Poor fluid management, both in relation to dehydration and over- hydration are significant patient safety issues.	Thank you for your comment. The TEG agreed the significant patient safety issues associated with dehydration. The definition of malnutrition has been clarified to include dehydration
004	National Nurses Nutrition Group (NNNG)	Statement 3	Treatment-Description page 10	*238*	*Comment on point 4 in the description of what the quality statement means*: People who need nutritional support (help to get all the nutrients they need) are offered one or more kinds of treatment, appropriate to their needs.....	Thank you for your comment. The wording of this statement has been amended in the final quality standard.
006	British Association for Parenteral and Enteral Nutrition (BAPEN)	Statement 3		239	Not clear how you are defining nutrition support - needs clarity particularly in relation to the ongoing food first / supplement debate. Nutrition support could include offering additional food and snacks in the first instance - but as stated implies ONS.	Thank you for your comment. The definition of nutrition support has been reviewed and amended.
009	Sheffield Teaching Hospitals	Statement 3		240	Agree complete nutritional requirements need to be provided, consumed and utilised but all forms of food should be offered first where the individual is able to take oral intake - hence include food fortification, etc	Thank you for your comment. The definition of nutrition support has been reviewed and amended
009	Sheffield Teaching Hospitals	Statement 3		241	gives a subtle message that a complete diet can only be achieved in many people by the addition of non-food e.g. oral nutritional supplements. There could be a danger that, as this is NICE, it is actually a guidance to supplement rather than a directive to get proper	Thank you for your comment. The definition of nutrition support has been reviewed and amended, and is clear that help with eating and dietary advice are included in this

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					nutritional help from a trained professional.	definition.
009	Sheffield Teaching Hospitals	Statement 3		242	The outcome of measure of nutritional status….does this mean that there is documented in the patient's notes a measure of their nutritional status? However, to us, the statement appears to be about providing guidance to achieve their nutritional requirements. Therefore the outcome is documented nutritional care plan to achieve individual requirements.	Thank you for your comment. The topic expert group reviewed all measures and outcomes in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity.
011	Alzheimer's Society	Statement 3	General	243	Alzheimer's Society believes that this quality statement could go further by requiring evidence that individuals have been involved in decisions made about their nutrition support and treatment. This may also include discussion with their carer, who may know the person with dementia best, and have some insight into their eating preferences and habits that might inform their nutritional care.	Thank you for your comment. The TEG agreed the importance of involving patients in all decisions about their care. The quality standard as a whole is intended to be patient / person centred. A link is also included in the standard to the Patient experience quality standard which is a cross cutting standard for all care services.
012	County Durham and Darlington Foundation Trust	Statement 3		244	This statement needs to clarify what form of nutritional support it relates to e.g. EN, PN or ONS or all of them. The statement says that it is in combination with any dietary intake but artificial nutrition support implies EN & PN and not ONS. Can ONS also relate to food fortification and not just ONS?	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified.
012	County Durham and Darlington Foundation Trust	Statement 3	Outcome	245	How is nutritional status going to be measured?	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue

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						should now have been clarified.
012	County Durham and Darlington Foundation Trust	Statement 3	Outcome	246	This standard is about treatment rather than incidence of malnutrition – should there be an outcome around number of people who receive nutritional support?	Thank you for your comment. The topic expert group reviewed all measures and outcomes in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 3	Treatment Statement	247	This standard is essential to ensure that individuals who have been identified as malnourished, or at risk of malnutrition, have access to the nutritional support they require, whether via the oral, enteral or parenteral routes. We suggest that the statement could be modified slightly to improve clarity and better link it to Quality Statement 1 (screening) e.g. 'In addition to any dietary intake, people who have been identified at risk of malnutrition receive nutrition support to ensure their complete nutritional requirements are met'.	Thank you for your comment. The wording of this statement has been amended in the final quality standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 3	Treatment. Draft Quality Measure (page 10)	**248**	**Structure:** In line with our comments above regarding Statement 3, we suggest that the wording for (a) be amended to provide greater clarity.	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 3	Treatment. Draft Quality Measure (page	**249**	**Structure:** We suggest that 'nutrition' be inserted between the words 'appropriate' and 'support' for clarity.	Thank you for your comment. The wording of the statement and associated measures and definitions

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			10)			have been amended. This issue should now have been clarified
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 3	Treatment. Draft Quality Measure (page 10)	**250**	**Process:** We suggest that the process section requires further consideration and clarification. Should the intention be to determine how many people identified as malnourished receive nutritional support, in which case the denominator should read 'the number of people identified at risk of malnutrition'? We are unclear where the information required for the current denominator would be found e.g. there is no requirement to collect data on the 'number of people who need nutrition support' within Quality Statement 2.	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 3	Treatment. Draft Quality Measure (page 10)	**251**	**Outcome:** We propose that the outcome measure be worded in such a way that it links back to Quality Statement 2. It could be perceived as difficult to measure 'nutritional status' in the community setting especially, and this term is also open to different interpretations e.g. weight / BMI, biochemical parameters, anthropometric measurements. An example of an outcome measure could be the number of people who have met their nutritional goals (how this is achieved and monitored would vary according to the individual and the healthcare setting).	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 3	Treatment. Description of what quality statement means for each audience	**252**	**General:** Please see our previous comments on the wording of the Quality Statement in order to provide greater clarity e.g. 'In addition to any dietary intake, people who have been identified at risk of malnutrition receive nutrition support to ensure their complete nutritional requirements are met'.	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified

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			(page 10)		**Health and Social Care Professionals and Commissioners:** We recommend that these statements are strengthened to ensure patients receive the treatment they require, revising 'aims to provide' to 'provides'.	
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 3	Treatment. Definitions (page 11)	**253**	**Complete nutritional requirements:** We welcome the clarification provided regarding the term 'complete nutritional requirements'. This is particularly important as many nutritional support strategies serve only to increase protein and calorie intakes, without any consideration for micronutrients, fibre or hydration.	Thank you for your comment
014	Nutricia Ltd	Statement 3	Treatment Statement	254	We support the sentiments of this statement but recommend amending the wording so it better links to the first two statements e.g. 'People who are at risk of malnutrition who receive nutrition support in addition to dietary intake'. Statements 1 and 2 refer to screening for malnutrition risk, however statement 3 refers to people who need nutritional support. However there is no statement to clarify how to make the step from screening for malnutrition, to determining who needs nutrition support. It would be helpful to clarify what is meant by 'any dietary intake'. Does this mean the person's normal dietary intake, or adjusted dietary intake as part of the nutrition support package?	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified

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					To meet 'complete nutritional requirements' may not be possible in all individuals or possible to measure, it may be more appropriate to reference back to meet the nutritional goals, as set under standard 2; and/or to link back to screening result for malnutrition risk.	
014	Nutricia Ltd	Statement 3	Treatment Measure	255	Wording of structure to be amended in line with comments made above on the statement. Recommend denominator amended to 'number of people at risk of malnutrition'.	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified
014	Nutricia Ltd	Statement 3	Treatment Measure	256	Outcome: The measure of nutritional status is not defined and could mean anything from BMI, to detailed assessments of micronutrient status etc and the latter would not be feasible to measure in a GP setting. Suggestions for alternative outcomes would be: 1. To measure outcomes as people who have met their goals set under Statement 2, which will be different per individual depending on their clinical concern (e.g. weight gain; hand grip strength etc) 2. Prevalence and incidence rates of malnutrition 3. Relevant and meaningful health economic measures – please see comments under question 1 at the end of this document on malnutrition on admission and readmission to hospital; together with reference to quality of life and patient experience measures.	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified
014	Nutricia Ltd	Statement	Treatment	257	Pls see previous comments on wording and comments	Thank you for your comment

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
		3	Description of what quality statement means for each audience		about feasibility of meeting their complete nutritional requirements and reference to 'any' dietary intake and 'any' nutrients.	
014	Nutricia Ltd	Statement 3	Treatment Definitions	258	As 'meeting complete nutritional requirements' is not clearly defined, and could require more complex analysis (such as assessing plasma levels of certain nutrients). It would not be feasible, therefore, for the majority of Healthcare professionals e.g. in a GP setting to assess if complete nutritional requirements have been met. It would be feasible for such HCPs to assess if malnutrition risk had been reduced based on screening results or to assess against specific goals set.	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified
015	Malnutrition Task Force (Malnutrition action group)	Statement 3		259	• The treatment needs to take into consideration all the factors that influence an individual's ability to maximise their nutrition needs, e.g. eating support - adapted crockery and cutlery, prompting to eat, environment, eating pattern etc. • There are 2 distinct elements in this statement. The term "Treatment" infers a healthcare professional decision is made to provide a treatment programme. From a social care perspective there would be a responsibility to enable a referral to a health professional; and also to implement and follow a treatment plan which has been developed. Could this be more clearly indicated in the description of what the statement means for different audiences, as health and social care professional would have different	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended. The issues you raised should now have been clarified.

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					responsibilities • We support the sentiments of this statement but recommend amending the wording so it better links to the first two statements e.g. 'People who are at risk of malnutrition who receive nutrition support in addition to dietary intake'. • Statements 1 and 2 refer to screening for malnutrition risk, however statement 3 refers to people who need nutritional support. However there is no statement to clarify how to make the step from screening for malnutrition, to determining who needs nutrition support. • It would be helpful to clarify what is meant by 'any dietary intake'. Does this mean the person's normal dietary intake, or adjusted dietary intake as part of the nutrition support package? • To meet 'complete nutritional requirements' may not be possible in all individuals or possible to measure, it may be more appropriate to reference back to meet the nutritional goals, as set under standard 2; and/or to link back to screening result for malnutrition risk. • Wording of structure to be amended in line with comments made above on the statement. • Recommend denominator amended to 'number of people at risk of malnutrition'. • Outcome: The measure of nutritional status is not defined and could mean anything from BMI, to detailed assessments of micronutrient status etc and the latter would not be feasible to measure in a GP setting.	

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					Suggestions for alternative outcomes would be: 4. To measure outcomes as people who have met their goals set under Statement 2, which will be different per individual depending on their clinical concern (e.g. weight gain; hand grip strength etc) 5. Prevalence and incidence rates of malnutrition • Relevant and meaningful health economic measures • Please see previous comments on wording and comments about feasibility of meeting their complete nutritional requirements and reference to 'any' dietary intake and 'any' nutrients. As 'meeting complete nutritional requirements' is not clearly defined, and could require more complex analysis (such as assessing plasma levels of certain nutrients). It would not be feasible, therefore, for the majority of healthcare professionals e.g. in a GP setting to assess if complete nutritional requirements have been met. It would be feasible for such HCPs to assess if malnutrition risk had been reduced based on screening results or to assess against specific goals set.	
028	Baxter Healthcare	Statement 3	statement	260	We believe that the patients' involvement in their own care is vital and as such would like to suggest that the Quality Statement should be rewritten to ensure that the patient is given informed choices about their care. Would NICE consider making the statement read "People who need nutrition support are educated and advised about alternative treatment options(including location of care) so that they are	Thank you for your comment. The TEG agreed the importance of involving patients in all decisions about their care. The quality standard as a whole is intended to be patient / person centred. A link is also included in the standard to the Patient experience quality standard

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					empowered and involved in decisions about the most appropriate treatment. Treatment should be timely, uncomplicated, subject to regular monitoring and review."	which is a cross cutting standard for all care services.
028	Baxter Healthcare	Statement 3	Outcome	261	The outcome currently covers a narrow measure of nutritional status. However there may be other unintended consequences of artificial nutritional support such as port/PEG site infection, dental issues or metabolic complications. Would NICE consider widening the remit of this outcome measure?	Thank you for your comment. The topic expert group reviewed all measures and outcomes in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity
029	The British Dietetic Association	Statement 3	Statement	262	Statements 1 and 2 refer to screening for malnutrition risk; however statement 3 refers to people who need nutritional support. However there is no statement to clarify how to make the step from screening for malnutrition to determining who needs nutrition support. Perhaps stating "aiming to meet/provide their complete nutritional requirements" may be more meaningful than as 'complete nutritional requirements' may not be possible in all individuals. Also for continuity of care the statement perhaps extend this point to include "no longer required" i.e. "providing their complete nutritional requirements until such time that nutritional support is no longer	Thank you for your comments. The topic expert group prioritised the areas of care they felt were most important for patients, based on the development sources listed. The topic expert group prioritised areas of care where practice is variable, or where implementation could have a significant impact on patient care and improved outcomes, and where there is potential to generate measurable indicators. All suggestions for additional statements were discussed by the topic expert group who considered they were inappropriate for

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					required", this provides an end point. With regard to measuring this in practice: how would this be measured in practice? Registered Dietitians may be capable of this assessment based on comparing intake with estimated requirements but given the knowledge of the majority of professionals unless all patients are under care of Dietitian or a professional with similar expertise is such a standard achievable? Would it be more helpful to include a treatment statement relating to nutritional goals, as set under standard 2; and/or to link back to changes in scores for screening result for malnutrition risk?	inclusion (for example, outside the scope of the quality standard), or already covered by existing statements. The wording of the statement and associated measures and definitions have been amended.
029	The British Dietetic Association	Statement 3	Draft Quality Measure	263	" People who need nutritional support (help to get all the nutrients they need) are offered one or more kinds of treatment… Suggest the addition of a line stating 'as appropriate to the needs of the patient'	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended.
029	The British Dietetic Association	Statement 3	Measure	264	Recommend denominator amended to 'number of people at risk of malnutrition'. Outcome – requires further definition. Are we measuring rates of malnutrition or rates of screening?	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended.
029	The British Dietetic Association	Statement 3	Measure	265	The measure of nutritional status is not defined and could mean anything from weight, BMI, more detailed assessments from food diaries / clinical assessments. One needs to consider how feasible and affordable it is to achieve such measures in a community setting.	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended.

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					Could the outcome measures be broadened as they may differ according to method of nutrition support e.g. weight gain, weight stability, normal BMI, hand grip strength, activities of daily living, independence, avoidance of readmission to hospital, quality of life, patient related outcomes , acceptability of treatment., compliance. Outcome: Should this include more detail i.e. weight, BMI, % weight change, risk of malnutrition? Can Outcome be linked to whether the goal(s) has been met? Meeting nutritional requirements may not be realistic and the goal may be to optimise nutritional intake and minimise weight loss / maintain QOL	
029	The British Dietetic Association	Statement 3	Description	266	Is it correct to say 'any' dietary intake and 'any' nutrients. Is the word 'any' superfluous? The linkages between quality measures 1 & 2 (screening and assessment) and quality measure 3 should be highlighted. Wording should be amended to reflect the fact that any treatment would be offered after screening. Providing complete nutritional requirements may not always be the treatment aim, for example, end of life care. It would be more beneficial to state that treatment is offered in line with nutritional support goals.	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended.

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					Should reference be made to swallowing assessments where indicated? The outcome measure 'measure of nutritional status' nutritional status is a challenging outcome to measure, consideration should be given to what this will consist of. This statement reads that there is an assumption is that people who need help to get all the nutrients they need will inevitably need 'treatments that aim to provide them with nutrients they do not get from the food they eat'. A more appropriate statement would be 'People who need nutritional support are offered treatments that ensure adequate dietary intakes supplemented with nutritional support products where appropriate' This reflects the importance of highlighting the principle of a food first approach here.	
029	The British Dietetic Association	Statement 3	Definitions	267	'Meeting complete nutritional requirements' is not clearly defined, is this achievable and affordable, it may require tests, blood /plasma analysis and as such may not be possible for the majority of professionals particularly in the community setting.	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended.
012	County Durham and Darlington Foundation Trust	Statement 3		268	Is it realistic to be having the standard that nutrition support will provide complete nutritional requirements? This is what we would all aim for but not always achievable	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended.
008	Motor Neurone	Statement		269	The definition of 'nutritional support' should be	Thank you for your comments. The

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	Disease Association	3			expanded so that it explicitly includes interventions to assist swallowing, such as referral to a speech and language therapist when dysphagia is detected, referral to an occupational therapist and physiotherapist for assistance with aids and positioning, and other interventions to aid swallowing.	wording of the statement and associated measures and definitions have been amended.
026	Royal College of Speech and Language Therapists	Statement 3		270	Nutritional support CG 32 1.6.7 states "*Healthcare professionals should ensure that the overall nutrient intake of oral nutrition support offered contains a balanced mixture of protein, energy, fibre, electrolytes, vitamins and minerals*." And not what the new document says….	Thank you for your comment. This point has now been clarified.
026	Royal College of Speech and Language Therapists	Statement 3	p11	271	Good point about cultural issues – most diets can be worked around this.	Thank you for your comment.
027	British Pharmaceutical Nutrition Group	Statement 3		272	Re: Q1 Offer of treatment does not necessarily lead to treatment uptake therefore no health outcomes can be associated with this statement	Thank you for your comment. The expectation is that this process would lead to an action that would have a direct impact on rates of malnutrition.
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Statement 3		273	Wording should be amended to reflect the fact that any treatment would be offered after screening. Providing complete nutritional requirements may not always be the treatment aim, for example, end of life care. It would be more beneficial to state that treatment is offered in line with nutritional support goals. It is also important to highlight the principle of a food first approach here. Should reference be made to swallowing assessments where indicated? The outcome measure 'measure of nutritional status' nutritional status is a challenging outcome to	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended

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					measure, consideration should be given to what this will consist of.	
001	NHS Commissioning Board Authority	Statement 3	Question 1	274	Can you suggest any appropriate healthcare outcomes for each individual quality statement: 1. Quality Statement 3 – Improvement in nutritional status or no further decline in nutritional status	Thank you for your comment. The topic expert group reviewed all measures and outcomes in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity
019	Hywel Dda Health Board	Statement 3		276	First section describing 'providing complete nutritional Requirements' – suggest this be changed to 'Aim to meet nutritional requirements/achieve these. Goals should be realistic based on individual assessment. Further emphasis in this section on what we can specifically measure in relation to nutritional treatment - this section needs to be elaborated upon, e.g. Measuring Food First initiatives, whether ONS are prescribed and taken effectively, whether Enteral Nutrition prescription is received as prescribed, whether information on nutrition is effectively received on admission and on transfer of care, whether protected mealtimes is delivered/Red tray system, whether documentation is effective e.g. screening, goals of treatment, food and fluid record charts, whether nutrition goals and treatment is monitored i.e. is screening reviewed at regular intervals. In terms of evidence for artificial feeding – a summary	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended

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					of training on ANS could be provided. BANS data could be used to measure this. Outcomes in terms of measuring nutritional status need to be elaborated upon – i.e. screening score / weight/ functional Ability/patient outcomes etc. Again within this section there needs to be emphasis on client centred goals and treatment. Within section on equality and diversity – people's special dietary requirements should be elaborated upon e.g. to include texture modification etc. Outcome here is measuring nutritional status: this would need to refer to the protocol for nutritional, anthropometric and clinical monitoring (NICE CG32) in making the assessment. It should refer to the definitions of malnutrition in NICE 32 to categorise nutritional status. Assessing that a patient is able to meet their complete nutritional requirements: this can be done by a Registered Dietitian. Local protocols/guidance would need to be in place to enable other HCP's make this judgement. Also prescribed ONS /vitamin mineral supplements may need to be included in local guidance for those on ONS to make sure that patients are enabled to meet 'complete requirements'. Specific guidance on whether to meet Lower reference Nutrient Intakes or Reference Nutrient Intakes (appropriate for 97% of the population) but which may not take into account disease specific requirements) should be included. Where enteral nutrition support is recommended, the	

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					use of feeds nutritionally complete in a specific volume or calorie intake should be recommended.	
020	Royal College of Psychiatrists	Statement 3		277	In considering the equality aspect of this standard, it should be noted that treatment should be available irrespective of the cause of the malnutrition. Whereas some mental health problems which may lead to malnutrition, eg dementia, would be seen as worthy of inclusion, there is a danger that in others, eg depression, anorexia nervosa, the patient is seen as 'choosing' not to eat sufficiently, and therefore not eligible for nutritional support in the same way.	Thank you for your comment. The equality considerations have been reviewed and amended to refer to this potential issue.
021	Royal College of Nursing	Statement 3		278	There is no mention in this about commissioning appropriately trained staff to support people who are unable to self manage. The treatment needs to include this.	Thank you for your comment. The TEG agreed that training was a key issue and reference has been made to this in the introductory text for the standard
022	South West London and St George's Mental Health Trust	Statement 3		279	Draft quality statement 3: 'people who need nutrition support are offered treatment……..With ONS (oral nutrition support) there are choices of different types and flavours of supplement. In my experience these choices have not often been made available to the patient, it is an essential quality statement that choice of supplements is made available, i.e. yoghurt-style supplements, juice and milk based supplements, pudding supplements and powder to mix with milk)	Thank you for your comment. The TEG agreed the importance of involving patients in all decisions about their care. The quality standard as a whole is intended to be patient / person centred. A link is also included in the standard to the Patient experience quality standard which is a cross cutting standard for all care services.
023	South West Yorkshire Partnership NHS Foundation Trust	Statement 3		280	Concern: *a) Evidence of local arrangements to ensure that people who need nutrition support are offered a treatment that, in combination with any dietary*	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended

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					intake, ***provides them with their complete nutritional requirements*** This would require a manual trawl through the notes to ensure that the dietitian/clinician has provided a full breakdown of the nutritional requirements. In addition, the audit would also need to check the calculations based on weight and BMR to check that the nutritional prescription recommended by the Health Care Professional (HCP) met the actual requirements (i.e. the auditor would need to be a dietitian to do this). This would take an inordinate amount of time to check calculations for every patient admitted at high risk. Calculating nutritional requirements is a core part of the dietitians training. I'm not sure that the quality standard should be auditing the ability of an HCP to do their job. The standard would be better worded as *People who need nutrition support are referred to a health care professional, who can ensure that they receive treatment that, in combination with any dietary intake, provides their complete nutritional requirements'.* In other words the referral to the appropriate health care professional should be the standard rather than whether a person has the ability to accurately calculate their requirements correctly.	

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					Concern: *b) Evidence of local arrangements to ensure that care settings are able to provide appropriate support* ***including artificial feeding*** *when needed.* Mental health nurses are not trained in the administration of enteral feeds so artificial feeding is rarely undertaken in mental health beds/hospitals. Mental Health Wards should therefore be exempt from the statement.	
023	South West Yorkshire Partnership NHS Foundation Trust	Statement 3		281	It is not always possible or realistic to provide the treatment of full nutritional requirements, for example with Dementia Patients, where they are running around or are not hungry, and in these instances the Dietitians would be trying to ensure that they maintain the patients weight (prevent further weight loss).	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended
024	Nottinghamshire Healthcare NHS Trust	Statement 3		282	Although a key recommendation in the NICE guidelines, assessment of **complete nutritional** requirements will be a very difficult quality measure to assess. A Dietitian will have the skills to assess **complete nutritional** requirements (as outlined in the definition) but not all people requiring nutrition support will see a Dietitian. How would this be audited?	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended
024	Nottinghamshire Healthcare NHS Trust	Statement 3	Measure	283	I don't think that '**measure of nutritional status'** is the correct outcome, how could this be measured?	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified.

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024	Nottinghamshire Healthcare NHS Trust	Statement 3		284	Does there need to be some acknowledgement that the treatment offered needs to be taken to provide their complete requirements quality statement 1	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended
024	Nottinghamshire Healthcare NHS Trust	Statement 3	Measure	285	How /who will work out their nutritional requirements? There needs to be some recognition that this not something that is just identified easily	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended
024	Nottinghamshire Healthcare NHS Trust	Statement 3	Description of what quality Statement means- people	**286**	**People** who need nutritional support (help to get all the nutrients they need) are offered one or more kinds of treatment that aim to provide them with any nutrients ~~they don't get~~ from the food they eat … nutrient deficient in the food they eat. I feel that is a better way of saying the same thing.	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified.
024	Nottinghamshire Healthcare NHS Trust	Statement 3	Measure	287	As regards 'outcome – measure of nutritional status'- think this needs more information and clarity as to how this will be achieved	Thank you for your comment. The wording of the statement and associated measures and definitions have been amended. This issue should now have been clarified.
025	British Specialist Nutrition Association (BSNA)	Statement 3		288	We support the sentiments of this Statement but recommend amending the wording so it better links to the first two Statements e.g. 'People who are at risk of malnutrition who receive nutrition support that, in combination with any dietary intake, provides their complete nutritional requirements'. Statements 1 and 2 refer to screening for malnutrition risk, however Statement 3 refers to people who need nutritional support. As it is currently drafted, there is no Statement to clarify how to make the step from	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended.

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					screening for malnutrition, to determining who needs nutrition support. To meet 'complete nutritional requirements', it may be more appropriate to reference back to meet the nutritional goals, as set under Statement 2; and/or to link back to screening result for malnutrition risk.	
025	British Specialist Nutrition Association (BSNA)	Statement 3	Structure measure	289	In line with our comments made above regarding Statement 3, we recommend that the wording of the Structure should be amended.	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended
025	British Specialist Nutrition Association (BSNA)	Statement 3	Process measure	290	We recommend that the denominator is amended to 'number of people at risk of malnutrition'.	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended
025	British Specialist Nutrition Association (BSNA)	Statement 3	Outcome measure	291	The outcome measure 'nutritional status' is not defined and could be interpreted to mean anything from body mass index, to a detailed assessment of micronutrient status, the latter of which would not be feasible to measure in a GP setting. Suggestions for alternative outcomes would be: 1. To measure outcomes as people who have met their nutrition support goals set under Statement 2, which will be different according to the individual and dependent on clinical concern (e.g. weight gain, hand grip strength etc.); 2. Prevalence and incidence rates of malnutrition; 3. Relevant and meaningful health economic measures – please see our response to Question 1 regarding malnutrition on admission and readmission to hospital; together with reference to quality of life	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					and measures of patient experience.	
025	British Specialist Nutrition Association (BSNA)	Statement 3	Description of what quality statement means for each audience	292	In line with our comments made above regarding Statement 3, we recommend that the wording of the Description should be amended. We also recommend that the descriptions of what the Quality Statement means for Commissioners and People who need nutrition support should be amended to state 'treatment that provides'; as it is currently drafted, we consider that 'aiming' to provide treatment is not the same as providing treatment.	Thank you for your comments. The wording of the statement and associated measures and definitions have been amended
014	Nutricia Ltd	Statement 4	Question 1	293	For Quality Statement 4, as stated previously, an outcome measure of effective training of patients and carers would be to reduce unnecessary hospital visits/A&E visits due to problems with artificial nutrition. E.g. an outcome indicator could be: 'Number of emergency hospital admissions over 12m due to problems with artificial nutrition'.	Thank you for your comment. The TEG discussed the outcome measures and agreed to have a more general outcome concerning adverse events / complications. This would include emergency hospital admissions.
001	NHS Commissioning Board Authority	Statement 4	Measure and audience descriptor	294	This measure starts to embrace elements of patient safety and should not be restricted to people that self-manage their own artificial nutrition support.	The TEG reviewed this comment and agreed that patient safety was a key issue and felt that the whole of the standard was based around patient safety issues. This statement focuses on the significant patient safety issues associated with self- managed artificial nutritional support.
004	National Nurses Nutrition Group (NNNG)	Statement 4	Self-management quality measure page 12	*295*	*Comment on point a) & b) sub-headed structure*: Suggest re-wording to: Evidence of local arrangements to ensure that systems are in place for people (and/or the carers of people) managing their own artificial nutrition support	Thank you for your comments. These comments were considered by the TEG when they reviewed the statement wording.

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					to:- a) be trained to recognise and respond to adverse changes in their wellbeing and in the management of their nutritional delivery system b) be able to contact a specialist for advice if they identify any adverse changes in wellbeing and in the management of their nutritional delivery system	
004	National Nurses Nutrition Group (NNNG)	Statement 4	Self-management description page 13	*296*	*Comment on point 4, sub-headed people, in description on what the quality statement means to the audience*: This statement is also relevant for section 3 on page 11	Thank you for your comment.
006	British Association for Parenteral and Enteral Nutrition (BAPEN)	Statement 4		297	The term self management might become ambiguous if we are going towards self screening - perhaps refine to call self-management of artificial nutritional support (presumably not including ONS here) - although defined lower down I think the title of the statement could be clearer.	Thank you for your comment. This has been clarified in the final quality standard.
009	Sheffield Teaching Hospitals	Statement 4		298	Agree for those needing HEF and HPN. When it is appropriate then those using ONS also need to be trained!	Thank you for your comment. The TEG acknowledged the need for information transfer and some education of those receiving ONS. However a statement to ONS would be too complex to measure and implement and therefore HEF and HPN is the focus.
009	Sheffield Teaching Hospitals	Statement 4		299	Patient outcome of confidence in managing their own artificial nutrition. Possibly a reduction in	Thank you for your comment. The TEG discussed and agreed that all

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					complication rates, or attendances at A&E/GP out of hours services of problems relating to artificial nutrition??	people receiving any form of nutrition support should be provided with training to help manage their care. However, the TEG felt that this statement focused on a key area for improvement and was also something that could be more easily measured
011	Alzheimer's Society	Statement 4	General	300	Alzheimer's Society welcomes proposed quality statement 4. It is important that people with dementia and carers are given the information and training they need to manage their own nutrition. Training should be available not only for guidance on enteral tube feeding and parenteral nutrition, but also more basic aspects of nutritional care, such as how to feed someone or encourage a person with dementia to eat. As a person's dementia progresses, carers are often responsible for all aspects of their care. If they do not know how to recognise signs of malnutrition or realise how important nutritional care is, it can be overlooked. Carers need to be trained in how best to meet the needs of the person they care for so that they can feel confident that they are providing good care, and to prevent nutritional care being neglected. The staff responsible for conducting training must also have an understanding and knowledge of dementia, and the specific challenges it can cause in providing nutritional care.	Thank you for your comment. The TEG discussed and agreed that all people receiving any form of nutrition support should be provided with training to help manage their care. However, the TEG felt that this statement focused on a key area for patient safety, quality improvement and was also something that could be more easily measured.
012	County Durham and Darlington Foundation Trust	Statement 4		301	Could artificial nutrition support be just nutrition support which would then encompass all forms of nutritional support	Thank you for your comment. The TEG discussed and agreed that all people receiving any form of

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						nutrition support should be provided with training to help manage their care. However, the TEG felt that this statement focused on a key area for patient safety, quality improvement and was also something that could be more easily measured
012	County Durham and Darlington Foundation Trust	Statement 4		302	Just changes rather than adverse changes – this is very negative. Would need to be standardised through this standard	Thank you for your comment. The focus of the statement is managing patient safety issues, hence the focus on adverse changes.
012	County Durham and Darlington Foundation Trust	Statement 4		303	Nutritional delivery system sounds as though this is just EN/PN what about ONS. Could it be nutritional support including ONS, EN & PN.	Thank you for your comment. The TEG discussed and agreed that all people receiving any form of nutrition support should be provided with training to help manage their care. However, the TEG felt that this statement focused on a key area for patient safety, quality improvement and was also something that could be more easily measured
012	County Durham and Darlington Foundation Trust	Statement 4		304	Could trained be changed to educated to recognise….. this would need changing throughout this standard	Thank you for your comment. The TEG retained the term trained.
012	County Durham and Darlington Foundation Trust	Statement 4	Outcome	305	How is the patient knowledge and experience of training and support going to be measured. What are realistic outcomes for this?	Thank you for your comment. The TEG reviewed the outcomes and agreed that a patient experience outcome could be included for this statement that related to patient perception of the training and how confident they were in managing

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						their own artificial nutrition support.
012	County Durham and Darlington Foundation Trust	Statement 4	Description	306	Should it be a specialist rather than an expert? The sentence in the numerator section states a specialist. This is generally the term used. This would need standardising throughout this statement.	Thank you for your comment. This has been clarified in the final version of the quality standard.
012	County Durham and Darlington Foundation Trust	Statement 4	Description. Health & social care professionals	307	..inform people how to contact a specialist… rather than ….tell people how to contact an expert…	Thank you for your comment. This has been clarified in the final version of the quality standard.
012	County Durham and Darlington Foundation Trust	Statement 4	Description. Health & social care professionals	308	..an expert who will be readily available.. How realistic is this, what is readily available?	Thank you for this comment. The TEG agreed that a specialist should be contactable by phone 24 hours per day , 7 days per week – this is included in the definitions section for this statement.
012	County Durham and Darlington Foundation Trust	Statement 4	Definitions. Artificial support	309	This should be defined earlier in the document but what about ONS. Does this mean this is not covered by these standards? Is this the same as artificial feeding which is the term used on statement 3 , draft quality measure, structure b. Should there be a definition for nutrition support which is a term used throughout the document?	Thank you for your comments. The definitions have been reviewed and clarified in the final quality standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 4	Self Management. Draft Quality Statement (page 12)	310	We welcome the inclusion of a statement that will help those individuals who require artificial nutritional support at home to retain their independence as far as possible. However, we believe that it should be clearly stated that 'self management' does not replace regular follow up and review by the healthcare professional. This should be captured throughout Quality Statement 4.	Thank you for your comment. This issue has been referenced in the support information for the statement.
013	Abbott Nutrition,	Statement	Self	311	Please see our previous comment above – while it is	Thank you – please see response

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
	Abbott Laboratories Ltd.	4	Management. Draft Quality Measure (page 12)		appropriate that patients and their carers receive training in managing their artificial nutrition support at home, this should not replace routine monitoring by a healthcare professional.	above.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 4	Self Management. Draft Quality Measure (page 12)	**312**	**Process:** The emphasis here appears to be related to the number of people who have received training and to the number of people who have been provided with contact details, but this will not necessarily translate into an increase in knowledge, nor to the improved safety or well-being of the individual. We suggest that this could be reworded to ensure the training delivered is more competency-based.	Thank you for your comment. The TEG agreed that the quality improvement issue was that people were trained to prevent, recognise and respond to adverse changes. The method of training was not prioritised and therefore not discussed.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 4	Self Management. Draft Quality Measure (page 12)	**313**	**Outcome:** We suggest that an appropriate measure of effective training would be to reduce unplanned hospital visits or A&E admissions due to complications associated with artificial nutrition support. These could include tube-related complications, such as blockage, or line or stoma site complications such as infection.	Thank you for your comment. The TEG discussed the outcome measures and agreed to have a more general outcome concerning adverse events / complications. This would include emergency hospital admissions
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 4	Self Management. Definitions (page 13)	**314**	**Management:** We believe that it would be helpful to define what is meant by 'urgent help' e.g. does this mean that patients and carers have access to a dedicated 24 hour helpline, or other? It would also be helpful to understand who would be considered to be 'an expert in nutritional support' if the expectation is that they are available to provide emergency help, including out of hours? These would be important considerations for service providers and commissioners.	Thank you for this comment. The TEG agreed that a specialist should be contactable by phone 24 hours per day, 7 days per week – this is included in the definitions for this section.
014	Nutricia Ltd	Statement	Self	315	This statement rightly focuses on training of patients	Thank you for your comment. The

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
		4	Management Statement		and carers to recognise adverse changes, however would recommend making more explicit that they should be trained on safe and appropriate usage of their nutritional delivery system, in order to prevent adverse events. This in turn will help ensure that people who are artificially fed retain their independence as far as possible.	TEG felt that the current wording covered the key quality issues that should be focused on.
014	Nutricia Ltd	Statement 4	Self Management Measurement	316	As above, importance of highlighting trained on safe and appropriate use	Thank you for your comment. The TEG felt that the current wording covered the key quality issues that should be focused on.
014	Nutricia Ltd	Statement 4	Self Management Measurement	317	Process: b) would suggest amending point regarding contact details so that they have access to 24 h emergency care if needed (in line with statement in definitions).	Thank you for this comment. The TEG agreed that a specialist should be contactable by phone 24 hours per day, 7 days per week – this is included in the definitions for this section.
014	Nutricia Ltd	Statement 4	Self Management Measurement	318	Outcome: A useful outcome measure of effective training would be to reduce unplanned hospital visits/A&E admissions in relation to tube feeding issues.	Thank you for your comment. The TEG discussed the outcome measures and agreed to have a more general outcome concerning adverse events / complications. This would include emergency hospital admissions
015	Malnutrition Task Force (Malnutrition action group)	Statement 4		319	• Self-management of enteral/parenteral nut support – training to all • It is assumed that as artificial nutrition is provided as part of a healthcare treatment plan/clinical decision, that access to translators for non- English speakers would be facilitated by the NHS as part of the treatment	Thank you for your comments. • Yes, the equality considerations for this statement makes reference to the need for training to be provided in the most appropriate language / method depending on

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					plan, rather than the care home the person lived in. • This statement rightly focuses on training of patients and carers to recognise adverse changes, however we would recommend making this more explicit by stating that they should be trained on safe and appropriate usage of their nutritional delivery system, in order to prevent adverse events. This in turn will help ensure that people who are artificially fed retain their independence as far as possible. • Process: b) would suggest amending point regarding contact details so that they have access to 24 h emergency care if needed (in line with statement in definitions). • Outcome: A useful outcome measure of effective training would be to reduce unplanned hospital visits/A&E admissions in relation to tube feeding issues.	the needs of the individual concerned • Thank you for your comment. The TEG felt that the current wording covered the key quality issues that should be focused on • Thank you for this comment. The TEG agreed that a specialist should be contactable by phone 24 hours per day, 7 days per week – this is included in the definitions for this section. • Thank you for your comment. The TEG discussed the outcome measures and agreed to have a more general outcome concerning adverse events / complications. This would include emergency hospital admissions
028	Baxter Healthcare	Statement 4	statement	320	People who are managing their own artificial nutrition support should not only be trained to recognise and	Thank you for your comment. The TEG felt that the current wording

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					respond to adverse changes in their wellbeing and management of nutrition delivery system. They should also be trained and educated to become expert in coping with their overall condition and management. Would NICE consider adding into this section a measure to ensure that patients follow a comprehensive and appropriate training and education programme for both theoretical knowledge and practical skills. Patients and carers should also be involved in decisions about the level of treatment they are willing and able to undertake by themselves.	covered the key quality issues that should be focused on
028	Baxter Healthcare	Statement 4		321	When patients are managing their own care, it is important that they have access not only to the nutritional support specialists, but also to the wider support network including homecare organisations and patient support organisations.	Thank you for your comment. The TEG agreed that it is important that people have access to a range of expertise. One of the intentions of this statement is that people have access to urgent advice. The statement doesn't cover the wider support networks that should be in place for people.
029	The British Dietetic Association	Statement 4	Measurement	322	As above, importance of highlighting training by suitably skilled staff/professionals on safe and appropriate use	Thank you. Please see response above.
029	The British Dietetic Association	Statement 4	Measurement	323	4 b) would suggest amending to state "access to a specialist in nutrition support to be available daily including out of hours contact number which should be a trained specialist	Thank you for this comment. The TEG agreed that a specialist should be contactable by phone 24 hours per day, 7 days per week – this is included in the definitions for this section.

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
029	The British Dietetic Association	Statement 4	Measurement	324	A useful outcome measure of effective training would be to reduce unplanned hospital visits/A&E admissions in relation to tube feeding issues (see Kurien, M et al European Journal of Clinical Nutrition (2012) 1 -4)	Thank you for your comment. The TEG discussed the outcome measures and agreed to have a more general outcome concerning adverse events / complications. This would include emergency hospital admissions
029	The British Dietetic Association	Statement 4	Statement	325	This statement refers to artificial nutrition support, can self-management not also apply to oral nutrition support? for oral nutrition support it may be that they determine intermittent rather than continuous use of oral nutrition support according to relapsing conditions. The statement correctly focuses on training of patients and carers to recognise adverse changes, however would recommend making more explicit that they should be trained on safe and appropriate usage of their nutritional delivery system, in order to prevent adverse events. This in turn will help ensure that people who are artificially fed retain their independence as far as possible.	Thank you for your comment. The TEG felt that the current wording covered the key quality issues that should be focused on
012	County Durham and Darlington Foundation Trust	Statement 4		326	What is artificial nutrition? This makes it sound as though it is just enteral (EN) and parenteral (PN). Oral nutritional support (ONS) is as important and should be included in this standard	Thank you for your comment. The TEG discussed and agreed that all people receiving any form of nutrition support should be provided with training to help manage their care. However, the TEG felt that this statement focused on a key area for patient safety, quality improvement and was also something that could

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
						be more easily measured
012	County Durham and Darlington Foundation Trust	Statement 4		328	What is a nutrition delivery system? Again sounds very EN/PN. Could it just be nutrition?	Please see above response.
008	Motor Neurone Disease Association	Statement 4		329	Individuals should be provided with contact details not just for specialists in nutrition support, but also for the professionals listed above in reference to quality statement 3. Awareness of an individual's condition, on the part of themselves or of health and social care professionals, should not be limited to recognising changes and reacting to them: it should include awareness of possible future developments in a disease affecting nutrition, and the ability to plan for them. The 'description of what the quality statement means for each audience' should be amended to this effect.	One intention of this particular statement is to ensure that people are able to have urgent support for potential complications related to their nutrition support. It is anticipated that people who are in receipt of artificial nutrition support will be under the care of a multi-disciplinary team who would be able to advise about wider issues and concerns relating to future care requirements.
026	Royal College of Speech and Language Therapists	Statement 4		330	The support for people described in this section seems to be very erratic or absent in clinical practice. This can be an area of high anxiety for individuals and carers and providing support and professional guidance and training is essential. Good to have in guidelines, and links well with statement 6 which I think is excellent to provide a joined up service to these highly vulnerable individuals.	Thank you for your comment.
026	Royal College of Speech and Language Therapists	Statement 4	p13	331	Diversity: need to allow for those who are not literate i.e. don't read/write in any language so we can't just produce written leaflets in 9 languages if you get my point.	Thank you for your comment. This issues has been reviewed and amendments made to the equality considerations for this statement
027	British Pharmaceutical Nutrition Group	Statement 4		332	Re Q1: Health outcome measures could include nutritional progress and complication rates (e.g.	Thank you for your comment. The TEG reviewed the measures and

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					enteral tube blockage, venous catheter sepsis, dehydration, metabolic complications)	agreed that a general outcome measure could be used that would include the issues you raise here.
001	NHS Commissioning Board Authority	Statement 4	Question 1	333	Can you suggest any appropriate healthcare outcomes for each individual quality statement? 1. Quality Statement 4 – Adverse changes do not impact on individuals well-being	Thank you for your comment. The TEG felt that adverse changes significantly increase the risk a person's well- being, being impacted upon.
019	Hywel Dda Health Board	Statement 4		335	This section should include reference to setting client centred goals. In terms of quality measures – training can be captured in the form of a database / BANS Reports/surveys can also include important data or could be developed further to capture this outcome and others within these standards. Patient experience should be captured as an outcome and should be elaborated upon with examples /guidance on how to achieve this e.g. ability to self-manage feeding, satisfaction, awareness of whom to contact in an emergency situation etc. What the quality statement means for the service provider – ensure systems are in place to support seamless transfer of care, prevention of re-admission and to support care closer to home. Definitions – Management - .. Access to urgent help from an expert in nutritional support when needed should also state 'out of hours' and in an emergency in line with NPSA guidance. Outcome: Patient knowledge and experience of training and support. Locally agreed nutrition policies and procedures should incorporate this standard.	Thank you for your comments. These will be fed to our implementation team to help inform their support tools.

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					Advice on grading patient's knowledge should be included for guidance and reference made to consider carers/advocates views for patients who are unable to communicate. Guidance on categorising adverse changes should be given.	
024	Nottinghamshire Healthcare NHS Trust	Statement 4	Measure	336	Structure, it mentions a Specialist, but gives no indication/guidance of who that would be and I believe it should be a dietitian	Thank you for your comment. The TEG reviewed this issue and agreed not to be too prescriptive as nutrition support should be provided by a multi-disciplinary team where a number of different professionals would be suitable to provide urgent advice.
024	Nottinghamshire Healthcare NHS Trust	Statement 4	Description of what the quality statement means for each audience	337	Service providers -, mentions that "an expert who will be readily available" this could be a gap in many Community Trusts	Thank you for your comment. It is recognised that this could be a gap. However, this is one of the reasons the TEG wanted to include this. The purpose of the quality standards is to drive improvements in care and this was identified as a key area for quality improvement and reducing local variation in access to services.
024	Nottinghamshire Healthcare NHS Trust	Statement 4	People	338	there need to be an acknowledgement that Parental Nutrition is a much more specialised area especially within the community	Thank you for your comment. This was acknowledged by the TEG.
025	British Specialist Nutrition Association (BSNA)	Statement 4		339	This Statement rightly focuses on training of patients and carers to recognise adverse changes in their wellbeing and in the management of their nutritional delivery system. However, we recommend that the Statement should be made more explicit to state that they should be trained on safety and appropriate use	Thank you for your comment. The TEG felt that the current wording covered the key quality issues that should be focused on. The issue concerning the need for

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					of artificial nutrition support in order to prevent complications. This is not limited to the nutritional delivery system, but would include storage of feed, line or tube care, administration of medication etc. This in turn will help ensure that people who are artificially fed retain their independence as far as possible. We recommend that it should be clearly stated that 'self management' should not replace regular follow up and monitoring by the healthcare professional.	continued reviewed by healthcare professionals in addition to training , has been referenced in the support information for the statement.
025	British Specialist Nutrition Association (BSNA)	Statement 4	Measure	340	Please see our previous comments, regarding the importance of training on safety and appropriate use.	Please see relevant response above.
025	British Specialist Nutrition Association (BSNA)	Statement 4	Process Measure	341	We recommend that the Process Measure (b) regarding contact details of a specialist in nutrition support should be amended in order that patients and/or carers have access to urgent support from experts in nutrition support. Clarification would be required in the section on Definitions for this Statement in order that Commissioners and Providers understand what is meant by 'urgent support' and 'experts in nutrition support'.	Thank you for your comment. The TEG agreed that people should be able to contact a specialist 24 hours a day 7 days per week. This would be auditable standard for this measure.
025	British Specialist Nutrition Association (BSNA)	Statement 4	Outcome measure	342	We suggest that a useful outcome measure of effective training would be to reduce unplanned hospital visits or A&E admissions in relation to tube feeding issues.	Thank you for your comment. The TEG discussed the outcome measures and agreed to have a more general outcome concerning adverse events / complications. This would include emergency hospital admissions
027	British Pharmaceutical Nutrition Group	Statement 5	Question 2	343	All the quality standards relate to identification, documentation and organisation they do not relate	The QS as a whole aims to describe high quality care across the care

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					directly to intervention or outcome QS 5: Regular review of patients receiving nutritional support should be by an appropriately skilled professional or clinical team	pathway. It is expected to improve care for people needing nutrition support. Outcome measures are stated where the topic expert group felt these were appropriate, which include patient and carer-reported outcomes. With regard to the person carrying out the review, the TEG agreed to use a general term, recognising that nutritional support covers a number of methods that can be overseen by both health and social care professionals.
027	British Pharmaceutical Nutrition Group	Statement 5	Question 3	344	QS5: Regular review of on-going nutritional care is necessary to optimise outcomes and minimise complications	Thank you for your comment. This was acknowledged by the TEG.
004	National Nurses Nutrition Group (NNNG)	Statement 5	page 14	*345*	*Comment on quality statement 5*: The review should be done by an appropriately trained healthcare professional with nutritional expertise	Thank you for your comment. The TEG agreed to use a general term, recognising that nutritional support covers a number of methods that can be overseen by both health and social care professionals.

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006	British Association for Parenteral and Enteral Nutrition (BAPEN)	Statement 5		346	Again I think we risk escalation of the food vs ONS debate - even those who are on a food first approach or ONS still need reviews as described above. The outcome isn't a result of the numerator and denominator specified here. All they will give is the numbers of patients being reviewed - without a measure of appropriateness. Need to review what information actually needs to be collected and how to do this. Who is going to define inappropriate?	Thank you for your comments. The intention of this statement is that all people receiving any form of nutrition support, including dietary advice and help with eating should have a review. The measures for this statement have been reviewed and amended by the TEG in the final version of the quality standard.
009	Sheffield Teaching Hospitals	Statement 5		347	Agree and it should include those on ONS so that there are planned intervals of reviews and ensuring the appropriateness	Thank you for your comments. The intention of this statement is that all people receiving any form of nutrition support, including ONS, dietary advice and help with eating should have a review.
009	Sheffield Teaching Hospitals	Statement 5		348	This sounds like a very tall order and doesn't make it clear if this is just people on prescribed supplements or those who are following a food based corrective programme after screening indicates that there are problems. Would the GPs take this on in the community? This would be a huge number of patients/residents etc and would involve currently unavailable levels of dietetic expertise in training and support for those undertaking the reviews.	Thank you for your comments. The intention of this statement is that all people receiving any form of nutritional support, including dietary advice and help with eating should have a review. The TEG reviewed concerns about lack of dietetic expertise. It was felt that a range of health and social care professionals could be involved in the review, particularly for people who are receiving lower level nutrition support such as help with eating and

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						dietary advice.
011	Alzheimer's Society	Statement 5	General	350	Alzheimer's Society supports draft quality statement 5. Dementia is a progressive condition, thus a person with dementia's support needs will change over time, including their need for nutritional support. In the later stages of their condition many people with dementia need help or encouragement with eating and drinking. Some people with dementia may develop problems with chewing or swallowing due to the muscles and reflexes not working properly and may choke on food or develop chest infections. This makes regular review of their care needs particularly important. Regular review of nutritional needs will help to prevent malnutrition occurring, by ensuring that people get the nutritional support they need to remain well-nourished and healthy. However we would stress that review should be available not only at planned intervals, but also in response to a change in a person with dementia's condition or needs.	Thank you for your comment. The TEG has reviewed the need for this statement to be more reactive to changes in clinical needs and have therefore amended the wording of the statement to make this explicit.
012	County Durham and Darlington Foundation Trust	Statement 5		351	A definition of nutrition support? But this probably needs to be earlier in the document	Thank you for your comment. This definition is included in the document.
012	County Durham and Darlington Foundation Trust	Statement 5		352	It could be that a social care professional would be offering a review of nutritional support.	Thank you for your comment. This is now acknowledged in the wording of the statement.
012	County Durham and Darlington Foundation Trust	Statement 5	Draft quality measure. Structure	353	Might not always be a health care professional, could be that it is care home staff/ social services/domiciliary carers.	Thank you for your comment. This is now acknowledged in the wording of the statement.
012	County Durham and Darlington Foundation	Statement 5	Draft quality measure.	354	This standard is about reviewing people receiving nutritional support not about appropriate nutritional	Thank you for your comment The expectation is that the review will

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	Trust		Outcome		support. Should the outcome be the number of people who were reviewed? Would the current recommended outcome be better suited for quality statement 3?	assess the effectiveness of the nutrition support being provided and therefore see a reduction in the number of people who are receiving ineffective nutrition support.
012	County Durham and Darlington Foundation Trust	Statement 5	Description	355	Health and social **C**are professionals	Thank you for your comment. This is now acknowledged in the wording of the statement.
012	County Durham and Darlington Foundation Trust	Statement 5	Description, people	356	If continuing to use lay terms for these sections, nutrients (food) it may not be food if they are receiving artificial nutrition	Thank you for your comment. The wording used in the section has been reviewed and amended where required.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 5	Review. Draft Quality Statement (page 14)	357	We support the ongoing review of all people receiving nutrition support to ensure that the treatment remains appropriate and is being effective in meeting the goals set (in Quality Statement 2). However, the draft Quality Statement does not currently capture efficacy of treatment, nor does it capture that there might be a need for ongoing monitoring (it simply specifies that people will be offered 'a' review). We suggest that the primary objective should be revised to assess the effectiveness of the nutrition support being delivered in meeting the goals set under Quality Statement 2.	Thank you for your comment The expectation is that the review will assess the effectiveness of the nutrition support being provided and therefore see a reduction in the number of people who are receiving ineffective nutrition support.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 5	Review. Draft Quality Measure (page 14)	358	We recommend that the draft quality measure is amended in line with the comments we have provided on the Statement. Whilst the draft statement refers to the people 'being offered a review', the process describes the proportion of people who have been reviewed. The	Thank you for your comment. Please see response to your previous comment.

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					latter would be a more meaningful measure.	
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 5	Review. Draft Quality Measure (page 14)	**359**	**Outcome:** The outcome measure appears to focus on the inappropriate and ineffective nutrition support, but we would suggest that it would be more appropriate to capture the effectiveness of the intervention in improving patient outcomes, as this should be the ultimate goal. Meaningful measures of outcomes here could again relate to achievement of nutritional goals, quality of life measures and patient experience measures. We would suggest that the word 'inappropriate' is somewhat subjective, and that this would benefit from being more clearly defined. For example, the recently published Malnutrition Pathway (www.malnutritionpathway.co.uk) provides some guidance on when to initiate and discontinue oral nutritional supplements – it may be helpful to cite this as an example.	We have considered all suggestions for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the TEG felt able to define these. The malnutrition pathway will be forwarded to the Implementation team at NICE as a potential example support tool for providers / commissioners to use.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 5	Review. Description of what…. (page 14)	360	We suggest that guidance should be provided on the expertise required by the healthcare professionals conducting the reviews to ensure they are appropriately qualified or trained to fulfil the role.	Thank you for your comments. The TEG reviewed concerns about the required expertise of the professional conducting the review. It was felt that a range of health and social care professionals could be involved in the review, particularly for people who are receiving lower level nutrition support such as help with eating and dietary advice. This has therefore been acknowledged in

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						the statement wording.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 5	Review. Definitions (page 15)	361	It would be beneficial to provide stakeholders with guidance on what constitutes a review, and we would suggest that Table 1 from CG32 be provided in its entirety within the Quality Standard document for ease of reference.	Thank you for your comment. There is a reference to this part of the clinical guideline in the quality standard.
014	Nutricia Ltd	Statement 5	Review Draft Statement	362	We support the ongoing review of all people in receipt of nutritional support. We suggest that the primary objective of this review, should be to assess the effectiveness of the nutritional support they are receiving in meeting the goals set under Statement 2. This would be a clearer and patient-centred statement. The points made in the existing statement regarding explanation of risks and benefits etc are very important, however they should be incorporated into conversations from the outset of the intervention, not just in review.	Thank you for your comment The expectation is that the review will assess the effectiveness of the nutrition support being provided and therefore see a reduction in the number of people who are receiving ineffective nutrition support. It is anticipated that the nutrition management plan as detailed in statement 2 will cover these issues.
014	Nutricia Ltd	Statement 5	Review Draft measure	363	Suggest rewording in line with comments on statement above. Note, the statement as written refers to the people 'being offered a review', the process describes the proportion of people who have been reviewed. The latter would be the most meaningful to measure.	Thank you for your comment. The TEG have reviewed all measures in the document and amended them where required.
014	Nutricia Ltd	Statement 5	Review Draft measure	364	Outcome: The outcomes as written appear to focus on inappropriate use of different treatments, however equally important, should be ensuring achievement of meaningful outcomes to the patient and thus ensuring the effectiveness of the intervention.	We have considered all suggestions for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve

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					Meaningful measures of outcomes here could again relate to achievement of nutritional goals; quality of life measures and patient experience measures. The inclusion of outcome measures related to inappropriate use, would need further clarity to define what is 'inappropriate'. The publication of the Malnutrition Pathway (www.malnutritionpathway.co.uk) provides some guidance in respect of when to utilise and stop oral nutritional supplements and could be a helpful source to cite as an example.	the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the TEG felt able to define these. The malnutrition pathway will be forwarded to the Implementation team at NICE as a potential example support tool for providers / commissioners to use.
014	Nutricia Ltd	Statement 5	Review Definitions	365	Stakeholders should be supported on what should constitute a review and a planned interval. It would be helpful for the Table 1 from NICE CG32 to be provided in its entirety as an appendix to the Quality Standard document.	Thank you for your comment. A reference to table 1 in the CG 32 is included in the definitions section of this statement
015	Malnutrition Task Force (Malnutrition action group)	Statement 5		366	i. There are 2 distinct elements to this statement. A healthcare professional would provide the review, however if the person is living in a care home, a social care professional would need to make sure that access to health professionals is supported and enabled. Perhaps the description for audiences could clarify that with a separate statement for social care professionals "to ensure that people are receiving a review from a healthcare professional and are supported to do so" ii. We support the ongoing review of all people in receipt of nutritional support. We suggest that the primary objective of this review, should be to	i. Thank you for your comments. The TEG reviewed concerns about the required expertise of the professional conducting the review. It was felt that a range of health and social care professionals could be involved in the review, particularly for people who are receiving lower level nutrition support such as help with eating and dietary advice. This has therefore been acknowledged in the statement wording. ii. Thank you for your comment. The

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					assess the effectiveness of the nutritional support they are receiving in meeting the goals set under Statement 2. This would be a clearer and patient-centred statement. iii. The points made in the existing statement regarding explanation of risks and benefits etc are very important, however they should be incorporated into conversations from the outset of the intervention, not just in review. iv. Suggest rewording in line with comments on statement above. Note, the statement as written refers to the people 'being offered a review', the process describes the proportion of people who have been reviewed. The latter would be the most meaningful to measure. v. Outcome: The outcomes as written appear to focus on inappropriate use of different treatments, however equally important, should be ensuring achievement of meaningful outcomes to the patient and thus ensuring the effectiveness of the intervention. vi. Meaningful measures of outcomes here could again relate to achievement of nutritional goals; quality of life measures and patient experience measures. vii. The inclusion of outcome measures related to inappropriate use would need further clarity to define 'inappropriate'. The publication of the Malnutrition Pathway (www.malnutritionpathway.co.uk) provides some guidance in respect of when to utilise and	expectation is that the review will assess the effectiveness of the nutrition support being provided and therefore see a reduction in the number of people who are receiving ineffective nutrition support. ii. It is anticipated that the nutrition management plan as detailed in statement 2 will cover these issues. iv – vii. We have considered all suggestions for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the TEG felt able to define these

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					stop oral nutritional supplements and could be a helpful source to cite as an example. viii. Stakeholders should be supported on what constitutes a review and a planned interval. It would be helpful for the Table 1 from NICE CG32 to be provided in its entirety as an appendix to the Quality Standard document. ix. Definitions -settings - bullet 2 initial registration with GP and when clinical concern - we should add screening of vulnerable groups e.g. older people over 65/75 x. Statement 5 - this needs to include integration of services as persons pass from one service to another that their nutritional support should be continued and plans in place to handover.	viii. Table 1 is referenced in the statement definitions. ix. The settings and situation stated are consistent with those in the clinical guideline which are based on the best available evidence. x. This issue is covered through statement 3.
028	Baxter Healthcare	Statement 5		367	We are unclear as to how this statement is separate from the earlier statement about care planning. A review should form an integral part of the on-going care of all patients having nutritional support. Would it be more appropriate to make this statement more specific for those patients at high risk of malnutrition and include that the review is not just offered but carried out with the patients' active participation together with the multi-professional team?	The topic expert group felt it was important to retain an individual statement on different aspects of nutrition care management to ensure each element is clearly addressed.
028	Baxter Healthcare	Statement 5		368	We would also like to note that Table 1 that is referred to in NICE guideline 32 is also table 10 in the full guideline (Feb 2006). This may cause confusion.	Thank you for your comment. Included in the statement is a link to the Clinical Guideline rather than the full guideline so this should reduce any possible confusion.
029	The British Dietetic Association	Statement 5	Draft Statement	369	We support the ongoing review of all people receiving nutritional support. We suggest that the primary	Thank you for your comments. The TEG agreed that the review would

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					objective of a review should be to assess the effectiveness of the nutritional support they are receiving in meeting the goals set under Statement 2. This would be clearer and goals that have been agreed with the patient i.e. patient-centred .Also explanation of risks and benefits etc are very important, but they should be incorporated into conversations from the outset of the intervention, not just in review. Also the "psychosocial" needs of the patient / carer are not mentioned but are key t positive outcomes (could mention self help groups and voluntary organisations here. Potential challenges with review due to handover of duty of care e.g. patients on discharge from acute settings to community. The TEG meeting 2 draft QS around monitoring has not transfrered into the final consultation document. Review and monitoring are not the same.	have several functions, one of which is the effectiveness of the nutrition support being provided. The description of what should be included in the review is not exhaustive and like any review of treatment, it should include assessment of any wider physical or mental health problems. The TEG agreed with the concerns raised about transfer between settings and anticipate this issue will be overcome through the actions described in statement 3. Following the TEG2 meeting, further work was done on the statements, including in collaboration with the TEG and the TEG chair and staff from the NICE team. Some statements were revised and amended before the standard was consulted upon.
029	The British Dietetic Association	Statement 5	Draft measure	370	Suggest rewording in line with comments on statement above. Note, the statement as written refers to the people 'being offered a review', the process describes the proportion of people who have been reviewed. The latter would be the most meaningful to measure.	Thank you for your comment. The quality improvement measure is concerned with the number of reviews that take place, with a presumption that a high proportion of people would accept an offered reviewed. The statement is intended to be person centred and promote

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
						patient choice. Therefore the term offered is used in this instance.
029	The British Dietetic Association	Statement 5	Draft measure	371	Outcome: The outcomes as written appear to focus on inappropriate use of different treatments, of equal importance is ensuring outcomes are meaningful to the patient, which is key to monitoring "effectiveness" of the intervention. Meaningful measures of outcomes here could again relate to achievement of nutritional goals; quality of life measures and the measurement of the patient experience. Clarity on use of "inappropriate" is required. What does this mean to others?	We have considered all suggestions for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the TEG felt able to define these.
029	The British Dietetic Association	Statement 5	Definitions	372	Would it be helpful for stakeholders to include information on what should constitute a review and a planned interval e.g. in appendix include Table 1 from NICE CG32	A reference to Table is included in the statement definitions with a link to the relevant document.
026	Royal College of Speech and Language Therapists	Statement 5		373	This section (and elsewhere e.g. screening) - reviews must be carried out by an *appropriately qualified* "healthcare professional".	Thank you for your comments. The TEG reviewed concerns about the required expertise of the professional conducting the review. It was felt that a range of health and social care professionals could be involved in the review, particularly for people who are receiving lower level nutrition support such as help with eating and dietary advice. This has therefore been acknowledged in the statement wording

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
026	Royal College of Speech and Language Therapists	Statement 5		374	A good point this regular review – this is often forgotten!	Thank you for your comment.
026	Royal College of Speech and Language Therapists	Statement 5	P15	375	CG 32 Table 1 is very comprehensive but it was published in 2006 – will this be reviewed in light of any recent evidence?	Thank you for your comment. There are no plans currently to update this guideline.
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Statement 5		376	Potential challenges with review due to handover of duty of care e.g. patients on discharge from acute settings to community.	Thank you for your comment. The TEG anticipates that statement 3 will contribute to overcome issues with transfer and handover of care at discharge.
019	Hywel Dda Health Board	Statement 5		379	People receiving nutritional support should have their nutritional care plan reviewed at regular intervals and this should be an integrated approach. Quality measures could further focus on levels of risk e.g. moderate and high risk (as identified by nutritional screening) are the interventions carried out as emphasised on the screening tool/nutritional care plan? Are High Risk patients referred to Dietetics? What Is the response time? Agree that Risks need to be identified also in terms of inappropriate Nutrition support? Need to capture MDT meetings to facilitate discharge planning/co-ordination of care etc. Outcome: rate of inappropriate, ineffective or unplanned forms of nutritional support. Documentation of the reasons for these outcomes should be addressed. Are they referring to table 1, protocol for nutritional, anthropometric and clinical monitoring of nutrition support in NICE CG32? This	Thank you for your comment. The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity. Reference to Table 1 in CG32 is included in the definition information for this statement.

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					Includes short and long-term goals. Is this what is to be referred to?	
023	South West Yorkshire Partnership NHS Foundation Trust	Statement 5		380	Concern: *a) The proportion of people receiving nutrition support who have the indications, route, risks, benefits and goals of their nutrition support reviewed by a healthcare professional at* ***planned intervals*** and *The* ***intervals between reviews will depend on the clinical needs*** *of an individual and the complexity of the nutrition support needed. Table 1 of NICE clinical guideline 32 provides a guide for intervals between reviews for people with more complex needs* This would be exceptionally difficult to audit accurately as a thorough understanding of the clinical presentation of each case would be required in order for the auditor to establish whether the correct interval had been achieved. It may be better to specify general rules for all e.g. All people identified to be at high risk of malnutrition during their hospital stay should be rescreened weekly and on discharge / transfer to another hospital.	Thank you for your comment. The topic expert group reviewed all measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for the final quality standard to improve clarity.
024	Nottinghamshire Healthcare NHS Trust	Statement 5	Measure	381	I am not clear that this outcome measure is capturing all that is needed, what about the effectiveness? It is not clear how the outcome could easily be measured, particularly how you can measure ineffectiveness	The topic expert group reviewed all outcomes measures in the draft quality standard and have prioritised and refined those they considered most important to measure the quality statements in the final standard. The measures have been revised for

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
						the final quality standard to improve clarity.
024	Nottinghamshire Healthcare NHS Trust	Statement 5	Measure	382	Is more information needed to clarify how outcomes listed will be captured?	Please see above response.
024	Nottinghamshire Healthcare NHS Trust	Statement 5	specific questions for consultation	383	Regarding consideration of if nutrition steering group could be established in community – setting can be complex and suggest need to consider local structure	Thank you for your comment. Statement 6 was not progressed in the final quality standard.
025	British Specialist Nutrition Association (BSNA)	Statement 5		384	We support the ongoing review of all people receiving nutritional support. We suggest that the primary objective of this review should be to assess the effectiveness of the nutritional support they are receiving in meeting the goals set under Statement 2. This would be a clearer and patient-centred statement. It is important that people receiving nutritional support should receive explanation by a healthcare professional of the indications, route, risks, benefits and goals of nutritional support, however such explanations should be addressed from the outset of the intervention, as well as in review.	Thank you for your comment. The expectation is that the review will assess the effectiveness of the nutrition support being provided and therefore see a reduction in the number of people who are receiving ineffective nutrition support. It is anticipated that the management care plan referenced in statement 2 will include the issues referred to in statement 5.
025	British Specialist Nutrition Association (BSNA)	Statement 5	Measure	385	We recommend that the draft measure is amended in line with the comments we have provided on the statement. Whilst the draft statement refers to the people 'being offered a review', the process describes the proportion of people who have been reviewed. The latter would be the most meaningful to measure.	Thank you for your comment. The quality improvement measure is concerned with the number of reviews that take place, with a presumption that a high proportion of people would accept an offered reviewed. The statement is intended to be person centred and promote patient choice. Therefore the term offered is used in this instance.
025	British Specialist	Statement	Measure	386	The Outcome Measure as written appear to focus on	We have considered all suggestions

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
	Nutrition Association (BSNA)	5			inappropriate use of different forms of nutrition support, however we believe that it is equally important to ensure achievement of meaningful outcomes to the patient. This would ensure the effectiveness of the intervention. Meaningful measures of outcomes here could again relate to achievement of nutritional goals, quality of life measures and patient experience measures. The inclusion of Outcome Measures related to inappropriate use, require further clarification to define what is 'inappropriate'. The publication of the Malnutrition Pathway (www.malnutritionpathway.co.uk) provides some guidance with regard to when to utilise and stop oral nutritional supplements and this could be a helpful source to cite as an example.	for suitable outcome measures. The TEG prioritised measures they considered most important for measuring the quality statements. The quality measures aim to improve the structures and processes of care that are considered to be linked to outcomes, as well as specifying outcomes directly where the TEG felt able to define these. The malnutrition pathway will be forwarded to the Implementation team at NICE as a potential example support tool for providers / commissioners to use.
025	British Specialist Nutrition Association (BSNA)	Statement 5	Definitions	387	Stakeholders should be supported on what should constitute a review and a planned interval. It would be helpful for the Table 1 from NICE CG32 to be provided in its entirety as an appendix to the Quality Standard document.	Thank you for your comment. A reference to table 1 form CG 32 is provided in the supporting information for this statement, alongside a link to the document.
009	Sheffield Teaching Hospitals	Statement 6	Question 3 and 4	388	Nutritional support term is not widely understood from our experience and may be interpreted as artificial nutrition only. Therefore recommend changing to the term Nutritional care. Nutritional care would be delivered by anyone whereas nutritional support requires the input from someone with expertise in this field.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
						services was important and have made reference to this in the introductory text for the standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 6	Question 3	389	Quality Statements 1 to 5 should not be considered in isolation as they describe the cycle of identification, goal setting, training and review. For example, screening alone will not drive improvements in quality of care – the outcome of the screening needs to be linked to a clear action plan. Statement 6 may be less relevant if Commissioners and Providers are able to access nutritional expertise as required.	Thank you for your comment. The intention is that no quality statement should be considered in isolation and that the quality standard be used in its entirety. Statement 6 has not been included in the final quality standard.
015	Malnutrition Task Force (Malnutrition action group)	Statement 6	Question 5	390	• The role of a Quality Standard should be to describe what good quality care should look like, with local commissioners and providers having the flexibility to determine how best to deliver that quality care. The situation may therefore be different across the country. Most importantly expertise in nutrition should be available locally if needed and there should be integration across health, social care and public health, through Health and Wellbeing Boards, to ensure a joined up approach. • Community steering groups would need to involve community groups/voluntary agencies, pharmacists etc. It may work if they become a sub group to a main group. • The nutrition steering group will need to involve members from the represented organisations who can take decisions and	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard.

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					implement change. Without this progress could be slow. • Nutrition Steering Committees can be effectively established in the community as some are already in existence such as Derbyshire cc which has membership from la/cc/lhwb/social care and hospital execs. • The steering groups could be effective in pulling together representatives from community health services, but social care is such a diverse sector it would be impossible to have representation from all local providers. Systems would need to be developed for the steering group to communicate with social care services. This communication should primarily be through providers but commissioners (both Local Authority and Clinical Commissioning Groups) need to be included so that they can commission nutrition services appropriately and monitor performance and improvement. A constant footprint will be the Clinical Commissioning Group; we therefore need to ensure that the National Commissioning Board put in the correct system levers to support good nutritional care, with local CCGs making commissioning decisions based on advice from a nutrition steering group of experts. The emphasis would need to be be on (i) getting the right key messages to the national commissioning board, (ii) setting the right	

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					policy and system levers (iii) local commissioning groups working with an expert local nutrition steering group so that appropriate CQUINS etc can be developed, nationally and locally. This requires the development of appropriate nutrition outcomes (currently a piece of work being considered by the MTF and the NHS III) which should de aligned with the final NICE Nutrition Quality Standards, as well as appropriate systems to measure outcomes (e.g. the NHS Safety Thermometer or other systems currently in use for national reporting). This will then support commissioning of good nutritional care with the option to commission for continual improvements in outcomes over time. • If Quality Statements 1-5 can be met, the establishment of a nutrition steering group may not be necessary (although please see comments above as this may be a very important quality statement); it is important that Commissioners and Providers have flexibility in determine how best to deliver these standards within their locality. It is also important that nutrition is recognised as integral to healthcare and will cross-over into many existing and new clinical pathways. What is, however, essential is that they should: • Have access to nutritional expertise if	

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					required (and it is important that nutrition experts are visible to their local commissioners, and have sufficient influence and impact) • That there is a joined-up approach to delivering nutritional support across Health Care, Social Care and Public Health; consideration needs to be given as to how this is achievable. We know what good nutritional care looks like; we are failing to organise the delivery of care in a fully integrated way to all individuals currently and any quality statements that support improvements in the structure and processes to deliver good nutritional care are to be fully supported. • In conclusion - these groups could work but we must ensure system wide commissioning and delivery, including social care, medicines management and involvement of patients and carers at all levels.	
026	Royal College of Speech and Language Therapists	Statement 6	Question 5	391	For draft quality statement 6: Can nutrition steering committees be effectively established in community settings? Yes, however interdisciplinary communication would need to be better and there would need to be an allocated lead. In agreement that management of nutritionally compromised in the community is more challenging than in a hospital setting where resources are readily available, it therefore makes sense to base	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					a steering committee in this setting as the general principles across other areas should be more easily applied. Example given of HEN community team	and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard.
027	British Pharmaceutical Nutrition Group	Statement 6	Question 5	392	NSCs could be established in community but communication and governance issues would be complicated	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard.
029	The British Dietetic Association	Statement 6	Question 5	393	A nutrition steering committee can be effectively established in the community. Locally (in East Sussex), community and acute services have merged and the nutrition steering group now covers both along individual care pathways. To ensure all community services are joined up the membership of the nutrition steering committee would need to include local mental health and social care organisations along with GP/CCG involvement. Such nutrition steering committees are not in widespread existence at the moment but recent experience of emerging CCGs and ignorance with regard to the complexity of providing artificial	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard.

ID	Stakeholder	Statement No	Comment on	Comment No.	Comments Please insert each new comment in a new row.	Response
					nutrition support and even effective oral nutrition support strategies, suggests that in the new landscape a Nutrition Steering Committee or Group may well be required. Most importantly expertise in nutrition should be available locally and the voice of appropriately skilled professions should be heard. There should be Senior Management level support to ensure seamless care across health, social care and public health.	
004	National Nurses Nutrition Group (NNNG)	Statement 6	page 16	*394*	*Comment on quality statement 6:* ...nutritional care that is overseen by nutrition steering group/nutrition team. We believe that a nutrition steering group can be established in the community, there are already the individual disciplines in place, what is needed is a nutrition nurse and a GP with an interest in malnutrition not just obesity. This is a great opportunity to include this in the standard in view of the new clinical commissioning groups being established.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard.
004	National Nurses Nutrition Group (NNNG)	Statement 6	Organisation-al priorities Draft quality measure page 16	*395*	*Comment on point b) under structure*: the representation from all relevant professional groups should be listed	*Please see above response*
006	British Association for Parenteral and Enteral	Statement 6		396	Is this something that is going to apply in all settings - for example are we suggesting there should be a	Thank you for your comment. Statement 6 has not been

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	Nutrition (BAPEN)				social services nutrition steering group or individual care homes or GP practices group - need to define exactly what is meant in each setting.	progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
009	Sheffield Teaching Hospitals	Statement 6		397	To make the communication work and ensure care is integrated GPs need to be involved an Acute / Community Trust Nutrition Steering Group cannot influence the way that GPs may work. I think a community steering group run by GPs would be ideal how this would then work with their commissioning role I do not know. I also think that there is a role for public health as equally with promoting a healthy diet / preventing obesity the public do not necessarily understand how to adjust their diet if they are underweight, acutely ill, frail and or have long term conditions or if they have a small appetite.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
009	Sheffield Teaching Hospitals	Statement 6		398	I don't think a nutrition steering group can exist unless it has "teeth" and therefore should have representatives from all those groups on whom it impacts who are able to make policy recommendations that are binding on their peers. That would mean that in a community setting there would have to be policy makers from the LMC, council	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate

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					and health trusts to ensure decisions are enforced.	model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
009	Sheffield Teaching Hospitals	Statement 6		399	The NICE document uses different words of group - page 16 and committee - page 4. Whichever word is used I think we need a group that includes the community so a city wide nutrition steering group would cover it! That group should be commissioned and accountable to CCG. The city wide group (multi professional) might then also cover for example a city wide food policy, setting nutritional standards for all care settings, nutritional screening, nutritional care planning, appropriate resources and cover by health professionals and giving reasonable consideration to cost!	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
012	County Durham and Darlington Foundation Trust	Statement 6		400	What is the role of the steering group. This is very health based, what about people who require nutritional support in other care settings?	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the

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						introductory text for the standard
012	County Durham and Darlington Foundation Trust	Statement 6		401	There is no process or outcome for this standard. What is the role of the steering group and what is the expected outcome from having a steering group?	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard.
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 6	Organisational Priorities. Draft Quality Statement (page 16)	402	Commissioners and Providers should have the flexibility to determine how best to deliver Statements 1 to 5 within their locality. We believe that it is possible that this could be achieved without establishing a nutrition steering group. However, it will be essential to ensure that access to nutritional expertise is available and that there is an integrated approach to delivering nutritional care across Health Care, Social Care and Public Health.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
013	Abbott Nutrition, Abbott Laboratories Ltd.	Statement 6	Organisational Priorities. Draft Quality Measures	403	This section is currently lacking in information relating to Process and Outcome. This content should be developed to align with the other draft Quality Statements.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there

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			(page 16)		We would suggest that more specific information is provided regarding the structure and purpose of the nutrition steering group, particularly with regard to driving improvements in quality of care.	wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
014	Nutricia Ltd	Statement 6	Organisational Priorities	404	If Quality Statements 1-5 can be met, the establishment of a nutrition steering group may not be necessary, indeed it is important that Commissioners and Providers have flexibility in determine how best to deliver these standards within their locality. It is also important that nutrition is recognised as integral to healthcare and will cross-over into many existing and new clinical pathways. What is, however, essential is that they should: - Have access to nutritional expertise if required - Include the nutritional homecare provider, if relevant, within discussions and decisions - That there is a joined-up approach to delivering nutritional support across Health Care, Social Care and Public Health.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard.
028	Baxter Healthcare	Statement 6		405	We would like to suggest that the statement supports nutrition steering groups that oversee patients in both the in-patient setting and those in the community and that robust communication between the hospital and community is essential in providing a seamless service.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders

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						concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
029	The British Dietetic Association	Statement 6	Organisational Priorities	406	The establishment of a nutrition steering group is important to provide an overall view. For standards 1-5 to be met it will require a team of suitable qualified practitioners however equally as CCGs evolve it is clear that a nutrition steering group/committee would minimise fragmentation of services and protect and provide skilled practitioners across a suitably sized geographical area. The composition and skills of members should be succinctly stated included in appendix or as a link or include in definitions. One of the challenges faced is that nutrition is integral to healthcare and will cut across many conditions and many clinical pathways. What is, however, essential is that patients and professionals should have access to nutritional expertise if required e.g. Dietitians, Nutrition Nurse specialists, Hospital Nutrition Team and that there is a joined-up approach to delivering nutritional support (oral, enteral and parenteral) across Health Care settings, Social Care settings and in Public Health (all these link into prevention and treatment of malnutrition too). Agree that a nutrition steering group is important.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard

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					Nutrition steering groups can be established in community settings. It is important to have an overarching structure across the health economy as nutrition is an issue relevant across a range of settings and with a number of areas of influence. Representation should include local authority colleagues, public health and relevant voluntary sector agencies along with healthcare professionals so that impact can be made across the whole pathway of care and a preventative approach can be taken to this health inequalities issue.	
029	The British Dietetic Association	Statement 6	General	407	This is also a priority at a national level, and as such, the nutritional needs of the population should be included in Joint Strategic Needs Assessment. This is about the wider health community not just the organisation. Management of malnutrition is a complex issue requiring a coordinated approach across all Health & Social care settings .	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
029	The British Dietetic Association	Statement 6	Definitions	408	The overall provision of care includes the provision of high quality food and catering services.	Thank you for your comment.
012	County Durham and Darlington Foundation	Statement 6		409	People access nutritional care that is overseen by a nutrition steering group – this seems to be quite acute	Thank you for your comment. Statement 6 has not been

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	Trust				focused, how will this work in social care settings, PCT or GP commissioning.	progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
008	Motor Neurone Disease Association	Statement 6		410	The range of health and social care professionals recommended in the guideline references given here is somewhat narrow: occupational therapists and physiotherapists in particular may also have a role, particularly in respect of assisting with swallowing.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
026	Royal College of Speech and Language Therapists	Statement 6		411	Community teams can be established with good outcomes, through a centralised specialised team where individuals and family members can direct questions and requests for review	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate

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						model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
026	Royal College of Speech and Language Therapists	Statement 6		412	Nutrition steering group in the community? It might require some acute input depending on how local bodies are organised but in most settings there will be the specialists e.g. dietetic, speech and language therapy, and stake holders such as GPs, community nurses, purchasers etc. CG 32 talks about MD nutrition support teams and nutrition steering committees. Is the nutrition steering group as labelled in the consultation document supposed to bridge both these? It seems that the word was chosen specifically on p16. This sort of attention to language either has to be super careful or choose something different e.g. multidisciplinary community nutrition team (getting rid of support/steering/groups/committees etc) which work in CG 32 acute structure.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
027	British Pharmaceutical Nutrition Group	Statement 6		413	Re Q1: There is no evidence that nutritional care overseen by a nutrition steering group impacts on health outcomes therefore no outcomes can be associated with this statement	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination

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						and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
016	NHS Central Lancashire (on behalf of the Lancashire Malnutrition Steering Group)	Statement 6		414	Agree that a nutrition steering group is important. Nutrition steering groups can be established in community settings. It is important to have an overarching structure across the health economy as nutrition is an issue relevant across a range of settings and with a number of areas of influence. Representation should include local authority colleagues, public health and relevant voluntary sector agencies along with healthcare professionals so that impact can be made across the whole pathway of care and a preventative approach can be taken to this health inequalities issue.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
001	NHS Commissioning Board Authority	Statement 6	Question 5	415	For draft quality statement 6: Can nutrition steering committees be effectively established in community settings? Nutrition Steering Committees should be set up in community settings but should have close links with colleagues in healthcare settings	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
005	Dorset County Council	Statement		416	Structure. I think this would be extremely difficult to	Thank you for your comment.

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		6			achieve. Dorset is ahead of the game and we are producing a Joint Nutritional Care Strategy and care path ways for health and social care to combat the risks of malnutrition and dehydration but that isn't the case for many areas. Also getting GP involvement is definitely a challenge!!	Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
019	Hywel Dda Health Board	Statement 6		420	Can Nutrition steering groups be established in community settings – challenging and would need wide representation including acute / secondary care and third sector agencies / Public Health etc. Difficult to comment on commitment but maybe that there could be an interface with trusts. Different settings in Wales and we can demonstrate that they can work.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
021	Royal College of Nursing	Statement 6		421	We are not sure that in the current climate, there will be sufficient expertise available in the community to ensure that such a group is set up and is robust enough to ensure that the nutrition pathways are effective and achieving good outcomes.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders

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						concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
023	South West Yorkshire Partnership NHS Foundation Trust	Statement 6		422	Concern: a) *Evidence of local arrangements to ensure care organisations have **a nutrition steering group** overseeing nutritional support care provision as part of the local governance framework.* Following Transfer of Community Service (TCS), many hospital Trusts have a number of hospitals within their organisation, spread across different districts. As such the arrangement for catering provision, pharmacy services, access to dietetics is likely to vary enormously between hospital sites and districts within the same Trust. One site may have a PFI with catering and another, an in-house catering service. The nutrition issues are therefore very different in each patch. It therefore makes sense to have a nutrition steering group in each patch to tackle local issues rather than one steering group for a disparate Trust.. In SWYPFT we have 3 independent nutrition steering groups based in the three districts which we cover. There is no overarching nutrition steering group and this seems to work extremely well (our Trust CQC status for Outcome 5 is green and our PEAT score was excellent). Could the statement therefore read:	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard

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					a) *Evidence of local arrangements to ensure care organisations have **a structure in place for steering the nutrition agenda** and overseeing nutritional support care provision as part of the local governance framework.*	
024	Nottinghamshire Healthcare NHS Trust	Statement 6	Specific questions for consultation	423	There would need to be time spent with regards to supporting community settings in the development of a steering group as there is currently a complex/fragmented infrastructure.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
024	Nottinghamshire Healthcare NHS Trust	Statement 6		424	General comment, both the term group and committee seems to be used, I see it as being very difficult to set up a group/committee in some Community organisations that will have the ability to influence anything significantly.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the

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						introductory text for the standard
025	British Specialist Nutrition Association (BSNA)	Statement 6		425	If Quality Statements 1-5 can be met, the establishment of a nutrition steering group may not be necessary, indeed it is important that Commissioners and Providers have flexibility in determine how best to deliver these standards within their locality. It is also important that nutrition is recognised as integral to healthcare and will cross-over into many existing and new clinical pathways. What is, however, essential is that access to nutritional expertise should be provided if required and that there is a joined-up approach to delivering nutritional support across Health Care, Social Care and Public Health.	Thank you for your comment. Statement 6 has not been progressed into the final quality standard. It was decided that there wasn't sufficient evidence or consensus amongst stakeholders concerning the most appropriate model for the steering groups. The TEG agreed that local co-ordination and leadership of nutrition care services was important and have made reference to this in the introductory text for the standard
013	Abbott Nutrition, Abbott Laboratories Ltd.	Appendix 1: Development Sources (page 19)	Appendix 1: Development Sources (page 19)	**426**	**Policy context:** We suggest that some of the documents listed are not 'policy' documents, but rather reports e.g. BAPEN's nutrition screening week reports. We suggest that the heading and descriptor be revised to reflect this, or that the non-policy documents listed are removed and listed separately e.g. as further reading. As mentioned previously, it may be helpful to include reference to the recently published Malnutrition Pathway document. The Pathway has been endorsed by the Royal Colleges and other professional bodies www.malnutritionpathway.co.uk	Thank you for your comments. The TEG and the NICE team have reviewed the appendices and made amendments where required.
014	Nutricia Ltd	Further References	Further References	427	In addition to NICE CG32 and the NPC Guidance, The recently published Malnutrition Pathway has been endorsed by the Royal Colleges and Professional organisations for GPs, nurses, dietitians and pharmacists and we recommend this as a further	Thank you for your comments. The TEG and the NICE team have reviewed the appendices and made amendments where required.

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					useful source for more specific guidance on appropriate management of malnutrition (www.malnutritionpathway.co.uk)	
015	Malnutrition Task Force (Malnutrition action group)	Further references	Further references	428	In addition to NICE CG32 and the NPC Guidance, The recently published Malnutrition Pathway has been endorsed by the Royal Colleges and Professional organisations for GPs, nurses, dietitians and pharmacists and we recommend this as a further useful source for more specific guidance on appropriate management of malnutrition (www.malnutritionpathway.co.uk)	Thank you for your comments. The TEG and the NICE team have reviewed the appendices and made amendments where required.
025	British Specialist Nutrition Association (BSNA)	Further references	Further references	429	In addition to NICE CG32 and the NPC Guidance, the recently published Malnutrition Pathway has been endorsed by the Royal Colleges and professional organisations for GPs, nurses, dietitians and pharmacists and werecommend this as a further useful source for more specific guidance on appropriate management of malnutrition (www.malnutritionpathway.co.uk)	Thank you for your comments. The TEG and the NICE team have reviewed the appendices and made amendments where required.