NICE National Institute for Health and Care Excellence

Quality Standards Advisory Committee 2

Oral health promotion in the community – post-consultation meeting
Blood transfusion – post consultation meeting

Minutes of the meeting held on Thursday 15th September 2016 at the NICE offices in Manchester

Attendees	**Standing Quality Standards Advisory Committee (QSAC) members** Michael Rudolf (MR) [Chair], Tessa Lewis (TL), Gillian Baird, Ashok Bohra, Julie Clatworthy, Jean Gaffin, Barry Attwood, Jim Greer, Guy Bradley-Smith, Michael Fairbairn, Ruth Studley, Ruth Halliday, Corinne Moocarme **Specialist committee members** Oral health promotion in the community – Gill Davies, Rebecca Harris, Ben Atkins, Martin Landers Blood transfusion - Graham Donald, Mary Marsden, David Blackwell, Mike Murphy, Timothy Walsh, Sue Robinson, Karen Madgwick **NICE staff** Craig Grime (CG), Kirsty Pitt (KP) [agenda items 1-5], Julie Kennedy (JK) [agenda items 6-10), Lisa Nicholls (LN)
Apologies	**Standing Quality Standards Advisory Committee (QSAC) members** Anjan Ghosh, Robyn Noonan, Malcolm Griffiths, Anita Sharma, Amanda Smith **Specialist committee members** Oral health promotion in the community - Michael Wheeler

Agenda item	Discussions and decisions	Actions
1. Welcome, introductions and plan for the day (private session)	The Chair welcomed the attendees and the Quality Standards Advisory Committee (QSAC) members introduced themselves. The Chair informed the Committee of the apologies and reviewed the agenda for the day.	

Agenda item	Discussions and decisions	Actions
2. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> • Gill Davies – holds shares with the Colgate Palmolive Group and has been paid to deliver a lecture for Colgate in the last year. • Rebecca Harris – council member for the British Association for the Study of Dentistry. May be involved in submitting grant applications and publishing academic work in the area of oral health promotion in the community which her employer (University of Liverpool) benefits. • Ben Atkins – Wrigley's ambassador, board member of the British Dental Foundation and General Practice owner. **Minutes from the last meeting** The Committee reviewed the minutes of the last meeting held on 14 July 2016 and confirmed them as an accurate record.	
3. QSAC updates	CG updated the committee on future plans for the committees and the accreditation programme coming to an end. The committee asked about a future QSAC away day. CG to follow up on this.	CG to follow up on QSAC away day.
4. Recap of prioritisation exercise	KP and CG presented a recap of the areas for quality improvement discussed at the first QSAC meeting for oral health promotion in the community: **At the first QSAC meeting on 14 April 2016 the QSAC agreed that the following areas for quality improvement should be prioritised for further consideration by the NICE team for potential inclusion in the draft quality standard:** • School based programmes – 1 statement progressed • Local Authority needs assessment – 1 statement progressed • Public service environments – not progressed • Dental care plans – 1 statement progressed • Advice – not progressed	

Agenda item	Discussions and decisions	Actions
	• Access to general dental practice – 2 statements progressed The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: https://www.nice.org.uk/Media/Default/Get-involved/Meetings-In-Public/Quality-Standards-Advisory-Committee/QSAC2/qsac-2-minutes-april-2016.pdf	
4.2 and 4.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	KP and CG presented the Committee with a report summarising consultation comments received on oral health promotion in the community. The Committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended to provide an initial basis for discussion. The Committee was therefore reminded to also refer to the full list of consultation comments provided throughout the meeting. The Committee was informed that comments which may result in changes to the quality standard had been highlighted in the summary report. Those comments which suggested changes which were outside of the process, were not included in the summary but had been included within the full list of comments, which was within the appendix. These included the following types of comment: • Relating to source guidance recommendations • Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation advice • General comments on role and purpose of quality standards • Requests to change NICE templates The committee highlighted that there was no expert in dental commissioning on the committee.	
4.4 Discussion and agreement of final statements	The Committee discussed each draft statement in turn and agreed upon a revised set. **These statements are not final and may change as a result of the editorial and validation processes.**	

Draft statement 1 – oral health needs assessments	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Local authorities carry out oral health needs assessments to identify groups at high risk of poor oral health as part of joint strategic needs assessments.	• Local authorities have a statutory requirement to collect local oral health data. • People with long-term medical conditions and looked-after children may be at high risk as well as socioeconomic groups. • Quality of life should be an outcome measure. • Possible cost savings from reducing tooth extractions, orthodontic treatment and number of fillings needed	Need to make sure oral health is a core component of joint strategic needs assessment (JSNA). The committee discussed structures already in place to undertake epidemiological surveys of oral health and whether the quality standard could refer to using a range of data sources to conduct the needs assessment, as described in recommendation 3 of the PH55 guideline. The committee felt a quality of life measure would be too far removed to be an outcome measure for this statement.	Committee agreed to keep statement wording as it is. Structure measure to be re-worded to align with statement wording. Reference to using a range of data sources to be added.
Additional comments/areas of discussion			
The committee discussed the definition of 'high risk of poor oral health'., and whether this could encompass groups other than those defined in the guideline by socioeconomic status, It was agreed to amend the introduction to the quality standard and to expand on the definitions under individual statements in order to clarify that there may be other reasons that people could be at high risk rather than just socioeconomic reasons. It was agreed that this should be mentioned as an equality consideration to ensure subgroups of populations who may be at high risk of poor oral health are not missed by an oral health needs assessment.			

Draft statement 2 – school and early years	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Local authorities promote oral health in early years settings	• Advice should also be given on sugar consumption and only tooth-friendly food and drink provided.	The committee agreed sugar consumption should be highlighted. The committee agreed to change the wording of the statement to clarify that oral health *improvement* should be promoted.	Expand rationale to include advice about sugar consumption. The committee agreed to keep the

and schools in areas where children and young people are at high risk of poor oral health	• HES data on tooth extractions may be unreliable. • Measure caries prevalence not frequency of tooth brushing. • Definition of high risk should include location and ethnicity. • Include parents and carers, and children with childminders. • Possible cost savings	Tooth extraction is a last resort. Important to reduce risk of dental decay rather than extraction in wording of rationale. It was queried whether "high risk" limited to socio-economic status disadvantaged people in rural areas. . The first outcome measure should be changed to measure level of plaque on teeth as a more reliable proxy for frequency of tooth brushing. This is measured in the epidemiological surveys.	statement wording with the addition of the word 'improvement' for clarity. Important to highlight that actions can only be done at those at high risk. Outcome measure (a) to be amended. Definition of high risk to be amended in line with other statements.

Draft statement 3 – oral health in care plans	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Health and social care services include oral health in care plans of people who are at high risk of poor oral health	• Focus should be on oral health assessments • Focus on assessments for looked-after children and special educational needs and disability. • Should include education services. • Structure measure is unclear and no process measure • Measures should capture more than just retention of teeth – not available at LA level. Consider quality of life.	The committee noted there is no process measure and one should be included. The committee discussed ensuring this statement is not limited to people with teeth. Support in getting dental care and accessing services should be included in the rationale. The measures reference the child and adult 10 yearly surveys – these surveys are not focussed on these groups so the data should be collected by local data collection. In the definition only children and young people are included. All people should be included.	The committee agreed to keep the statement wording. Process measure to be included. Remove reference to 10 yearly surveys in measures. Update rationale and definitions based on committee discussion. Definition of high risk to be amended in line with other statements.

	• Possible cost savings		

Draft statement 4 – information for people who don't have a dentist	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Dental practices provide up-to-date information about whether they are accepting new NHS patients	• Publication of information is current practice – part of role of NHS England. • More important to ensure access for particular population groups who find it difficult. • Professionals should explain to people at high risk of poor oral health why their services are important. • Terms 'up-to-date' and 'accepting new patients' should be defined	Statement not progressed as the committee agreed this information is available already and the statement would not improve access.	The committee agreed not to progress this statement.

Draft statement 5 – routine attendance after emergency care	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Dental practices providing emergency care provide information about the benefits of	• Not necessary – should only signpost people who ask about routine care. • Unachievable as patient choice whether to access routine care. • Already current practice.	The committee discussed including information about how to access routine dental care and examples of the benefits such as reduced costs in the long term. The committee agreed that it needs to be clear that this statement only applies to people who do not access routine care.	The committee agreed to keep the statement and to add in provision of information about how to access routine dental care. Examples of benefits and link to NHS Choices website to be added

attending for routine care	• Imparting oral health information at emergency appointment may not result in uptake of routine services. • People who only want to access urgent care are key to encourage returning to receive preventative messages	The committee discussed whether this statement could include people accessing emergency dental care at hospital emergency departments. Add link to NHS Choices.	to rationale. NICE team to check the scope of the guideline to see if hospital emergency departments are included.

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
1. Messages and interventions based on PHE's Delivering Better Oral Health.	The committee discussed the suggested additional statements from stakeholders. 1. This has been included as part of statement 2.	The additional suggested statements were not progressed by the committee.
2. Healthy food and drink choices in public service settings.	2. Statements on healthy food and drink choices in public service settings can be found in the quality standards on obesity in children and young people/adults: prevention and lifestyle weight management programmes (QS94 and 111).	
3. Data collection to enable needs assessment.	3. The committee agreed that this was a statutory requirement for local authorities and that the area for quality improvement was including oral health needs assessments in joint strategic needs assessments, as specified in statement 1.	

4. Importance of sugar consumption in oral health.	4. The committee agreed to cover advice on sugar consumption as part of statement 2.	
5. Promoting fluoride.	5. The committee agreed this was covered in statement 2.	

Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on oral health promotion in the community. It was agreed that the committee would contribute suggestions as the quality standard was developed. The committee discussed whether reduction in A&E attendance for dental problems was an overarching outcome. It was suggested re-ordering the outcomes to emphasise the importance of the link between the quality standard and the prevalence of dental caries.	Overarching outcomes to be reordered. NICE team to check the scope of the guideline to see if hospital emergency departments are included.
Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the committee to consider any relevant issues. It was agreed that the committee would contribute suggestions as the quality standard was developed.	NICE team to capture discussions about subgroups of populations who may be at high risk of poor oral health as part of the equality and diversity considerations.
5. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the oral health promotion in the community quality standard. The Chair thanked the specialist committee members for their input into the development of this quality standard	
6. Welcome and code of conduct for members of the public attending the	The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow. It was stressed that they were not able to contribute to the meeting but were there to observe only. They were also reminded that the committee is independent and advisory therefore the discussions and decisions made today may change following final validation by NICE's guidance	

meeting (public session)	executive.	
7. Committee business (public session)	**Declarations of interest** The Chair asked standing QSAC members to declare any interests that were either in addition to their previously submitted declaration or specific to the topic(s) under consideration at the meeting today. The Chair asked the specialist committee members to declare all interests. The following interests were declared: <u>Specialist committee members</u> • Graham Donald - current member of the National Blood Transfusion Committee, of its Patient Involvement Working Group and of its Patient Blood Management Working Group. Current member of the Steering Group of Serious Hazards of Transfusion (SHOT). Current member of the James Lind Alliance Blood Transfusion Priority Setting Partnership. Does not get paid for these memberships, but does receive expenses. Formerly a member of the NICE Guideline Development Group for the recently published Blood Transfusion Guideline. I was paid an honorarium of £150 per day in respect of work done in connection with this Guideline. • Mary Marsden - member of the North West Regional Transfusion committee – attending 2 meetings a year and study days. Worked on the blood transfusion NICE guideline. • Mike Murphy – is an employee of NHS Blood & Transplant, England's blood supplier. Chair of the recently published NICE guidelines on blood transfusion. Medical lead for blood transfusion at Oxford University Hospitals. This has been in collaboration over the last 14 years with a number of commercial partners but I have never had any pecuniary interest. Our group has more recently developed an electronic decision support process for reducing inappropriate use of blood, but again I have no pecuniary interest in any developments of this work. Publishes original papers and reviews on good transfusion practice. These include a recent review published in the BMJ in December 2014 on the reduced harms to patients of restrictive red cell transfusion practice. Is involved in other national and international efforts to improve transfusion practice including participation as a co-investigator in clinical trials. Is on the Board of Directors of the American Association of Blood Banks (the US professional organisation for blood transfusion). I receive no remuneration for this role other than reimbursement of expenses in attending meetings. • Timothy Walsh - was a member of the NICE Transfusion Guideline Development. Chaired the BCSH Guideline Development group for Transfusion in Critical Illness. Has received grants to my Institution (Edinburgh University) from HTA and the Scottish Chief Scientists Office to undertake transfusion research. • Sue Robinson - honorarium paid for talk and participation round table discussion NATA (Network for advancement of transfusion alternatives) management anaemia in pregnancy Feb 2015.	

	Honorarium Novartis Perceptorships for lecture in MPN pregnancy Annual 2015. Research Grant ITP in pregnancy Database Amgen 2013 Octopharma 2013	
8. Recap of prioritisation exercise	GF and JK presented a recap of the areas for quality improvement discussed at the first QSAC meeting for blood transfusion: **At the first QSAC meeting on 14 April 2016 the QSAC agreed that the following areas for quality improvement should be progressed for further consideration by the NICE team for potential inclusion in the draft quality standard:** • Alternatives to blood transfusion for patients having surgery – 2 statements progressed • Haemoglobin levels – 1 statement progressed • Platelets – 1 statement progressed • Patient information and consent – 1 statement progressed • Electronic patient identification system – not prioritised The full rationale for these decisions is available in the prioritisation meeting minutes which can be found here: https://www.nice.org.uk/Media/Default/Get-involved/Meetings-In-Public/Quality-Standards-Advisory-Committee/QSAC2/qsac-2-minutes-april-2016.pdf	
8.2 and 8.3 Presentation and discussion of stakeholder feedback and key themes/issues raised	GF and JK presented the committee with a report summarising consultation comments received on blood transfusion. The committee was reminded that this document provided a high level summary of the consultation comments, prepared by the NICE quality standards team, and was intended to provide an initial basis for discussion. The committee was therefore reminded to also refer to the full list of consultation comments provided throughout the meeting. The committee was informed that comments which may result in changes to the quality standard had been highlighted in the summary report. Those comments which suggested changes which were outside of the process, were not included in the summary but had been included within the full list of comments, which was within the appendix. These included the following types of comment: • Relating to source guidance recommendations • Suggestions for non-accredited source guidance • Request to broaden statements out of scope • Inclusion of overarching thresholds or targets • Requests to include large volumes of supporting information, provision of detailed implementation	

	advice • General comments on role and purpose of quality standards • Requests to change NICE templates	
8.4 Discussion and agreement of final statements	The Committee discussed each draft statement in turn and agreed upon a revised set. **These statements are not final and may change as a result of the editorial and validation processes.**	

Draft statement 1 – oral iron	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People with iron deficiency anaemia are offered oral iron before and after surgery	• Support for statement around addressing iron deficiency • Suggested inclusion of additional details of what department/staff group is responsible • Details around timescales required	The main focus of this statement is on preventing unnecessary transfusions and minimising risks. The committee discussed that there was no means of identifying people with iron deficiency anaemia in the statement. They considered if the type of admission will make a difference in this statement, such as day patient or in patient. This could be highlighted in the definitions regarding identification of people with iron deficiency anaemia. This should not preclude looking for the cause of iron deficiency before surgery. Committee members felt this was misunderstood at consultation. The committee suggested the wording should say “offer iron supplementation” rather than oral iron to allow for variation in treatment and intravenous iron to be included. They agreed that the measures are not meaningful if they only include oral iron as it is not appropriate for all people with iron deficient anaemia and is not appropriate at certain times before and after surgery. . Timescales are also important as the sooner treatment is started the better. If no timescale is included in the guideline a timescale can be included based on expert opinion. 2 weeks was suggested as an appropriate timescale.	The committee agreed to progress the statement and change the wording to offer iron supplementation and define oral and intravenous iron in the definitions. Make amendments to the rationale/definitions sections to clarify that the statement does not preclude looking for the cause of iron deficiency before surgery. Include timing in the definitions.

		It was agreed that the purpose of this statement is to target people who are found to have iron deficiency anaemia. They should be offered iron supplement or therapy at least 2 weeks before surgery. Define iron supplementation as per the guideline which recommends offering oral iron and considering intravenous as an alternative.	

Draft statement 2 – tranexamic acid for adults	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
Adults who are having surgery and expected to have moderate blood loss are offered tranexamic acid	• Concerns this statement may have limited impact given that only a third of transfusions are given to surgical patients • Define moderate blood loss within the statement • Define contraindications for tranexamic acid use • Query about who is responsible for making this happen • Outcome measures significantly impacted by confounding factors	The committee discussed that the focus on this statement was another way to minimise the need for and risk of blood transfusion. Blood transfusion rates after surgery is the key outcome measure for this statement. The other outcome measures can be attributed to a variety of factors and therefore should not be included. They agreed that whilst mortality is stated as an outcome for this area in the guideline it should just be included in the overarching outcomes for the quality standard. How to measure transfusion rates was discussed. NICE team to get input from SCM's outside the meeting. The committee did not express any desire to include the definition of moderate blood loss within the statement wording.	The committee agreed to progress the statement wording as it is**.**

Draft statement 3 - reassessment after single-unit red blood cell transfusions	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People who receive a single-unit red blood cell transfusion, or an equivalent volume, are clinically reassessed and have their haemoglobin levels checked after the transfusion	• Concerns that the value of single unit transfusion policy is not universally accepted • Concerns that the statement does not indicate what outcome is required or what actions the assessment informs • Unclear if this relates to all red cell transfusions or just to transfusions specified as 'single-unit' • Timeframe required • NHS Blood and Transplant already measuring this	The committee discussed the statement and agreed the wording needs amending. Single unit is not appropriate if a patient is actively bleeding. Use the word restrictive in the statement. The intention of the statement is to assess if a further blood transfusion is needed. Statement wording needs re-ordering. It should include heavy/active bleeding in the definitions. The aim is to avoid unnecessary blood transfusions and adverse events, which are rare. There is a potential risk of under transfusion that can be avoided. The committee discussed potential resource implications linked to this statement for community hospitals or care homes. The NICE team agreed to discuss this with the resource impact team and advised that if the impact is considered significant some additional text could be added to the quality standard acknowledging this. .The measures do not reflect the discussion so need updating.	The committee agreed to progress the statement. Wording of statement to be amended following discussion. Single unit is not appropriate in the wording. Ensure the measures reflect the discussion and revised statement wording.

Draft statement 4 – prophylactic platelet transfusions	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)

People with a platelet count below 10×10^9 per litre who are not bleeding or having invasive procedures or surgery are offered prophylactic platelet transfusions	• Concerns that this statement could encourage inappropriate use as prophylactic platelet transfusions are not appropriate for all patients • Reference to bleeding or invasive procedures could be removed from the statement • Add a list of conditions that would exclude people from this statement • NHS Blood and Transplant already measuring this	The committee discussed this statement and did not feel the statement really addressed the issue of the need to reduce inappropriate platelet transfusions in people who did not need them. The specialist committee members clarified that the issue is overuse not underuse and some initiatives are already in place to address this. The committee agreed the wording of this statement was not clear and did not include a significant part of the population. It was agreed to remove this statement and not progress it for inclusion in the quality standard.	The committee agreed to remove this statement and not progress it based on the discussion that took place.

Draft statement 5 – patient information	Themes raised by stakeholders	Committee rationale	Statement revised (Y/N)
People who may have or who have had a transfusion are given verbal and written information about the benefits and risks of transfusion	• Suggested reword to 'People who may need or who have had..' • People who have sample taken for other requirements e.g. antenatal screening should be excluded • Information for the measures would currently be in patients notes so would be hard to measure apart from sporadic clinical audit	The committee discussed whether this is above what is already in the patient experience quality standard and felt that it was. Stakeholders felt patients should receive the information but also if possible before transfusion rather than after. Highlight in rationale that this provides a chance to discuss alternatives to blood transfusion and that if you have a transfusion you cannot subsequently be a blood donor in the future. This is above the generic information patients are given. The committee was happy with statement and agreed it should include patients before and after surgery.	The committee agreed to progress this statement. Update rationale and measures based on committee discussion.

Additional statements suggested	Committee rationale	Statement progressed (Y/N)
1. Acute decision making or clinically pressing and important behaviour regarding transfusion practice	This area was not covered in guideline.	None of the additional suggested statements were progressed based on the rationale provided.
2. 'People who receive a blood transfusion must be correctly identified at the time of blood sampling for pre transfusion testing and again at the commencement of each transfusion event.'	Nothing in the SIGN guideline to support this and only says consider in the NICE guideline so unable to include as a quality statement.	
3. Observation	NICE team agreed to look at the introduction to quality standard and include reference to the fact	

and monitoring of patients receiving transfusions	that the biggest problem nationally is people are given the wrong transfusion..	
4. Blood transfusion in neonates and preterm infants	The NICE guideline for blood transfusion covers the assessment for and management of blood transfusions in adults, young people and children over 1 year old. There is currently no guidance on blood transfusion for neonates and preterm infants.	
5. Monitoring whether patients benefit from their blood transfusion or otherwise	The committee agreed that this is not an area that is suitable for inclusion as a quality statement.	

Overarching outcomes	The NICE team explained that the quality standard would describe overarching outcomes that could be improved by implementing a quality standard on blood transfusion. It was agreed that the Committee would contribute suggestions as the quality standard was developed.	
Equality and diversity	The NICE team explained that equality and diversity considerations should inform the development of the quality standard, and asked the Committee to consider any relevant issues. It was agreed that the Committee would contribute suggestions as the quality standard was developed.	
9. Next steps and timescales (part 1 – open session)	The NICE team outlined what will happen following the meeting and key dates for the blood transfusion quality standard.	
10. Any other business (part 2 – Private session)	The following items of AOB were raised: • The chair thanked Jim Greer for his input into the committee as he is retiring from the committee.	

	The Chair thanked the specialist committee members for their input into the development of this quality standard, **Date of next QSAC 2 meeting: Thursday 13th October – liver disease and healthy workplaces: improving employee mental and physical health and wellbeing improving**	