NICE National Institute for Health and Care Excellence

Quality standards advisory committee 2 meeting

Date: 8 May 2018

Location: NICE office, Level 1a City Tower, Piccadilly Plaza, Manchester, M1 4TD

Morning session: Oesophago-gastric cancer – prioritisation of quality improvement areas

Afternoon session: Intermediate care including reablement – review of stakeholder feedback

Minutes: Draft

Attendees

Quality standards advisory committee 2 standing members:

Michael Rudolf (chair), Gillian Baird (vice-chair), Jean Gaffin, Malcolm Griffiths, Steven Hajioff, Corinne Moocarme, Jane Putsey

Specialist committee members:

Morning session – Oesophago-gastric cancer
David Exon
Mark Harrison
Jo Harvey
David Simpson
Robert Willert
Luke Williams

Afternoon session - Intermediate care including reablement
Lisa Langford
Frances McCabe
Andrew Nwosu
Claire Waddell

NICE staff
Mark Minchin (MM) {1-9}, Rachel Gick (RG) {items 1-9} Nick Baillie (NB) {items 10-15}, Melanie Carr (MC) {items 10-15}, Julie Kennedy (JK), Jamie Jason (Notes)

Apologies James Crick, Guy Bradley-Smith, Jane Bradshaw, Michael Varrow, Robyn Noonan, Moyra Amess, Mathew Sewell, David Weaver, Julie Clatworthy, Allison Duggal, Ruth Studley

Specialist members – Intermediate care Kate Burgess

1. Welcome, introductions objectives of the meeting
The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to prioritise areas for quality improvement for the oesophago-gastric cancer quality standard. The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow.
2. Confirmation of matter under discussion and declarations of interest
The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the morning session was oesophago-gastric cancer, specifically: • Diagnosis and assessment • Nutritional support • Management • Other forms of support • Organisation of services The Chair asked all QSAC members and specialist members to declare verbally any interests that have arisen since the last meeting and all interests specifically related to the matters under discussion during the morning session.

3. Minutes from the last meeting

The committee reviewed the minutes of the last QSAC 2 meeting held on 10 April 2018 and confirmed them as an accurate record.

4. QSAC updates

There were no updates from the NICE team.

5. Prioritisation of quality improvement areas – committee decisions

RG provided a summary of responses received during the oesophago-gastric cancer topic engagement, referred the committee to the full set of stakeholder comments provided in the papers and the committee then discussed each of the areas in turn. The committee discussed the comments received from stakeholders and specialist committee members at topic engagement **(in bold text below)**.

Diagnosis and assessment

- **Sequencing of diagnostic tests –** Prioritised.

The committee discussed the importance of ensuring PET-CT is undertaken and reported before endoscopic ultrasound (EUS) is requested. While there is not a specific recommendation on sequencing of tests the committee agreed that having a statement on PET-CT scans that includes a timescale will help to ensure it happens before EUS is requested.

As no timescale is recommended in the NICE guideline the committee agreed that a consensus-based timescale will be used in the draft quality standard and publicly consulted on. The committee requested that the NICE team liaise with NHS England with regards to using the oesophago-gastric cancer timed clinical pathway that is currently being developed.

The committee agreed that obtaining a timely reported PET-CT in appropriate patients (as defined in ng83 recommendation 1.3.1) is an area for quality improvement.

ACTION: NICE team to draft a statement and ask a question at consultation regarding the timescale. NICE will liaise with NHS England regarding publication of the timed clinical pathway for oesophago-gastric cancer.

- **Early diagnosis - direct access to endoscopy -** Not prioritised.

The committee noted that this area was already covered in another NICE quality standard. However, the chair noted that the importance of this could be highlighted with a link.

The committee agreed not to prioritise this as an area of improvement recognising it is already covered by the NICE quality standard on suspected cancer (QS124 - statement 2)

ACTION: NICE team to include a link to the suspected cancer quality standard in the draft quality standard.

- **HER2 testing – Not prioritised.**

The committee agreed not to prioritise this as an area of improvement as it only affected a very small number of people.

Nutritional support

- **Specialist dietetic advice and nutritional support –** Prioritised.

The committee discussed that patients can present having already lost a significant amount of weight. This can have an impact on their treatment options.

The committee agreed to focus the statement on radical treatment to reflect the findings of the evidence

review in the NICE guideline on the assessment and management of oesophago-gastric cancer.

The committee discussed whether the statement should focus on assessment and/or support. They agreed that the focus should be on tailored specialist dietetic support as assessment can be undertaken by a non-specialist.

The committee discussed whether the support was more important before, during or after treatment. It was agreed that support before and after radical treatment would be a priority area for improvement.

The committee felt this could have a resource impact and NICE agreed to check with the resource impact team.

The committee agreed to prioritise a statement for tailored specialist nutritional support before and after radical treatment.

ACTION: NICE team to discuss any resource impact for this area with the resource impact team.

ACTION: NICE team to define radical treatment.

ACTION: NICE team to draft a statement for tailored specialist nutritional support before and after radical treatment.

Management

- **Radical treatment** – Not prioritised.
- **Palliative management** – Not prioritised.

The committee discussed both these areas and felt that a quality standard would not add value.

The management of people with oesophago-gastric cancer is generally already being done well. There is some variation in palliative care but centralisation of services has reduced this variation.

Concerns about lymph node dissection were raised but the guidance only has consider recommendations on this area and it is difficult to base a measurable statement on these.

The committee discussed using stents within a timeframe but they agreed that variation in practice for this area is minor so it is not an area for quality improvement.

The committee also noted that the patient pathway was very long and could involve many investigations but did not feel that the quality standard could address this issue. The sequencing of specific diagnostic tests was discussed earlier in the meeting.

The committee agreed not to prioritise these areas.

Other forms of support

- **Information –** Not prioritised.
- **Psycho-social support -** Not prioritised.

The committee discussed that the information currently given was already very comprehensive.

The committee agreed not to prioritise this as an area of improvement as there was not a great variation in practice.

Organisation of services

- **Specialist oesophago-gastric cancer multi-disciplinary team** - prioritised
- **Access to clinical nurse specialist (CNS)** - prioritised
- **Centralisation of services**

The committee was informed that there are a small number of clinical nurse specialists spread across a number of hospitals. The named contact for a patient might not always be an oesophago-gastric clinical nurse specialist. They agreed it is important that people with oesophago-gastric cancer have access to a specialist nurse throughout their care journey.

The committee agreed that input from an oncologist and radiologist specialising in oesophago-gastric cancer in multi-disciplinary team (MDT) meetings is important in helping to ensure the correct decisions are made and optimal management happens for people with oesophago-gastric cancer.

The committee agreed that appropriate specialist input into MDT reviews is an area for quality improvement.

ACTION: NICE team to draft a statement on access to a clinical nurse specialist (CNS) and ask at consultation.

ACTION: NICE team to draft a statement on people with oesophago-gastric cancer having their treatment reviewed by an MDT with oncologist and specialist radiologist with an interest in oesophago-gastric cancer.

ACTION: NICE team to develop a definition of a specialist radiologist with an interest in oesophago-gastric cancer.

6. Additional quality improvement areas suggested by stakeholders at topic engagement

The following areas were not progressed for inclusion in the draft quality standard.

- **4D CT planning** - Not prioritised as a statement due to lack of source guidance.
- **Access to clinical trials** - Not prioritised as a statement as this is in the remit of NIHR.
- **Audits and registries** - Not prioritised as a statement. Quality statements focus on actions that demonstrate high quality care or support, not the methods by which evidence is collated. However, audits, registries and suggested methods of data collection may be referred to in the data sources for quality measures.
- **Diagnosis of Barrett's oesophagus** - Not prioritised as a statement. The identification of Barrett's oesophagus, along with other complications of reflux and oesophago-gastric reflux disease are already covered by a statement relating to referral to a specialist service in the NICE quality standard on dyspepsia and gastro-oesophageal reflux disease in adults (QS96).
- **IMRT planning/delivery [Intensity-modulated radiation therapy]** - Not prioritised as a statement due to lack of source guidance.
- **Nationwide funding for dietetic services** – Not prioritised a statement as nationwide funding is not in NICE's remit; quality standards are intended for areas and issues local commissioners can influence.
- **New guidance (concerning the functioning of MDTs).** Inclusion of healthcare professionals in certain roles and their input into reviews was prioritised (see above). Additional guidance is outside of the remit of quality standards. Suggestions for additional guidance will be passed on to the NICE centre for guidelines.
- **Participation in a local cancer alliance** – Not prioritised as this does not relate to the effectiveness of an intervention.
- **Quality of gastroscopy [upper GI endoscopy]** – Not prioritised; this issue is covered by NICE's quality standard on suspected cancer (QS124 - statement 2).
- **Quality of management of Barrett's oesophagus** – Not prioritised; this issue is covered by existing quality standards / guidance: gastro-oesophageal reflux disease and dyspepsia in adults: investigation and management refers to communicating the need for life-long endoscopies to people diagnosed with Barrett's oesophagus. Reviewing evidence regarding the benefits and cost-effectiveness of interventions are beyond the scope of a quality standard. Also, Barrett's oesophagus was not identified as a priority area in relation to oesophago-gastric cancer.

- **Quality of survivorship initiative services** – Not prioritised as a separate statement, though support for GPs and primary care professionals may be referred to in the audience descriptors.
- **Thickening powder to modify fluids (training and other contextual factors)** – Not prioritised as a statement: quality statements focus on the resulting action from having well trained staff that demonstrate high quality care or support, rather than the training. Training should underpin all the statements.

7. Resource impact and overarching outcomes

The committee noted there was some cost increase in early diagnosis but not as a result of direct access but wider criteria for eligibility.

Section 5 details discussion / actions supporting consideration of resource impact in relation to tailored, specialist nutritional support.

RG requested that the committee submit suggestions to the NICE team relating to the overarching outcomes of the quality standard when it is sent to them for review.

8. Equality and diversity

The committee agreed the following groups should be included in the equality and diversity considerations: It was agreed that the committee would continue to contribute suggestions as the quality standard was developed.

Age	Disability
Gender reassignment	Sex
Pregnancy and maternity	Race
Religion or belief	Sexual orientation
Marriage and civil partnership	

The committee were asked if we would have benefited from any specialist knowledge that was not present at today's meeting. A committee member suggested input from a dietitian would be relevant for this quality standard. The NICE team explained that this had been considered but as there a number of specialists who have a good awareness of nutrition issues for this group of patients it was decided not to recruit a dietitian. Comments were sought (and received) from the BDA through the normal stakeholder engagement process during topic engagement. The NICE team agreed to consider appointing an additional specialist committee member (dietician) now nutrition has been identified as a priority area, and to seek input from dieticians at consultation stage.

9. Close of morning session

The specialist committee members for the oesophago-gastric cancer quality standard left and the specialist committee members for the intermediate care including reablement quality standard joined.

10. Welcome, introductions and objectives of the afternoon

The Chair welcomed the intermediate care including reablement specialist committee members and QSAC members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the afternoon, which was to review stakeholder comments.

The Chair informed the committee that due to a number of apologies the meeting was not quorate. However, we still had 4 specialist members present and the meeting would go ahead. The NICE team will email all decisions to absent members to ratify what was decided.

11. Confirmation of matter under discussion and declarations of interest

The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the afternoon session was intermediate care including reablement.

The Chair asked both standing and specialist QSAC members to declare verbally all interests specifically related to the matters under discussion during the afternoon session.

12.1 Recap of prioritisation meeting and discussion of stakeholder feedback

MC provided a recap of the areas for quality improvement prioritised at the first QSAC meeting for potential inclusion in the intermediate care including reablement draft quality standard.

MC summarised the significant themes from the stakeholder comments received on the intermediate care including reablement draft quality standard and referred the committee to the full set of stakeholder comments provided in the papers.

The committee noted that it would be helpful to clarify the definition of intermediate care and also to make it clear that the quality standard applies to all types of intermediate care service.

ACTION: NICE team to add a definition of intermediate care at the beginning of the quality standard to make it clear which services are included.

12.2 Discussion and agreement of amendments required to quality standard

Draft statement 1: **Discussion about intermediate care** **Adults being assessed for intermediate care have a discussion about the support the service will and will not provide.**	The committee heard that there was support for the statement from stakeholders and agreed it should be progressed for inclusion in the final quality standard with the following amendments and issues to be explored by the NICE team: • Emphasising that people should be aware they are being assessed for intermediate care and what the options may be, for example, care at home or in a care home. • Clarifying that the person carrying out the assessment is responsible for having the discussion with the person about what support the service will and will not provide. • Make the intent of the statement clearer in the rationale and audience descriptors. • Add a broad definition of the type of information to include in the discussion based on NG74 recommendations 1.5.1 and 1.5.2. **ACTION: NICE team to retain the wording of the statement but amend the supporting information to reflect the issues raised by the committee.**
Draft statement 2 **Starting bed-based intermediate care** **Adults accepted for bed-based intermediate care start the service within 2 days of referral.**	The committee heard that there was support for the statement from stakeholders and agreed it should be progressed for inclusion in the final quality standard with the following amendments and issues to be explored by the NICE team: • Add a definition to clarify it is 2 calendar days/48 hours. • Clarify that timescale is within 2 days of referral not within 2 days of the referral being accepted. • Consider if hospital readmission rates could be a useful outcome measure. The committee agreed that although there are significant resource implications for this statement there are also likely to be important gains for the healthcare system as a whole. On balance the committee agreed the statement is achievable as it is already being achieved in some areas and there has already been a reduction in the waiting time for bed-based intermediate care in recent years. It was pointed out that there is a risk that people may not be accepted for bed-based intermediate care if the 2 day target cannot be met, but the committee nevertheless felt that this is an

<table>
<tr><td></td><td>important area which should be included in the quality standard.

ACTION: NICE team to retain the wording of the statement but amend the supporting information to reflect the issues raised by the committee.</td></tr>
<tr><td>Draft statement 3
Personal goals

Adults starting intermediate care discuss and agree personal goals.</td><td>The committee heard that there was support for the statement from stakeholders and agreed it should be progressed for inclusion in the final quality standard with the following amendments and issues to be explored by the NICE team:
Agreed to revise wording to replace ‘personal goals’ with ‘personalised goals’.
Reinforce the need for the review of goals in the rationale and audience descriptors.
Ensure measures require personalised goals to be recorded.
ACTION: NICE team to revise the wording of the statement and amend the supporting information to reflect the issues raised by the committee.</td></tr>
<tr><td>Draft statement 4
A plan for when the service ends

Adults using intermediate care discuss and agree a plan for when the service ends.</td><td>The committee heard that there was support for the statement from stakeholders and agreed it should be progressed for inclusion in the final quality standard with the following amendments and issues to be explored by the NICE team:
Revise wording to reduce any potential ambiguity i.e. ensure it cannot be read as just having a timescale for the end of the service and includes having a plan for meeting any ongoing support needs.
Ensure people are made aware that they may need to pay for any ongoing care once intermediate care ends.
ACTION: NICE team to revise the wording of the statement and amend the supporting information to reflect the issues raised by the committee.</td></tr>
<tr><td colspan="2">12.3 Additional quality improvement areas suggested by stakeholders at consultation</td></tr>
<tr><td colspan="2">The following areas were not progressed for inclusion in the final quality standard:
Primary/secondary care practitioner awareness of intermediate care - this relates to statement 1 which requires practitioners to have knowledge of the service in order to have a discussion with the person being assessed about the options available. The committee agreed that a separate statement was not required.
Holistic assessment of needs – there are no specific recommendations in the guideline on having a holistic assessment but the committee did consider assessment of need for referral to other services at the first meeting but did not prioritise.
Response times for home-based intermediate care, reablement and crisis response - the committee agreed there are no suitable recommendations for the development of a statement on response times for services other than bed-based intermediate care.
Access to a multidisciplinary team – this was considered at the first meeting but not prioritised as it is covered in the NHS England commissioning guidance.
Case manager – the committee did not consider this to be a priority and there are no suitable recommendations in the guideline to support development of a statement.
How to provide support – this is included in the audience descriptors for statement 3 and the committee agreed that a separate statement was not needed.
Measuring outcomes on discharge – this is included as an outcome measure for statement 3 and</td></tr>
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there are no recommendations to support development of a separate statement. 8. **Staff training and development** – quality standards do not include statements on training because the focus should be on what the training will improve rather than the training itself. The committee discussed that there is currently wide variation in the provision of intermediate care and reablement services with limited provision in some areas due to funding. The committee agreed this is an important issue but that the provision of services is not an issue that can be addressed by the quality standard.
13. Resource impact and overarching outcomes
The committee confirmed that the statements should be achievable by local services given the net resources required to deliver them. The committee suggested that it would be helpful to align the overarching outcomes with those included in the rehabilitation after critical illness quality standard where relevant. They also suggested adding the following outcomes to the quality standard: Independence Satisfaction Carer quality of life MC requested that the committee submit any further suggestions to the NICE team relating to the overarching outcomes of the quality standard when it is sent to them for review.
14. Equality and diversity
MC provided an outline of the equality and diversity considerations included in the quality standard so far and requested that the committee submit any further suggestions when the quality standard is sent to them for review.
15. Any other business
None.
Close of meeting