National Institute for Health and Care Excellence

NICE Quality Standards Consultation – antimicrobial stewardship

Closing date: Please send this electronically by 5pm on **24th December 2015** to QSconsultations@nice.org.uk

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Please note: comments submitted on the draft quality standard are published on the NICE website.	
Would your organisation like to express an interest in formally supporting this quality standard? ☐ Yes ☐ No For information about supporting quality standards please visit http://www.nice.org.uk/Standards-and-Indicators/Developing-NICE-quality-standards	

The Institute is unable to accept

- Comments received after the consultation deadline
- Comments submitted not on this proforma
- More than one response per stakeholder organisation
- Confidential information or other material that you would not wish to be made public
- Personal medical information about yourself or another person from which your or the person's identity could be ascertained

Please provide comments on the draft quality standard on the form below, putting each new comment in a new row. When feeding back, please note the section you are commenting on (for example, section 1 Introduction). If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor). If your comment relates to the standard as a whole then please put 'general'.

In order to guide your comments, please refer to the general points for consideration on the NICE website as well as the specific questions detailed within the quality standard.

Please add rows as necessary.

Section	Comments
-	The Faculty of General Dental Practice (UK) is based at The Royal College of Surgeons of England. We are the largest of the UK dental faculties and provide a national voice for over 4,700 fellows and members. Around 95% of dental care in the UK is provided in the primary dental care setting. The FGDP(UK) improves the standard of primary care dentistry delivered to patients through standard setting, postgraduate training and assessment, publications, policy development, and research. The FGDP(UK) offers continuing professional development and training opportunities for all registered dental professionals.
-	The Faculty of Dental Surgery (FDS) is a professional body committed to enabling dental surgeons to achieve and maintain excellence in practice and patient care. We currently have over 5,500 fellows and members, based in the UK and across the world.
Quality Standards Advisory Committee and NICE project team (pp25-26)	It is disappointing that NICE has developed these draft quality standards to date without dental input and expertise. Dentists prescribe around 10% of antimicrobials in the UK yet there are no dental professionals among the 18-strong advisory committee. The consultation document seems to assume in places that policy developed by other healthcare professionals will automatically be suitable for dentists, but this is not always the case. As with other areas of healthcare, there is growing concern about, and evidence of, inappropriate prescribing within dentistry, and the appointment of one or more dental professionals to the advisory committee could have helped ensure a document more pertinent to dentistry and ultimately therefore better help to reduce inappropriate

Section	Comments
	antimicrobial prescribing by dentists.
Statement 1	While we agree with the quality statement itself, dental infections and conditions are not self-limiting. They require definitive management by dental/surgical intervention by dental professionals, and are not therefore comparable to coughs and colds. This statement is therefore not relevant for dentistry. In particular, the specific reference to toothache as a self-limiting condition (see “What the quality statement means for patients service users and carers”, p8) is inaccurate. Toothache is a symptom of several conditions (including dentine sensitivity, acute reversible pulpitis, irreversible pulpitis, dental abscess, and local infection spreading to sublingual, submandibular or parapharyngeal spaces), none of which are self-limiting and all of which require professional intervention. Toothache should therefore be removed from the list of self-limiting conditions contained in the statement. Nonetheless, we agree that antibiotics should not be prescribed for these conditions, and therefore for toothache, with the exception of preventing the spreading of an existing infection when the appropriate professional intervention is not immediately possible. We also recognise the need, where antibiotics are not being prescribed, to educate and inform patients about the reasons for this. The profession would welcome assistance in the education of the public in this regard as this would help reverse the current momentum of expectation for antimicrobial dispensing during clinical consultations. The definition given of self-limiting conditions (p9) should also be corrected to refer to those that are likely to resolve without any treatment, not just those that will resolve without antimicrobial treatment.
Statement 2	Dentists should not consider the option of delayed prescribing in anything other than rare and exceptional circumstances, and this should be noted in the statement. We are not aware of evidence supporting the practice of delayed prescribing within dentistry, and there should be little or no need for it. As FGDP (UK) guidance notes, “antimicrobial prescribing in primary care is only indicated…for the definitive management of active infectious disease” (Antimicrobial Prescribing for General Dental Practitioners, 2012, FGDP(UK)).

Section	Comments
	Following appropriate examination and definitive treatment, if there is uncertainty about whether a condition will resolve, patients should be given clear advice on re-attending for further assessment. The need for delayed prescribing would only arise where known future circumstances will make it impossible for the patient to access an appropriate dental professional for further assessment.
Statement 3	We support this statement, and note that the accurate recording of prescribing is already required of dental professionals (Responsible Prescribing, 2008, General Dental Council). However we also note that ESPAUR data shows that it is not yet routine practice in dentistry. We therefore also support the expectation that commissioners will only commission providers who meet the antimicrobial recording requirements, as this will encourage best practice. For the same reason, we further believe that data on antimicrobial prescribing by individual practitioners should be collected.
Statement 4	We recognise the need for antimicrobial prescribing to be specific to the pathogen, and therefore agree with this statement. However, should it later be suggested that microbiological sampling be extended to primary care dentistry, we would not support that. The correct treatment of infections is removal of the cause (and prescribing empirically where antibiotics are appropriate). The additional cost of sampling would not be justified, and the additional waiting time for results could harm the patient.
Statement 5	We agree with this statement. Collection of prescribing data is a valuable tool at all these levels, can be used comparatively to allowing benchmarking and identification of outliers, trends and educational needs, and provides useful data for policy-makers. Robust data on individual dental prescribing is particularly important and has been shown to reduce antibiotic prescribing.
Statement 6 and Consultation Question 4	The collection and monitoring of prescribing data for all dental care would be a significant aid to stewardship, and we welcome this developmental statement, recognising that its realisation would greatly support Quality Statement 5. As the British Dental Association's Antimicrobial Resistance in Dentistry Summit (2014) concluded, *"without the*

Section	Comments
	ability to prescribe electronically, the collection and provision of comprehensive prescribing data is an excessively onerous and time-consuming task". However there are not currently the systems in place to enable this. Most dental practices do not have access to NHS patient health records, and for the electronic collection of prescription data to be implemented, significant funding would need to be provided to enable primary dental care to acquire the necessary technology to participate. Contracting of dentistry would also have to be modernised to allow monitoring and recording of prescribing. Mechanisms to overcome the lack of information governance and IT access have been recommended in the NHS dental specialist commissioning guides, and we would recommend NICE also consider these by way of answer to whether the sector will need "specific, significant changes to be put in place, such as redesign of services or new equipment" (Consultation Question 4). However, even if all this were achieved within NHS dentistry, it should be noted that there could still remain a significant data gap with regard to private dental practice, where it is common practice to purchase and dispense antimicrobials outwith NHS systems.
Consultation Question 1	There is insufficient emphasis on the training and education of both healthcare practitioners and patients. We support the recommendations from the British Dental Association's Antimicrobial Resistance in Dentistry Summit (2014) that training in stewardship be developed for the whole dental team, education materials be developed for patients, and stewardship be embedded in the Good Practice Scheme.
Consultation Question 2	With respect to dentistry, yes - if the systems and structures were available, data collection and monitoring of antimicrobial prescribing to support the proposed quality measures would be possible. However it must be recognised that dentistry, particularly primary care dentistry, is starting from a different place compared with many other healthcare settings. Dental practices are individual businesses, which are not networked into the main electronic patient record system, and which are not yet party to the NHS culture of

Section	Comments
	sharing patient information.
Diversity, equality and language (p22)	We agree with the statement that “People using antimicrobials and their families or carers (if appropriate) should have access to an interpreter or advocate if needed.”

What will happen to your comments
A summary of the consultation comments, prepared by the NICE quality standards team, and the full set of consultation comments will be shared with the Quality Standards Advisory Committee (QSAC). The QSAC will then meet to review the comments and the quality standard will refined with input from the QSAC chair and members.

Please note that NICE does not respond to consultation comments submitted on NICE quality standards. Instead, following the publication of the quality standard, NICE will provide stakeholders who submitted comments with a link to the minutes of the meeting that will summarise the committee discussions and decisions.

The summary of consultation comments and full set of comments received from registered stakeholders will be published on the NICE website alongside the quality standard. Comments received from individuals and non-registered stakeholders will be considered by the QSAC but will not be published on the website.

NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.

Comments received in the course of consultations carried out by the Institute are published in the interests of openness and transparency. The comments are published as a record of the submissions that the Institute has received, and are not endorsed by the Institute, its officers or advisory committees.