

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

NICE guidelines

Equality impact assessment

Otitis media with effusion in under 12s

The impact on equality has been assessed during guidance development according to the principles of the NICE equality policy.

3.0 Guideline development: before consultation

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?

Throughout the development of the guideline the committee were aware that special considerations might be necessary for certain groups. When drafting recommendations, the committee considered if specific recommendations for certain groups were needed to address any inequalities or if particular groups could be disadvantaged by the draft recommendations. The committee were keen to make the recommendations as inclusive as possible but to highlight specific groups when it was felt to be necessary or beneficial.

Various equalities issues identified during scoping are outlined below (in cursive).

Age

The guidelines covers children under 12 years of age. Within this age group, OME is most common in pre-school aged children. (EIA 1.0)

The committee recognised the importance of including children in discussions about OME, so made recommendations to address this (recommendations 1.1.1, 1.1.3 and 1.1.8).

The committee felt that it was important that children were informed about OME and different management options, so made recommendations to address this (recommendations 1.1.2 and 1.1.5).

The committee were aware of the importance of ensuring that information on OME was available in a range of formats that were appropriate to people's needs, so made a recommendation to address this (recommendation 1.1.6). This was felt to be particularly relevant to children under 12, as this population covers a wide range of ages and development, so it is important that information is available that is appropriate for the individual child.

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The committee were aware that some children, especially very young children, may not engage with or may not be able to use auto-inflation devices. Therefore, although they recommended the use of auto-inflation devices in children (recommendation 1.5.1) they added that this be considered if they are able to engage with the treatment.

The committee recognised the importance of including children in discussions about the benefits and risks of, as well as shared decisions around, grommets and adenoidectomy, so made recommendations to address this (recommendations 1.6.2 and 1.6.4).

Disability

Children with complex needs, including learning disabilities and children with sensory disorders and autism may be at an increased risk of delayed detection of OME because the impact of OME may be less apparent. For example, the inability to follow instruction at school may be attributed to a difficulty in understanding rather than to difficulty hearing. Persistent or fluctuating OME can lead to increased risk of adverse outcomes which may already be increased in these children, such as problems with learning, speech and language development, listening skills, auditory processing skills and impact on social relationships and confidence. (EIA 1.0)

After consultation, it was noted at scope sign-off that some children at risk of having OME misinterpreted can be at higher risk of having OME in the first place through craniofacial abnormalities. (EIA 2.0)

The committee were aware of the risk of delayed detection of OME and made a number of recommendations about recognising OME which included factors, such as a lack of concentration or attention, poor educational progress, delayed speech and language development, and hearing difficulties, that should be taken into consideration (recommendations 1.2.1, 1.2.2 and 1.2.3). This was considered to be particularly relevant for children with disabilities where OME might not be recognised.

The committee were aware of the importance of ensuring that a range of formats appropriate to people's needs were used when making information available, so made a recommendation to address this (recommendation 1.1.6). This may be particularly relevant for children with a disability who may need accessible versions, such as Easy read, Braille or captioned videos.

The committee were aware that decisions over the use of bone conduction devices or air conduction hearings aids may be influenced by factors such as narrow ear canals, linked to craniofacial abnormalities and which may be an issue for children with Down's syndrome, or small parts, which may be an issue for children with learning disabilities. So included these as examples in relevant recommendations

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(recommendations 1.4.2 and 1.4.3).

The committee recognised the importance of discussions with children, parents and carers about the benefits and risks of, as well as shared decisions around, grommets so made recommendations to address this (recommendations 1.6.2). This may be particularly relevant to children with Down's syndrome, as craniofacial abnormalities can lead to narrow ear canals which can impact on decisions around grommet insertion.

The committee were aware that abnormality of the palate should be taken into consideration when considering the need for adjuvant adenoidectomy. So included this in a recommendation (recommendation 1.6.3).

The committee recognised the importance of individualised follow-up plans for children who have an increased risk of unrecognised OME with hearing loss. So made a recommendation to cover this (recommendation 1.6.13). This may be particularly relevant for children with Down's syndrome, learning disabilities or neurodevelopmental issues.

Socio-economic factors

Children from families of lower socioeconomic status may be disadvantaged, for example they may have difficulties affording transport to access treatment. (EIA 1.0)

The committee were aware of potential barriers to treatment for OME. So made recommendations that parents and carers should have the opportunity to contact audiology services to discuss the need for further hearing assessment for their child if they are concerned about recurrence of hearing loss (recommendations 1.3.3 and 1.6.14). Having direct referrals to Audiology services without the need to go through GP referral could improve access to treatment for children from families of lower socioeconomic status.

Children who are non-English speaking or whose first language is not English

The inability to follow instruction at school may be attributed to a language barrier rather than a hearing loss potentially leading to undiagnosed and untreated OME which could further impact on the child's developmental outcomes. (EIA 1.0)

The committee were aware that issues such as a child's lack of concentration or attention and poor educational progress might actually be an indication of OME, so made a recommendation about this (recommendation 1.2.2). This might be relevant in diagnosing OME if reported to healthcare professionals.

The committee were aware of the importance of ensuring that a range of formats appropriate to people's needs were used when making information available. So made a recommendation about this (recommendation 1.1.6). This might be relevant

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for some children who are non-English speaking or whose first language is not English by helping to highlight what OME is and aiding its diagnosis.

The committee recognised the importance of advising parents and carers of children with OME and hearing loss about ways they can support their child including in educational settings, so made a recommendation to address this (recommendation 1.1.7). One of the ways support is suggested is informing teachers that the child has OME, and asking if adjustments can be made in school to help.

Children who move between places, for example travellers or refugees

Children who move between places and do not have permanent places of residence are not likely to have the same level of monitoring and treatment as their peers and could therefore end up with untreated OME. (EIA 1.0)

The recommendations in the guideline aim to improve the monitoring and treatment of OME in all children and the implementation of these recommendations should hopefully help all children with OME including those who move between places and do not have permanent places of residence.

Looked-after children

Looked after children may have multiple placements and carers or inadequate handover of care between placements and the impact of OME on their hearing may not be recognised and managed appropriately. (EIA 1.0)

The committee were aware of the risk of delayed detection of OME and made a number of recommendations about recognising OME. Some of these recommendations covered more clinical features such as delayed speech and language development, hearing difficulties and asthma (recommendations 1.2.1 and 1.2.3). Another recommendation covered other factors, such as behavioural problems, a lack of concentration or attention, and poor educational progress, that people might not always associate with OME, but the committee wanted to raise awareness of as possible indicators of OME (recommendations 1.2.2). The committee made a further recommendation that if OME is suspected based on these features or indicators and the child's clinical history then they should be referred for formal assessment (recommendation 1.2.5). The aim of these recommendations is to improve recognition and assessment of OME, which will then lead to more children having their OME managed appropriately. This may improve the recognition and management of OME in looked after children.

3.2 Have any **other** potential equality issues (in addition to those identified during the scoping process) been identified, and, if so, how has the Committee addressed them?

No other potential equality issues (in addition to those identified during the scoping process) have been identified.

3.3 Have the Committee's considerations of equality issues been described in the guideline for consultation, and, if so, where?

The Committee's considerations of equality issues have been described in the committee's discussion of the evidence sections in evidence reviews B, E, F, I, J, M and N as well as in the rationale and impact sections linked to the recommendations mentioned in box 3.1.

3.4 Do the preliminary recommendations make it more difficult in practice for a specific group to access services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No, the preliminary recommendations do not make it more difficult in practice for a specific group to access services compared with other groups.

3.5 Is there potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability?

No, there is not potential for the preliminary recommendations to have an adverse impact on people with disabilities because of something that is a consequence of the disability.

3.6 Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in box 3.4, or otherwise fulfil NICE's obligation to advance equality?

No, there are not any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access to services identified in box 3.4, or otherwise fulfil NICE's obligation to advance equality.

Completed by Developer: Tim Reeves

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