**National Institute for Health and Care Excellence**

**Quality Standards Advisory Committee 2 meeting**

**Tuesday 10 September 2024**

**Meningitis (bacterial) and meningococcal disease - review of stakeholder feedback**

**Minutes:** FINAL

**Quoracy:** The meeting was quorate.

**Attendees:**

**Quality Standards Advisory Committee 2 standing members:**

Anica Alvarez Nishio (Chair), Peter Hoskin, Mark temple, Dominika Froehlich-Jeziorek, Louis Savage, Nadim Fazlani, Murugesan Raja, Steve Hajioff, Rachael Ingram, Devina Maru

**Specialist committee members:**

Saul N Faust (left at 12noon), David Metcalfe, Ian Maconochie

**NICE staff**

Mark Minchin (MM), Christine Harris (CH), Eileen Taylor (ET), Nicola Greenway (NG), Christina Barnes (notes)

**NICE observers**

Peter Shearn

**Apologies**

Standing committee members: Rebecca Payne, Esabel Chabata, Lindsay Rees, Jane Putsey, Nick Screaton , Linda Glennie, Julia Gallagher , Ruth Studley, Moyra Amess

Specialist committee members: Martin Vernon, Linda Glennie, Michael Bryan

1. **Welcome, introductions objectives of the meeting**

The Chair welcomed the attendees and public observers, 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 review stakeholder feedback.

1. **Confirmation of matter under discussion and declarations of interest**

CH gave an overview of the changes which have come into effect for the NICE declarations of interest (DOI) policy. The main changes require the register to include:

* Declarations of specific NHS employment
* Alignment with interests as stated on the ABPI disclosure database

CH assured the committee that all declarations will be checked with each committee member before any DOI are published on the register of interests.

The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion was **meningitis (bacterial) and meningococcal disease update** specifically

* Antibiotics prior to hospital admission and recognition of bacterial meningitis and meningococcal disease
* Investigating suspected bacterial meningitis or meningococcal disease in hospital
* Treatment for bacterial meningitis or meningococcal disease in hospital
* Discharge and follow up
* Information and support

The Chair asked standing QSAC members and specialist committee members to declare any interests additional to those that were circulated. Or any interests specifically related to the matters under discussion. No further declarations were declared.

1. **Minutes from the last meeting**

The committee reviewed the minutes of the last QSAC 2 meeting held on 09 April 2024 and confirmed them as an accurate record.

**Recap of prioritisation meeting and discussion of stakeholder feedback**

ET provided a recap of the areas for quality improvement prioritised at the first QSAC meeting for potential inclusion in the meningitis (bacterial) and meningococcal disease update draft quality standard.

ET summarised the significant themes from the stakeholder comments received on the meningitis (bacterial) and meningococcal disease update draft quality standard and referred the committee to the full set of stakeholder comments provided in the papers.

**General**

* General support of the QS and agreement in general with the areas of focus of the quality statements
* A stakeholder also confirmed that data can be collected
* Suggestion to include more information about meeting the specific needs of the presenting patient (adult or child)
* Concerns raised that the QS does not emphasise the importance of accurate and timely diagnosis of meningitis
* As this is a rare condition more robust guidance on named clinicians need to be quantified for example named Rehab Consultants

A discussion took place about the prescribing of antibiotics outside of the hospital setting, within the community and how the delay can have an adverse impact on the outcome of the patient. However, it was noted that this had been discussed at the first committee meeting for this topic and had not been taken forward in the quality standard due to issues with measurement.

**Discussion and agreement of amendments required to quality statements**

**Draft statement 1: People sent home after clinical assessment indicates they are unlikely to have bacterial meningitis or meningococcal disease are given safety netting advice. [2012, updated 2024]**

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard, with the following amendments and issues to be explored by the NICE team:

A stakeholder comment on the audience descriptor regarding information being given if appropriate was highlighted and it was agreed that the NICE team would amend the wording to avoid confusion. In addition, a stakeholder noted an inconsistency in terminology in the quality standard and equality and health inequalities assessment relating to the rash that may be present with bacterial meningitis or meningococcal disease. It was agreed that the NICE team would make the relevant amendments to ensure consistency.

The committee noted a concern raised that the equality and diversity section for this quality statement references resources that may be helpful in identifying a rash in children however there is no such resource referenced relating to adults. It was accepted that no resources of this type have been identified for adults.

The committee discussed the type of advice (written or verbal) and who gives it. It was noted that a clinician may be giving safety netting advice for a number of conditions meaning that providing a lot of written advice may cause anxiety and information overload. It was also noted that if only verbal advice is being given, this could cause difficulties in measurement. It was agreed that a nurse or clinician in the assessing team should be the person to give the advice.

**ACTIONS:**

* **Progress statement**
* **Refinement of the statement to provide more clarity to show that this is for those people who have been clinically assessed for bacterial meningitis or meningococcal disease and are considered unlikely to have one of those conditions.**
* **Further clarity required around the denominator of population**
* **Review definition of good quality advice, for example if this should specify whether it is written and/or oral.**

**Draft statement 2: People with suspected bacterial meningitis do not have neuroimaging before lumbar puncture unless clinically indicated. [New 2024]**

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard.

The committee discussed the effectiveness of the statement as it can read in a negative way. It was noted that further clarity is required to ensure that lumbar puncture should be carried out before neuroimaging unless clinically indicated. The committee consensus was the statement wording needed to be refined.

The committee noted the importance of this quality statement, lumbar puncture ensures the correct diagnosis can be made, meaning tailored antibiotics can be given promptly. In most cases, neuroimaging is not needed and carrying this out unnecessarily delays administration of tailored antibiotics.

The committee discussed stakeholder comments that the contraindications are difficult to identify. They noted the contraindications are clear in the NICE guideline and can be easily recognised by a clinician.

The committee also noted a stakeholder comment relating to quality statements 2 and 3 that other conditions (viral meningitis and encephalitis) have similar symptoms and there may be a randomness to the diagnosis being made. The committee agreed that this does not impact these quality statements as they would be the correct steps for these conditions.

The committee discussed the data sources for the measure. It was suggested that the statement was measurable and the data could be found by viewing the patient’s electronic medical records to see the order in which tests were done in the pathway or via imaging records. The committee were satisfied the statement is measurable.

**ACTIONS:**

* **Progress statement.**
* **Refinement of the statement wording so that is a positive action.**

**Draft statement 3: People with suspected bacterial meningitis or suspected meningococcal disease receive intravenous antibiotics within 1 hour of arrival at hospital. [2012, updated 2024]**

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard,

ET informed the committee that advice has been obtained from a NICE clinical adviser due to stakeholder concerns that this statement may contradict the recommendations made within the NICE sepsis guideline. The clinical adviser explained that there is no contradiction. It was noted that both conditions can occur at the same time therefore clinicians will think about both suspected diagnoses in parallel and manage the patient accordingly. In addition, it was noted that NEWS2 would be completed on arrival at hospital, which is the same time that people would be assessed for any condition. The committee agreed with this.

The committee discussed the definition of the arrival at hospital, this needs to be more prescriptive due to concerns raised around the potential delays of waiting ambulances. It was discussed that physical arrival or booking in time would be the most measurable as this is ‘time stamped’, though this may also be impacted. MM advised the committee that the NICE team could review some of the national audits, such as stroke, to ascertain the definitions of a time stamp across NICE guidance. A committee member highlighted a quality standard is to help organisations make modifications to processes and drive improvements to ensure safety issues are dealt with accordingly. The committee consensus was that the clock starts from first point of contact and agreed that this needed to be more prescriptive within the quality standard.

The committee discussed if this statement should be expanded to cover other settings in addition to secondary care or should exclude patients who were given antibiotics prior to arrival at hospital. The committee agreed that this statement should be aimed at secondary care only and not have any exclusions. They explained that the specific antibiotics needed would only be given in secondary care as they are not held in primary care or by ambulance crews.

**ACTION:**

* **Refinement of the definition of when the clock starts and arrival at hospital**
* **Review timeframe by looking at other QS and National Audits**

**Draft statement 4: People who have had bacterial meningitis or meningococcal disease are offered an audiological assessment within 4 weeks of them being well enough for testing. [2012, updated 2024]**

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard.

The importance of the audiological assessment being carried out promptly was reiterated by the committee, noting that the result of this assessment is needed to establish whether cochlear implant is needed. Due to bone fusion, this implant must be given within 6 months of the illness.

The committee discussed the current landscape of the audiology services and agreed that there should be enough capacity within the system to carry out audiological assessment within hospital or community settings to avoid the transfer of work and potential resource impact within primary care.

Saul N Faust left the meeting due to other commitments.

The committee also discussed stakeholder comments on the definition of people being well enough for testing. The committee agreed that the wording of the statement was a little vague and required more clarity around the use of the words ‘offered’ and ‘well enough for testing’ within the quality standard. ET confirmed that ‘offered’ could be changed to ‘have’.

**ACTION:**

* **Refine wording of statement to provide clarity of the term ‘offered’ and terms ‘well enough for assessment’**

**Draft statement 5: People who have had bacterial meningitis or meningococcal disease have a follow-up appointment in secondary care within 6 weeks of discharge from hospital. [2012, updated 2024]**

The committee agreed that as there was support for the statement from stakeholders it should be progressed for inclusion in the final quality standard.

The committee noted a stakeholder query on which healthcare professional would carry out the follow up appointment and felt this would be agreed locally as this will depend on individual circumstances.

The committee discussed the way in which the follow up assessment should be delivered. It was suggested that follow up should not be carried out virtually as a face to face follow up will enable full assessment of mobility, activities in daily life etc.

A committee member shared a link to a psychological assessment tool which can be found on the BACCH website <https://bacch.org.uk/pages/resources>

The committee discussed the potential resource impact raised by a stakeholder and advised this may apply to paediatrics and may also apply to adults, though it was noted that this population are small in number so the impact would not be expected to be significant. In addition, during the development of the guideline, resource impact was considered and this was not identified as an area that would have a significant impact.

**ACTION:**

* **Progress statement as worded**
* **Provide clarity in the definition of the healthcare professional carrying out the follow up appointment**
* **Consider adding a caveat how the follow up assessment is to be delivered such as face to face to enable full mobility assessment which would not be able to be done virtually**
1. **Additional quality improvement areas suggested by stakeholders at consultation**

The following areas were not progressed for inclusion in the final quality standard as the committee agreed that they were not a priority in relation to the five quality improvement areas already included:

Steroids

Primary Care

Additional guidance

ET confirmed that steroids and actions to be taken in primary care had been discussed and not prioritised during the first committee meeting. It was noted that additional guidance is outside the remit of quality standards and that the information from stakeholders would be passed to the guidelines team for consideration during future guideline updates.

1. **Resource impact**

The committee considered the resource impact of the quality standard.

A committee member noted that quality statements 3, 4 and 5 could have a resource impact, though it was noted that this is a small population therefore it is unlikely that they would lead to a significant impact. In addition, these areas were not noted as having a significant resource impact during guideline development.

A committee member felt that statement 3 could lead to potential cost savings as giving antibiotics promptly could lead to a reduction in significant longer-term health conditions.

Ian Maconochie left the meeting due to other commitments.

1. **Equality and Diversity**

ET provided an outline of the quality and diversity considerations included so far and requested that the committee submit suggestions when the quality standard is sent to them for review, reiterating that the areas must be specific to the quality standard topic.

**ACTION:**

* **Check the equalities information in QS aligns with the EHIA**
1. **Any other business**
* **Next steps**

ET confirmed that draft quality standard will be sent to committee members on 26 September 2024 until 03 October 2024.

* **New formed QSAC**

CH outlined the intentions for the QSAC going forward.

CH highlighted the key changes within the new non-staff reimbursement policy which came into effective from August 2024, this includes:

* Increase locum back fill rates
* Forms that need to be completed
* How payments are made.
* Submission of claims need to be made within 3 months of the meeting.

CH informed members that the next QSAC meeting will be held on **Friday 17 October 2024**, this will be the first meeting of the newly formed QSAC and will be a in person meeting and will be held at the NICE Manchester Offices. CB we will be in contact with all members shortly to seek any necessary travel requirements and get that booked in line with the NICE travel and expenses policy.

CH outline the intentions of the day. The morning will be the post consultation QSAC meeting for Ovarian cancer topic and the afternoon will be an away day for all QSAC standing members remaining on the new committee.

The Chair noted that this will be the last meeting of the QSAC2 so gave a huge thank you to all the standing committee members and specialist committee members that have been involved over the years. Thank you, to all the committee members who are to remain as standing members of the new QSAC. Wishing all the best to those members who have decided to step away from the QSAC. NICE appreciates all the work you have done to help make meaningful change.

* **Future QSAC meeting dates**

Thursday 17 October 2024 – Ovarian cancer and QSAC Away Day

Thursday 28 November 2024 – Cardiovascular risk assessment and lipid modification

**Close of meeting**