# Quality standard consultation comments and NICE responses

| ID | Stakeholder | Section | Stakeholder comments | NICE response |
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| General comments | | | |  |
| 1 | British Society of Physical and Rehabilitation Medicine | General | The guidelines do not include statements on screening for longer term disabilities like weakness, spasticity, cognitive issues and communication difficulties. | Thank you for your comments.  The quality standards advisory committee (QSAC) noted that the follow-up appointment in secondary care should pick up any longer-term issues caused by bacterial meningitis or meningococcal disease and ongoing care would be arranged accordingly.  There are no specific guideline recommendations around screening for longer term disabilities. Guideline development is outside the remit of quality standards. The comments have been passed on to the guideline development team for consideration when the guideline is next updated. |
| 2 | Faculty of Intensive Care Medicine | General | Thank you for the opportunity to comment on this draft quality standard. The FICM Professional Affairs and Safety Committee provided feedback on question 1 only. | Noted. |
| 3 | Meningitis Research Foundation | General | Whilst we largely agree with the quality statements within this quality standard, we feel that as a whole, the Quality Standards do not adequately emphasise the importance of an accurate and timely diagnosis of meningitis.  Accurate and timely diagnosis of meningitis was an area which stakeholders deemed extremely important in their suggestions on key areas for quality improvement, yet this is not proportionately reflected in the final quality standard. For example, there were a total of 15 comments supporting improvements to the timing and accuracy of diagnostic testing within the areas of CSF & blood samples (4), unnecessary CT scans (5) and reducing time to LP (6), with only 1 quality standard reflecting this. In comparison, 2 quality standards in the area of after-care (Statements 4 and 5) reflect 8 stakeholder comments identifying these as key areas for quality improvement. Whilst we agree that improvements to after care are vital, there is a risk that if meningitis is not confirmed in the first place, then patients might not receive any follow up at all, regardless of what quality statements exist in this key area.  Accurate and timely diagnosis is vital for antimicrobial stewardship, driving appropriate acute treatment for patients and providing them with the diagnosis they need for access to appropriate follow-up care. As diagnosis is key to appropriate downstream patient care and could therefore have an impact on a larger number of patients, we would like to see a statement about the importance of performing timely LP and blood samples included in the QS. | Thank you for your comments.  The QSAC consider all areas raised by stakeholders and specialist committee members. They prioritise the areas for inclusion in the quality standard based on their discussions around which are key areas for quality improvement. A key aspect of these considerations are the measurability of quality statements, as they must be measurable in order to assess quality improvement. The committee considered diagnosis of meningitis during the first QSAC and noted the difficulties in diagnosing meningitis and measuring this. It was therefore decided that this area would not be included in the quality standard.  It is important to note, however, that the QSAC did include a quality statement on lumbar puncture being carried out, without being delayed by unnecessary neuroimaging, to obtain a confirmed diagnosis of bacterial meningitis. |
| 4 | NHS England – Clinical Programme Team | General | Need to emphasize the importance of reasonable adjustments and accessible communication throughout the standard, ensuring care is tailored to meet people’s needs.  If the Quality Standard is all age does it need to include more information about meeting the specific (different) presenting needs of children and adults?  Deterioration can be more acute in people with a learning disability and clinicians should be acting more quickly where people have a learning disability to escalate concerns.  The guidance appears to assume a patient will have capacity / give consent. There can be significant issues relating to previous trauma in contact with health care for invasive procedures such as injections – lumbar puncture etc. Guidance would be strengthened with reference to reasonable adjustments for blood tests and lumbar puncture.  Given known issues around diagnostic overshadowing with people with a learning disability it would be helpful to give a low threshold (assuming clinically safe) for proceeding with treatment – similarly for autistic people who may not be able to describe symptoms.  In line with the diagnostic overshadowing – consider comorbidities and impact on signs well as race – does a petechial rash present as clearly in all case? | Thank you for your comments.  Reasonable adjustments have been included where they are needed to implement the actions in the quality statements and also in the equality and health inequalities assessment (EHIA).  All other areas highlighted here have been noted in the EHIA. |
| 5 | Royal College of Nursing - Emergency Care Forum Committee | General | As above – this is a rare condition. More robust guidance on named clinicians need to be quantified i.e. Ambulance Service to receiving department Named Rehab consultants. Physician to Audiology. | Thank you for your comments. These amendments have not been made to the quality standard as these are decisions which should be made locally. |
| 6 | UK Health Security Agency | General | Pages 7 and 11 refers to ‘Adapted’ from NICE’s guidelines on meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management’ in what way is text being adapted? Shouldn’t this be a straightforward reference to NICE? | Thank you for your comment. As the definition is not an exact repetition of the recommendation, but does contain the same information, NICE house style is to note that this has been adapted from the recommendation. |
| Question 1 responses | | | |  |
| 7 | Association of Paediatric Emergency Medicine (APEM) | Question 1 | Yes, but we are wondering where the standard sits with the current move towards targeting antibiotics in people who aren’t in septic shock and aiming to give antibiotics between 1 and 3 hours? | Thank you for your comment. Please see the responses to statement 3 which address this point. |
| 8 | Faculty of Intensive Care Medicine | Question 1 | No, this draft quality standard does not accurately reflect the key areas for quality improvement.  (See quality statements 2 & 3 for FICM comments) | Noted. |
| 9 | Meningitis Now | Question 1 | We agree that the draft quality standard reflects the key areas for improvement. In particular, safety netting information, hearing assessment and follow-up are often problematic for those who we support. | Thank you for your comment. |
| 10 | Royal College Emergency Medicine | Question 1 | No comments | Noted. |
| 11 | Royal College of Nursing - Emergency Care Forum Committee | Question 1 | Reflects key areas of Quality Improvement (QI) but time of re-assessment of standard needs to be quantified. | Thank you for your comment. The published quality standard will be reviewed in the future if changes are made to the underpinning guidance or there are indications that the quality statements are being widely achieved. |
| Question 2 – data collection | | | |  |
| 12 | Royal College Emergency Medicine | Question 2 | No comments | Noted. |
| 13 | Royal College of Nursing - Emergency Care Forum Committee | Question 2 | Yes. However, key departments in each organisation responsible for Multi-disciplinary Team (MDT), data sharing agreements, audit standards and local QI could be quantified or at least given and a guide example. | Thank you for your comment. These are decisions that are made locally, therefore they are not specified within quality standards. |
| 14 | [Royal College of Paediatrics and Child Health](http://niceplan2/guidelines/Stakeholders.aspx?GID=2521&PreStageID=9341) | Question 2 | I am being conservative on that | Noted. |
| Question 3 – resource impact | | | |  |
| 15 | Royal College Emergency Medicine | Question 3 | No comments | Noted. |
| Question 6 – challenges using the guideline | | | |  |
| 16 | Meningitis Now | Question 5 | We believe, that given meningitis is a relatively rare disease, ensuring that all relevant health professionals are aware of these standards may be problematic. This may be more challenging in adult settings, where many health professionals have less experience in treating/caring for patients with meningitis or meningococcal disease. As a charity, we are keen to help in the promotion of these quality standards in whatever way we can. | Thank you for your comments which have been passed to our implementation team. In addition, we will be in contact to include Meningitis Now as a supporting organisation for this quality standard to help to promote it. |
| 17 | Royal College Emergency Medicine | Question 5 | No comments | Noted. |
| 18 | Royal College of Nursing - Emergency Care Forum Committee | Question 5 | Yes. we have no further comments on this matter. | Noted. |
| 19 | [Royal College of Paediatrics and Child Health](http://niceplan2/guidelines/Stakeholders.aspx?GID=2521&PreStageID=9341) | Question 5 | 1.Climate Change is a challenge for spread and management of bacterial meningitis and meningococcal disease  2. The wars especially, the devastating war in Palestine which targets children, women, men, neonates, elderly, hospitals, health centres, medical and nursing staff and the unjust blockade on food, medicine and water which violated all the recommendations of United Nations, WHO, UNICEF and human Rights is the greatest challenge to implementing of this guidelines | Thank you for your comments. These issues are outside the remit of NICE. |
| Statement 1 | | | |  |
| 20 | Association of Paediatric Emergency Medicine (APEM) | Statement 1 | Safety netting is standard practice for children who are discharged home after attending with fever. Leaflets can be adapted if necessary to include links to online resources. Will NICE be suggesting which online sources of information can be used? | Thank you for your comments. This is a decision to be taken locally and is not specified in quality standards. |
| 21 | British Society of Physical and Rehabilitation Medicine | Statement 1 | Safety netting advice: This is currently done in clinical practice. The issue is that the brief safety netting advice given in busy clinical settings may not be understood properly by vulnerable people with communication difficulties such as people living with cerebral palsy, learning difficulties, those with language of communication other than English. The statement should include guidance on safety netting advice for these vulnerable groups.  There should be a more robust advice for people who are immunocompromised such as those on steroids, disease modifying drugs for multiple sclerosis, cancer etc. | Thank you for your comment. The updated quality standard and EHIA address these areas. |
| 22 | Meningitis Now | Statement 1 | Data Source: will assessment be dependent on the quality and consistency of information recorded by individual health practitioners in the patient records? How will these variables this be accounted for? | Thank you for your comment. The quality of data recording and its assessment would be considered locally. |
| 23 | Meningitis Research Foundation | Statement 1 | We are very pleased to see this quality standard include a statement about the importance of safety netting advice. Within the quality standard there is wording that says “Healthcare professionals (such as GPs and emergency department clinicians) provide safety netting advice to people who are being sent home after clinical assessment without a diagnosis of bacterial meningitis or meningococcal disease, and their parents and carers **if appropriate**”.  We would argue that it is always appropriate to make parents and carers aware of symptoms of serious illnesses such as meningitis and so suggest that the words if appropriate are removed. We would also advise that the word “clinical” should be replaced with the word assessment (including full clinical evaluation and investigations as indicated). In young children, clinical assessment alone is often not adequate to exclude meningitis or sepsis and tests are required. | Thank you for your comment. This sentence has been restructured to make it clear the information should be given to people sent home and, if appropriate, to their parents and carers. |
| 24 | NHS England -Antimicrobial Prescribing and Medicines Optimisation Team | Statement 1 | Should the quality statement read ‘People *with suspected bacterial meningitis or meningococcal disease* who are sent home after clinical assessment indicates that they are unlikely to have bacterial meningitis or meningococcal disease are given safety netting advice’? Otherwise it reads that any patient who is clinically assessed (perhaps for headache/migraine) and who is unlikely to have bacterial meningitis will need to be given safety netting advice about bacterial meningitis/meningococcal disease, when this was never a possible differential diagnosis?  “Denominator – the number of people sent home after clinical assessment shows it is unlikely that they have bacterial meningitis or meningococcal disease” – see above point. Suggest this should be narrowed down to only include those where there was a clinical suspicion of meningitis rather than all patients discharged who are unlikely to have meningitis?  Would it make sense to define what good quality information to patients should contain rather than having the current very unspecific recommendation to give “advice” on signs / symptoms to look out for and when to return to hospital? The bliss MRF information linked only pertains to children with no information linked relevant to adult patients. | Thank you for your comments.  The wording of this quality statement has been amended to avoid confusion.  The information provided is agreed locally and is not with NICE’s remit to specify.  The information linked has been updated to include information on teenagers and young adults. No information was identified that relates to adults so none could be included. |
| 25 | NHS England – Clinical Programme Team | Statement 1 | Greater reassurance for children and families needed. It’s very transactional at a very difficult time for people and their families and carers. What if there are disagreements? Should Martha’s Rule be referenced here?  4.5 Information and support – this links to earlier general statement about diagnostic overshadowing and impact of co morbidities on signs and symptoms, information should include spotting signs of acute deuteriation – and provided to families / paid carers  and adhere to the NHS Accessible Communication standard. | Thank you for your comments. This statement relates specifically to the giving of safety-netting information. Any disputes around diagnosis are not addressed by this quality statement.  The content of safety-netting information is a local decision and not within NICE’s remit to specify. The quality standard and EHIA do state that information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations |
| 26 | Royal College Emergency Medicine | Statement 1 | Quality statement 1: Safety netting advice  Agree in principle, however as patients tend to present with symptoms rather than labels. Similarly, they do not get discharged home with labels of ‘not bacterial meningitis’; effectively this standard almost becomes meaningless. There is significant complexity when considering children. A standard that references discharging patients who present with a fever or rash might be more practical.  Measurement  As currently configured measurement is not practical. We note specifically that the suggested data collection makes no use of information that is already routinely collected as part of the Emergency Care Data Set (ECDS) submission required of all emergency departments. | Thank you for your comment which was considered by the QSAC. This quality standard has been reworded for clarity.  Thank you for your comments highlighting that some information is recorded in ECDS. References to this dataset have now been included where suitable throughout the quality standard. |
| 27 | Royal College of General Practitioners | Statement 1 | We believe that GP access and the delays due to workforce challenges require attention, as it is important to be able to identify who among the presenting patients may have meningitis. The entire system, including 111/999 and other services, need to work collectively to reduce long delays that impact individual patient health. Additionally, it is important to consider all elements of safety netting as we would for other conditions, as well as descriptions of red flag symptoms. | Thank you for your comment. These issues are outside the remit of quality standards. |
| 28 | UK Health Security Agency | Statement 1 | Under ‘Equality and diversity considerations’ on page 7 it states ‘non-blanching rash’, NICE also refers to ‘Pale, mottled skin or cyanosis may be difficult to see on brown, black or tanned skin’ | Thank you for your comment. The quality standard and EHIA now both state non-blanching rash for consistency. |
| Statement 2 | | | |  |
| 29 | Association of Paediatric Emergency Medicine (APEM) | Statement 2 | We wondered if it may be sensible to reorganise the statement to read: People with suspected bacterial meningitis should have lumbar puncture before neuroimaging if they do not have any risk factors for an evolving space-occupying lesion, or symptoms or signs of raised intracranial pressure.  We also wondered if it would be helpful to stipulate that infants with open fontanelles are a different group of patients who may present or behave with raised intracranial pressure differently. | Thank you for your comment. This quality statement has been reworded for clarity.  In the consultation version, the indications for neuroimaging were not specified in the quality statement as this would be difficult to read and follow. It included a definition of the clinical indications for neuroimaging.  Infants with open fontanelles were considered however the quality statement has been developed to cover the broadest population. |
| 30 | Faculty of Intensive Care Medicine | Statement 2 | **Quality Statement 2**  The Faculty of Intensive Care Medicine's Professional Affairs and Safety (FICMPAS) Committee has concerns regarding the guidance standard that *'People with suspected bacterial meningitis do not have neuroimaging before lumbar puncture unless clinically indicated.'*  'Clinically indicated' is inadequately defined for this to be a meaningful sentence.  *'Risk factors for an evolving space-occupying lesion'* or *'any of these symptoms or signs of raised intracranial pupillary reactions'* are far less easy to identify than the guidance recognises.  It would be useful to give examples of risk factors for an evolving space-occupying lesion as we do not think this can be presumed knowledge. Clarity would also be essential from an audit perspective, which is what you are trying to promote in relation to these standards.  Our main concern is that as a guidance statement it perhaps is defensible but as an audit standard it is not.  In real world terms we are concerned the guidance (and worse the planned audit) on - lumbar puncture before neuroimaging will become ‘lumbar puncture must occur before antibiotics’ which means patients will have delay before receiving lifesaving antibiotics.  We understand the science, but we consider the guidance inadequately accounts for how, where and when the guidance must be used, i.e. the reality of the emergency department and hospital environment.  Organising a lumbar puncture and finding those with the skills to rapidly and safely perform one, takes time and resources. In comparison, CT scans do not.  Trying to organise a lumbar puncture risks delaying antibiotics in ways that a CT scan is much less likely.  Long and well [established intensive care clinical practice](https://www.nbt.nhs.uk/sites/default/files/ICU%20Lumbar%20Puncture%20LocSSIP.pdf) is to CT scan, or at least consider very carefully, before lumbar puncture.  We strongly consider that the priority treatment is the commencement of antibiotics/antivirals as soon as there is a suspicion of meningoencephalitis; i.e. before lumbar puncture or CT scan; especially in patients with altered GCS or neurology. This we consider is the safest, pragmatic and professionally defensible course of action.  We accept that the patient cohorts for which you are trying to provide guidance are not the same as intensive care patients (our cohort). However, the real world conditions healthcare professionals will be working in when applying your guidance will mean they risk being left confused and morally distressed by the decision making burden; and patients will be placed at risk by antibiotic/antiviral delay.  At the very least we do not think lumbar puncture before neuroimaging is robust enough to be a quality standard that is audited.  We would value the specific opinion of the Royal College of Emergency Medicine on this issue, especially if they can provide some ‘real world’ feedback. | Thank you for your comments which were discussed by the QSAC. Please note that this quality statement has been reworded for clarity.  The specialist committee members on the QSAC felt clinical indications was clearly defined, using the guideline recommendations. They also felt that clinicians would be able to identify these clinical indications.  The QSAC noted your concern of delay to antibiotics. The quality statement relates to lumbar puncture without unnecessary neuroimaging to avoid delays in diagnosis.  The NICE guideline notes that ideally lumbar puncture would be carried out before antibiotics are given, and that antibiotics should be given within 1 hour.  It is important to note that the QSAC members include clinicians working in the NHS who are aware of the realities of the NHS environment. |
| 31 | Meningitis Research Foundation | Statement 2 | We agree that this statement is important for reducing delays to LP. The word “routine” should be added prior to neuroimaging. Also imaging should not be undertaken to rule out raised intracranial pressure. We are not sure that this statement in isolation addresses the priority of ensuring that an LP is carried out/blood sample taken before antibiotics are administered as soon as possible. | Thank you for your comment.  The QSAC considered the suggested addition to the quality statement and did not include this as the definitions for this quality statement are clear.  The intent of this quality statement is to ensure that lumbar puncture is not delayed by unnecessary neuroimaging. Whilst ideally lumbar puncture would be carried out before antibiotics are administered, that is another concept which this quality statement does not address. Each quality statement can only contain one concept in order to ensure measurability. |
| 32 | Meningitis Research Foundation | Statement 2 | Quality statement 2 could help reduce delays to LP which is vital to improving the diagnosis of meningitis. However, this QS on its own does would not increase overall rates of LPs being performed or blood samples taken prior to administration of antibiotics, which is the key action required in order to increase confirmed cases of meningitis and identify the causative pathogens. We also consider that scans are often undertaken in the mistaken belief that they will show whether it is safe to perform a LP. The quality statement should make it clear that raised intracranial pressure is a clinical diagnosis. | Thank you for your comment. It is noted that raised intracranial pressure is a clinical diagnosis. The NICE guidance lists symptoms / signs of intracranial pressure and notes that neuroimaging should be carried out before lumbar puncture if the person has any of them.  Quality statements can only contain one concept. The intention of this quality statement is to reduce delays in lumbar puncture caused by unnecessary imaging. |
| 33 | NHS England – Clinical Programme Team | Statement 2 | The guidance appears to assume a patient will have capacity / give consent. There can be significant issues relating to previous trauma in contact with health care for invasive procedures such as injections – lumbar puncture etc. Guidance would be strengthened with reference to reasonable adjustments for blood tests and lumbar puncture. | Thank you for your comment. This has been added to the EHIA. It has not been included in the quality standard as the focus of this quality statement is not about the decision to carry out lumbar puncture, but about whether neuroimaging is needed when the decision has been made. |
| 34 | Royal College Emergency Medicine | Statement 2 | Quality statement 2: Lumbar puncture  Broadly agree in principle, however the reality in most emergency departments is that if bacterial meningitis or meningococcal disease is suspected then antibiotics will be commenced before LP is performed (this highlights the tension between quality statement 2 and quality statement 3). Whilst this widespread practice might be at odds with the NICE recommendations ([Recommendations | Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management | Guidance | NICE](https://www.nice.org.uk/guidance/ng240/chapter/Recommendations#recognising-bacterial-meningitis-and-meningococcal-disease) 1.4.9) it is pragmatic given the logistical and resource issues of getting an LP performed within 1 hour of arrival at hospital triggered based on symptoms and clinical assessment alone. The usual course of events would be antibiotics given +/- antivirals, neuroimaging if indicated and then LP later on, usually performed by the admitting medical team. We would therefore question the stated rationale that performing lumbar puncture without delay reduces the time in starting antibiotic treatment.  Measurement  Should this be confirmed and suspected bacterial meningitis ?  Suspected bacterial meningitis is part of the ECDS dataset, as are ‘suspected viral meningitis’ and ‘suspected encephalitis’. All three conditions have overlapping symptoms and at the point of selecting a diagnosis in the emergency department, when not all test results are back, there may be a certain randomness to which of these diagnoses is chosen. This will lead to concerns about data quality. | Thank you for your comment. The QSAC noted the pressures within emergency departments and felt it is possible for lumbar puncture to be carried out quickly.  The rationale has been amended to specify that tailored antibiotics can be started.  As lumbar puncture is carried out to diagnose bacterial meningitis the QSAC did not add confirmed bacterial meningitis to the measure.  Comments on the other similar conditions were noted by the QSAC who felt the measures are appropriate. The ECDS has now been included throughout the quality standard where relevant. |
| 35 | UK Health Security Agency | Statement 2 | Page 9 under Data source part b) - should it be ‘valid’ clinical indication? | Thank you for your comment. The QSAC did not feel this change was needed. |
| Statement 3 | | | |  |
| 36 | Association of Paediatric Emergency Medicine (APEM) | Statement 3 | We feel that this may difficult to achieve in the more well group of children in whom meningitis may be suspected and who require lumbar puncture prior to antibiotics. Obviously in children with septic shock or features of raised intracranial pressure there will be no challenge. We also wondered where this sits with the current move towards targeting antibiotics in people who aren’t in septic shock and aiming to give antibiotics between 1 and 3 hours? | Thank you for your comment. Clinical advice was obtained to clarify this issue and discussed with the QSAC. The clinical advice noted that clinicians need to consider both suspected diagnoses (meningitis or suspected meningococcal disease and sepsis) in parallel, and manage the patient accordingly. |
| 37 | Faculty of Intensive Care Medicine | Statement 3 | **Quality Statement 3**  We do not disagree with the timing of antibiotics, and its auditing, but would highlight that the approach seems different to recent antibiotics sepsis guidance by NICE and the AoMRC. This guidance emphasised the use of NEWS2, and highlighted that the evidence base for one hour administration of antibiotics was less than has been previously advocated.  There is a high risk of confusion or perceived contradiction here. | Thank you for your comments. Clinical advice was obtained to clarify this issue and discussed with the QSAC.  The clinical advice noted that the sepsis guideline recommends the use of NEWS2 and that this is not in the bacterial meningitis and meningococcal disease quality standard. It was explained that NEWS 2 is a generalised ‘track and trigger’ score for severe illness, whereas the red flags in the guideline on bacterial meningitis and meningococcal disease are more specific, particularly for meningitis. In practice, it is likely that NEWS2 will be calculated for people who are unwell on admission to the emergency department, and antibiotics should be started at the earliest time recommended by either the sepsis or bacterial meningitis and meningococcal disease guideline. Clinicians need to think about both suspected diagnoses (meningitis or suspected meningococcal disease and sepsis) in parallel and manage the patient accordingly. |
| 38 | NHS England -Antimicrobial Prescribing and Medicines Optimisation Team | Statement 3 | This standard contradicts the NICE guidance on sepsis, which is advocating a more nuanced approach to immediate antibiotics based on the NEWS2 score.  It also appears that the guidance (and therefore this quality standard statement) is extrapolating the evidence on outcome data on timing of antibiotics for patients with bacterial meningitis and / or meningococcal sepsis to a wider group of patients with “suspected” bacterial meningitis and / or meningococcal sepsis and assuming that there will be the same risk/benefit ratio in both groups – this wouldn’t be expected to be true and is challenging to monitor as there is no clear definition of “suspicion of meningitis” within the standards.  There will be patients who are relatively well in whom there is a low level of suspicion of meningitis, which would not necessitate antibiotics within an hour, but some thought / investigation. How is this accounted for in the quality standards to support targeting quick antibiotic administration to those most likely to benefit whilst avoiding the harms associated with overtreatment in those unlikely to benefit?  Does this statement still hold true if the patient has received antibiotic treatment in community prior to transfer to hospital (e.g. IM benzylpenicillin)? | **Thank you for your comments.** Clinical advice was obtained to clarify this issue and discussed with the QSAC.  The clinical advice noted that the sepsis guideline recommends the use of NEWS2 and that this is not in the bacterial meningitis and meningococcal disease quality standard. It was explained that NEWS 2 is a generalised ‘track and trigger’ score for severe illness, whereas the red flags in the guideline on bacterial meningitis and meningococcal disease are more specific, particularly for meningitis. In practice, it is likely that NEWS2 will be calculated for people who are unwell on admission to the emergency department, and antibiotics should be started at the earliest time recommended by either the sepsis or bacterial meningitis and meningococcal disease guideline. Clinicians need to think about both suspected diagnoses (meningitis or suspected meningococcal disease and sepsis) in parallel and manage the patient accordingly.  The QSAC noted comments on antibiotics that were administered prior to hospital admission. They noted that the relevant antibiotics are not held in GP practices or by ambulance services therefore it would be very unlikely that they would be administered before the person arrives in the emergency department. |
| 39 | NHS England – Clinical Programme Team | Statement 3 | What if the triage does not work or the ambulance waits mean children and adults cannot get the antibiotics within an hour? Is this covered in another standard to reduce the risk?  Noted statement on reasonable adjustments and language and communication – they should be actively part of the standard to ensure that people can access the support they need – too often people are not given access to tests because they are perceived to present as challenging or not giving consent when actually no adjustments have been made. | Thank you for your comment. The QSAC noted this concern however this quality statement relates specifically to actions taken in emergency departments. This is not addressed in another quality standard as delays in ambulance transfer are not within NICE’s remit. If triage did not work, causing a delay in antibiotic administration, it is expected that changes would be made locally to avoid this occurring again.  Issues around reasonable adjustments, language and communication are included in the quality standard and EHIA. |
| 40 | Meningitis Research Foundation | Statement 3 | We agree that this is a very important quality statement for inclusion | Thank you for your comment. |
| 41 | Royal College of General Practitioners | Statement 3 | There has been a change from giving antibiotics through IM as opposed to now using IV routes. We do not feel that GP is set up to give IV antibiotics and that delays may be caused by attempts to vaccinate when the patient could be transferred to a more appropriate setting. We question the evidence around this and are concerned about the impact of delivering this in general practice. The estimated time of reaching the hospital within an hour is further complicated by rurality and ambulance response times. | Thank you for your comment. This quality statement relates specifically to actions to be taken in the emergency department. |
| 42 | Royal College Emergency Medicine | Statement 3 | Quality statement 3: Antibiotic treatment  Agree. There is no reference to in the standard regarding patients who have had pre-hospital antibiotics.  Measurement  Should this be confirmed and suspected bacterial meningitis, meningococcal disease ?  Suspected bacterial meningitis and suspected meningoccocal disease are part of the ECDS dataset, as are ‘suspected viral meningitis’ and ‘suspected encephalitis’. All three conditions have overlapping symptoms and at the point of selecting a diagnosis in the emergency department, when not all test results are back, there may be a certain randomness to which of these diagnoses is chosen. This will lead to concerns about data quality. | The QSAC noted comments on antibiotics that were administered prior to hospital admission. They noted that the relevant antibiotics are not held in GP practices or by ambulance services therefore it would be very unlikely that they would be administered before the person arrives in the emergency department.  Confirmed disease has not been included in the measurements as this confirmed diagnosis may not yet have been made.  Comments on the other similar conditions were noted by the QSAC who felt the measures are appropriate. |
| 43 | Royal Pharmaceutical Society | Statement 3 | The statement of receiving IV antibiotics 1hr after arrival at hospital is a little loose. When a patient thinks they arrive and when different members of the multidisciplinary team think they have arrived is always varied. Considering this is a disease of reasonably high mortality and morbidity it may be best to be more directed e.g. 1 hr of registering at the hospital. | Thank you for your comment. A definition of arrival at hospital, for measurement purposes, has now been included. This is based on NHS England’s Emergency Care Data Set’s user guidance. |
| 44 | Royal Pharmaceutical Society | Statement 3 | This statement currently just say ‘receive antibiotics’. There are different antibiotics depending on the circumstances (allergy, neonates, listeria etc) and thus as a minimum it should be “all appropriate antibiotics” unless all are happy that it is the major antibiotic that must be within 1hr. | Thankyou for your comment. The QSAC discussed the different antibiotics and other medications at the first committee meeting. The decision taken was that the quality statement would focus on the timing of the necessary antibiotics. |
| Statement 4 | | | |  |
| 45 | Association of Paediatric Emergency Medicine (APEM) | Statement 4 | No comments | Noted. |
| 46 | Meningitis Now | Statement 4 | We are aware of people waiting for longer than 4 weeks (of being well enough for testing). Will availability of appointments for audiology assessment be an issue in some areas thereby preventing timely assessment? | Thank you for your comment. The QSAC discussed availability of appointments alongside estimated patient numbers, and felt that appointments would be available. |
| 47 | Meningitis Research Foundation | Statement 4 | We agree that this is an important statement, but think that it would be possible for this to be covered by statement 5 by including additional wording to that QS. This would free up space for an additional QS that covers the importance of performing timely LP and blood samples and ensuring a clinical assessment for raised intracranial pressure | Thank you for your comment. Audiological assessment has been included as a specific area because this would not take place at the same time as the 6-week follow up. |
| 48 | Royal College Emergency Medicine | Statement 4 | No comments | Noted. |
| 49 | Royal College of General Practitioners | Statement 4 | We are concerned that many audiology services may be delivered by community trusts and hospital follow-ups, when not organised well, could cause the transfer of work to primary care. This will result in an unacceptable workload for primary care and delays to the process. | Thank you for your comment. The resource impact work carried out when the NICE guidance was updated in 2023 did not expect a significant resource impact in providing these assessments given the small numbers of people affected. It is expected that the majority should take place in secondary care, prior to inpatient discharge and some changes have been made to the supporting information of the quality statement to clarify this. It is also noted that bacterial meningitis and meningococcal disease are relatively rare conditions. |
| Question 5 (on statement 4) | | | |  |
| 50 | Royal College Emergency Medicine | Question 5 | No comments | Noted. |
| 51 | Royal College of Nursing - Emergency Care Forum Committee | Question 5 | Nothing has been omitted. | Noted. |
| 52 | UK Health Security Agency | Question 5 | Page 14 under Process part a) - please define ‘uncomplicated’.  Where it states ‘within 4 weeks of discharge from hospital’ - NICE states '.12.7  Offer an audiological assessment within 4 weeks of the person being well enough for testing (and preferably before discharge).' Are we saying that being fit for discharge is the only way of defining as patient as being 'well enough'. Also, this measurement would miss those that had an earlier appointment (accept numbers may be small given that such services are not widely available) | Thank you for your comments. Based on stakeholder feedback and QSAC discussions, the definition, for measurement purposes, has been updated. |
| Statement 5 | | | |  |
| 53 | Association of Clinical Psychologists | Statement 5 | ACP-UK is pleased to see that there is now reference that there must be a follow up and an assessment, which would look to identify psycho-social, neurological, neurodevelopmental aspects, and that would be used to make onward referrals. | Thank you for your comment. |
| 54 | Association of Clinical Psychologists | Statement 5 | ACP-UK is also pleased that there is acknowledgment of post-infection review and care. However, we feel it should be more specific and robust in terms of a review of mood/cognition and adjustment to hearing changes (if appropriate), and around post-severe illness adjustment for the individual and family, which is particularly significant in children and young people. | Thank you for your comment. The QSAC considered this. No amendment has been made to the list of areas to be covered in the follow up appointment as this is detailed in the NICE guidance. The list does include psychosocial problems. |
| 55 | Association of Paediatric Emergency Medicine (APEM) | Statement 5 | No comments | Noted |
| 56 | Association of Paediatric Emergency Medicine (APEM) | Statement 5 | Follow up in secondary care within 6 weeks as per statement 5 may be difficult to achieve due to current waiting time pressures in the paediatric population. Additional resources may need to be put in place to achieve this. | Thank you for your comment which was discussed by the QSAC. The resource impact work carried out when the NICE guidance was updated in 2023 did not expect a significant resource impact in providing these appointments given the small numbers of people affected. However, current waiting time pressures were acknowledged and should be factored into any quality improvement activity to measure performance. |
| 57 | British Society of Physical and Rehabilitation Medicine | Statement 5 | Assessment during follow up should include assessment mobility, activities of daily living, communication, cognition and control of bladder and bowel. If the patient has any such issues, they need referral to a specialized rehabilitation medicine team. | Thank you for your comment. The QSAC considered this. No amendment has been made to the list of areas to be covered in the follow up appointment as this is detailed in the NICE guidance. It is expected that, as a result of this follow-up appointment, referrals would be made to any further services needed. |
| 58 | British Society of Physical and Rehabilitation Medicine | Statement 5 | People with meningitis develop longer term complications such as weakness, spasticity, seizures and cognitive impairment in addition to audiological issues. Please include guidance for all patients to be assessed for mobility, activities of daily living and cognition prior to discharge. If the patient was found to have anu of these issues please refer to a specialist rehabilitation medicine team. They may need transfer to a specialist rehabilitation facility or ongoing community rehabilitation. | Thank you for your comment. As noted above, as a result of this follow-up appointment, it is expected that referrals would be made to any further services needed.  Additional guidance is out of the remit of NICE quality standards. The comments have been passed on to the guideline development team for consideration when the guideline is next updated. |
| 59 | Meningitis Now | Statement 5 | We are pleased to see a quality standard relating to follow-up. This is an area which has been problematic, particularly for adults who have had bacterial meningitis or meningococcal disease, who often report no follow-up after discharged from hospital. However, how will the requirement for follow-up be communicated to the relevant health professionals, given that adult patients can potentially be treated in a variety of ward settings, and that many health professionals will have little experience in treating a patient with meningitis? | Thank you for your comment. This is an issue which would be addressed locally as different services have different pathways to deal with this. |
| 60 | Meningitis Research Foundation | Statement 5 | We are pleased to see inclusion of this quality statement on follow-up care, but think this could be amended so that hearing tests are also covered E.g People who have had bacterial meningitis or meningococcal disease have a follow-up appointment in secondary care within 6 weeks of discharge from hospital which includes a discussion about results from hearing tests. | Thank you for your comment. The purpose of the quality statement is to ensure that people have a follow-up appointment after discharge. One of the areas to be discussed in that appointment, as detailed in the definition, is the result of the audiological assessment. |
| 61 | NHS England -Antimicrobial Prescribing and Medicines Optimisation Team | Statement 5 | Who should this follow up appointment be with? The discharging team, the neurology team, someone else? Given the variety of the issues to be considered in the review (bones & joint damage, neurological problems, psychosocial problems etc.), who is best placed to conduct the review? | Thank you for your comment. The QSAC noted that this appointment should take place with a secondary care doctor / paediatrician. The specialism of the clinician would be decided locally. |
| 62 | NHS England – Clinical Programme Team | Statement 5 | Re discharge – everyone to be invited for a follow up – risk of significant issues for people with a learning disability “21% of people with bacterial meningitis arranged a follow up appointment themselves and 26% did not have follow up but stated they would have liked this.” When they are known to have significant issues accessing healthcare – with many relying on others and for those from ethnic communities these issues are compounded. At the very least, everyone who is either a) on GP learning disability register or b) has a reasonable adjustment digital flag on their health record. | Thank you for your comment. This has been included in the EHIA. The quality standard notes that everyone should be provided with information on follow up that they can easily understand themselves. It also notes that some people may need advocacy and this should be offered. |
| 63 | NHS England – Clinical Programme Team | Statement 5 | Care after hospital discharge – will this include reference to reasonable adjustments – people may need reasonable adjustments as a result of the impact of the illness or they may have changed. | Thank you for your comment. This has been added to the EHIA so that organisations can consider this when people are being discharged following bacterial meningitis or meningococcal disease. |
| 64 | Royal College Emergency Medicine | Statement 5 | No comments | Noted. |
| Additional areas | | | |  |
| 65 | British Society of Physical and Rehabilitation Medicine | Additional areas | A key area for quality improvement is management of long term complications after meningitis. The patients with meningitis are oftem managed by the infectious disease teams or acute medical teams . The current practice is to complete the course of antibiotics and discharge. Unfortunately around 20% experience long term sequalae. The document has no mention about long term sequalae other than audiological damage. Around 20% suffer from long term complications such as weakness, cognitive decline, spasticity, seizures. Currently, there is no guideline for management of longer term complications. This draft do not address this key aspect which requires improvement. Reference: https://doi.org/10.1016/S1473-3099(10)70048-7. | Thank you for your comment. Additional guidance is out of the remit of NICE quality standards.  The comments have been passed on to the guideline development team for consideration when the guideline is next updated. |
| 66 | British Society of Physical and Rehabilitation Medicine | Additional areas | Specific guidelines about safety netting advice for people living with long term disabilities. | Thank you for your comment. Additional guidance is out of the remit of NICE quality standards. The comments have been passed on to the guideline development team for consideration. |
| 67 | Royal College of Nursing - Emergency Care Forum Committee | Additional areas | There is mention of primary care (PC). There is no mention of urgent primary care (UPC) (Out of Hours – (OOHs)) settings. There is no mention of Intravenous (IV) in the community or establishing IV access whilst awaiting emergency transfer. There is no mention of transfer delay action plans including Intramuscular Injections (IM) antibiotics or telephone consultation advice between PC or UPC OOHs with community staff experiencing delays of achieving golden hour antibiotics administration. | Thank you for your comment. The actions to be taken if meningitis is identified in primary care, particularly around ensuring antibiotic administration within 1 hour were discussed by the QSAC at the first committee meeting. This was not prioritised for inclusion in the quality standard due to concerns about the measurability of a statement covering antibiotics administered before arrival at hospital. |
| 68 | [Royal College of Paediatrics and Child Health](http://niceplan2/guidelines/Stakeholders.aspx?GID=2521&PreStageID=9341) | Additional areas | I think steroid indications in bacterial meningitis not covered and my comment to include that in this guidelines | Thank you for your comment. The use of steroids was discussed at the first quality standards advisory committee and was not prioritised for inclusion in the quality standard. This was because the use of specific steroids suggested by stakeholders was not considered to be a key area for quality improvement. In addition, the committee also noted limited evidence of the impact of steroids in preventing hearing loss in people strongly suspected of having meningitis. |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.