Quality standards advisory committee 1 meeting

Date: 6 December 2018

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

Morning session: Hearing loss (adult onset) – prioritisation of quality improvement areas

Afternoon session: Lyme disease – prioritisation of quality improvement areas

Minutes: Final

Attendees

Quality standards advisory committee 1 standing members:

Bee Wee (chair), Simon Baudouin, Gita Bhutani (Vice-chair), Umesh Chauhan, Jane Dale, Phillip Dick, Sunil Gupta, Linda Parton, Ian Reekie, Jane Scattergood, Hazel Trender, Hugo Van Woerden, Liz Wrigley.

Specialist committee members:

Morning session – Hearing loss (adult onset): Julia Garlick, Katherine, Harrop-Griffiths, Mark Sweeney, Jane Wild

Afternoon session – Lyme disease: Robin Brittain-Long, Nick Davies, Saul Faust, Veronica Hughes, Stella Huyshe-Shires, Caroline Rayment

NICE staff
Mark Minchin (1-15), Sabina Keane (1-8), Julie Kennedy (1-8), Rachel Gick (9-15), Nicola Greenway (9-15), Laura Worthington (1-15), Ian Mather (1-15)

NICE observers
Gareth Murphy

Apologies Tim Fielding (vice-chair), Nicola Hobbs, John Jolly, Teresa Middleton, Anita Sharma, Melanie Ferguson (SCM Hearing loss), Nick Beeching (SCM Lyme Disease)

1. Welcome, introductions objectives of the meeting
The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to prioritise areas for quality improvement for the hearing loss quality standard. The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow.
2. Confirmation of matter under discussion and declarations of interest
The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the morning session was the hearing loss: specifically: • Assessment and referral • Treatment • Assessment and management in audiology services • Follow-up in audiology services • Information and support The Chair asked standing QSAC members to declare verbally any interests that have arisen since the last meeting and all interests specifically related to the matters under discussion during the morning session. The Chair asked the specialist committee members to verbally declare all interests. Interests declared are detailed in appendix 1.
3. Minutes from the last meeting
The committee reviewed the minutes of the last QSAC1 meeting held on 1 November 2018 and confirmed them as an accurate record.

4. Prioritisation of quality improvement areas – committee decisions

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

The following areas were prioritised for inclusion in the draft quality standard.

Assessment and referral

- **Assessment - Prioritised**
- **Referral – Prioritised**

The committee discussed assessment and referral as quality improvement areas for adults with hearing difficulties or suspected hearing difficulties, sudden or rapid onset of hearing loss and hearing loss with suspected or diagnosed dementia, mild cognitive impairment or a learning disability.

The committee felt that early recognition of all hearing loss conditions is important from the outset as late diagnosis is linked to poor health outcomes.

In terms of assessment the committee agreed to focus a statement on adults who present first time with hearing loss as this is not being consistently done. It was felt to be important with economic benefit..

In terms of referral the committee agreed to focus a statement on adults with sudden or rapid onset of hearing loss having a timely referral. This was felt to be important as many people with these conditions are not referred within an appropriate timeframe but timing is crucial and people need to be referred immediately or urgently.

It was agreed that the referral timeframes for these different hearing conditions would be included in the measures of this draft statement.

ACTION: NICE team to draft a statement on adults with hearing difficulties or suspected hearing difficulties being referred for an audiological assessment
ACTION: NICE team to draft a statement on adults with adults with sudden onset or rapid worsening of hearing loss in one or both ears having a timely referral for a diagnostic assessment

Treatment – removing ear wax

- **Primary or community care services – Prioritised**
- **Ear irrigation devices – Not prioritised**

The committee discussed the need for ear wax removal to be managed in primary and community based settings as currently these services have limited or no access to manage ear wax. Treatment in these settings by suitably trained healthcare professionals was supported to enable people being managed closer to home in a timely manner.

The committee also discussed the use of ear irrigation devices. NICE team explained that recommendation NG98 1.2.3 is a consider recommendation reflecting limited evidence. With this in mind the committee agreed not to progress a statement on ear irrigation.

Action: NICE team to draft a statement on adults having ear wax removed in primary care or community ear care services.

Assessment and management in audiology services

- **Audiological assessment-Not prioritised**
- **Personalised care plans-Not prioritised - to be included in access to hearing aids and follow-up statements in supporting information**
- **Access to hearing aids- Prioritised**
- **Assistive listening aids- Not prioritised.**

The committee discussed these 4 quality improvement areas in turn.

The committee discussed how the audiological assessment should be comprehensive to help gain an understanding of the person's needs.

The committee discussed the importance of personalised care plans. These should include joint goals and needs. The committee agreed not to progress a statement on this area but it was agreed that these care plans would be included in two draft statements on hearing aid access and follow-up in audiology services.

The committee discussed access to hearing aids and how CCGs currently manage access to hearing aids resulting in variation in access to hearing aids. The committee agreed to progress a statement on this area as currently adults in need are not being provided with hearing aids at all or are receiving 1 when they need 2.

The committee discussed the use of assistive listening aids and how these can help people to communicate and live independently in their own home. The committee however agreed not to progress a statement on this area.

Action: NICE team to draft a statement on adults with aidable hearing loss in both ears being given 2 hearing aids.

Follow-up in audiology services

- **Follow-up in audiology services- Prioritised.**

The committee discussed how follow-up appointments are essential 6 to 12 weeks after the hearing aids are fitted. Face-to face appointments were recommended as hearing aids often need adjusting and this cannot be done via a telephone appointment. If follow-up appointments are not provided, then some people may not use their hearing devices to the full potential. The committee agreed that this statement would focus on follow-up of hearing devices rather than the long-term aftercare of hearing loss. It was also agreed

that personalised care plans can be referred to in the supporting information of this statement.

Action: NICE team to draft a statement on adults with hearing aids have a face-to-face follow-up audiology appointment 6 to 12 weeks after the hearing aids are fitted.

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

Assessment and referral

- **Hearing loss with suspected or diagnosed dementia, mild cognitive impairment or a learning disability –** This will be covered by the dementia quality standard that is currently in development.

Assessment and management in audiology services

- **Assisted listening devices –** The NHS do not provide these. Assistive listening devices are discussed as part of the care plan. They are then provided by social services or purchased privately.

Information and support

- **Support to access services –** This will be covered by the patient experience quality standard that is currently being updated. Also information and support will be included in the draft statement on follow-up appointments.

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

The following additional areas were not progressed for inclusion in the draft quality standard with the below reasons.

- Cochlear implants - These devices are covered in NICE technology appraisal guidance TA166. Technology appraisal guidance is generally not considered as a source for quality standards as NICE technology appraisals are generally underpinned by a 3 month funding direction.
- Data and outcome measures - Quality statements focus on actions that demonstrate high quality care or support, not the methods by which evidence is collated. However, audits and suggested methods of data collection may be referred to in the data sources for quality measures
- Hearing aid use and dementia incidence- This suggestion has not been progressed as this area is a research recommendation. Quality statements must be based on source guidance recommendations which have a clear evidence base.
- National screening programmes and public health campaigns - This suggestion has not been progressed as this area is not within the scope of this quality standard.
- Patient awareness and information - This area has not been progressed as quality statements must be based on source guidance recommendations which have a clear evidence base.
- Service improvements - Quality statements focus on evidence based, measurable actions that demonstrate high quality care or support not these broader aspects of service improvement.
- Staff training - Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee is therefore asked to consider which components of care and support would be improved by increased training. However, training may be referred to in the audience descriptors.

6. Resource impact and overarching outcomes

SK requested that the committee submit suggestions to the NICE team relating to the resource impact at consultation.

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

7. Equality and diversity.

SK provided an outline of the equality and diversity considerations included so far and requested that the committee submit suggestions when the quality standard is sent to them for review.

The committee highlighted that care home residents are at an increased risk.

The committee also highlighted housebound people and people with hearing loss and dementia as being

high risk.

8. Close of morning session

The specialist committee members for the Hearing loss (adult onset) quality standard left and the specialist committee members for the Lyme disease quality standard joined.

9. Welcome, introductions and objectives of the afternoon

The Chair welcomed the Lyme disease specialist committee members and QSAC members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the afternoon, which was to prioritise areas for quality improvement for the Lyme disease quality standard.

The Chair welcomed the public observers and reminded them of the code of conduct that they were required to follow.

10. Confirmation of matter under discussion and declarations of interest

The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the afternoon session was Lyme disease: specifically;

- Diagnosis and assessment
- Antibiotic management
- Non-antibiotic management
- Awareness and information

The Chair asked both standing specialist QSAC members to declare verbally all interests specifically related to the matters under discussion during the afternoon session. Interests declared are included in appendix 1.

11. Prioritisation of quality improvement areas – committee decisions

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

The committee highlighted that incidence can be estimated, through numbers of positive blood tests. The committee heard there is little current practice data on Lyme disease. It was also highlighted to the committee that the majority of the available current practice data presented are from 3 studies of varying quality. The committee agreed to consider this when prioritising the areas.

Diagnosis and assessment

- **Clinical Assessment**

People presenting with the erythema migrans (EM) rash should be diagnosed and treated without further testing. This statement is based on recommendation 1.2.11. The committee noted a link to the resource showing EM rashes should be included in the supporting information. The committee recognised that currently GPs do not always recognise the rash, and do not always feel confident in diagnosing Lyme disease without ordering laboratory investigations. It was agreed that measuring the number of diagnosis based on EM rashes using, for example, electronic medical records (EMR) is feasible.

Action: NICE team to develop a statement on people being diagnosed and treated based on presentation with an EM rash without waiting to be tested for Lyme disease.

- **Laboratory investigations to support diagnosis**

A repeat ELISA test should be carried out at an accredited local NHS lab to support diagnosis – This statement would be based on recommendation 1.2.17. The committee recognised the quality improvement issue is that people are not being re-tested. The committee heard from specialist committee members that the ELISA first test can be a false-negative due to the 6-week incubation period. The committee agreed that ELISA retesting would be carried out at a local NHS lab.

There was a discussion of high-risk groups. The committee was aware of unpublished local data suggesting a high prevalence of Lyme disease among children with facial palsy.

Action: NICE team to develop a statement on people having a second ELISA test.

Action: NICE team to refer to these tests being carried out at local laboratories in the supporting information.

Antibiotic management

- **Standardisation of antibiotic treatment**

Prescribing antibiotics in accordance with NICE guidelines, particularly in relation to dose and duration, were highlighted as key quality improvement areas. The committee agreed a statement on this area would be based on recommendations 1.3.4 and 1.3.5. This would cover antibiotic treatment in adults and children. The committee discussed how this could be measured, and concluded that data would be available in the EMR.

Action: NICE team to develop a statement on antibiotic management, to cover adults and children.

Awareness and information

- **Raising awareness**

Stakeholders suggested improved awareness of Lyme disease among the public and among healthcare professionals to support early diagnosis and treatment. The committee observed that public awareness would be a key issue among people who do not have regular exposure to ticks. The committee discussed that it is important that the general public are aware of ticks, how to avoid them, and know what to do if they are bitten by one. PHE's toolkits are available online for local authorities to raise awareness of how people can avoid and remove ticks. The committee therefore agreed to progress a structural statement, with the action based on recommendation 1.1.3.

The committee acknowledged that healthcare professionals' awareness has improved since the NICE guideline on Lyme disease was published. Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee therefore considered which components of care and support would be improved by increased training. However, training may be referred to in the audience descriptors. The committee felt that part of improving GP awareness would be to aid the diagnostic process and therefore could be included in the statement on diagnosing Lyme disease.

Action: NICE team to develop a structural/service statement, focusing on making information available to raise public awareness of tick avoidance strategies.

Action: NICE team to investigate linking to the RCGP eLearning resource.

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

Diagnosis and assessment

- **Testing standards** – the committee did not progress this, as it is clear in the guideline that testing

should be done in accredited labs. The committee did not feel it to be a key area for quality improvement.

Antibiotic management

- **Doxycycline and pregnancy** – The committee did not progress this area because prescribers should already consider pregnancy when prescribing as part of current practice.

Non-antibiotic management – The committee did not progress a statement in this area, as explained below:

- **Reassessment** – The committee agreed that patients should be assessed for other diagnoses as part of standard clinical practice.

- **Specialist advice and referral** – The committee acknowledged the importance of referral to specialists. The committee agreed that it would not be clear to which speciality people would be referred. Therefore it would not be possible to measure a statement for this area.

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

Clinical epidemiology and research

There was also a request from the committee to make Lyme disease a notifiable disease. This is beyond the scope of a quality standard.

Improving laboratory investigations

Improving laboratory tests was suggested as a quality improvement area. This area is beyond the scope of a quality standard.

13. Resource impact and overarching outcomes

The committee suggested that the following be added to the overarching outcomes of the quality standard:

- Public awareness of Lyme disease

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

14. Equality and diversity

The committee agreed the following groups should be included in the equality and diversity considerations:

- Rurality
- Homeless people in rural and urban areas
- Lyme disease is less likely to be considered as a diagnosis in older people
- There can be access issues to medical history of people from eastern European countries. Vaccination against tick-borne encephalitis was suggested as one aspect of their medical history for consideration.

It was agreed that the committee would continue to contribute suggestions as the quality standard was developed.

15. Any other business

None.

Close of meeting

Appendix 1: Declarations of interest

Table 1: Morning session

Name	Membership	Declaration
Katherine Harrop-Griffiths	SCM	GDG Chair
Julia Garlick	SCM	Former member of community health services.
Jane Wild	SCM	GDG committee member

Table 2: Afternoon session

Name	Membership	Declaration
Caroline Rayment	SCM	GDG committee member
Robin Brittain-Long	SCM	GDG committee member
Nick Davies	SCM	GDG committee member
Veronica Hughes	SCM	GDG committee member
Stella Huyshe-Shires	SCM	GDG committee member