NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

EQUALITY IMPACT ASSESSMENT

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NICE guidelines

Equality impact assessment

Meningitis (bacterial) and meningococcal disease: recognition, diagnosis and management

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 (to be completed by the Developer before consultation on the draft guideline)

3.1 Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
1. People with dark skin, for example of African, African-Caribbean, Middle Eastern and South Asian origin, as the detection of the typical rash associated with meningococcal disease can be harder to identify on dark skin. The committee wrote recommendations about recognising bacterial meningitis and meningococcal disease and emphasised the need for more careful investigations in order to identify non-blanching rashes on brown and black skin. They alerted practitioners to look for rashes all over the body and included reminders of this throughout the tables of symptoms and signs 1.1.7 When looking for a rash:

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- check all over the body (including nappy areas), and check for petechiae in the conjunctivae
- note that rashes can be harder to detect on brown, black or tanned skin
- tell the person and their family members or carers to look out for any changes in the rash, because it can change from blanching to non-blanching.

Table 1 Symptoms and signs of bacterial meningitis in babies, children and young people **Table 2 Symptoms and signs of bacterial meningitis in adults and,** **Table 3 Symptoms and signs that indicate meningococcal disease for babies, children, young people and adults**	
Non-blanching rash	Mainly in meningococcal disease (with or without meningococcal meningitis). May be difficult to see on brown, black or tanned skin. Look for petechiae in the conjunctivae.
Pale, mottled skin or cyanosis	May be difficult to see on brown, black or tanned skin.

2. People of older age who may present with atypical features

The committee wrote recommendations about recognising bacterial meningitis and meningococcal disease and emphasised the signs and symptoms that are sometimes missed in older people with delirium. They also emphasised some symptoms and signs that are more or less common in older adults.

Table 2 Symptoms and signs of bacterial meningitis in adults and, **Table 3 Symptoms and signs that indicate meningococcal disease for babies, children, young people and adults**	
Fever, headache, neck stiffness and altered level of consciousness or cognition	Fever is less common in older adults. Headache and neck stiffness are harder to identify in adults with cognitive impairment. Neck stiffness is harder to identify in adults with dementia or arthritis Altered level of consciousness or cognition may be missed in young adults and older adults
Altered level of consciousness or altered cognition (including confusion or delirium)	Fever, headache, neck stiffness and altered level of consciousness or cognition is the red flag combination for bacterial meningitis. Bacterial meningitis may be missed in older adults with delirium or altered consciousness Meningococcal disease may be missed in older adults with delirium or altered consciousness. In young people and young adults, altered level of consciousness may be assumed to be caused by alcohol or substance misuse, and bacterial meningitis can be missed as a result.
Altered behaviour (unusually aggressive or subdued)	Bacterial meningitis may be missed in older adults with delirium or altered consciousness

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	Meningococcal disease may be missed in older adults with delirium or altered consciousness. In young people and young adults, altered behaviour may be assumed to be caused by alcohol or substance misuse, and bacterial meningitis can be missed as a result
Lethargy	Common in older adults.
Neck stiffness, including more subtle discomfort or reluctance to move the neck	Fever, headache, neck stiffness and altered level of consciousness or cognition is the red flag combination for bacterial meningitis. Neck stiffness is less likely and harder to identify in older adults. Neck stiffness is harder to identify in adults with cognitive impairment, dementia or arthritis.

3. **People of older age who may find accessing care more difficult as services cannot be designed with their particular needs in mind.**

Although the committee did not make any specific recommendations about follow up care for older people the recommendations they made in this area were mindful of being inclusive to all needs and to ensuring that older people have very clear guidance about what they can expect in terms of follow up investigations and care.

4. **People from disadvantaged socio economic backgrounds, who are at increased risk of meningitis. People from lower socio-economic and disadvantaged backgrounds, as well as being at higher risk of disease may also not be treated equally in relation to follow up care for sequelae due to difficulties in navigating a complex care system. People from disadvantaged socioeconomic backgrounds who may have poor access to follow up care.**

   The committee made a large number of recommendations about follow up care, setting out very clearly what a person can expect in terms of follow up care and when.

   The committee also made recommendations about what information and support should be offered both before and after confirmation of a diagnosis. There is clearly a lot of information that could be shared before diagnosis but

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the committee wanted to focus clinicians and patients on what information and support was most critically needed while waiting for a diagnosis, so that patients and their families received information and support that helped them understand the reasons for the suspected diagnosis and the way in which investigations will help inform the right course of treatment for them. There was also careful consideration of information following diagnosis and in relation to potential long term complications. As older people and people from disadvantaged socio economic backgrounds are at higher risk of not accessing follow-up care and support the committee felt it was important also to focus on the most critical follow up assessments, information and support needed and to be clear about the responsibilities of the hospital team before discharge to help set these up. These priority areas for follow up were informed by both qualitative and quantitative evidence to help support people (especially from more vulnerable groups) in navigating the care system post discharge and to be clear who will be their main source of contact for any follow up. **Safety netting** 1.1.16 If you send a person home after clinical assessment for bacterial meningitis and meningococcal disease: • consider a safety netting arrangement • tell them what to do if they develop new symptoms, if a rash changes from blanching to non-blanching, or if existing symptoms get worse (for example, ask them to return to the GP or ring NHS 111 or 999). 1.1.17 Be aware that many of the symptoms and signs of bacterial meningitis and meningococcal disease are also indicators of many other serious conditions in babies, children, young people and adults (for example other forms of sepsis, intracranial bleed or ischaemia, and pneumonia) **Information and support for people with suspected bacterial meningitis or meningococcal disease** 1.3.1 Discuss the following with people with suspected bacterial meningitis or meningococcal disease and their family members and carers: • the reasons for their suspected diagnosis, and any uncertainty about their initial diagnosis • when they can expect to know more • the need for investigations (including lumbar puncture for bacterial meningitis) • the timing of investigations and antibiotics 1.3.2 For people who are unlikely to have meningitis or meningococcal disease, but who are sent home from hospital with an unconfirmed diagnosis: • explain which symptoms and signs to look out for, and what changes should prompt them to return to hospital • direct them to sources of online information.

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Information and support after diagnosis

1.11.1 Early in the management of confirmed bacterial meningitis or meningococcal disease, discuss the following with people and their family members or carers:

- what might happen during the course of the disease
- the uncertainty about their initial prognosis, and when they can expect to know more
- the risk of passing on the infection
- whether their close contacts need to take any preventative measures (for meningococcal meningitis or meningococcal disease)
- visible effects (such as drips and other invasive devices), swelling (for people receiving fluid resuscitation), and how rashes can spread and turn purple
- effects of sedative withdrawal, such as agitation or abnormal neurological behaviour
- the potential short and long-term outcomes, taking account of the severity of their illness and their need for critical care.

1.11.2 Repeat information over time and check the person understands, as they may be distressed and unable to ask questions when they are first diagnosed.

1.11.3 Provide emotional and pastoral support for people and their family members and carers during hospitalisation

1.11.4 Consider referral for psychological interventions, for people with bacterial meningitis or meningococcal disease who are in distress and who need more specialist psychological support

1.11.5 Before discharge from hospital, explain to the person and their family members or carers:

- how to access support, including contact details of meningitis charities
- what assessments, aftercare and follow-up they will receive (now and long-term)
- any uncertainties about what long-term effects they might experience

Planning for care after discharge

1.12.9 For people who have had bacterial meningitis or meningococcal disease, tell their GP (and health visitor and school nurse if relevant), and explain any follow-up plans.

1.12.10 Tell the person and their family members and carers who their main point of contact will be after discharge.

1.12.11 Document the follow-up plan for managing complications in the discharge summary.

1.12.12 The hospital team should coordinate with the following professionals for care after discharge:

- tertiary and primary care and other specialists
- allied professionals and community teams that will be involved in follow-up (for example audiology and speech and language therapy departments).

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1.13.1 For babies , children and young people who have had bacterial meningitis or meningococcal disease, arrange for a review with a paediatrician at 4 to 6 weeks after discharge from hospital . As part of this review, cover:

- the results of their hearing test, and whether cochlear implants are needed
- damage to bones and joints
- skin complications (including scarring from necrosis)

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- psychosocial problems (if relevant, see the NICE guideline on post-traumatic stress disorder)
- neurological and developmental problems, in liaison with community child development services.

1.13.2 For adults who have had bacterial meningitis or meningococcal disease, arrange for a review at 4 to 6 weeks after discharge from hospital. As part of this review, cover:

- the results of their hearing test (if available at this time), and whether cochlear implants are needed
- damage to bones and joints
- skin complications (including scarring from necrosis)
- psychosocial problems (if relevant, see the NICE guideline on post-traumatic stress disorder)
- neurological problems
- care needs.

5. Important that parents and carers receive accessible information about the symptoms, diagnosis and treatment of meningitis. The information and support needs of carers and parents in relation to receiving accessible information about the symptoms, diagnosis and treatment may be considered in the protocols for the questions covering the key issue of 'information and support'.

The committee made reference to the information and support needs of family, parents and carers in a number of recommendations ranging from identification of symptoms, early hospital care, planning for discharge and follow up care. The committee wanted to be clear about the difference between information that should be shared and discussed to ensure it is understood as well as simple signposting. The guideline also refers readers to NICE standard guidelines on patient experiences in adult NHS services and babies, children and young people's experience of healthcare.

1.1.7 When looking for a rash:

- check all over the body (including nappy areas), and check for petechiae in the conjunctivae
- note that rashes can be harder to detect on brown, black or tanned skin
- tell the person and their family members or carers to look out for any changes in the rash, because it can change from blanching to non-blanching.

1.1.11 For people with reduced consciousness or communication difficulties, ask family members or carers about recent changes in symptoms.

1.3.1 Discuss the following with people with suspected bacterial meningitis or meningococcal disease and their family members and carers:

- the reasons for their suspected diagnosis, and any uncertainty about their initial diagnosis
- when they can expect to know more

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

- the need for investigations (including lumbar puncture for bacterial meningitis)
- the timing of investigations and antibiotics

1.11.1 Early in the management of confirmed bacterial meningitis or meningococcal disease, discuss the following with people and their family members or carers:

- what might happen during the course of the disease
- the uncertainty about their initial prognosis, and when they can expect to know more
- the risk of passing on the infection
- whether their close contacts need to take any preventative measures (for meningococcal meningitis or meningococcal disease)
- visible effects (such as drips and other invasive devices), swelling (for people receiving fluid resuscitation), and how rashes can spread and turn purple
- effects of sedative withdrawal, such as agitation or abnormal neurological behaviour
- the potential short and long-term outcomes, taking account of the severity of their illness and their need for critical care.

1.11.3 Provide emotional and pastoral support for people and their family members and carers during hospitalisation.

1.11.5 Before discharge from hospital, explain to the person and their family members or carers:

- how to access support, including contact details of meningitis charities
- what assessments, aftercare and follow-up they will receive (now and long term)
- any uncertainties about what long-term effects they might experience.

1.12.11 Tell the person and their family members and carers who their main point of contact will be after discharge.

1.12.15 Consider referral to psychosocial support for people who have had bacterial meningitis or meningococcal disease and their family members and carers. Arrange this after discharge if needed.

6. People who have recently come from countries or events (such as the Hajj) where there is an increased risk of developing meningococcal disease.

The committee recommended seeking advice from an infection specialist for people who have recently travelled outside of the UK and may be at risk of antimicrobial resistance

1.6.4 Get infection specialist advice for:

- people who have recently travelled outside of the UK and may be at risk of antimicrobial resistance

- people who are colonised with cephalosporin-resistant gram-negative bacteria

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?

Yes, the committee discussed how symptoms in young people can be missed because practitioners sometimes assume that confusion, delirium or aggressive or subdued behaviour may be caused by drink or drugs. So the committee made recommendations to remind practitioners that these symptoms could be indicators of meningitis when seen together with other signs, symptoms and risk factors

Young people whose symptoms might be missed due to assumptions about their behaviour

Table 2 Symptoms and signs of bacterial meningitis in adults and, Table 3 Symptoms and signs that indicate meningococcal disease for babies, children, young people and adults	
Altered level of consciousness or altered cognition (including confusion or delirium)	In young people and young adults, altered level of consciousness may be assumed to be caused by alcohol or substance misuse, and bacterial meningitis can be missed as a result.
Altered behaviour (unusually aggressive or subdued)	In young people and young adults, altered behaviour may be assumed to be caused by alcohol or substance misuse, and bacterial meningitis can be missed as a result.

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 have been included in the recommendations, and the committee discussion sections of the evidence reports as outlined in the sections above.

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 recommendations do not make it more difficult for specific groups to access services.

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, the recommendations do not have the potential to have an adverse impact on people with disabilities.

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?
N/A

Completed by Developer Lisa Boardman (Guideline Lead, CfG)

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Approved by NICE quality assurance lead Kay Nolan

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