2013

Commissioning guide:

Otitis media with effusion

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Introduction

This document provides advice for commissioners on the best management of otitis media with effusion (OME).

The 'best value' concept is to describe how services should be developed to ensure effective, equitable and sustainable health outcomes by using the invested resources wisely. The best model to achieve this end is to use the model of 'integrated care pathways', the intention of which is to ensure all the parts of the pathway are in place and working well together, coupled with the use of key measures to drive learning through innovation and improvement.

OME is a common condition of early childhood in which a build up of fluid in the middle ear space can cause hearing impairment. The hearing loss is usually transient and self-limiting over several weeks but may be more persistent and lead to educational, language and behavioural problems. It is most common in young children, with a bimodal peak at 2 and 5 years of age; 80% of children will have had at least one episode of OME by the age of 10 years.

In most instances of uncomplicated, straightforward OME, no intervention is required because the fluid clears spontaneously.

1 High value care pathway for otitis media with effusion

OME may be overlooked because of the insidious nature of the condition and suspicion of hearing loss in children must be acted on effectively. Consequently, if parents, carers or professionals have concerns that a child might have hearing loss due to OME, then an initial assessment should be undertaken followed by a more formal assessment to confirm the diagnosis. See the [National Institute for Health and Clinical Excellence (NICE) clinical guideline CG60 quick reference guide] for further information on care pathways, including prevention, recognition, initial and formal assessment and access to effective interventions. Commissioners should ensure that all the component parts of the integrated pathway are in place and working well to enable effective and equitable outcomes.

The NICE clinical guideline CG60 on surgical management of OME recommends that persistent bilateral OME and hearing loss should be confirmed over a period of three months before intervention is considered, and that a child's hearing should be re-tested at the end of this time.[1] Commissioners will need to ensure there is timely access to and sufficient service capacity for hearing assessments suitable for the stage of development of the child presenting with OME.

Without an agreed integrated care pathway, children may be placed on multiple waiting lists as general practitioners (GPs) attempt to gain access to the service for their patients in the quickest possible way.[1] The Department of Health report *Improving Access to Audiology Services in England* states that commissioners should carry out a rigorous needs assessment of the local population and review existing provision of audiology services to identify gaps and the potential for improvements.[2] This may also provide the opportunity to review current practice and to develop a single integrated care pathway with clinicians as well as other health and social care professionals and educational professionals (eg paediatricians, audiovestibular physicians, health visitors, school nurses, speech and language therapists, and teachers). The pathway should identify clear criteria for referral and support consistent thresholds for surgical or alternative management of OME in line with the NICE clinical guideline.[1]

The integrated care pathway should include prevention through public health programmes to decrease exposure to cigarette smoke during infancy and childhood.

Primary care practitioners should be competent to recognise hearing impairment associated with OME.

During the active observation period, advice on hearing, communication, educational and behavioural strategies to minimise the effects of the hearing loss should be offered.

Commissioners may wish to consider delivering a service for the management of OME in children in a number of different ways; different approaches to organising services might be relevant and appropriate according to the

area.

Examples include:

- joint clinics of paediatric audiologists and a competent doctor for assessing the medical and developmental aspects in a child (eg ear, nose and throat [ENT] surgeon, paediatrician with special audiology interest, paediatric audiovestibular physician)
- one-stop consultant-led primary care clinics with paediatric audiology assessment facilities
- direct surgical listing from any of the above

Commissioners should ensure that there is timely and sufficient access to surgical treatment as well as the provision of hearing aids where this is chosen as an alternative to surgery. They should also ensure there is capacity for continued observation and hearing and language assessments.

Surgical treatment (grommet insertion) should be provided in an appropriate environment and by suitably trained clinicians. It will be most commonly delivered as a day-case procedure. Adjuvant adenoidectomy may be required, which is taken as a surgical decision.

2 Procedures explorer for otitis media with effusion

Users can access further procedure information based on the data available in the quality dashboard to see how individual providers are performing against the indicators. This will enable clinical commissioning groups (CCGs) to start a conversation with providers who appear to be 'outliers' from the indicators of quality that have been selected.

The procedures explorer tool is available via the Royal College of Surgeons website.

3 Quality dashboard for otitis media with effusion

The quality dashboard provides an overview of activity commissioned by CCGs from the relevant pathways and indicators of the quality of care provided by surgical units.

The quality dashboard is available via the Royal College of Surgeons website.

4 Levers for implementation

4.1 Audit and peer review measures

The following measures and standards are those expected at primary and secondary care. Evidence should be made available to commissioners if requested.

	Measure	Standard
	NICE audit tool	Provider is using the NICE clinical guideline CG60 audit tool
	Local/national audit	Provider submit data of evidence of access to speech, language and communication therapists to any relevant local or national audit
Community services / primary care	Referrals	Measure of GP and community-based referrals (eg from health visiting or school nursing teams) – source, numbers and proportion that end up having treatment (to identify appropriate access)
	Patient information	Patients are provided with appropriate information
	Patient satisfaction/ patient reported outcome measures (PROMs)	Providers submit data for patient satisfaction or validated PROM (eg OM-6 – http://www.ncbi.nlm.nih.gov/pubmed/9339979)
Secondary care	Data submission	Providers submit data that regulatory standards are met

4.2 Quality specification/CQUIN (Commissioning for Quality and Innovation)

Measure	Description	Data specification (if required)
Day-case rates	Provider demonstrates >80% day-case rate	Data available from Hospital Episode Statistics

5 Directory

5.1 Patient information for otitis media with effusion

Name	Publisher	Link
Glue ear decision aid (2012)	Right Care	http://sdm.rightcare.nhs.uk/pda/glue-ear/
Glue ear: a guide for families	National Deaf Children's Society (NDCS)	http://www.ndcs.org.uk/family_support/glue_ear/
Harvey gets grommets	NDCS	http://www.ndcs.org.uk/family_support/glue_ear/
Glue ear (OME)	ENT UK	https://entuk.org/docs/patient_info_leaflets/09023_glue_ear
Map of Medicine – otitis media with effusion (registration required)	Map of Medicine	http://www.mapofmedicine.com/solution/editorialmethodology/currentpathways

5.2 Clinician information for otitis media with effusion

Name	Publisher	Link
CG60: Surgical management of OME	NICE	http://guidance.nice.org.uk/CG60/

6 Benefits and risks of implementing this guide

Benefits

The potential benefits of robustly commissioning an effective service for the surgical management of OME in children include:

- Reduced risk of inappropriate surgical or medical management (including antibiotic prescribing, which may be high in some areas given the low clinical benefits)[3]
- Provision of timely and efficient clinical management of OME in children by ensuring appropriate audiological assessment and surgical intervention when required
- Improving clinical outcomes such as improved hearing, reduced ear pain, reduced infection, and improved reported speech and language development
- Reduced demand for ENT services

- By improving GP access to paediatric audiology; agreeing and consistently applying referral criteria, ensuring consistent and effective care for children and their parents or carers
- Reduction of inequalities by decreasing regional variations in the threshold for surgery and improving access to services for the surgical management of OME
- Increased patient choice, improving partnership working as well as the experience and engagement of children and their parents or carers
- Ensuring value for money, by increasing the consistency of service provision across providers. This may include opportunities for clinicians to undertake local service redesign to meet local requirements in novel ways.
- Enhanced psychosocial development including speech and education
- Reduced chance of missing middle ear disease

Risks

- There is a risk of unmet need.
- This may lead to an increase in referrals to paediatric audiology, and may require better and timelier access to services than is currently available in some areas. There would need to be a greater provision of hearing aids, requiring resource.
- Currently, there are significant variations in quality, models of paediatric hearing services, activity levels, workforce skill mix, productivity and costs.[1] Most audiology services are located in National Health Service acute hospitals although some (in particular those for children) are provided on an outreach basis in the community.[1] While pathways should be standardised, there is a risk in trying to overly formulise pathways; the precise configuration of services and means of delivering pathways may vary according to local needs. For example, the Department of Health document *The NHS in England: Operating Framework for 2007/08* identified the risks to delivery of the 18-week objective associated with hearing services care pathways.[4] *Transforming Services for Children with Hearing Difficulty and Their Families* noted that, for many children, the maximum waiting period of 18 weeks to consultant-led treatment will need to be much shorter in order to minimise the impact on their education and development.[3] For this period to be shortened to give value to patients, clear pathways responsive to local needs would need to be commissioned.

7 Further information

7.1 Research recommendations

- Research into cause of variations in care – epidemiology, access, referral pathways and local care according to guidance

- Value of speech and language therapy – early effect after grommet insertion and longer term benefits
- Development of appropriate PROM for OME
- Use of hearing aids or sound field amplification in classrooms as an alternative to grommets, including a randomised controlled trial of children with the NICE grommet intervention criterion randomised to either surgery or hearing aids
- Benefits of hearing aid provision and additional support required (eg teachers of the deaf)
- Measuring outcomes following treatment (eg improvement in speech and educational outcomes)
- Best practice and outcomes for children with complex medical and developmental profiles who have long-term OME

7.2 Evidence base

1. National Institute for Health and Clinical Excellence. *Surgical Management of Otitis Media With Effusion in Children*. London: NICE; 2008.
2. Department of Health. *Improving Access to Audiology Services in England*. London: DH; 2007.
3. Department of Health. *Transforming Services for Children with Hearing Difficulty and Their Families*. London: DH; 2008.
4. Department of Health. *The NHS in England: Operating Framework for 2007/08*. London: DH; 2007.

7.3 Guide development group for otitis media with effusion

A commissioning guide development group was established to review and advise on the content of the commissioning guide. This group met once, with additional interaction taking place via email.

Name	Job title/role	Affiliation
Andrew McCombe	Chair, Consultant ENT surgeon	ENT UK
Natalie Bohm	Darzi Fellow, Clinical Academic Lecturer in ENT	ENT UK
Adam Beckman	President	British Academy of Audiology
Brigid MacArdle	Consultant in Audiovestibular Medicine	British Association of Audiovestibular Physicians
George Browning	Consultant ENT Surgeon	ENT UK
Haytham Kubba	Consultant ENT Surgeon	ENT UK
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Natalie Ronan	Patient Representative	
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Will Brassington	Consultant Audiologist / Head of Audiology	British Academy of Audiology
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Paul Little	Professor of Primary Care Research	
Sebastian Hendricks (representing on behalf of Kevin Munro, Chair of BSA)	Consultant Audiovestibular Physician and Paediatrician Chair of Paediatric Audiology Interest Group	BSA
Sheena Round	Consultant Speech and Language Therapist	Royal College of Speech and Language Therapists
Simon Lenton	Chair of the British Association for Community Child Health (BACCH)	BACCH
Vicki Kirwin	Audiology Specialist	NDCS

7.4 Funding statement

The development of this commissioning guidance has been funded by the following sources:

- Right Care funded the costs of the guide development group, literature searches and contributed towards administrative costs.
- The Royal College of Surgeons of England and ENT UK provided staff to support the guideline development.

7.5 Conflict of interest statement

Individuals involved in the development and formal peer review of commissioning guides are asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her secondary interest. It is intended to make interests (financial or otherwise)

more transparent and to allow others to have knowledge of the interest.

The following interests were declared by members:

Name	Job title/role	Interest
Andrew McCombe	Chair, Consultant ENT Surgeon	Works for Frimley Park Hospital NHS Foundation Trust and undertakes surgery for glue ear Family member works for Frimley Park Hospital NHS Foundation Trust as an anaesthetist
Professor Anne Schilder	Research Professor, Professor in Paediatric Otorhinolaryngology and Director of ENT Clinical Trials Programme, University College London Ear Institute	Supported by NIHR research professorship to develop a programme for clinical trials in ENT
Sebastian Hendricks	Consultant Audiovestibular Physician and Paediatrician	Clinical Lead for Service in North Central London Non-Executive Board Member of CCG Member of BAAP and BAPA
Monica Lakhanpaul	Consultant Paediatrician	Clinical Director for the National Collaborating Centre for Women's and Children's Health (NCC-WCH) at the time of publication of the NICE guideline *Surgical Management of Otitis Media With Effusion in Children*. No longer director at the NCC-WCH.