Acute respiratory infection in over 16s: initial assessment and management, including using virtual wards

# Stakeholder comments table

# 18 September 2023 to 2 October 2023

| **ID** | **Organisation name** | **Statement or question number** | **Comments** |
| --- | --- | --- | --- |
| 1 | Action for Smoking and Health | General | Smoking cessation is a surprising omission from this quality standard given that:   * Smoking is included in your existing guidance for [Chronic obstructive pulmonary disease in over 16s: diagnosis and management NICE guideline NG115](https://www.nice.org.uk/guidance/ng115) (2019). * Smoking [doubles the likelihood of developing community-acquired pneumonia](https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs#:~:text=Conclusion-,Hiding%20in%20plain%20sight%3A%20Treating%20tobacco%20dependency%20in%20the%20NHS,reducing%20demand%20on%20NHS%20services.), in smokers relative to non-smokers. * Current smokers are [more than five times as likely as non-smokers to contract influenza](https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs) (confirmed on virology). * Smoking cessation reduces the absolute risk of all cause readmissions by 12% and smoking-related admissions by 9% at 1 year. These benefits accrue over years. To see an estimate of the impact of reducing readmissions on individual Trusts and ICBs, use [this calculator](https://ash.org.uk/resources/view/tobacco-dependence-treatment-service-roi-calculator). * Smokers have [poorer treatment outcomes](https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs) including reduced response to treatments. * Reducing rates of smoking helps make progress on priorities in the [23/24 operational planning guidance](https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf) and the NHS Long Term Plan (LTP), including a requirement to take “*measures to improve health and* ***reduce inequalities****… paying due regard to the NHS Long Term Plan primary and secondary prevention priorities, including… smoking cessation.*” |
| 2 | Association of Respiratory Nurses | General | Variation in service provision dependant on locality and equity of step down/step up teams  Out of hours service provision.  Workforce including ACPs and MDT consultant health care  Professionals to deliver advice/ward round/equipment drop off.  Alternatives to digital technology for those with Learning disabilities/difficulties.  Oxygen titration/weaning guidelines to prevent unnecessary hospital delays/admission.  Clarification on CRB-65/CURB-65 from step down to step up.  Consider Acute respiratory illness as opposed to acute respiratory infection (ER) |
| 3 | Diabetes UK | General | We welcome this guidance and its timely dissemination ahead of the winter season. This is useful guidance which included all the main aspects of using the virtual ward we would want to see included.  We are aware from health care professionals and people living with diabetes that people with diabetes are sometimes being treated on virtual wards. Whilst they usually manage their own condition at home, having an acute respiratory infection is likely to impact on their diabetes, making it more difficult to manage, especially if they are being treated with glucocorticoids. We would therefore encourage this guidance to specially mention diabetes as a condition that may require additional specialist access. |
| 4 | NHS England- Clinical Policy Unit, National Clinical Director | General | This QS is not clearly helpful in improving patient outcomes. The standards are largely non evidence based, difficult to measure. We think this guideline risks reputational damage to NICE and is far below the quality and utility of other NICE QS documents. It does not align to the ARI guideline, which is a problematic document also. |
| 5 | NHS England- Infection Prevention and Control Team | General | * Disappointing that there are no prevention strategies for onward transmission captured throughout the document eg/ respiratory hygiene, hand hygiene etc. Especially in virtual and home environments.   • Fails to address standard infection prevention and controls (SCIPs)  • Please can you advise on your subject matter expertise in the initial document for IPC. |
| 6 | NHS England- LD & Autism programme | General | We strongly suggest the document makes reference to making reasonable adjustments.  This is a legal requirement as stated in the Equality Act 2010. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need. Possible examples include; allocating a clinician by gender, taking blood samples by thumb prick rather than needle, providing a quiet space to see the patient away from excess noise and activity.  We recommend including reference to the Reasonable Adjustment Digital Flag (RADF) and the RADF Information Standard which mandates all providers and commissioners of health services and publicly funded social care to identify, record, flag, share, meet and review Reasonable Adjustments, including details of their underlying conditions.  [DAPB4019: Reasonable Adjustment Digital Flag - NHS Digital](https://digital.nhs.uk/data-and-information/information-standards/information-standards-and-data-collections-including-extractions/publications-and-notifications/standards-and-collections/dapb4019-reasonable-adjustment-digital-flag) |
| 7 | NHS England- LD & Autism programme | General | We recommend including reference to the importance of Communication: Using simple, clear language, avoiding medical terms and ‘jargon’ wherever possible. Some people may be non-verbal and unable to describe verbally how they feel. Pictures may be a useful way of communicating with some people, but not all. |
| 8 | NHS England- LD & Autism programme | General | Please note recent LeDeR research:  kcl.ac.uk/ioppn/assets/fans-dept/leder-main-report-hyperlinked.pdf |
| 9 | NHS England- Primary Care | General | Generally, the quality standard document is good and describes a high-quality service for patients with ARI over 16 years of age. However I would recommend that there are some references to patients with health inequalities such as LD&A, mental health, social deprivation, ethnic minority groups, homeless, etc because there will be additional challenges for these groups such as lack of suitable accommodation for VW, difficultly understanding remote monitoring, educational and language barriers, problems with self-monitoring and self-care when mentally unwell and much more. For some of these patients, additional support will be necessary. |
| 10 | NHS England- Primary Care | General | I welcome the new guidelines for management of ARIs and I feel that a generic approach will aid primary care physicians significantly. I do, however, feel that the guideline focuses heavily on pneumonia as a diagnosis. As primary care physicians we are not simply looking for pneumonia, but rather we are trying to identify factors that help us determine care pathway. The decision of self care/antibiotics/urgent review/emergency admission is not determined by a diagnosis, but rather the possible diagnoses together with observations, clinical indicators and gestalt at time of review. I feel that triaging should be based on a more generic algorithm (including red flags for severe ARI) to help determine patient disposition rather than pneumonia diagnosis. |
| 11 | Royal College of Nursing | General | Please consider having the summary steps also in a graphic algorithm for a poster. |
| 12 | Royal College of Physicians | General | The RCP is grateful for the opportunity to respond to the above consultation.  We would like to endorse the response submitted by the British Thoracic Society (BTS). |
| **Question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?** | | | |
| 13 | Action for Smoking and Health | Question 1 | No. Interventions leading to smoking cessation are key areas for quality improvement activity. Some of those areas are laid out in the [NICE quality standard 209 Tobacco: preventing uptake, promoting quitting and treating dependence](https://www.nice.org.uk/guidance/ng209/resources/tobacco-preventing-uptake-promoting-quitting-and-treating-dependence-pdf-66143723132869) and should be integrated into this guidance on managing acute respiratory infection. |
| 14 | Antimicrobial Working Group, Aneurin Bevan University Health Board | Question 1 | Since COVID-19 pandemic the amount of antibiotics prescribed has increased to higher than pre pandemic levels with a particular increase in use of antibiotics that could be used to treat respiratory infections (according to local data). Assessment and diagnosis of acute respiratory infections are therefore a key area for quality improvement, especially to move back to face-to-face assessment for patients with infection, as it is believed that remote consultation is linked to a higher prescribing rate for antimicrobials. This area for quality improvement is vital for good antimicrobial stewardship. |
| 15 | Association of Respiratory Nurses | Question 1 | The key areas for quality improvement are reflected in the document, but it could also include guidance or recommendations for workforce skills and development especially for virtual wards. (SM)  Further guidance in relation to workforce staffing, with models differing across the country – in more detail who should form the virtual ward MDT with guidance on number of WTEs per virtual bed capacity. (JT) |
| 16 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Question 1 | Consider adding IV to oral antibiotic switch to this document – Many virtual wards are offering IV antibiotics to patients with RTIs. Significant work is being undertaken in the acute sector to ensure timely IVOS with the CQUIN this year. Assurance around appropriate use of IV medicines should be part of virtual ward and ARI hubs too. IV-to-oral switch is included as part of the metrics for the [National medicines optimisation opportunities 2023/24](https://www.england.nhs.uk/publication/national-medicines-optimisation-opportunities-2023-24/). Data will be reported routinely in ePACT2 to support the national medicines optimisation opportunities. |
| 17 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Question 1 | Consider including the requirement to provide the national UKHSA TARGET Patient Information leaflet for respiratory tract infections which are published on the [RCGP web site](https://elearning.rcgp.org.uk/mod/book/view.php?id=12647) in a variety of languages |
| 18 | NHS England- Clinical Policy Unit, National Clinical Director | Question 1 | No. The use of 5 days antibiotic courses is welcome. Other statements are very generic and common sense should apply to any patient on a non-elective pathway – eg safety netting, discharge summary and follow up. Smoking cessation sign posting could also be referenced as part of the discharge and follow up pathway. |
| 19 | NHS England- Infection Prevention and Control Team | Question 1 | No – a key area for quality improvement would be prevention and ongoing transmission and /or minimisation of continuing harm. |
| 20 | NHS England- Primary Care | Question 1 | Yes, the pathway described with evidence-based use of antibiotics, adequate information provided for patients, support with use of remote monitoring, MDT input with robust leadership and governance, care planning and escalation plans reflects all areas of possible QI. |
| 21 | PMD Device Solutions Limited | Question 1 | There is no assessment or consideration on how best to manage patients with a pre-existing comorbidity such as COPD. In such cases, pulse oximetry will already be compromised and respiratory rate elevated. Without accurate monitoring in a virtual ward capacity of these two vital signs, the respiratory status of the patient is unknown. Higher respiratory rate, although normal, may not trigger the right care at the right time. Deviations from personalised normal, only attainable through continuous respiratory rate monitoring can put signs of deterioration into context. There is a dangerous over-reliance and significant mis-understanding of the difference between good gas exchange (Blood Oxygen levels measured by pulse oximetry) and ventilatory drive (respiratory rate measured by objective means). In this cohort, continuous respiratory rate has been shown to be a significant discriminator in this cohort between those with abnormal vitals wrt NEWS2 yet stable and those with abnormal vitals with respect to personalised norms: NICE MIB299. Reference Doherty2022 – which demonstrated for severe COPD patients with an exacerbation in the community that 100% of hospitalisations were avoided over 12 weeks when using continuous respiratory rate to trigger timely interventions when abnormal vitals were observed wrt personalised norms. |
| 22 | Primary Care Respiratory Society (PCRS) | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  This quality standard does not attempt to address the fact that asthma and COPD exacerbations can co-exist - or not - with acute respiratory infection. There is considerable complexity in deciding whether the presenting symptoms of a patient with underlying asthma or COPD represents an acute respiratory infection alone, a combination of exacerbation and infection (often viral, less often bacterial) or exacerbation without infective cause. It is the opinion of PCRS that there is frequent diagnostic error in this regard. We are not aware of specific guidance to help manage this complexity which might inform a quality standard. However, PCRS believes that awareness of this diagnostic complexity is sometimes lacking in health professionals and can be due to a lack of sufficient training in this area. PCRS believes there is opportunity for quality improvement in this area. |
| 23 | Royal College of Nursing | Question 1 | The key areas are there but they lack the people-centred approach from Statements 1-3. They sound very generic, and task focused. It currently feels like anyone can do it and not the right professionals. |
| **Question 2: Can data for the proposed quality measures be collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected.** | | | |
| 24 | Action for Smoking and Health | Question 2 | Information on smoking cessation interventions is patient level data that can easily be gathered during assessments. Some of this data is already being gathered by NHSE via their Tobacco Dependence Service Dashboard.  We have no feedback to give on resource requirements and costs for the other proposed quality measures. |
| 25 | Antimicrobial Working Group, Aneurin Bevan University Health Board | Question 2 | Collection of the data for this quality standard may prove difficult if patients cross between primary and secondary care as electronic prescribing is not universally available yet across Wales. Furthermore, it may be difficult to interpret the primary care antimicrobial usage data to isolate antibiotics used for respiratory infections specifically rather than their use for other indications. |
| 26 | Association of Respiratory Nurses | Question 2 | Data can be collected at local level, however lack of interoperability between acute and community systems could make some data collection/merging difficult. Eg Data collected around initial assessment may not transfer through to who is delivering or accessing information on virtual ward, dependent on who is delivering virtual ward care.(SM) |
| 27 | British Thoracic Society | Question 2 | Some of the data will be difficult to collect locally as there are so many variable systems; some operating manually or with electronic records. Data collection will rely on links to primary care etc. Also depend on how mature organisations are with electronic patient records etc |
| 28 | NHS England- Clinical Policy Unit, National Clinical Director | Question 2 | The only measurable outcome that directly relates to an evidence base in antibiotic duration. |
| 29 | NHS England- Primary Care | Question 2 | Yes, this data could be collected locally, it will require templates (preferably electronic to enable searches etc) and the staff will require induction and training in how to complete these returns. |
| 30 | Primary Care Respiratory Society (PCRS) | Question 2 | Can data for the proposed quality measures be collected locally?  Yes, PCRS has members within ARI/ virtual ward services that collect this data routinely. |
| 31 | Royal College of Nursing | Question 2 | A template proforma can be used to capture the data in a standardise format. This could be in a digital format too. |
| **Question 3: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.** | | | |
| 32 | Action for Smoking and Health | Question 3 | Integrating smoking cessation interventions into the management of acute respiratory infection has potential cost savings due to reducing admissions, readmissions, improving treatment efficacy. To see an estimate of the impact of reducing readmissions on individual Trusts and ICBs, use [this calculator](https://ash.org.uk/resources/view/tobacco-dependence-treatment-service-roi-calculator).  Staff training can be achieved using free online modules (by [e-Learning for Healthcare](https://www.e-lfh.org.uk/programmes/alcohol-and-tobacco-brief-interventions/) and [National Centre for Smoking Cessation Training](https://elearning.ncsct.co.uk/vba-launch)), that require minimal staff time and can be carried out flexibly to accommodate clinical work.  We have no feedback to give on data collection for the other proposed statements. |
| 33 | Association of Respiratory Nurses | Question 3 | Challenges for implementation will always be around staffing resource and organisation. Differing models around the country can make guideline implementation difficult, especially cross over care delivery between primary and secondary care.(SM) |
| 34 | British Thoracic Society | Question 3 | This system may not be adopted by many places in the UK but for those engaging with the virtual ward process for ARI, they will probably be more committed and have ring fenced resources to apply to this kind of programme. There is a case for savings and improved quality of care (admissions, bed days and GP attendances) but may not see this for a year or more during which time a lot of investment required for this kind of service to run. Resource requirements will also be needed for auditing against standards. This will likely not have been included in initial costings |
| 35 | NHS England- Primary Care | Question 3 | No, I do not think local services have adequate resources now to manage this pathway and collect the data. At the moment there is likely to be a degree of variation away from ideal quality standards and staff will therefore need time for training and education. Once they are trained the time required to support patients to manage their condition such as educating them in use of remote monitoring and helping them understand their care plans and escalation etc will take additional time and longer face to face or virtual consultations. Maybe once patients have become accustomed to managing their conditions with more autonomy there may be some opportunities to reduce the additional support but I cannot envisage any opportunities for disinvestment. |
| 36 | Royal College of Nursing | Question 3 | Having the right people doing the initial assessment is key so that people can be diagnosed and treated without delay. As the avoidance of Emergency Department as a first port of call is encouraged; the professionals managing the 111 phones lines should be suitably trained and competent. |
| **Question 4: We are aware that this quality standard has a broad remit across the acute respiratory infection pathway. Would there be any benefit in having separate quality standards for different parts of the pathway or would it be better to focus only on the acute respiratory infection virtual ward? Please say what would be most useful in practice.** | | | |
| 37 | Action for Smoking and Health | Question 4 | Challenges to integrating smoking cessation into standard management of acute respiratory infection include:   1. Improving clinical practice to include treating tobacco dependency: this can be facilitated by making use of existing hospital-based tobacco dependence treatment services, and the expertise of tobacco dependence advisors. 2. Making pharmacological treatments available to patients: nicotine replacement therapy is included in hospital formularies and e-cigarettes are going to be distributed free of charge by local authorities as part of the government’s “Stop to Stop” scheme and healthcare settings are ideally placed so support distribution.   We have no feedback to give on challenges for the other proposed statements. |
| 38 | Association of Respiratory Nurses | Question 4 | There would be value in having a specific Virtual ward guidance, as not all statements are as workable in virtual environment. Treatment of ARI in general is well covered in other guidelines but Virtual ward is emerging. (SM) |
| 39 | British Thoracic Society | Question 4 | The statement as it is, is not very helpful at all and quite broad and basic and so specific areas covered and linking to NICE guidance such as diagnosis, treatment etc will be useful depending on the model of VW. If mainly step down then easier to audit in one place. If step up and taking cases from multiple agencies then more difficult to measure some metrics at start of pathway |
| 40 | NHS England- Clinical Policy Unit, National Clinical Director | Question 4 | Yes, some statements eg 5-8 are largely generic to any non-elective pathway |
| 41 | NHS England- Primary Care | Question 4 | The quality standard should apply to all parts of the pathway and include VW but it might be better to have a phased in QI approach due to pressures in workforce etc. |
| 42 | Primary Care Respiratory Society (PCRS) | Question 4 | We are aware that this quality standard has a broad remit across the acute respiratory infection pathway. Would there be any benefit in having separate quality standards for different parts of the pathway or would it be better to focus only on the acute respiratory infection virtual ward?  PCRS would prefer a separation of this QS so that each applies separately to virtual wards and traditional primary care. The groups of patients using virtual wards are considerably different to those only using primary care. The assessment equipment, scoring systems, health care professional resource are all quite different and would impact what could be delivered within each of the two pathways (virtual ward or primary care) |
| 43 | Royal College of Nursing | Question 4 | It is good to have a focused approach in the initial part. |
| **Question 5: For draft quality statements 4, 5, 6, 7 and 8: We have suggested that surveys could be used to collect feedback from adults admitted to an acute respiratory infection virtual ward. In practice, how are virtual ward providers gathering feedback from people using the service?** | | | |
| 44 | Association of Respiratory Nurses | Question 5 | Routinely collating data from patient feedback forms, either in paper or on line format.(SM)  Patient Advisory Groups – reviewing service delivery, digital wearables/support provision – including and understanding barriers, patient information leaflets (JT) |
| 45 | British Thoracic Society | Question 5 | Surveys and questionnaires are good if filled in at the time, PREMS and quality of life scores useful too. VWs that are using technology companies will / should have electronic surveys incorporated into pathway |
| 46 | NHS England- Primary Care | Question 5 | I don’t know how VW providers are gathering feedback but I would imagine that these patients require some level of support and in patients with HI they will require more support. |
| 47 | Royal College of Nursing | Question 5 | Feedback is essential. It can help improve the service and increase trust in the population. Text message surveys are a good way with the three key questions for example, what was good about the services? How can it be improved? Do you have any other comments/feedback/suggestions?  Also, an option for telephone call feedback to support an inclusive approach. |
| **Statement 1: Adults first presenting with suspected acute respiratory infection have a documented assessment of symptoms and signs.** | | | |
| 48 | Action for Smoking and Health | Statement 1 | Initial assessment: smoking status should be included in the initial assessment. This does not necessarily need to be done by the admitting clinician; in the [COSTED trial](https://www.uea.ac.uk/groups-and-centres/addiction-research-group/costed-trial) smoking status was recorded by the receptionist in A&E. During the initial clinical assessment the number of cigarettes smoked should be ascertained. |
| 49 | Antimicrobial Working Group, Aneurin Bevan University Health Board | Statement 1 | We support a documented initial assessment to aid improved infection management for patients presenting with suspected acute respiratory infection. |
| 50 | Association of Respiratory Nurses | Statement 1 | Is the recommendation for general or specialist respiratory assessment. Should there be a more national template for this. Where does the NRAP fit into the assessment?(SM) |
| 51 | British Thoracic Society | Statement 1 | We would expect that this happened anyway: rather its more important to ensure those that require hospitalisation are sent across and those that can safely be managed at home are doing so.  There are times/ patients when it is appropriate for a Clinician to advise and prescribe over the telephone eg Bronchiectasis with recurrent infections and sputum regularly tested. And those where telephone triage would mean that the patient is sent to ED straight away (risk of sepsis/ drowsy etc) rather than delaying to see in primary care first. |
| 52 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 1 | In addition to seeking documentation of symptoms and signs, it would significantly improve quality of care and optimal use of antibiotics if information was provided (not just for patients on virtual wards) to empower patients and support shared decision-making such as: natural history of disease; expected prognosis without antibiotic treatment (e.g. risk of hospital admission); benefits of antibiotics; risks of antibiotics; alternatives to antibiotics including self-care; red flags / safety-netting. |
| 53 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 1 | In addition to seeking documentation of symptoms and signs, we strongly recommend requiring documentation of a rationale for prescribing antibiotics, such as evidence of severity of infection or vulnerability/risk of patient (e.g. immunocompromise). |
| 54 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 1 | * *Symptoms and signs with high probability of indicating pneumonia in people with suspected acute respiratory infection (when there is no alternative explanation such as asthma):*   This decision rule is likely to be highly sensitive for detecting pneumonia (low risk of false negative in disease-positive cohort) but is also likely to have low specificity (high risk of false positives in disease-negative cohort), which will lead to over-prescribing of antibiotics.  Is one symptom or sign sufficient to constitute a diagnosis of pneumonia or is more than one symptom/sign or are specific combinations required? If a patient is short of breath due to heart failure and has cough due to pulmonary oedema and happens to present with diarrhoea, will this be considered “high probability” of pneumonia?  Can NICE provide information within the QS on the sensitivity and specificity of this decision rule? How does NICE propose to mitigate the risk of over-prescribing of antibiotics? |
| 55 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 1 | * *Use FeverPAIN or Centor criteria to identify people with a sore throat that may be caused by streptococcal bacteria*   Suggest amend the wording to improve consistency of NICE content and reflect that used in the NICE guidance NG84 which is : Use [FeverPAIN](https://www.nice.org.uk/guidance/ng84/chapter/terms-used-in-the-guideline#feverpain-criteria) or [Centor](https://www.nice.org.uk/guidance/ng84/chapter/terms-used-in-the-guideline#centor-criteria) criteria to identify people who are more likely to benefit from an antibiotic and manage in line with recommendations 1.1.4 to 1.1.13 |
| 56 | NHS England- Clinical Policy Unit, National Clinical Director | Statement 1 | This is vague. Surely every clinical encounter in an acute pathway should include this. |
| 57 | NHS England- Primary Care | Statement 1 | Pg 4 line 3 - increasingly primary care utilises triage tools such as AccuRx, eConsult etc to triage patients who call for urgent appointments. Based on the parameters in Box 1, can we recommend that primary care practices employ an automatic F2F triage for patients who tick 2 or more of these criteria (if patients are able to check these)? – this may not be within the purview of these guidelines |
| 58 | NHS England- Primary Care | Statement 1 | Pg5 line 6 – language feels slightly ambiguous – ARI vs pneumonia? |
| 59 | NHS England- Primary Care | Statement 1 | This quality statement is the gold standard but in reality there will be huge variation across providers. Larger providers with robust governance and regular audit of consultations will do better |
| 60 | PMD Device Solutions Limited | Statement 1 | Within the Equality and diversity considerations, it has been well established that increasing Respiratory Rate is a pre-marker for declining pulse oximetry i.e. Respiratory Failure. It should be noted that objective measures of Respiratory Rate should be sought for patients who are suffering from a pre-existing long term conditions such as COPD – otherwise the measure of pulse oximetry alone will present a patient safety risk. |
| 61 | Primary Care Respiratory Society (PCRS) | Statement 1 | PCRS supports this QS. However, with regard to “Healthcare professionals should recognise that some pulse oximetry devices have been reported to overestimate oxygen saturation levels in people with darker skin. Adjustments should be made when interpreting the test results to ensure that treatment is provided when appropriate” This describes a problem that PCRS is aware exists. However, there is no practical guidance about what ‘adjustments’ should be made. It would be helpful if NICE commented on the available evidence that supports an appropriate adjustment or highlighted that it was a research need. |
| 62 | Royal College of Nursing | Statement 1 | We welcome the equality and diversity considerations.  How can one get the information about a person’s colour without making them suspicious over the phone? A lot of people now have saturation monitors including via smart watches and can give this information when they call. Being comfortable and confident about asking questions on race and ethnicity should be strengthen.  From the reviewer’s experience, no one has ever asked them to be about their race on these calls (perhaps they already have it on file). |
| 63 | British Thoracic Society | Statement 1- Question 1 | We would have assumed that any clinical assessment would cover key generic features from the history and examination as well as initial observations. It is key here to aim to differentiate between those who have a viral infection and those who might have a bacterial cause and those that might be safely managed on a virtual ward; so, in essence to follow the eligibility criteria. This statement will otherwise be hard to measure as well. |
| 64 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 1- Question 2 | Coding for acute respiratory tract infection consultations in primary care electronic health care records is variable, both choice of code, and often no code. This will impact the ability to measure this statement. |
| **Statement 2: Adults presenting with suspected acute respiratory infection are only prescribed antimicrobials following a face-to-face assessment.** | | | |
| 65 | Antimicrobial Working Group, Aneurin Bevan University Health Board | Statement 2 | We support and welcome the quality standard for face-to-face assessment is required for acute respiratory infections prior to prescribing antimicrobials. |
| 66 | Association of Respiratory Nurses | Statement 2 | Is there capacity in the system, notably GP services for face to face assessment, and how does this fit in with self-management and rescue medication.(SM) |
| 67 | British Thoracic Society | Statement 2 | Although diagnostics are not discussed here, it is important to incorporate pathways for (1) covid, (2) influenza and (3) streptococcal and well as other bacterial causes if ARI. In some cases, a test may be undertaken at home and antiviral therapy started with only a virtual review. Some cases may be able to have treatment from telephone consultation eg bronchiectasis with sputum already sent in. |
| 68 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 2 | Does the language around “prescribing antimicrobials” need to change to allow this guidance to be applied to services who use PGDs for management of this patient group? |
| 69 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 2 | As per Statement 1 for assessment of possible pneumonia:  This decision rule is likely to be highly sensitive for detecting pneumonia (low risk of false negative in disease-positive cohort) but is also likely to have low specificity (high risk of false positives in disease-negative cohort), which will lead to over-prescribing of antibiotics.  Is one symptom or sign sufficient to constitute a diagnosis of pneumonia or is more than one symptom/sign or are specific combinations required? If a patient is short of breath due to heart failure and has cough due to pulmonary oedema and happens to present with diarrhoea, will this be considered “high probability” of pneumonia?  Can NICE provide information within the QS on the sensitivity and specificity of this decision rule? How does NICE propose to mitigate the risk of over-prescribing of antibiotics? |
| 70 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 2 | ***Outcome***  *a) Rate of unplanned hospital admissions for acute respiratory infection.*  Unsure why this outcome is part of this statement where the focus is on appropriate prescribing of an antimicrobial. Is this a balancing measure for quality of care? |
| 71 | NHS England- Clinical Policy Unit, National Clinical Director | Statement 2 | Might it not be safer to start the antimicrobials before attending for assessment eg in someone with chronic lung disease and a rescue pack. Is this evidence based? |
| 72 | NHS England- Primary Care | Statement 2 | Pg4 line 11 - why can we not prescribe remotely? If the data of POCT CRP/PCT testing is limited, the POCT for viral illness is not recommended, then there will be cases when GPs will feel that antibiotics are indicated but a F2F appointment is not necessarily indicated. |
| 73 | NHS England- Primary Care | Statement 2 | Pg6 line 1 - CRB65 in context of ARI seems of limited value as a prognostic tool. It has been shown to overpredict mortality across all groups in community settings (https://bjgp.org/content/60/579/e423) but also I query the non-specific nature of the parameters. I wonder whether a NEWS2 based approach would be of more utility as complex co-morbid patients can develop acute illness which may mimic ARIs. In primary care CRB65 is to aid admission decision-making and I feel that NEWS2 will determine this with more nuance. |
| 74 | NHS England- Primary Care | Statement 2 | This is a clear quality statement and provides better care for patients but will have unintended consequences for patients without transport, rural populations and those with health inequalities and will increase demand for face-to-face consultations as many patients are likely to be receiving antibiotics prescribed over the phone. The E&D considerations are not addressing issues of access and uptake. |
| 75 | PMD Device Solutions Limited | Statement 2 | Within the Equality and diversity considerations, it has been well established that increasing Respiratory Rate is a pre-marker for declining pulse oximetry i.e. Respiratory Failure. It should be noted that objective measures of Respiratory Rate should be sought for patients who are suffering from a pre-existing long-term conditions such as COPD – otherwise the measure of pulse oximetry alone will present a patient safety risk. |
| 76 | Primary Care Respiratory Society (PCRS) | Statement 2 | PCRS supports but see comment in response to question 3 |
| 77 | Royal College of Nursing | Statement 2 | We agree with face-to-face consultations. Building enough capacity is the main risk as ever, but with good auditing and data capture, flexible capacity can be in place especially in the autumn and winter months. |
| 78 | Society Acute Medicine | Statement 2 | It should include point of care ultrasound as a diagnostic tool. If they’re allowing ‘reduced breath sounds’ and ‘crackles’ as diagnostics tools (both of which have very limited evidence) then they should allow POCUS which has an evidence base which is at least comparable. |
| 79 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 2- Question 2 | ***Data source:*** *Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from electronic patient records and prescribing data.*  Routine prescribing data does not report indication for prescription or consultation type (virtual/face to face) so will not be able to support the measurement of this statement. Do the electronic health care record systems have the functionality to report antibiotic prescribing by type of consultation (face to face)? |
| 80 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 2- Question 2 | ***Data source:*** *Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records and prescribing data.* [*NHS England’s antibiotic quality premium monitoring dashboard*](https://www.england.nhs.uk/publication/antibiotic-quality-premium-monitoring-dashboard/) *includes total prescribing of antibiotics in primary care.* [*OpenPrescribing.net*](https://openprescribing.net/measure/) *includes the prescribing measure ‘antibiotic stewardship: volume of antibiotic prescribing (KTT9)’, which allows comparisons between sub-integrated care board locations.*  Neither of the above data links are suitable. The NHS England’s antibiotic quality premium monitoring dashboard link is no longer published on this link so do remove. And the data set it linked to is not appropriate for the purposes of this statement as it reports a total antibiotic prescribing metric at an ICB level. NHSE England publish Antimicrobial Stewardship dashboards hosted on the PrescQIPP open data [Antimicrobial Stewardship Hub](https://www.prescqipp.info/our-resources/webkits/antimicrobial-stewardship/) that allow user to select antibiotic and age and organisation. However indication and consultation route is not included in the data set.  The OpenPrescribing.net dashboard is not appropriate either for the same reason (same NHSBSA data source).  Aggregated prescribing data for primary care are collected as metrics for the [NHS Oversight Framework](https://www.england.nhs.uk/nhs-oversight-framework/) and published on [FutureNHS](https://future.nhs.uk/A_M_R/view?objectID=33692656) and [Model Health System](https://model.nhs.uk/) (both require registration and log in). No information on antiviral prescribing for influenza or Covid-19 is currently routinely available in these databases.  The appropriate data source will be via the primary care electronic health record (EMIS Web, SystmOne/TPP, Vision) where indication may be recorded and consultation route will be reported. Noting the comment for Statement 1 re coding completeness and accuracy of indication coding in the electronic record. |
| 81 | Antimicrobial Working Group, Aneurin Bevan University Health Board | Statement 2- Question 3 | There have been some staffing concerns raised by GPs about the potential increase in face-to-face consultation required to meet this quality standard / new guidance. |
| 82 | Primary Care Respiratory Society (PCRS) | Statement 2- Question 3 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?  Regarding QS 2: - Adults presenting with suspected acute respiratory infection are only prescribed antimicrobials following a face-to-face assessment  PCRS has already provided feedback on this issue within the GID NG10376 consultation and to restate here; PCRS thinks that in the majority of situations a face-to-face assessment is necessary before prescribing antibiotics but that there are exceptions and the language used in guidance and QSs should reflect this to allow services to practice with pragmatism and remain adherent to the QS. |
| **Statement 3: Adults prescribed an antibiotic for an acute respiratory infection are given a 5-day course, or 5 to 10 days if phenoxymethylpenicillin is prescribed for acute sore throat.** | | | |
| 83 | Antimicrobial Working Group, Aneurin Bevan University Health Board | Statement 3 | Agree with the quality statement for duration of antimicrobials for acute respiratory infections, although would wish to strengthen the guidance of when 10 days is deemed appropriate for acute sore throat. [AWMSG Primary Care Antimicrobial Guidelines](https://awttc.nhs.wales/files/guidelines-and-pils/primary-care-antimicrobial-guidelines-2022-pdf/) recommend “If patient is immunocompromised, confirmed Group A Streptococcus infection or has a problematic recurrence of infection: 10 days”. |
| 84 | British Thoracic Society | Statement 3 | Need to discuss as per local antimicrobial prescribing guidelines. Some patients with bronchiectasis may be given 2 weeks…need to clarify this point. |
| 85 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 3 | Antibiotic Duration  The inclusion of this Quality Standards is particularly welcome. Antibiotic Duration is an NHS England AMR Programme workstream and will also be reported in Model Health System datasets and as part of the metrics for the [National medicines optimisation opportunities 2023/24](https://www.england.nhs.uk/publication/national-medicines-optimisation-opportunities-2023-24/). Data will be reported routinely in ePACT2 to support the national medicines optimisation opportunities.  To minimise data capture burden consider changing the statement to focus on the duration of antibiotic prescribed for an acute respiratory infection by antibiotic (rather than indication which is not reported in routine data sets) and make use of the NHS England [Optimising antibiotic duration dashboard](https://www.prescqipp.info/our-resources/webkits/antimicrobial-stewardship/optimising-antimicrobial-use-dashboard/) hosted as open access on the PrescQIPP Antimicrobial Stewardship Hub routinely reported complete data set for primary care. This currently reports for amoxicillin and doxycycline and will soon include phenoxymethylpenicillin V at all primary care organisational levels. |
| 86 | NHS England- Clinical Policy Unit, National Clinical Director | Statement 3 | This is evidence based and counter referenced to appropriate NICE guidance. |
| 87 | NHS England- Primary Care | Statement 3 | This is ok |
| 88 | Primary Care Respiratory Society (PCRS) | Statement 3 | PCRS supports |
| 89 | Royal College of Nursing | Statement 3 | Considerations for anaphylaxis management and penicillin allergies - We believe that this is already in place in most settings but worth mentioning, especially in specialised hubs for this work. |
| **Statement 4: Adults admitted to an acute respiratory infection virtual ward are given verbal and written information about the service, including how and when they will be contacted by healthcare professionals and how to use any remote monitoring equipment.** | | | |
| 90 | Action for Smoking and Health | Statement 4 | Virtual wards: smoking status of patient (and ideally family, carers, significant others, co-living partners) is ascertained, given very brief advice that takes 30 seconds to deliver (VBA), offered and provided with a choice of nicotine replacement therapy (NRT) and referred for behavioural support.  Quality measures: proportion of adult admissions to acute respiratory infection virtual ward where smoking status is ascertained, number given VBA, number offered NRT, proportion referred for behavioural follow up. Proportion of staff trained in VBA and able to give follow up advice in routine virtual ward monitoring, including on NRT and screening for withdrawal symptoms. |
| 91 | Association of Respiratory Nurses | Statement 4 | Achievable within specific Virtual ward teams, but variation in service provision, documentation and tertiary support services. (SM) |
| 92 | British Thoracic Society | Statement 4 | This is an already a known fact and would assume would happen. What remote monitoring should then be: a basic list would be useful. Acknowledgement of digital inequality and ethnic diversity that can impact on the information provided is important and well noted. Perhaps change to appropriate information (patient specific) is given. |
| 93 | NHS England- Clinical Policy Unit, National Clinical Director | Statement 4 | This would seem a generic expectation of anyone on a non-elective pathway. Low value as a quality standard. Not evidence based, albeit common sense. |
| 94 | NHS England- Primary Care | Statement 4 | This is ok and does mention health inequality concerns. There will be resource implications for areas of greater need due to higher rates of health inequality |
| 95 | Primary Care Respiratory Society (PCRS) | Statement 4 | PCRS supports |
| 96 | Royal College of Nursing | Statement 4 | Consideration for neurodiverse individuals should be considered as well. |
| **Statement 5: Adults admitted to an acute respiratory infection virtual ward are cared for by a multidisciplinary team that has access to speciality advice and diagnostics and is led by a named consultant practitioner or GP with suitable expertise.** | | | |
| 97 | Action for Smoking and Health | Statement 5 | Multi-disciplinary team: all members of the virtual ward multi-disciplinary team are trained in giving VBA to encourage smoking cessation, providing NRT and onward referrals to smoking cessation services. |
| 98 | Association of Respiratory Nurses | Statement 5 | In relation to virtual ward - Hospital consultant time is a difficult resource. Timings of MDT. No specialist consultant out of hours if it is a consultant led service. Acute consultants can struggle with remote assessment and plans of care as used to a completely different model of care. (SM) |
| 99 | British Thoracic Society | Statement 5 | The teams will vary depending on local commissioning very much; what is the minimum structure and how is that role commissioned?.How do you define suitable expertise? |
| 100 | Diabetes UK | Statement 5 | For Quality Statement 5 (pg 22), consider including “including for other unrelated long-term health conditions, such as diabetes” between ‘advice’ and ‘if needed’ |
| 101 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 5 | Quality measures that are listed under this quality statement do not provide a framework to support assessment that an appropriate MDT is in place, i.e. has measures on access to diagnostics, led by consultant and patient satisfaction, but nothing to reflect the need for an MDT approach. MDT is key to support antimicrobial stewardship. There is also a potential gap in creating measures around physiotherapy input to these services. |
| 102 | NHS England- Clinical Policy Unit, National Clinical Director | Statement 5 | Generic common sense not specific to acute respiratory infection. |
| 103 | NHS England- Primary Care | Statement 5 | Agreed the MDT approach is ideal |
| 104 | Primary Care Respiratory Society (PCRS) | Statement 5 | PCRS supports |
| 105 | Royal College of Nursing | Statement 5 | Outcome on monitoring how many people on the virtual wards later require hospitalisation would be helpful for the long-term effectiveness analysis. A thirty-day window could be a starting point perhaps. |
| 106 | Society Acute Medicine | Statement 5 | They should define ‘senior clinical decision maker’ undertaking daily review on the virtual ward. And I am uncomfortable at the suggestion that virtual ward patients have access to the MDT in the same way inpatients do, to ensure equitability. Most of these patients should be pretty well, but at risk of hypoxia or respiratory distress only. They should not have therapy, mobility or other issues that require the MDT – if they do they should be admitted to hospital. You cannot/should not manage people with complicated respiratory infections requiring an MDT on a virtual ward in my view. |
| **Statement 6: Adults admitted to an acute respiratory infection virtual ward are supported to self-manage their condition.** | | | |
| 107 | Action for Smoking and Health | Statement 6 | Patient satisfaction should include measures related to advice on smoking. Measures could be similar to those included in the Quality Improvement in Tobacco Treatment [(QuITT) programme](https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/quitt), run by the National Collaborating Centre for Mental Health (NCCMH - affiliated with the Royal College of Psychiatrists).   1. The percentage of patients that felt empowered to quit or continue to be smoke free 2. The percentage of patients who felt that the support to quit smoking was tailored to their needs and preferences. |
| 108 | Association of Respiratory Nurses | Statement 6 | Face to face assessment conflicts with self-management in terms of rescue meds.(SM) |
| 109 | British Thoracic Society | Statement 6 | How can this be recorded easily or meaningfully? It will be hard to do this. Optimisation of their current health behaviours and lifestyle. It is essential but not measurable – on how many conditions should we give advice to self-manage, what level of documentation would satisfy audit? |
| 110 | Diabetes UK | Statement 6 | For Quality Statement 6, consider including “or other unrelated long-term health conditions such as diabetes” i.e. …conditions such as asthma, chronic obstructive pulmonary disease or other unrelated long-term health conditions such as diabetes – this could be in brackets if needed. |
| 111 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 6 | Consider adding **referral to** vaccination services and pulmonary rehab alongside smoking cessation services as an example of key interventions to reduce recurrent infections. |
| 112 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 6 | Support to self-manage their condition  We recommend signposting to the [“How to…”](https://elearning.rcgp.org.uk/mod/book/view.php?id=12649&chapterid=793) resource on the RCGP TARGET website to support health professionals with structured clinical review of patients with recurrent acute infective exacerbations of COPD and receiving repeat or long-term antibiotics. |
| 113 | NHS England- Clinical Policy Unit, National Clinical Director | Statement 6 | Statement 6 is nebulous, albeit worthy, and difficult to define or deliver consistently. |
|  | NHS England- Infection Prevention and Control Team | Statement 6 | ‘Supported to self-manage’ – should include the prevention of harm to self and others (GIRFT/Long Term Plan/Code of Practice).  NHS England IPC Board Assurance Framework – BAF 2023   * The provision of information includes and supports general principles on the prevention and control of infection.   • Roles and responsibilities of specific individuals etc are clearly outlined to support good standards of IPC and AMR including: hand hygiene, respiratory hygiene, PPE (mask use if applicable). Supporting patients’ awareness and involvement in the safe provision of IPC (eg cleanliness)  • Published materials from national/local public health campaigns (eg seasonal and respiratory infections and vaccination programmes) should be utilised to inform and improve knowledge of patients/service users etc and minimise the risk of transmission of infections. |
| 114 | NHS England- Primary Care | Statement 6 | Self-management quality statement is good but the E&D reference to mental health is very dismissive. Someone with ARI AND a mental health condition would require support to access MH care rather than just ‘information’. In a hospital ward the responsibility would be that of the admitted team to navigate this for the patient. The patient is physically ill and trying to cope at home and therefore may require more help. |
| 115 | Primary Care Respiratory Society (PCRS) | Statement 6 | PCRS supports |
| 116 | Royal College of Nursing | Statement 6 | Support with food and nutrition, housing condition for example, damp conditions, poor heating, and the socio-economic impacts (cost of living) on recovery and self-management should be considered always together with smoking cessation. It is important that we do not miss opportunities and think more holistically about health and social care provision for the individual. |
| Statement 7: Adults admitted to an acute respiratory infection virtual ward have a personalised self-escalation plan, including details of who to contact in and out of hours. | | | |
| 117 | Action for Smoking and Health | Statement 7 | Information should be given to patients on how to access behavioural support in the community and they should be signposted to the NHS stop smoking app. |
| 118 | British Thoracic Society | Statement 7 | This is important and can be measured easily. |
| 119 | NHS England- Primary Care | Statement 7 | The E&D reference to mental health is very dismissive. Someone with ARI AND a mental health condition would require support to access MH care rather than just ‘information’. In a hospital ward the responsibility would be that of the admitted team to navigate this for the patient. The patient is physically ill and trying to cope at home and therefore may require more help. |
| 120 | Primary Care Respiratory Society (PCRS) | Statement 7 | PCRS supports |
| 121 | Society Acute Medicine | Statement 7 | should be merged with statement 4 – it seems unnecessary to have it as a separate standard given it is so self-evident |
| **Statement 8: Adults discharged from an acute respiratory infection virtual ward are given a discharge summary including follow-up details that is also shared with their GP.** | | | |
| 122 | Action for Smoking and Health | Statement 8 | Discharge summary: should also include information on smoking status and what interventions have been initiated to treat tobacco dependency. |
| 123 | Association of Respiratory Nurses | Statement 8 | Discharge process difficult on virtual ward where care shared between acute and community due to interoperability of IT systems. NHSE directive for bed management causes some difficulty in managing normal process or new virtual ward services (SM) |
| 124 | British Thoracic Society | Statement 8 | This is important and measurable. |
| 125 | NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream | Statement 8 | Consider specifying explicitly that the discharge summary must include details of antimicrobials prescribed. This is vital for tracking patient exposure to antimicrobials and risk of resistance. |
| 126 | Primary Care Respiratory Society (PCRS) | Statement 8 | PCRS supports |

## Registered stakeholders who submitted comments at consultation

* Action for Smoking and Health
* Aneurin Bevan University Health Board
* Association of Respiratory Nurses
* British Thoracic Society
* Diabetes UK
* NHS England AMR Programme – Antimicrobial Prescribing and Medicines Optimisation (APMO) workstream
* NHS England – Clinical Policy Unit, National Clinical Director
* NHS England Infection Prevention and Control Team
* NHS England Learning disability and Autism programme
* NHS England Primary Care
* Primary Care Respiratory Society (PCRS)
* PMD Device Solutions Limited
* Royal College of Nursing
* Society Acute Medicine