NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Bronchiolitis in children

Date of Quality Standards Advisory Committee post-consultation meeting:
23rd March 2015.

2 Introduction

The draft quality standard for bronchiolitis in children was made available on the NICE website for a 4-week public consultation period between 26 January and 22 February 2016. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 12 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard:

- Stakeholders asked how we planned to capture parents' experience of care within the quality standard. This was considered important to ensure continuous learning from experience.
- One stakeholder highlighted the importance of using accessible language. They suggested that we review the SIGN guidance, around how to effectively relay information to parents; an adaption of this should be included within the quality standard.

Consultation question 1: A key issue is making an accurate diagnosis in primary care, and this is not included in the QS. Within practice, it can be very difficult to distinguish bronchiolitis from low grade pneumonia or other respiratory infections. Many clinicians in primary care lack confidence in diagnosing bronchiolitis, and it can be challenging to differentiate it from other infections, due to the lack of any objective tests. The stakeholder queried why this area had not been included in the quality standard, as it was included within the key areas for prioritisation in the clinical guideline.

Consultation question 2 If a GP prescribes antibiotics, because of diagnostic uncertainty, they will not record a diagnosis of bronchiolitis. Instead a different diagnosis, such as cough, upper respiratory tract infection or lower respiratory tract infection will be noted. Therefore gathering accurate data for quality statement 3 may be difficult. The presence or absence of antibiotics in a particular at-risk age group could be measured. It was suggested that the link with bronchiolitis will be unreliable.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Parents and carers of children with bronchiolitis are informed that the condition is usually self-limiting and why medication is not being used.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Most hospitals will have written information available about bronchiolitis, but would need to conduct an audit to ascertain actual provision.
- Availability of translated information leaflets to other languages is limited and use of an interpreter in these cases would be sufficient.
- One stakeholder asked their lay members to comment on the quality standard
  - Lay members were unaware of bronchiolitis and how common it is. Therefore they felt it was important that good information should be available for parents.
  - 'Self-limiting' is not a clear term for lay people.
- Various stakeholders agreed with the statement, but asked how it would be measured. There is currently no method of recording this conversation in the templates used by GPs. The measures in the quality standard are too broad and unsuitable as a method of assessment.
- One stakeholder felt the statement was not appropriate; parents and carers will return if they disagree with information given and it is difficult to assess whether the condition is going to be self-limiting.
- This statement could be a tick box exercise; there is no way of checking the quality of the information given.
- One stakeholder suggested that when a clear diagnosis of bronchiolitis is made, this statement would be standard practice, therefore is unnecessary.

5.2 Draft statement 2

Parents and carers of children with bronchiolitis are given key safety information if they are caring for the child at home.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- One stakeholder asked their lay members to comment on the quality standard:
  - Lay members were unaware of bronchiolitis and how common it is. Therefore they felt it was important that good information should be available for parents.
  - Insufficient explanation of 'nasal flaring' and 'chest recession' but, conversely, the terms 'apnoea', 'cyanosis' and exhaustion are well described. Red flag features need to be unambiguous to parents being sent home with a sick child.
- There needs to be more clarity around whether the key safety information should be given in a verbal or written format.
- Stakeholders suggested using and promoting information provided as part of the 'more than a cold campaign' funded and developed by AbbVie Ltd.
- Stakeholders felt clarity was needed around when and where key safety information is provided. Particular comments were made around how information is given when parents and carers are caring for their child at home. Stakeholders queried whether a particular code was required to record this.
- Highlighting the impact of smoking in the 'key safety information' is not an evidence based behavioural change intervention and is not likely to prevent someone from smoking.
- Statement 2 is a tick box exercise, as there is no way of checking the information given.
- When a clear diagnosis of bronchiolitis is made, this statement would be standard practice, therefore is unnecessary.

5.3 Draft statement 3

Healthcare professionals do not prescribe antibiotics to treat bronchiolitis in children.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Stakeholders suggested that audits can ascertain what proportions of children with a primary diagnosis of bronchiolitis are given antibiotics. However, the NICE sepsis guidelines may mean that a higher proportion of children are initially given antibiotics in future because of tachycardia, raised respiratory rates and prolonged capillary refill time at presentation to hospital. Stakeholders suggested that antibiotics could be stopped once a diagnosis of bronchiolitis is confirmed.
- Concerns were raised around children whose bronchiolitis becomes bacterial or who also have a bacterial infection. Stakeholders suggested that these circumstances should be recognised within this statement, as antibiotics would be appropriate. Therefore a 0% prescription target would be an unsuitable target and should not be used as a measure against this statement. Stakeholders also questioned how this would be audited.

5.4 Draft statement 4 (placeholder)

Early discharge with support from community nursing teams.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Saturation monitoring before discharge from hospital is important, as parents or carers can become anxious if they see that saturation falls below 90%. Therefore, community nurses would need to check saturations, weigh children and check their feeding after discharge from hospital.
- Concerns were expressed around the capacity of community nursing teams to support this discharge. If necessary, those with increased risk factors such as preterm babies, babies under 6 weeks old and those with heart murmurs should be given priority.
- Some children discharged from hospital may still need to be supported with oxygen at home, which would require a risk assessment before use.
- Stakeholders suggested that if discharge procedures are effective and appropriate, as required by statements 1 and 2, then this statement is not needed.
- This statement should better reflect the importance of parent or carer involvement at discharge, particularly when the child has other long term conditions.
- One stakeholder felt that involvement of community nursing teams was appropriate in palliative care situations only.
- It is unclear whether how this specifically relates to bronchiolitis and whether it relates to a paediatric team only.

Stakeholders were also invited to respond to the following specific question:

Do you know of any relevant evidence-based guidance that could be used to develop the placeholder statement? If so, please provide details. If not, would new evidence-based guidance relating to discharge with involvement from community nursing teams have the potential to improve practice? If so, please provide details.

Stakeholders did not suggest any relevant evidence-based guidance related to discharge with involvement with involvement from community nursing teams.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Stakeholders suggested that prior awareness of the symptoms of bronchiolitis, and appropriate action to take could reduce the number of hospital admissions. Therefore an additional quality statement around raising awareness of bronchiolitis amongst parents and carers, particularly in those with children at high risk of bronchiolitis (such as those with congenital heart disease, born prematurely or low birth weight, or with bronchopulmonary dysplasia). Stakeholders suggested this could also detail times of the year when incidence of bronchiolitis is at its highest.
- Stakeholders noted the prevalence of unnecessary x-rays, as highlighted in the briefing paper.
- One stakeholder suggested it would be helpful to include a statement reinforcing the recording of vital signs a clinician should be checking for, in any child with suspected bronchiolitis as the basis for an accurate diagnosis. These could include temperature, respiration rate, wheeze and crackles, pulse rate, oxygen saturations and unilateral and bilateral signs. The stakeholder also suggested we include:
  - What action GPs should take to be sure what it is they are hearing
  - What to do if the child is too distressed for any sounds to be confidently heard
  - The equipment a GP surgery should have in order to diagnose bronchiolitis effectively such as pulse oximetry. The stakeholder suggested the quality standard should be clear on which probes or kits GP practices should have and what thresholds are ok; home with caution or hospital.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
1	NHS England	General	General	May I ask how you plan to capture parents experience of care within this quality standard to ensure continuous learning from experience is embedded?
2	Primary Care Respiratory Society UK (PCRS -UK)	General	General	Overall, we were not enthused by the quality standard for bronchiolitis and feel it will not make much difference to the quality of care. This is primarily because the key area for improvement is making a diagnosis, which this does not cover. And the first 2 QStatements are just tick box exercises, so may do little or nothing to improve care.
3	Primary Care Respiratory Society UK (PCRS -UK)	General	General Further points	"*that people should not smoke in the child's home because it increases the risk of more severe symptoms in bronchiolitis*" (p11) While it is excellent that the draft QS has picked up on smoking as a cause of more severe symptoms, this should be worded in line with evidence on what will deter people from smoking. Current wording implies that people should be told not to smoke which isn't an evidence based behavioural change intervention and is not likely to engage someone with a quit smoking attempt. Settings other than the child's home should be covered – any smoking near the child may cause symptoms to be more severe, regardless of the setting. Respiratory infection in children is a 'teachable moment' to support parents and household members to consider quitting smoking if the health professional is trained in providing very brief advice (VBA).

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
				We recommend that NICE considers adding a research recommendation regarding 1) Use of exhaled CO in carers presenting with acutely unwell children to support a discussion about risks of tobacco smoking to child lung health and lung development 2) Use of cotinine for children attending A+E with bronchiolitis so that the extent of smoking and bronchiolitis severity can be measured better
4	British Lung Foundation, on behalf of the Bronchiolitis Coalition	General	General additional statement	We welcome these quality standards. However, these Quality Statements limit the provision of key safety information on bronchiolitis to the parents and carers of those with bronchiolitis. Prior awareness of the symptoms of bronchiolitis and appropriate action to take can reduce the number of hospital admissions. NICE should include an additional Quality Statement advising public health professionals to raise awareness of bronchiolitis amongst parents and carers, particularly those with children at high risk of bronchiolitis, and during the high season. This could be included as an extension to Statement 2 or as a separate Statement. As NICE suggest in the briefing paper which accompanies these Statements, many patients with bronchiolitis receive unnecessary x-rays. These can often lead to a greater use of antibiotics as x-ray imaging may display characteristics similar to pneumonia. NICE state that, "*This unnecessary treatment has adverse impacts on side effects, length of stay, cost and antimicrobial resistance*." Given the prevalence of unnecessary x-rays, NICE should add an additional Statement advising against their use. This could potentially be in tandem with the caution against antibiotic prescription expressed in Statement 3.

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
				We would like to see the importance of using accessible language when communicating with parents and carers stressed in the guidance. NICE should review guidance offered to healthcare professionals by SIGN on how to effectively relay information to parents, and consider including an adaptation of this within an overarching note.
5	Royal College of General Practitioners (RCGP)	General	General	I support the recommendations which are otherwise excellent but there is significant educational need in Primary Care over diagnosing and coding bronchiolitis (rather than chest infection) and giving parents key safety information. (JA)
6	AbbVie Ltd	General	General Data Collection to measure Quality Standards	AbbVie does not believe that the data currently collected on bronchiolitis across the NHS is sufficiently detailed to measure the impact of the Quality Standards. For example, the data currently collected by the NHS do not capture the number of admissions for children at highest risk of severe bronchiolitis requiring hospital care, such as premature babies, and cannot be interrogated to identify the cause of the admission and more importantly what their subsequent outcomes were which will be crucial given the need to assess the impact of the proposed Quality Standards. As a result, it will be a significant challenge for the NHS to assess the value of the Quality Standards and whether they are being implemented.
Statement 1				
7	Royal College of Paediatrics and Child Health (RCPCH)	QS1	QS1	Most DGH's would have written information available for parents about bronchiolitis, but would need to audit the notes to ascertain what proportion of parents were actually given these. Also, availability of translations of these leaflets into multiple other languages needed is limited! If there were a record of the use of an interpreter to give verbal information, that would be sufficient in these cases.

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
8	Primary Care Respiratory Society UK (PCRS -UK)	QS1	QS1	We asked members of our lay reference group to comment on this QS too – - Importantly, our lay members (mostly adults with lung disease) were not aware of bronchiolitis and how common it is, so felt that it was even more important that good information should be available for parents who could be hearing about the condition for the first time when their child is ill - 'self-limiting' is not a clear statement for lay people. It needs to be spelt out clearly to parents what this means (it is used without explanation 9 times within the section aimed at "Explaining bronchiolitis to parents and carers (p7-8 (QS1))".) - Written material given to them needs to be written clearly in lay terms, since a parent with a sick child is unlikely to be taking in all the clinician is telling them at a stressful time, so written material needs to be a good reference source to return to and to stand independently of a healthcare professional.
9	National Paediatric Respiratory and Allergy Nursing Group (NRANG)	QS1	QS1	Agree with this statement but how would this be measured?
10	British Lung Foundation, on behalf of the Bronchiolitis Coalition	QS1	QS1	We welcome this quality statement and agree with the rationale behind it. It is the experience of healthcare professionals we have spoken to that, when done well, parents and carers respond positively to such conversations. However, we would like NICE to outline how they intend to measure the outcomes from it. There is currently no method of recording this conversation in current templates used by General Practitioners. The friends and family test is too broad and therefore an unsuitable method of assessment.
11	Royal College of General Practitioners (RCGP)	QS1	QS1	Inform Parents and carers of children with bronchiolitis that the condition is usually self-limiting and why medication is not being used would not be appropriate, they will be back if they don't believe us. It is not easy for a hospital

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
				and primary care environment to assess. (SH)
12	Aneurin Bevan Health Board Emergency Medicine (royal college of emergency medicine)	QS1	QS1	Yes it does reflect key area for QI
Statement 2				
13	Royal College of Paediatrics and Child Health (RCPCH)	QS2	QS2	Most DGH's would have written information for parents and also give verbal instructions about when to return to hospital, but many parents do return and are again reassured and discharged. It would be important to distinguish between babies who genuinely need readmission with bronchiolitis, and those who just came for reassurance. This would be impossible to ascertain from coding alone, and review of lengths of stay in hospital would be needed.
14	Primary Care Respiratory Society UK (PCRS -UK)	QS2	QS2	We asked members of our lay reference group to comment on this QS too – - Importantly, our lay members (mostly adults with lung disease) were not aware of bronchiolitis and how common it is, so felt that it was even more important that good information should be available for parents who could be hearing about the condition for the first time when their child is ill - There is also insufficient explanation of 'nasal flaring' and 'chest recession'. Conversely, the terms 'apnoea', 'cyanosis' and even 'exhaustion' are well described. Red flag features need to be unambiguous to parents being sent home with a sick child. - Written material given to them needs to be written clearly in lay terms, since a parent with a sick child is unlikely to be taking in all the clinician is telling them at a stressful time, so written material needs to be a good reference source to return to and to stand independently of a healthcare professional.

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
15	National Paediatric Respiratory and Allergy Nursing Group (NRANG)	QS2	QS2	Agree strongly with the statement – however NICE should be clearer on how this information should be given (written/verbal). There is other information around which supports this – “more than a cold “campaign.
16	British Lung Foundation, on behalf of the Bronchiolitis Coalition	QS2	QS2	We support this statement. Healthcare professionals should make clear to parents and carers what symptoms to monitor, what deterioration would look like, and the most appropriate person to contact in the event of deterioration. Additionally, NICE should consider placing emphasis on the importance of providing information at discharge and we recommend that this information is included as part of a routine discharge pack. Parents are carers should be informed of the expected length of the condition at discharge. Evidence has shown that this reduces unnecessary General Practice visits. NICE should review the ‘more than a cold’ campaign, which was supported by the British Lung Foundation, as an example of best practice in written guidance for parents and carers. Consideration should also be given to enhancing, and promoting the use of, current information which is available in neonatal units.
17	Royal College of General Practitioners (RCGP)	QS2	QS2	It is unclear how we are giving to parents and carers of children with bronchiolitis key safety information if they are caring for the child at home. Is this written, video, or spoken, proof, do we need a code in health care? Given key safety advise regarding bronchiolitis to parents and carers of child to prove this for audit purposes can be appropriate. Bearing in mind that some hospital do not provide enough computers it would need to be determinate how we record this, we would probably to do a paper trawl. (SH)
18	AbbVie Ltd	QS2	QS2	AbbVie broadly supports Statement 2 and recognises the crucial need for high quality and accessible information for parents. Although prevention sits outside the scope of this Quality Standard AbbVie would like to see Statement 2 include a

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
				requirement on HCPs to raise awareness with parents about how they can reduce the risk of their child getting bronchiolitis and which children are at higher risk of severe bronchiolitis. This would play a key role in reducing the spread of infection and the number of children with bronchiolitis. . AbbVie would like to emphasise that Statement 2 should also include specific information on the infants and children and groups that are more likely to be at risk of severe bronchiolitis. In high risk populations such as infants with congenital heart disease, or those born prematurely with low birth weight and/or with bronchopulmonary dysplasia/chronic lung disease, bronchiolitis may have severe symptoms resulting in the need for hospital care, a higher risk of a prolonged stay in hospital and supportive care on paediatric intensive care units, including ventilation. RSV (respiratory syncytial virus) is the most common cause of bronchiolitis. Tobacco smoke exposure and overcrowding of family homes have been shown to be socio-economic prognostic factors for increased risk of severe RSV infection requiring hospitalisation. These risk factors are indicators of social deprivation and more likely to be experienced by families on lower incomes, often living in poor housing conditions. Infants born into such families are thus more vulnerable to RSV infection. There are several documented risk factors for severe RSV infection requiring hospitalisation, including pollution/exposure to passive smoking, day care attendance, school age siblings, overcrowding in the family home, lack of breastfeeding and age at the start of the RSV/bronchiolitis season.
19	Aneurin Bevan Health Board Emergency Medicine (royal college of emergency	QS2	QS2	Quality Measures I believe it is possible to collect this data through audit The provision of a suitable Patient information leaflet (PIL) to include natural history of the disease, guidance for patients including safety net advice, red flags

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
	medicine)			and advice on when return to hospital is indicated could be included on PIL. Use of the PIL can be linked, certainly on our IT system, to individual patients. We can print off PIL for patients such that it is automatically linked to the patient record giving audit trail. This can them be easily audited for all patients with discharge diagnosis of bronchiolitis. In same way a audit programme particularly if part of departmental/ RCEM programme can audit its use and also use of antibiotics/ CXR's in this group of patients
Statement 3				
20	Royal College of Paediatrics and Child Health (RCPCH)	QS3	QS3	Audits can ascertain what proportion of babies with a primary diagnosis of bronchiolitis are given antibiotics, but beware that the NICE sepsis guidelines may mean that a higher proportion of babies are given initial antibiotics in future because of tachycardia, raised respiratory rates and prolonged capillary refill time at presentation to hospital. Antibiotic treatment can be stopped once the diagnosis of bronchiolitis has been confirmed!
21	National Paediatric Respiratory and Allergy Nursing Group (NRANG)	QS3	QS3	Support the reduction of prescribing antibiotics. However some children do have to have antibiotics due to their condition becoming a bacterial infection. There should be some acknowledgement made by NICE regarding this.
22	British Lung Foundation, on behalf of the Bronchiolitis Coalition	QS3	QS3	We support efforts to reduce the unnecessary prescription of antibiotics to treat bronchiolitis, as it is a viral infection. Clinicians estimate that current prescription rates are around 30%, which is too high. A recent study by March et al found that antibiotic prescription rates for bronchiolitis in Wales varied significantly across Welsh hospitals in 2013/14[1].

[1] Murch et al *Arch Dis Child* 2015; 100: 654-658

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
				However, there are some cases where children will also have a bacterial infection and will require antibiotics. NICE should consider adding an additional element to this statement which recognises those circumstances in which antibiotic prescription would be appropriate. In light of this, a 0% prescription target would be an inappropriate, NICE should not measure performance of this Statement against it.
23	Royal College of General Practitioners (RCGP)	QS3	QS3	Nobody making the diagnosis of bronchiolitis prescribes antibiotics to treat bronchiolitis in children, they only diagnose it if they think no antibiotics needed. How are we going to audit this? Computerised diagnosis of bronchiolitis and antibiotic given? GPs and hospitals will diagnose pneumonia and then give antibiotic if they think needed. (SH)
Statement 4 (placeholder)				
24	Royal College of Paediatrics and Child Health (RCPCH)	QS4	QS4	Changing from continuous oxygen saturation monitoring to intermittent saturation monitoring before discharge from hospital is important. Parents become anxious if they see that the saturation dips below 90% even when the baby is feeding well. Community nurses would need to spot check saturations, weigh babies and check on feeding after discharge from hospital. They may not have the capacity to follow up all the babies, but those with risk factors such as preterm babies, babies under 6 weeks and those with heart murmurs should have community follow up.
25	National Paediatric Respiratory and Allergy Nursing Group (NRANG)	QS4	QS4	NPRANG would have concerns that NICE recommends this early discharge, as NPRANG committee covers a wide geographical spread across the UK. We are aware that many of the areas in the UK that do not have the manpower to support this discharge, without more resources being made available. CCN teams would be the ideal people to support patients/ families. If they are discharged early we are assuming that there may be some need for oxygen at home – this brings added issues of criteria such as risk assessments etc etc.

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
26	British Lung Foundation, on behalf of the Bronchiolitis Coalition	QS4	QS4	Parents have told us that they appreciate this level of follow up. However, the BLF has also consulted with community nurses about this prospect, and given their existing responsibilities and current workload pressures, we doubt if they would have the resource to support the measures in this Statement effectively. Furthermore, there is no evidence we are aware of that this measure would have a beneficial effect. This measure should not be required if effective and appropriate discharge procedures and patient communication is in place, as required by Statements 1 and 2. We therefore recommend that this Statement is removed.
27	Royal College of General Practitioners (RCGP)	QS4	QS4	A placeholder means that they lack the evidence to put this forward at present but would like to include if there is evidence. So few people are admitted with bronchiolitis in the first place. A placeholder is a community nursing team, a general team or paediatric. Do they really need it? (SH)
28	Royal College of General Practitioners (RCGP)	QS4	QS4	The QS should be a full sentence but it does not describe care easily accessible to parents and young children. Community paediatric and nursing teams exist in some areas, (based from the hospital) but not universally. The standard also ignores the importance of parent and carer understanding and involvement at discharge, especially where the child has other long term conditions. These can be the most frequent re-admissions. I recommend that hospital teams work with parents and primary care for supporting early discharge home. This means communication with and upskilling the parents and nurse practitioners in Primary Care. In palliative care situations specialist community nursing teams are appropriate. (JA)
Consultation questions				
29	Primary Care Respiratory Society UK (PCRS -UK)	Question 1	Q1 Does this draft quality standard accurately	In primary care, the key issue is making an accurate diagnosis, yet this is not picked up in the QS at all. In practice, it can be very difficult to distinguish bronchiolitis from low grade pneumonia or other respiratory infection. Many clinicians in primary care lack confidence in diagnosing bronchiolitis, and the lack

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
			reflect the key areas for quality improvement?	of any definitive objective tests to differentiate it from other infections poses a real challenge. The main guideline recognises this, since diagnosis features heavily in the section 'Key priorities for implementation'. It is therefore surprising that there is no quality statement focussing on diagnosis in primary care. What would be helpful is to reinforce the recording of vital signs a clinician should be checking for, in any child with suspected bronchiolitis, as the basis for an accurate diagnosis - temperature, respiration rate, wheeze and crackles, pulse rate and oxygen saturations. What about unilateral and bilateral signs – could NICE make a statement about this? What about upper airway sounds that transmit? What action do you want a GP to take to be sure what it is they are hearing? What if the child is too distressed for any sounds to be confidently heard? The quality standard could also focus on the equipment a GP surgery should have in order to diagnose most effectively. Surely it should be encouraging the use of an objective measurement such as pulse oximetry. What probe/ kit does NICE advise a practice should have and what are the thresholds for ok, home with caution and hospital? In the event of uncertainty, it is not unreasonable for a clinician to prescribe antibiotics On the occasions that a clear diagnosis of bronchiolitis is made, the measures covered in statements 1&2 are obvious, and what any sensible clinician would do, so it seems unnecessary to state them. The guidance about assessing severity includes a statement about cyanosis. A cyanosed child is not commonly seen in general practice (one member said he had never seen one in 12 years of full time general practice).

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				There is an important missed opportunity to highlight the contribution that smoking can make to the severity of respiratory infection. See comments under 'Further points'.
30	Primary Care Respiratory Society UK (PCRS -UK)	Question 2	Q2 If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? (in primary care)	It is difficult to see how gathering data on statements 1&2 would be anything other than a tick box exercise. There is no way of checking the quality of information given, unless this is broken down into the individual pieces of advice that should be given, which can be ticked off. Re statement 2 - is this written, video, or spoken, proof? Should there be a READ code in health care … "Given key safety advice regarding bronchiolitis to mother and child to prove this for audit purposes." Re Qstatement 3 – if a GP believes a patient needs antibiotics due to diagnostic uncertainty, they will not record a diagnosis of bronchiolitis; they will record a different diagnosis, such as cough, URTI, LRTI. So gathering accurate data for Q statement 3 will not be straightforward. Presence or absence of antibiotics in a particular at-risk age group could be measured, but we suspect the link with the code bronchiolitis and children with bronchiolitis will not be reliable
31	Aneurin Bevan Health Board Emergency Medicine (royal college of emergency medicine)	Q3	Q3	No sorry
32	Aneurin Bevan Health Board Emergency Medicine (royal college	Q4	Q4	No

ID	Stakeholder	Statement No	Comment on	Comments Please insert each new comment in a new row.
	of emergency medicine)			
	No comment			
33	Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI)	General	General	Having reviewed the draft standards we have no comments to make but support their implementation
34	British Infection Association (BIA)	General	General	The BIA is content with this Quality Standard. Thank you.
35	British Society for Antimicrobial Chemotherapy (BSAC)	General	General	Members of the British Society for Antimicrobial Chemotherapy (BSAC) have no comments to this draft Bronchiolitis quality standard.
36	Department of Health (DoH)	General	General	I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
37	NHS England	General	General	May I ask how you plan to capture parents experience of care within this quality standard to ensure continuous learning from experience is embedded?

Registered stakeholders who submitted comments at consultation

- AbbVie Ltd
- Aneurin Bevan Health Board Emergency Medicine (royal college of emergency medicine)
- Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI)
- British Infection Association (BIA)
- British Lung Foundation, on behalf of the Bronchiolitis Coalition
- British Society for Antimicrobial Chemotherapy (BSAC)
- Department of Health (DoH)
- National Paediatric Respiratory and Allergy Nursing Group (NRANG)
- NHS England
- Primary Care Respiratory Society UK (PCRS -UK)
- Royal College of General Practitioners (RCGP)
- Royal College of Paediatrics and Child Health (RCPCH)

Appendix 2: Quality standard internal checks table

Comment number	Page number Or **'general'** for comments on the whole document	Statement number Or **'general'** for comments on the whole document	Comments
NICE implementation			
1	7 and 9	1 and 2	These statements appear a little obvious and are largely about giving information. Consider combining statements 1 and 2 into one statement.
2	14	4	The statement is too general and needs to be more specific to bronchiolitis.