**National Institute for Health and Care Excellence**

**Date: 9 October 2023**

**Acute respiratory infection in over 16s: initial assessment and management, including using virtual wards – review of stakeholder feedback**

**Minutes:** Final

**Attendees**

Sunil Gupta (Chair) GP and Chair of the Quality Standards Advisory Committee, NICE

Melanie Carr, Technical Analyst, NICE

Craig Grime, Technical Adviser, NICE

Jamie Jason, Coordinator, NICE

Jonathan Underhill, Clinical Advisor, NICE

Martin Allen, GIRFT National Clinical Lead for Respiratory Medicine and National Specialty Adviser for Physiological Science

Tom Bewick, Consultant Respiratory Physician

David Cruttenden-Wood, General and colorectal surgeon, Clinical Director for Virtual Healthcare Hampshire Hospital NHS Foundation Trust

Daniel Horner, Consultant in Emergency Medicine & Intensive Care

Tessa Lewis, GP

Nichola Macduff, A and E nurse

Carole Pitkeathley, Lay member

Alan Thomas, Lay member

Avril Tucker, Community Pharmacist

Martin Williams, Microbiologist

**Apologies**

Susan Bewley, Chair of NICE Guidelines committee

Rachael Ingram, Head of clinical operations, Mastercall

Daniel Furmedge, Consultant Geriatrician

Caroline O’Keeffe, GP

1. **Welcome, introductions objectives of the meeting**

The Chair welcomed the attendees and asked for declarations of interest.

1. **Recap of prioritisation meeting and discussion of stakeholder feedback**

MC provided a recap of the areas for quality improvement prioritised at the first workshop for potential inclusion in the draft quality standard.

MC summarised the significant themes from the stakeholder comments received on the draft quality standard and referred the group to the full set of stakeholder comments provided in the papers.

The group discussed some feedback that the statements for virtual wards are generic and could apply to any non-elective pathway. They suggested that given the relative immaturity of virtual ward services it should not be assumed that they will have all the components in place that other services have. They agreed that the quality standard will be helpful for virtual ward services that are developing quickly across the country and will help to ensure there is some consistency.

The group also discussed the proposal to split the quality standard into 2 to separate the virtual ward statements. They agreed that it should not be split as this stage as it covers a patient journey. If NICE does more work on virtual wards in future, not focussed on specific conditions, it may be helpful to have a separate quality standard.

**Discussion and agreement of amendments required to quality statements**

**Draft statement 1:** **Adults first presenting with suspected acute respiratory infection have a documented assessment of symptoms and signs.**

The group confirmed that assessment of symptoms and signs is not always recorded. It was felt that this is important because it can have an impact on any follow-up care required. They noted that it is important for the assessment to consider alternative diagnoses.

CG asked for clarification on whether documentation of symptoms and signs can be transferred from remote services. The group confirmed that it can be transferred. It was heard that ideally all services would have the same system but currently they don’t so an email may be sent, or a letter would be scanned and put on file.

The group discussed stakeholder feedback on using pulse oximetry in people with darker skin and noted that the Medicines and Healthcare products Regulatory Agency will issuing further advice on this soon.

It was agreed that this statement should be progressed.

**Draft statement 2: Adults presenting with suspected acute respiratory infection are only prescribed antimicrobials following a face-to-face assessment.**

The group agreed that the gold standard of care is face-to-face assessment and there is currently wide variation in practice. It was acknowledged that there are circumstances when remote prescribing may be appropriate but that should be an exception. It was suggested the statement should say ‘not routinely’ as per the updated guideline recommendation.

It was suggested that to help with measurability, clear justification for any antibiotics that are prescribed remotely should be required.

There was some concern that the exception of remote prescribing could become the norm for some groups such as those living in rural areas. The measure will provide a benchmark so that variations in practice can be identified and investigated.

It was agreed that this statement should be progressed with the wording revised to ‘not routinely’.

**Draft 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.**

The group noted that the 10 days for a sore throat was reduced to 5 when antibiotic supply was limited. 10 days is good practice, with 5 days the risk of relapse is greater.

The group discussed whether this statement should include people with an underlying respiratory comorbidity. There were some differences in opinion as COPD guidelines do specify 5 days whereas other conditions such as bronchiectasis are likely to require longer. The group did not want to make the statement confusing and suggested excluding some conditions such as bronchiectasis.

It was agreed that this statement should be progressed.

**Draft 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.**

The group discussed that there is currently variation in care and sometimes people admitted to virtual wards are not being given any information, and sometimes they may even be unaware they are on a virtual ward.

There was a suggestion to blend statements 4 and 6. However, it was felt that self-care is extremely important. People need to be taught how to self-manage.

It was also suggested there is overlap with statement 7 on having a self-escalation plan.

It was felt that amalgamating too many statements would lose the aim.

There was a concern that giving information or leaflets could become a tick box exercise and not be sufficiently performed.

It was agreed that this statement should be progressed but consider merging with statements 6 and/or 7.

**Draft 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.**

The group agreed to remove the process measure on daily ward round by a senior clinician decision maker because it is difficult to define. It was suggested that it is more important to ensure that the virtual ward has a systematic approach to the frequency of reviews.

It was noted that the aim of this statement was to ensure someone is accountable for the patient and there is access to a multidisciplinary team and access to specialist advice and diagnostics.

It was agreed that this statement should be progressed.

**Draft statement 6: Adults admitted to an acute respiratory infection virtual ward are supported to self-manage their condition.**

**Draft 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.**

The group discussed statements 6 and 7 simultaneously.

The group would like to reject merging statement 6 as this covers additional primary care measures.

The group agreed that this should include smoking cessation and also vaccine services.

It was suggested that personalised should be removed from the self-escalation plan.

It was agreed that statement 6 and 7 should be progressed. Consider merging 7 with 4.

**Draft 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.**

It was agreed that this statement is important and in particular that the person gets the discharge summary.

They agreed that details of antimicrobials should be included in the discharge summary.

It was agreed that this statement will be progressed.

1. **Additional quality improvement areas suggested by stakeholders at consultation**

The following areas were not progressed for inclusion in the final quality standard.

* Prevention of onward transmission such as respiratory hygiene, hand hygiene- this is included in QS121 antimicrobial stewardship and will be strengthened in statement 6 on self-management.
* Diagnosis of ARI and/or exacerbation in people with asthma and COPD- no guidance identified.
* Intravenous to oral antibiotic switch on virtual wards- there is a recommendation on review within 48 hours in NG139 pneumonia but the evidence has not been reviewed for virtual wards and there were some views that IV antibiotics should not be given on a virtual ward,

**Close of meeting**