NICE National Institute for Health and Care Excellence

NICE quality standard

Acute respiratory infection in over 16s: initial assessment and management including virtual wards (hospital at home)

Quality standard

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This standard is based on NG237, NG120, NG84, NG79, NG15, CG138, NG94 and NG138.

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Quality statement 1: Documented initial assessment

Quality statement

Adults first presenting with suspected acute respiratory infection have a documented assessment of symptoms and signs.

Rationale

A clinical assessment of the symptoms and signs of suspected acute respiratory infection at first presentation informs a provisional diagnosis. Considering the symptoms and signs in the context of the person's overall health and circumstances will inform decisions about treatment or referral for further assessment. Including a fully documented assessment in the person's record will promote a consistent approach to diagnosis across remote and in person settings and will support better management of any follow-up care.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of diagnoses of acute respiratory infection in adults with a documented assessment of symptoms and signs at initial presentation.

Numerator – the number in the denominator with a documented assessment of symptoms and signs at initial presentation.

Denominator – the number of diagnoses of acute respiratory infection in adults.

Data source: Data can be collected from information recorded locally by healthcare

professionals and provider organisations, for example, from electronic patient records.

What the quality statement means for different audiences

Service providers (such as NHS 111, 999 call centres, general practice and community pharmacies) ensure that processes are in place for people first presenting with suspected acute respiratory infection to have a documented initial assessment of symptoms and signs.

Healthcare professionals (such as NHS call handlers, GPs, advanced care practitioners, nurse practitioners and community pharmacists) assess symptoms and signs in people first presenting with suspected acute respiratory infection and document all initial assessments in patient records.

Commissioners ensure that they commission services that have processes for documenting assessment of symptoms and signs in people first presenting with suspected acute respiratory infection.

Adults with suspected acute respiratory infection have an initial assessment of their symptoms and signs that is included in their record.

Source guidance

Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management. NICE guideline NG237 (2023), recommendations 1.2.2 and 1.3.1

Definitions of terms used in this quality statement

Acute respiratory infection

An acute illness (present for 21 days or less) affecting the respiratory tract with symptoms such as cough, sore throat, fever, sputum production, breathlessness, wheeze or chest discomfort or pain, and no alternative explanation. [NICE's guideline on suspected acute respiratory infection in over 16s, terms used in this guideline section]

Assessment of symptoms and signs

In people with a suspected acute respiratory infection, think 'could this be sepsis?' and assess for it.

Assessment of symptoms and signs of acute respiratory infection should include identification and recording of severity of symptoms and rate of deterioration as well as noting symptoms and signs of concern, such as:

- Symptoms of concern for lower respiratory tract infection include, new or increased, breathlessness or confusion.
- Use FeverPAIN or Centor criteria to identify people with a sore throat who are more likely to benefit from an antibiotic.
- Bacterial acute sinusitis may be more likely if several of the following are present:
  - symptoms for more than 10 days
  - discoloured or purulent nasal discharge
  - severe localised unilateral pain (particularly pain over teeth and jaw)
  - fever
  - marked deterioration after an initial milder phase.

Acute respiratory infection symptoms and signs should be considered in the context of the person's overall health and circumstances when making decisions about treatment or referral for further assessment. The threshold for treatment or referral for further assessment may be lower for people who are more likely to have a poor outcome, for example, people with comorbidities or multimorbidity and people who are frail. [NICE's guideline on acute respiratory infection in over 16s, recommendations 1.1.1, 1.2.2, 1.2.3 and 1.3.2; NICE's guideline on sore throat (acute): antimicrobial prescribing, recommendation 1.1.3; and NICE's guideline on sinusitis (acute): antimicrobial prescribing, symptoms and signs section]

Equality and diversity considerations

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.

Adults should be supported to ensure they can communicate effectively with NHS services during remote and face-to-face assessments. For remote assessments this should include making sure the person is able to use any digital technology and offering alternatives, when necessary. It also includes ensuring services are accessible to those who do not speak or read English. Adults should have access to an interpreter or advocate if needed. Any support provided should be culturally and age appropriate.

Quality statement 2: Prescribing antimicrobials

Quality statement

Adults first presenting with suspected acute respiratory infection are not routinely prescribed antimicrobials based only on remote assessment.

Rationale

Wherever possible it is important to carry out a face-to-face assessment of severity of illness and risk to inform decisions about care and treatment before prescribing antimicrobials. This may support diagnostic accuracy and will support antimicrobial stewardship and appropriate escalation of care, when needed. Sometimes there may be a sound reason to prescribe remotely such as if the person cannot attend face-to-face or the severity of illness can be adequately assessed remotely and there is a low risk of an alternative diagnosis, and the prescriber is confident that antimicrobials are needed. If antimicrobials are prescribed remotely the person should know when and how to seek further medical help.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of prescriptions for antimicrobials for adults with an acute respiratory infection that are given without a face-to-face assessment.

Numerator – the number in the denominator that are given without a face-to-face assessment.

Denominator – the number of prescriptions for antimicrobials for adults with an acute respiratory infection.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from electronic patient records. Local areas may wish to compare variation in achievement levels in the context of population needs.

Outcome

Rate of antimicrobial prescribing for acute respiratory infection.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from electronic patient records. NHS England's optimising antimicrobial use dashboard includes data on prescribing volume in primary care for specific antibiotics that can be used to treat acute respiratory infection in primary care. Results can be compared across different localities and age groups, however, the indication for use is not reported.

What the quality statement means for different audiences

Service providers (such as NHS 111, general practice, acute respiratory infection hubs and community pharmacies) have protocols and processes in place to ensure antimicrobials are not routinely prescribed to adults first presenting with suspected acute respiratory infection based only on remote assessment.

Healthcare professionals (such as NHS call handlers, GPs, advanced care practitioners, nurse practitioners and community pharmacists) ensure they do not routinely prescribe antimicrobials to adults first presenting with suspected acute respiratory infection based only on remote assessment. They arrange face-to-face assessments if antimicrobials may be needed.

Commissioners ensure that they commission services that do not routinely prescribe antimicrobials to adults first presenting with suspected acute respiratory infection based only on remote assessment. They ensure clear pathways are in place for face-to-face assessments to be carried out in an appropriate setting based on severity of symptoms,

rate of deterioration and presence of any comorbidities.

Adults with suspected acute respiratory infection are not usually given antiviral or antibiotic treatment based only on a remote assessment. If they may need antiviral or antibiotic treatment, they will usually have a face-to-face assessment.

Source guidance

Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management. NICE guideline NG237 (2023), recommendation 1.2.4

Definitions of terms used in this quality statement

Acute respiratory infection

An acute illness (present for 21 days or less) affecting the respiratory tract with symptoms such as cough, sore throat, fever, sputum production, breathlessness, wheeze or chest discomfort or pain, and no alternative explanation. [NICE's guideline on acute respiratory infection in over 16s, terms used in this guideline section]

Equality and diversity considerations

Commissioners should work with providers to tackle higher antibiotic prescribing rates in more deprived areas. Prescribing targets should reflect the needs of the local population.

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.

Adults should be supported to ensure they can communicate effectively with NHS services during remote and face-to-face assessments. For remote assessments this should include making sure the person is able to use any digital technology and offering alternatives, when necessary. It also includes ensuring services are accessible to those who do not speak or read English. Adults should have access to an interpreter or advocate, if needed. Any support provided should be culturally and age appropriate.

Quality statement 3: Antibiotic duration

Quality statement

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.

Rationale

When a decision is made to prescribe antibiotics for acute respiratory infection, the shortest course that is likely to be effective should be prescribed to reduce the risk of antimicrobial resistance and adverse effects. This will be a 5-day course or 5 to 10 days if phenoxymethylpenicillin is prescribed for acute sore throat (5 days may be enough for symptomatic cure for acute sore throat but 10 days may increase the chance of microbiological cure for example, where there is recurrent infection). All people taking antibiotics should be reassessed if symptoms worsen rapidly or significantly, or do not start to improve within 3 days of taking the antibiotic.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of antibiotic courses prescribed for community-acquired pneumonia, acute cough, acute sore throat or acute sinusitis that are for 5 days (or up to 10 days if phenoxymethylpenicillin for sore throat).

Numerator – the number in the denominator that are for 5 days (or up to 10 days if phenoxymethylpenicillin for sore throat).

Denominator – the number of antibiotic courses prescribed for community-acquired pneumonia, acute cough, acute sore throat or acute sinusitis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from electronic patient records. For measurement purposes, it may be appropriate to exclude groups with long-term conditions that require antibiotics for a longer duration (for example, bronchiectasis) based on local antimicrobial prescribing guidelines. NHS England's optimising antimicrobial use dashboard includes data on prescribing duration for specific antibiotics that can be used to treat acute respiratory infection in primary care. Results can be compared across different localities and age groups, however, the indication for use is not reported.

What the quality statement means for different audiences

Service providers (such as general practice, acute respiratory infection hubs, urgent treatment centres, virtual wards and hospitals) ensure that healthcare professionals prescribing antibiotics to treat acute respiratory infection are aware that the shortest effective course is usually 5 days except when prescribing phenoxymethylpenicillin as the first-choice oral antibiotic for sore throat (5 to 10 days).

Healthcare professionals (such as GPs, community pharmacists, nurse practitioners, advanced care practitioners, advanced paramedics and hospital clinicians) prescribe a 5-day course of antibiotics to treat acute respiratory infection or 5 to 10 days if prescribing phenoxymethylpenicillin for acute sore throat (5 days may be enough for symptomatic cure but 10 days may increase the chance of microbiological cure for example, where there is recurrent infection). They give advice on possible adverse effects of the antibiotics and when to seek medical help. They also advise people to seek further help if their symptoms do not show signs of improving after 3 days of antibiotic therapy.

Commissioners ensure that they commission services that follow best practice guidance on antimicrobial stewardship.

Adults with an acute respiratory infection receive a short (usually 5-day) course when prescribed an antibiotic.

Source guidance

- Pneumonia (community-acquired): antimicrobial prescribing. NICE guideline NG138 (2019), recommendation 1.2.1

- Cough (acute): antimicrobial prescribing. NICE guideline NG120 (2019), recommendation 1.3.1
- Sore throat (acute): antimicrobial prescribing. NICE guideline NG84 (2018), recommendation 1.3.1
- Sinusitis (acute): antimicrobial prescribing. NICE guideline NG79 (2017), recommendation 1.2.1
- Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. NICE guideline NG15 (2015), recommendation 1.1.24

Definitions of terms used in this quality statement

Acute respiratory infection

An acute illness (present for 21 days or less) affecting the respiratory tract with symptoms such as cough, sore throat, fever, sputum production, breathlessness, wheeze or chest discomfort or pain, and no alternative explanation. [NICE's guideline on acute respiratory infection in over 16s, terms used in this guideline section]

Equality and diversity considerations

Commissioners should work with providers to tackle higher antibiotic prescribing rates in more deprived areas. Prescribing targets should reflect the needs of the local population.

Quality statement 4: Information about acute respiratory infection virtual wards

Quality statement

Adults admitted to an acute respiratory infection virtual ward are given verbal and written information about the service.

Rationale

When adults are admitted to an acute respiratory infection virtual ward it is important that they, and their family or carers, are given verbal and written information so that they understand the purpose of the service, how it will work and are able to use any equipment needed. Making sure they know how and when they will be contacted by healthcare professionals and have details of who to contact in and out of hours if they need extra advice and support will help to promote confidence that the service can meet their individual needs.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of adult admissions to an acute respiratory infection virtual ward where verbal and written information about the service is given.

Numerator – the number in the denominator where verbal and written information about the service is given.

Denominator – the number of adult admissions to an acute respiratory infection virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Proportion of adults admitted to an acute respiratory infection virtual ward who are satisfied with the information and support provided to use the service.

Numerator – the number in the denominator who are satisfied with the information and support provided to use the service.

Denominator – the number of adults admitted to an acute respiratory virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient surveys.

What the quality statement means for different audiences

Service providers (virtual ward providers) ensure that written information is available, and processes are in place, for adults admitted to an acute respiratory infection virtual ward to be given verbal and written information about the service.

Healthcare professionals (such as doctors, GPs, nurse practitioners, advanced clinical practitioners, nurses, pharmacists and care navigators) give adults admitted to an acute respiratory infection virtual ward verbal and written information about the service.

Commissioners ensure that they commission acute respiratory infection virtual ward services that give verbal and written information about the service to those admitted.

Adults admitted to an acute respiratory infection virtual ward are given verbal and written information about the service, including how and when healthcare professionals will contact them, who to contact if they need support during or after hours, and how to use any remote monitoring equipment, including what to do if they have any problems with the equipment.

Source guidance

- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendations 1.5.14 and 1.5.17
- Guidance note: virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease. NHS England (2023), appendix on acute respiratory infection pathway – stage 2: admission
- Supporting information: virtual ward including hospital at home. NHS England (2022), principle 3

Definitions of terms used in this quality statement

Acute respiratory infection virtual ward

These support personalised care for people with confirmed or suspected acute respiratory infections, including COVID-19 and non-infective chronic obstructive pulmonary disease exacerbations, who are stable or improving but require acute level care and choose to be cared for at home. They do this by providing an alternative to a hospital admission and/or to support safe early discharge from hospital for people who require ongoing hospital monitoring and treatment. They require a combination of face-to-face care and digital technology in the place a person calls home, including care homes. [Adapted from NHS England's guidance note on virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease, introduction section]

Information about the service

This should include:

- how and when they will be contacted by healthcare professionals.
- details of who to contact in and out of hours if they need support.
- how to use any remote monitoring equipment including what to do if they experience any problems with the equipment.

[Adapted from NHS England's guidance note on virtual ward care for people with acute

respiratory infection including chronic obstructive pulmonary disease, appendix on acute respiratory infection pathway – section on stage 2: admission; and NHS England's supporting information: virtual ward including hospital at home, principles 3 and 4 and expert opinion]

Equality and diversity considerations

Some people may be digitally excluded because they do not have their own smart device such as a smartphone. This could be linked to their age, socio-economic factors, mental health or disability. It is important that suitable smart devices and training should be provided so that these people can benefit from the virtual ward if they wish to do so. Providers should consider loaning a smart device and providing internet access for those who do not have it. They should also consider different accessibility features including smart devices with large screens and buttons, screen-reading software, translation services and apps in multiple languages.

Healthcare professionals should be aware that some people may need more support and information to enable them to use virtual ward services, for example, because of disability, mental health needs or socio-economic deprivation. Healthcare professionals should provide help to access mental health support, if needed, to people who have mental health needs and are admitted to an acute respiratory infection virtual ward.

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare services. Information should be in a format that suits their needs and preferences, including those who are digitally excluded and people with neurodiverse conditions. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate, if needed. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 5: Multidisciplinary team

Quality statement

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.

Rationale

Having a multidisciplinary team with access to expertise in managing the medical conditions on an acute respiratory infection virtual ward means there can be equitable access to speciality advice and diagnostics as there would be in hospital. Designating a named consultant practitioner (including a nurse or an allied health professional consultant) or GP with suitable expertise to lead the team, with clear lines of clinical responsibility and governance, supports coordination of expertise and continuity of care. Informing the person admitted to the virtual ward, and their family and carers, who is responsible for their care and treatment will provide reassurance and promote confidence that the service will meet their needs.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

a) Evidence of local arrangements to ensure that a multidisciplinary team is responsible for providing care on an acute respiratory infection virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from local service agreements.

b) Evidence that the acute respiratory infection virtual ward multidisciplinary team has access to speciality advice and diagnostics.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service protocols and escalation procedures.

c) Evidence that a named consultant practitioner or GP with suitable expertise leads the acute respiratory infection virtual ward multidisciplinary team.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service governance and accountability structures.

Outcome

Proportion of adults admitted to an acute respiratory infection virtual ward who had confidence and trust in the virtual ward team.

Numerator – the number in the denominator who had confidence and trust in the virtual ward team.

Denominator – the number of adults admitted to an acute respiratory virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient surveys.

What the quality statement means for different audiences

Service providers (virtual ward providers) ensure that care on an acute respiratory infection virtual ward is provided by a multidisciplinary team that has access to speciality advice and diagnostics and is led by a named consultant practitioner or GP, with relevant experience or training. They ensure that rotas and systems are in place for staff with expertise to be available to give advice when needed.

Healthcare professionals (such as doctors, GPs, nurse practitioners, advanced clinical

practitioners, nurses, pharmacists and care navigators) work as part of a multidisciplinary team to provide care for adults admitted to an acute respiratory infection virtual ward. They ask for input from the virtual ward named consultant practitioner or GP, when expertise is needed.

Commissioners ensure that acute respiratory infection virtual wards have a multidisciplinary team that has access to speciality advice and diagnostics and is led by a named consultant practitioner or GP, with relevant experience or training.

Adults admitted to an acute respiratory infection virtual ward are cared for by a team of healthcare professionals who have access to specialist advice, if needed. They know the name of the consultant or GP who leads the team.

Source guidance

- Emergency and acute medical care in over 16s: service delivery and organisation. NICE guideline NG94 (2018), recommendations 1.1.5 and 1.1.6
- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendation 1.4.5
- Supporting clinical leadership in virtual wards - a guide for integrated care system clinical leaders. NHS England (2023), sections on clinical governance and integrated services
- Guidance note: virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease. NHS England (2023), section on staffing and oversight
- Supporting information: virtual ward including hospital at home. NHS England (2022), principle 1

Definitions of terms used in this quality statement

Acute respiratory infection virtual ward

These support personalised care for people with confirmed or suspected acute respiratory

infections, including COVID-19 and non-infective chronic obstructive pulmonary disease exacerbations, who are stable or improving but require acute level care and choose to be cared for at home. They do this by providing an alternative to a hospital admission and/or safe to support early discharge from hospital for people who require ongoing hospital monitoring and treatment. They require a combination of face-to-face care and digital technology in the place a person calls home, including care homes. [Adapted from NHS England's guidance note on virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease, introduction section]

Quality statement 6: Support to self-manage on a virtual ward

Quality statement

Adults admitted to an acute respiratory infection virtual ward are supported to self-manage, including having a self-escalation plan.

Rationale

Providing support to help adults self-manage their symptoms and any long-term conditions when they are admitted to an acute respiratory infection virtual ward can prevent deterioration and future hospital admission. Including a clear self-escalation plan that details what to do if their health starts to deteriorate, or does not improve, will support patient safety. It will also help to provide reassurance that their care will be escalated, if needed.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

Proportion of adult admissions to an acute respiratory infection virtual ward where advice and information to support self-management was given.

Numerator – the number in the denominator where advice and information to support self-management was given.

Denominator – the number of adult admissions to an acute respiratory infection virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of adult admissions to an acute respiratory infection virtual ward with a documented self-escalation plan.

Numerator – the number in the denominator with a documented self-escalation plan.

Denominator – the number of adult admissions to an acute respiratory infection virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Proportion of adults admitted to an acute respiratory infection virtual ward who felt they had enough support to manage their condition and knew what to do if they felt unwell.

Numerator – the number in the denominator who felt they had enough support to manage their condition and knew what to do if they felt unwell.

Denominator – the number of adults admitted to an acute respiratory virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient surveys.

What the quality statement means for different audiences

Service providers (virtual ward providers) ensure that adults admitted to an acute respiratory infection virtual ward are supported to self-manage and have a self-escalation plan. They ensure that staff have access to information on self-management for specific conditions and are aware of and can refer to local services such as stop smoking support. They ensure staff have the skills to develop self-escalation plans to meet individual needs.

Healthcare professionals (such as doctors, GPs, nurse practitioners, advanced clinical

practitioners, nurses, pharmacists and care navigators) provide advice and information to adults admitted to an acute respiratory infection virtual ward to support them to self-manage. This may include referral to other services such as stop smoking support. It will also include providing a self-escalation plan to the person and their family and carers, so they know what to do if their health deteriorates or does not improve.

Commissioners ensure that they commission acute respiratory infection virtual ward services that support adults to self-manage, including referral to other services such as stop smoking support, if needed, and providing a self-escalation plan. Commissioners ensure that appropriate escalation processes are in place to maintain patient safety, including out of hours support.

Adults admitted to an acute respiratory infection virtual ward receive advice and information to help them manage their symptoms and any long-term conditions while they are unwell. They have a personalised plan for what to do if they feel unwell, their symptoms get worse, or they are not improving.

Source guidance

- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendation 1.4.6 and 1.5.11
- Making the most of virtual wards, including hospital at home: practical guidance for clinicians to maximise use of virtual wards for the benefit of patients. Getting It Right First Time (GIRFT) and NHS England (2023), acute respiratory infection – cohorts and optimisation
- Guidance note: virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease. NHS England (2023), overview of the acute respiratory infection virtual ward and appendix on acute respiratory infection pathway – stage 2: admission
- Supporting information: virtual ward including hospital at home. NHS England (2022), principle 3

Definitions of terms used in this quality statement

Acute respiratory infection virtual ward

These support personalised care for people with confirmed or suspected acute respiratory infections, including COVID-19 and non-infective chronic obstructive pulmonary disease exacerbations, who are stable or improving but require acute level care and choose to be cared for at home. They do this by providing an alternative to a hospital admission and/or to support safe early discharge from hospital for people who require ongoing hospital monitoring and treatment. They require a combination of face-to-face care and digital technology in the place a person calls home, including care homes. [Adapted from NHS England's guidance note on virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease, introduction section]

Support to self-manage

This will vary depending on individual needs and any long-term conditions, but may include:

- advice to drink plenty of fluids
- how to treat fever and cough with over-the-counter medications
- how to minimise the risk of transmission of infection to others, including, respiratory and hand hygiene, and avoiding close contact with other (vulnerable) people
- advice about smoking cessation, behavioural support, prescription, and referral
- review and advice about vaccination (influenza, pneumococcal and COVID)
- ensuring inhaler technique is optimal, if used
- education about breathing techniques and chest clearance, if relevant
- self-management education and use of rescue packs (prescribed corticosteroids and antibiotics for people with chronic obstructive pulmonary disease, if they are unwell)
- advice about where to source further written information
- referral to local self-help groups.

[GIRFT and NHS England's making the most of virtual wards, including hospital at home (2023), acute respiratory infection – cohorts and optimisation; NICE's guideline on tobacco: preventing uptake, promoting quitting and treating dependence, recommendations 1.14.5 and 1.14.6; and expert opinion]

Self-escalation plan

People admitted to an acute respiratory infection virtual ward and their carers should agree a person-held personalised escalation plan. On admission people should be given an information leaflet including clear information around escalation. Escalation may include calling the acute respiratory infection virtual ward telephone number, NHS 111/999 or out of hours, or attending their nearest emergency department. People in specific groups such as pregnant women and vulnerable adults should receive relevant safety netting and escalation advice. In the event of deterioration, the person-held escalation plan should assist remote assessment by NHS 111/999/acute respiratory infection virtual ward teams and help reduce inappropriate readmissions. [NHS England's guidance note on virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease, appendix on acute respiratory infection pathway – stage 2: admission]

Equality and diversity considerations

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare services. Information should be in a format that suits their needs and preferences, including those who are digitally excluded and people with neurodiverse conditions. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate, if needed. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Healthcare professionals should be aware that some people may need more support and information to enable them to self-manage while admitted to a virtual ward, for example, because of disability, mental health needs or socio-economic deprivation. Healthcare professionals should provide help to access mental health support, if needed, to people who have mental health needs and are admitted to an acute respiratory infection virtual ward.

Quality statement 7: Virtual ward discharge summaries

Quality statement

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.

Rationale

Providing the person with a clear discharge summary to confirm diagnosis and details of any antimicrobials prescribed, and to identify further investigations, reviews or other follow-up that may be required, will support optimal management following an admission to an acute respiratory infection virtual ward. Sharing this information with the person's GP will support transition of care back to the community.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Process

a) Proportion of discharges from an acute respiratory infection virtual ward where a discharge summary including follow-up details is given to the person.

Numerator – the number in the denominator where a discharge summary including follow-up details is given to the person.

Denominator – the number of discharges from an acute respiratory infection virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of discharges from an acute respiratory infection virtual ward where a discharge summary including follow-up details is shared with the person's GP.

Numerator – the number in the denominator where a discharge summary including follow-up details is shared with the person's GP.

Denominator – the number of discharges from an acute respiratory infection virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Proportion of adults discharged from an acute respiratory infection virtual ward who knew what would happen next with their care.

Numerator – the number in the denominator who knew what would happen next with their care.

Denominator – the number of adults discharged from an acute respiratory virtual ward.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient surveys.

What the quality statement means for different audiences

Service providers (virtual ward providers) ensure that processes are in place to provide a discharge summary, including follow-up details, to adults discharged from an acute respiratory infection virtual ward and their GP.

Healthcare professionals (such as doctors, GPs, nurse practitioners, advanced clinical practitioners, nurses, pharmacists and care navigators) give a discharge summary, including follow-up details, to adults discharged from an acute respiratory infection virtual ward. Healthcare professionals also ensure this information is shared with the person's GP.

Commissioners ensure that they commission acute respiratory infection virtual wards that

provide a discharge summary, including follow-up details, to adults discharged from an acute respiratory infection virtual ward and their GP.

Adults discharged from an acute respiratory infection virtual ward are given information about their diagnosis and care, along with any follow-up required. This will also be shared with their GP.

Source guidance

- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services. NICE guideline CG138 (2012, updated 2021), recommendation 1.4.3
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE guideline NG27 (2015), recommendation 1.5.6
- Making the most of virtual wards, including hospital at home: practical guidance for clinicians to maximise use of virtual wards for the benefit of patients. Getting It Right First Time (GIRFT) and NHS England (2023), acute respiratory infection – cohorts and optimisation
- Guidance note: virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease. NHS England (2023), appendix on acute respiratory infection pathway – stage 4: recovery and discharge

Definitions of terms used in this quality statement

Acute respiratory infection virtual ward

These support personalised care for people with confirmed or suspected acute respiratory infections, including COVID-19 and non-infective chronic obstructive pulmonary disease exacerbations, who are stable or improving but require acute level care and choose to be cared for at home. They do this by providing an alternative to a hospital admission and/or to support safe early discharge from hospital for people who require ongoing hospital monitoring and treatment. They require a combination of face-to-face care and digital technology in the place a person calls home, including care homes. [Adapted from NHS England's guidance note on virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease, introduction section]

Discharge summary, including follow-up details

This should include confirmation of diagnosis and details of any antimicrobials prescribed, and facilitate further investigations, if indicated, and appropriate follow-up (preferably in other community services where appropriate.) This could include pharmacy-led new medication reviews for adults started on inhalers, follow-up chest X-ray for adults with community-acquired and COVID-19 pneumonia, referral to vaccination services and smoking cessation follow-up. Where a comprehensive geriatric assessment, chronic obstructive pulmonary disease bundle or advance care plan has been started this must be clearly communicated. The person should be given clear safety netting advice that includes instructions on how to seek help if they feel unwell on discharge. [NHS England's guidance note on virtual ward care for people acute respiratory infection including chronic obstructive pulmonary disease, appendix on acute respiratory infection pathway – stage 4 recovery and discharge; GIRFT and NHS England's making the most of virtual wards, including hospital at home (2023), acute respiratory infection – cohorts and optimisation; and expert opinion]

Equality and diversity considerations

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with healthcare services. Information should be in a format that suits their needs and preferences, including those who are digitally excluded and people with neurodiverse conditions. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate, if needed. For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Update information

Minor changes since publication

January 2024: Definitions and references in statements 4 to 7 have been updated to reflect publication of NHS England's updated guidance note on virtual ward care for people with acute respiratory infection including chronic obstructive pulmonary disease.

November 2023: The recommendation numbers given in the source guidance and definition inserts for statements 1 and 2 were updated to reflect how the recommendations were numbered upon the publication of NICE's guideline on suspected acute respiratory infection in over 16s. The definition of assessment of symptoms and signs in statement 1 has also been updated to reflect the updated recommendation 1.3.2 in NICE's guideline on acute respiratory infection in over 16s.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the costing statement for the NICE guideline on acute respiratory infection to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Association of Respiratory Nurse Specialists
- Primary Care Respiratory Society
- Royal College of Nursing (RCN)