NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Emergency and acute medical care in over 16s

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 01 February 2018

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for emergency and acute medical care. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Emergency and acute medical care in over 16s: service delivery and organisation
NICE guideline expected in 2018.

2 Overview

2.1 Focus of quality standard

This quality standard will cover the organisation and delivery of emergency and acute medical care in the community and in hospital. It will include young people (16-17 years) and adults (18 years and over) who seek, or are referred for emergency NHS care for a suspected or confirmed acute medical emergency. This quality standard will not cover acute clinical management of specific medical conditions requiring urgent or emergency care as this will be addressed within the quality standards for the relevant conditions.

2.2 Definition

Acute medical emergency

Acute life-threatening emergencies, acute exacerbation of chronic illnesses and routine health problems that need prompt action. A medical emergency can happen to anyone, for example in people:

- without a previously diagnosed medical condition
- with an acute exacerbation of underlying chronic illness
- after surgery

- after trauma.

Incidence and prevalence

Annually the NHS[1] provides approximately 110 million urgent same-day patient contacts. Approximately 85 million of these are urgent GP appointments, and the rest are A&E or minor injuries-type visits. Estimates suggest that between 1.5 and 3 million people who present at A&E each year could have their needs addressed in other parts of the urgent care system. They present at A&E because it seems like the best or only option. The rising pressures on A&E services also stem from continued growth in levels of emergency admissions and from delayed transfers of care when patients are fit to leave hospital.

In 2016-2017 there were 23 million A&E attendances which were cared for. This is 1.2 million more than 3 years ago.

NHS England reports the monthly A&E Attendances and Emergency Admissions[2] on the total number of attendances in the calendar month for all A&E types, including Minor Injury Units and Walk-in Centres, and of these, the number discharged, admitted or transferred within four hours of arrival. Every winter this pressure increases further.

For December 2017:

- The total number of attendances was 2,016,000, an increase of 3.7% on the same month last year. Of these, attendances at A&E departments were 1.0% higher. Attendances over the latest twelve months are higher than levels in the preceding twelve month period (an increase of 0.5%).
- There were 520,000 emergency admissions in the month, 4.5% higher than the same month last year. Emergency admissions via A&E departments increased by 5.6% over the same period. Emergency admissions over the last twelve months are up 2.9% on the preceding twelve month period.
- There were 69,100 four-hour delays from decision to admit to admission this month, which compares to 61,700 in December 2016.
- Of these, 497 were delayed over twelve hours (from decision to admit to admission), compared to 553 in the same month last year.
- 4 out of 137 reporting trusts with type 1 departments achieved the 95% standard on all types during the month. With additional local activity also 7 out of 137 reporting trusts with A&E departments achieved this standard.

[1] NHS England (2017) NHS Five Year Forward View: Next steps on the NHS Five Year Forward View: Urgent and emergency care
[2] NHS England (2018) A&E Attendances and Emergency Admissions December 2017-18

Management

Service demands

Please see Appendix 1 on the current emergency and acute medical care pathway.

The 2016 review[3] of urgent and emergency care emphasised the current variation in service configuration with 'walk-in centres', 'minor injury units', 'urgent care centres' opening in the past 30 years with a vast range of similarly named facilities that all offer slightly different services, at slightly different times, in different places. A telephone service, NHS Direct, was introduced in 1998, and 2015 was replaced by NHS 111.

Acute and emergency care is a challenge for all health services with an aging population meaning more complex and costly admissions. High volumes of emergencies impact adversely on hospital planned admissions, performance metrics, and Trust income.

According to the 2016 review of urgent and emergency care[4], service demand has been rising annually with the average number of consultations in general practice rising from 4.1 to 5.5 per patient per year between 1999 and 2008 which indicates the greater demand and complexity in primary care.

This review outlined areas for change including shifting treatment and advice from acute hospital based services to home or close to home. The vast majority of people already seek and receive treatment and care for their urgent and emergency care needs in the most appropriate setting. However, it was reported that millions of people every year could receive advice and treatment closer to home.

Innovative schemes have shown how early assessment, with good communication between primary and community health services and hospital specialists, can improve outcomes by keeping people out of hospital. The 2016 review suggested that these schemes should be developed and expanded.

National outcome frameworks

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

[3] NHS England (2016) The Keogh Urgent and Emergency Care Review
[4] NHS England (2016) The Keogh Urgent and Emergency Care Review

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3a Emergency admissions for acute conditions that should not usually require hospital admission 3b Emergency readmissions within 30 days of discharge from hospital* **Helping older people to recover their independence after illness or injury** 3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service* ii Proportion offered rehabilitation following discharge from acute or community hospital*
4 Ensuring that people have a positive experience of care	**Improving people's experience of integrated care** *4.9 People's experience of integrated care***
5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicators*** *5a Deaths attributable to problems in healthcare* *5b Severe harm attributable to problems in healthcare* ***Improvement areas*** **Improving the culture of safety reporting** 5.6 Patient safety incidents reported
Alignment with Adult Social Care Outcomes Framework and Public Health Outcomes Framework * Indicator is shared Indicators in italics in development	

Table 2 Adult social care outcomes framework 2016–17

2 Delaying and reducing the need for care and support	***Overarching measure*** **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs** **Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services** 2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services* 2D Outcomes of short-term services: sequel to service *Placeholder 2E The effectiveness of reablement services* **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** 2C Delayed transfers of care from hospital, and those attributable to adult social care
3 Ensuring that people have a positive experience of care and support	***Overarching measures*** ***People who use social care and their carers are satisfied with their experience of care and support services*** *Placeholder 3E Effectiveness of integrated care*
Alignment with NHS Outcomes Framework * Indicator is shared Indicators in italics in development	

Table 3 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.11 Emergency readmissions within 30 days of discharge from hospital*
Alignment with NHS Outcomes Framework * Indicator is shared	

3 Summary of suggestions

3.1 Responses

In total 27 stakeholders responded to the 2-week engagement exercise 17/11/2017-01/12/2017.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

NHS Improvement's patient safety division submitted comments during stakeholder engagement, which are summarised in this paper and can be found in full in appendix 3.

Full details of all the suggestions provided are given in appendix 3 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
First points of contact with healthcare services: • Access to diagnostics	• BACCN, BIA
Alternatives to hospital care • Multidisciplinary intermediate care • Advance care planning	• AACE, SCM4, SCM6 • AACE, SCM4, RCEM
Managing hospital admissions • Assessment on admission to hospital • Liaison psychiatry • Discharge planning	• RCPofE, SCM1, SCMS3, SCM5 • RCGP, RCEM • SAM, RCP, SCM1, SCM4
Timing and frequency of consultant review	• NELA,SAM, RCP, SCMS3, RCEM
MDT care • Multidisciplinary team meetings • Enhanced inpatient access to physiotherapy	• SCM4 • SCM6
Organising handovers • Structured patient handovers	• SCM6, SCR, SCM3

Suggested area for improvement	Stakeholders
Additional areas • Training • Care access • Infection control • Integrated patient information systems and facilities signposting • Admission through elderly care assessment units • Specific conditions, treatments and procedures • Patient safety • National early warning scores (NEWS) • Immediate decisions on care and treatment • Overlapping published NICE guidance	AACE, BACCN, BIA, BSIR, MCP, NHSE,NHSIPS, RD, NELA, RCEM, RCGP, RCN, RCGP, SCM2
AACE, Association of Ambulance Chief Executives BACCN, British Association of Critical Nurses BIA, British Infection Association BSIR, British Society of Interventional Radiology MCP, Mencap NHSE, NHS England NHSIPS, NHS Improvement Patient Safety RC, Resuscitation Council RD, Roche Diagnostics Ltd NELA, Royal College of Anaesthetists (National Emergency Laparotomy Audit (NELA) team) RCEM, Royal College of Emergency Medicine RCGP, Royal College of General Practitioners RCN, Royal College of Nursing RCPCH, Royal College of Paediatrics and Child Health RCP, Royal College of Physicians RCPE, Royal College of Physicians of Edinburgh SAM, Society for Acute Medicine SCM, Specialist Committee Member SCR, The Society and College of Radiographers TPF, The Pituitary Foundation	

Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 1332 papers were identified for emergency and acute medical care in over 16s. In addition, 2 papers were suggested by stakeholders at topic engagement and 2 papers internally at project scoping.

Of these papers, 12 have been included in this report and are included in the current practice sections where relevant. Appendix 2 outlines the search process.

4 Suggested improvement areas

4.1 First points of contact with healthcare services

4.1.1 Summary of suggestions

Access to diagnostics

Stakeholders highlighted the need for improved community access to point-of-care C-reactive testing to avoid hospital investigations and admissions.

4.1.2 Selected recommendation from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendation
Access to diagnostics	**GP access to laboratory investigations** NICE guideline NGXX Recommendation 1.1.2

GP access to laboratory investigations

NICE NGXX – Recommendation 1.1.2

Provide point-of-care C-reactive protein testing for people with suspected lower respiratory tract infections. [See chapter 7 on GP access to laboratory investigations.]

4.1.3 Current UK practice

Hughes et al. (2016)[5] evaluated point-of-care C-reactive protein (POC CRP) testing to support antibiotic prescribing decisions. Their evaluation included a patient focus group and user questionnaire in a North Wales general practice over a 3 month period. During this period, a total of 94 patients received a POC CRP test to support clinical decisions and importantly this testing significantly reduced antibiotic prescribing with only 25% of these RTI symptom patients receiving an antibiotic to treat their condition. This compares favourably with the higher UK reported figure of a 54% antibiotic prescribing rate for RTI consultations within primary care. However,

[5] Clinical Pharmacist (2016) Hughes A, Gwyn L, Harris S and Clarke C Evaluating a point-of-care C-reactive protein test to support antibiotic prescribing decisions in a general practice Volume 8, No 10

the patients were not always managed according to NICE (2014) CG91 guideline on pneumonia in adults.

4.1.4 Resource impact assessment

This area is not included in the draft resource impact report for the draft NICE guideline. It was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year) but is listed in the report as an area to be considered locally in the context of local current arrangements.

4.2 Alternatives to hospital care

4.2.1 Summary of suggestions

Multidisciplinary intermediate care

Stakeholders supported multidisciplinary intermediate care as being a cost-effective alternative to hospital care through coordination and communication between service providers. It was reported as positively reducing hospital admissions, length of stay and associated mortality.

Advance care planning

Stakeholders supported advance care planning for people in the community and in hospital who are approaching the end of their life and are at risk of a medical emergency. It was suggested that advance care planning improves patient and carer satisfaction as it can reduce ambulance calls, admissions and the associated disruption to the patient's ongoing community care.

A stakeholder supported the need for advanced personalised care plans for patients known to be at risk of potential life threatening conditions as these can be effective in improving their emergency management leading to better outcomes.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Multidisciplinary intermediate care	**Multidisciplinary intermediate care** NICE guideline NGXX Recommendation 1.1.6
Advance care planning	**Advance care planning** NICE guideline NGXX Recommendation 1.1.9

Multidisciplinary intermediate care

NICE NGXX Recommendation 1.1.6

Provide multidisciplinary intermediate care as an alternative to hospital care to prevent admission and promote earlier discharge. Ensure that the benefits and risks

of the various types of intermediate care are discussed with the person and their family or carer[6]. [See chapter 12 on alternatives to hospital care.]

Advance care planning

NICE NGXX Recommendation 1.1.9

Offer advance care planning to people in the community and in hospital who are approaching the end of life and are at risk of a medical emergency[7]. Ensure that there is close collaboration between the person, their families and carers, and the professionals involved in their care. [See chapter 15 on advance care planning.]

4.2.3 Current UK practice

Multidisciplinary intermediate care

The National Audit of Intermediate Care (NAIC) service user audit (2017)[8] was conducted between May-August 2017. The average age of intermediate care service users in this sample was 80 years in home based services, 83 years in bed based services and 79 years in reablement services. The report examined the use of documented care plans and the reviews of these at least once a week by a multidisciplinary team. The results suggested that service users have better outcomes when they have a documented care plan that has been reviewed by a multidisciplinary team.

Advance care planning

The Urgent and Emergency Care Review (2013)[9] proposed the need to accelerate the development of comprehensive and standardised care planning, so that important patient information about conditions, their values and future wishes are known to relevant healthcare professionals. Patients will then be better supported to deal with that condition before it deteriorates, or if additional help is required.

4.2.3 Resource impact assessment

This area is not included in the draft resource impact report for the draft NICE guideline. It was not identified as an area of the guideline that would be likely to have

[6] NICE has published a guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs and is developing a guideline on intermediate care including reablement.
[7] NICE is developing a guideline on end of life care for adults in the last year of life.
[8] NHS Benchmarking Network (2017) National Audit of Intermediate Care-Summary Report- England
[9] NHS England (2013) Transforming urgent and emergency care services in England- Urgent and Emergency Care Review

a significant resource impact (>£1m in England each year) but is listed in the report as an area to be considered locally in the context of local current arrangements.

4.3 Managing hospital admissions

4.3.1 Summary of suggestions

Assessment on admission to hospital

A stakeholder supported appropriate standardised assessment pathways to ensure consistent, efficient and effective care. The appropriate use of risk stratification tools for hospital admissions such as CURB-65 in young people was highlighted, however it was felt that these tools must be considered with caution.

Stakeholders suggested that people with undifferentiated medical emergencies that require hospital admission should be assessed and treated in an Acute Medical Unit (AMU) with a multidisciplinary team led by a Consultant in Acute Medicine.

Liaison psychiatry

A stakeholder highlighted the importance of managing psychiatric emergencies with effective, calm handling. It was reported that these emergencies are often neglected leading to the escalation of patient distress and increased risk of harm.

Timely mental health reviews and Child and Adolescent Mental Health Services (CAHMS) intervention was also highlighted as important by stakeholders.

Discharge planning

A stakeholder highlighted the need for an estimated discharge date to be documented within 24 hours of acute admission. This should include information on physical, psychological and functional reablement as well as necessary additional support which is most likely needed within the community.

Another stakeholder also highlighted that increasingly complex patients may require follow-up post discharge.

4.3.2 Selected recommendation from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Assessment on admission to hospital	**Standardised criteria for hospital admission** NICE guideline NGXX Recommendation 1.2.1 **Assessment through acute medical units** NICE guideline NGXX Recommendation 1.2.2
Liaison psychiatry	**Liaison psychiatry** NICE guideline NGXX Recommendation 1.2.3
Discharge planning	**Discharge planning** NICE guideline NGXX Recommendation 1.2.4

Standardised criteria for hospital admission

NICE NGXX Recommendation 1.2.1.

Use validated risk stratification tools to inform clinical decisions about hospital admission for people with medical emergencies. [See chapter 21 on standardised criteria for hospital admission.]

Assessment through acute medical units

NICE NGXX Recommendation 1.2.2.

Assess and treat people needing hospital admission with undifferentiated medical emergencies in an acute medical unit. [See chapter 24 on assessment through acute medical units.]

Liaison psychiatry

NICE NGXX Recommendation 1.2.3.

Consider providing access to liaison psychiatry services for people with medical emergencies who have mental health problems. [See chapter 23 on liaison psychiatry.]

Discharge planning

NICE NGXX Recommendation 1.2.4.

Start discharge planning at the time of admission for a medical emergency. [See chapter 35 on discharge planning.]

4.3.3 Current UK practice

Assessment on admission to hospital

The 2016 Society for Acute Medicine Benchmarking Audit (SAMBA)[10] examined national quality of care and level of consultant involvement delivered by acute medicine and AMU. This audit included admission data of 4140 patients from 94 units. Data indicated 2437 (59%) patients had their initial consultant review by a Consultant Acute Physician. It was concluded that Consultant Acute Physicians overseeing patients presenting to the AMU have a significant supervisory contribution to patient outcomes

Liaison psychiatry

Guidance for commissioners of liaison mental health services to acute hospitals (2013)[11] reported that mental health conditions account for approximately 5% per cent of A&E attendances, 25% of primary care attendances, 30% of acute inpatient bed occupancy and 30% of acute readmissions.

The Five Year Forward View For Mental Health (2016)[12] reported that comprehensive liaison mental health services are currently available in only one in six (16%) of England's 179 acute hospitals. Paediatric mental health liaison services was however reported as more comprehensive with 79% of hospitals reporting cover, but these frequently do not operate out of hours.

Discharge planning

The 2016 Rapid Improvement Guide to implement SAFER Patient Flow Bundle[13], merged 5 elements of emergency care best practice, including Expected Date of Discharge and Clinical Criteria for Discharge:

- A– All patients will have an Expected Discharge Date (EDD) and Clinical Criteria for Discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.
- E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

[10] Society of Acute Medicine (2016) SAMBA2016- Annual report
[11] Joint Commissioning Panel for Mental Health (2013) Guidance for commissioners of liaison mental health services to acute hospitals
[12] The independent Mental Health Taskforce to the NHS in England (2016) The Five Year Forward View For Mental Health
[13] NHS Improvement (2016) SAFER Patient Flow Bundle

4.3.4 Resource impact assessment

This area is not included in the draft resource impact report for the draft NICE guideline. It was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year) but is listed in the report as an area to be considered locally in the context of local current arrangements.

4.4 Timing and frequency of consultant review

4.4.1 Summary of suggestions

Timing and frequency of consultant review

Stakeholders supported early consultant reviews as being crucial for patients with a potential high risk of death, including those who deteriorate. For these patients waiting until the next scheduled ward round for senior review was felt to be inappropriate as timing of diagnosis and treatment will affect patient experience and outcomes. Twice daily consultant review was suggested.

Stakeholders suggested different review times for people presenting with an acute medical emergency:

- within 4 hours of arrival in the hospital (either in the emergency department or another assessment area) by a competent medical decision maker (CMDM)
- 8 hrs if the patient has arrived on an Acute Medical Unit (AMU) between the hours of 8am-8pm
- within 14 hours of arrival to hospital by a consultant
- people who are admitted should be have an additional consultant review within 24 hours of the first consultant review.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Timing and frequency of consultant review	**Early versus late consultant review** NICE guideline NGXX Recommendation 1.2.5
	Frequency of consultant review NICE guideline NGXX Recommendation 1.2.5

Timing and frequency of consultant review

NICE NGXX Recommendation 1.2.5

For people admitted to hospital with a medical emergency, consider providing the following:

- consultant assessment within 12 hours of admission to determine the person's care pathway
- daily consultant review, including weekends and bank holidays
- more frequent (for example, twice daily) consultant review based on clinical need.

Evaluate each of these options locally, taking into account current staffing models, case mix and severity of illness.

[See chapter 19 on early versus late consultant review and chapter 26 on frequency of consultant review.]

4.4.3 Current UK practice

Timing and frequency of consultant reviews

A 2017 Seven Day Clinical Standards report[14] identified 10 seven day clinical standards and stated that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible. At the latest within 14 hours from the time of admission to hospital.

Bell et al. (2013)[15] demonstrated an association between recommended working patterns for medical consultants on call and better outcomes in patients admitted as medical emergencies. Continuity of care with early senior decision input was recommended to deliver improved patient outcomes

4.4.4 Resource impact assessment

This area is not included in the draft resource impact report for the draft NICE guideline. It was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year) but is listed in the report as an area to be considered locally in the context of local current arrangements.

[14] NHS England (2017) Seven Day Clinical Standards
[15] PloS One (2013) Derek Bell, Adrian Lambourne, Frances Percival, Anthony A. Laverty, David K. Ward Consultant Input in Acute Medical Admissions and Patient Outcomes in Hospitals in England: A Multivariate Analysis; 6 8(4):e61476

MDT care

4.5.1 Summary of suggestions

Multidisciplinary team meetings

A stakeholder highlighted that due to the complexity of acute medical admissions coordinated multidisciplinary care is needed as early as possible to reduce length of stay and cost.

Enhanced inpatient access to physiotherapy

A stakeholder reported limited access to 7-day physiotherapy services on general inpatient wards. However this 7-day inpatient access was felt to be important to improve quality of life and reduce length of stay. In particular, immobility after illness can be detrimental to elderly patients.

4.5.2 Selected recommendation from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 9 to help inform the committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Multidisciplinary team meetings	**Multidisciplinary team meetings** NICE guideline NGXX Recommendation 1.2.6
Enhanced inpatient access to physiotherapy	**Enhanced inpatient access to physiotherapy and occupational therapy** NICE guideline NGXX Recommendation 1.2.8

Multidisciplinary team meetings

NICE NGXX Recommendation 1.2.6

Provide coordinated multidisciplinary care for people admitted to hospital with a medical emergency. [See chapter 29 on multidisciplinary team meetings.]

Enhanced inpatient access to physiotherapy

NICE NGXX Recommendation 1.2.8

Provide access to physiotherapy and occupational therapy 7 days a week for people admitted to hospital with a medical emergency. [See chapter 31 on enhanced inpatient access to physiotherapy and occupational therapy.]

4.5.3 Current UK practice

Multidisciplinary team meetings

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder's knowledge and experience.

Enhanced inpatient access to physiotherapy

A 2015 report[16] concluded that since 2011 the Heart of England Foundation Trust had provided seven day services across 3 hospitals for inpatients and attendees at A&E. Service users reported high satisfaction levels with the weekend therapy service with staff support for seven day services increasing from 72% (2011-12) to 87% (2012-13).

4.5.4 Resource impact assessment

Providing access to physiotherapy and occupational therapy 7 days a week is included in the draft resource impact report for draft NICE guideline. Additional physiotherapy and occupational therapy staff may be needed, but there is substantial local variation and the national impact could not be estimated. Such resources are not available immediately. There is likely to be a minimum time lag of 1 to 3 years to train such staff to allow organisations time to include in financial plans.

Providing coordinated multidisciplinary care is not included in the draft resource impact report for the Emergency and Acute medical care guideline. It was not identified as an area that would have a significant resource impact (>£1m in England each year).

[16] The Charted Society of Physiotherapy (2015) Physiotherapy works for 7 days

4.6 Structured patient handovers

4.6.1 Summary of suggestions

Structured patient handovers

A stakeholder reported that structured handovers are not always undertaken which can lead to patient anxiety due to repeated investigations. Structured handover during care handovers to therapeutic and diagnostic radiography departments was highlighted as a specific area to improve patient outcomes and satisfaction.

4.6.2 Selected recommendation from development source

Table 10 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 9 to help inform the committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Structured patient handovers	**Structured patient handovers** NICE guideline NGXX 1.2.11

Structured patient handovers

NICE NGXX Recommendation 1.2.11

Use structured handovers during transitions of care and follow the recommendations on transferring patients in the NICE guideline on acutely ill patients in hospital. [See chapter 32 on structured patient handovers.]

4.6.3 Current UK practice

Structured patient handovers

The 2015 Acute Care toolkit 1[17] highlighted the variability of handover systems. This toolkit aimed to improve the handover process and in turn increase patient safety.

[17] Royal College of Physicians (2011) Acute care toolkit 1- Handover

The 2013 report[18] identified 11 principle standards of care including the need to implement robust arrangements for transferring of care.

4.6.4 Resource impact assessment

This area is not included in the draft resource impact report for the draft NICE guideline. It was not identified as an area of the guideline that would be likely to have a significant resource impact (>£1m in England each year) but is listed in the report as an area to be considered locally in the context of local current arrangements.

[18] Royal College of Physicians (2012) Future hospital: Caring for medical patients

Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 1 February 2018.

Training

The training of emergency care staff including paramedics with enhanced competencies was suggested as an area of quality improvement.

These suggestions have not been progressed. Quality statements focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. The committee is therefore asked to consider which components of care and support would be improved by increased training. However, training may be referred to in the audience descriptors.

Care access

Stakeholders highlighted access to a number of healthcare services needs to be considered. There are no recommendations on these areas (other than research recommendations) within the draft Emergency and acute medical care (EAMC) NICE guideline:

- Access to an appointment with a GP within 48 hours
- Access to an emergency ambulance for life-threatening emergencies within 15 minutes
- Admission or transfer from the Emergency Department within 4 hours
- Access to acute mental health services within 4 hours of referral.
- 7-day access to GPs.
- 7-day diagnostic radiology.
- 4-hour waiting time target in A&E departments
- GP access to radiology.
- Extended access to GP services.
- GP streaming in Emergency Departments.
- Urgent care centres.
- MR scanning and MR scan reports

- Paramedic direct referral to Emergency Ambulatory Care and the extended hours of Emergency Ambulatory Services (EAS).
- The role of Advanced Clinical Practitioners.
- Extended access to social care services.
- Access with care adjustments for people with learning disability.
- Integrated care.
- Care home facilities

Infection control

Stakeholders highlighted the need to protect patients from communicable diseases and healthcare associated infections as a key principle of healthcare provision. They specifically highlighted antimicrobial stewardship and flu vaccination as priority areas. There are no recommendations on this area within the draft EAMC NICE guideline.

Integrated patient information systems and facilities signposting

A number of stakeholders supported the need for integrated care through integrated patient information systems across care settings and organisations. This will improve communication and collaborative thinking along the care pathway as well as improved accuracy of data collection and save clinical time.

A stakeholder highlighted that acute and emergency care facilities are difficult to navigate and understand with acronym names. This is confusing for patients and leads to delays in attending the correct facilities.

A stakeholder highlighted that patients have to make multiple contacts in order to resolve an urgent healthcare problem which can delays treatment, risks deterioration, undermines patient experience, wastes resources, and reduces quality. The stakeholder suggested the need for systems to resolve problems by the first or second healthcare contact. There are no recommendations on this area (other than research recommendations) within the draft EAMC NICE guideline.

Admission through elderly care assessment units.

A stakeholder highlighted the importance of care home arrangements to manage urgent medical problems and minimise disruption to the residents, ambulance service and emergency departments.

Another stakeholder suggested that acute hospitals should also consider the provision of Acute Frailty Units alongside Acute Medical Units when appropriate.

There are no recommendations on this area (other than research recommendations) within the draft EAMC NICE guideline.

Specific conditions, treatments and procedures

Stakeholders highlighted the importance of specific conditions, treatments and procedures in emergency and acute medical care:

- sepsis
- dental care
- emergency laparotomy recognition and surgery
- NT-proBNP testing for patients presenting with heart failure symptoms
- carbon monoxide poisoning identification and care pathways
- tourniquets.

This quality standard will not cover acute clinical management of specific medical conditions requiring urgent or emergency care as this will be addressed within the quality standards for the relevant conditions.

Also there are no recommendations on this area (other than research recommendations) within the draft EAMC NICE guideline.

Patient safety

A stakeholder highlighted a number of patient safety risks on emergency medicine and acute care:

- oxygen tubing being connected to air flowmeters
- the introduction of NatSSIPs for all invasive procedures
- failure to recognise acute coronary syndromes in Kawasaki disease patients
- use of injectable phenytoin
- inappropriate use of naloxone
- ingestion of button batteries.

There are no recommendations on this area within the draft EAMC NICE guideline.

National early warning scores (NEWS)

Stakeholders supported NEWS to be used by all healthcare professionals across primary and secondary care for consistent communication and patient safety.

There are no recommendations on this area within the draft EAMC NICE guideline.

Immediate decisions on care and treatment

Stakeholders raised the importance of time to having a discussion regarding resuscitation needs or having a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form completed.

There are no recommendations on this area (other than research recommendations) within the draft EAMC NICE guideline.

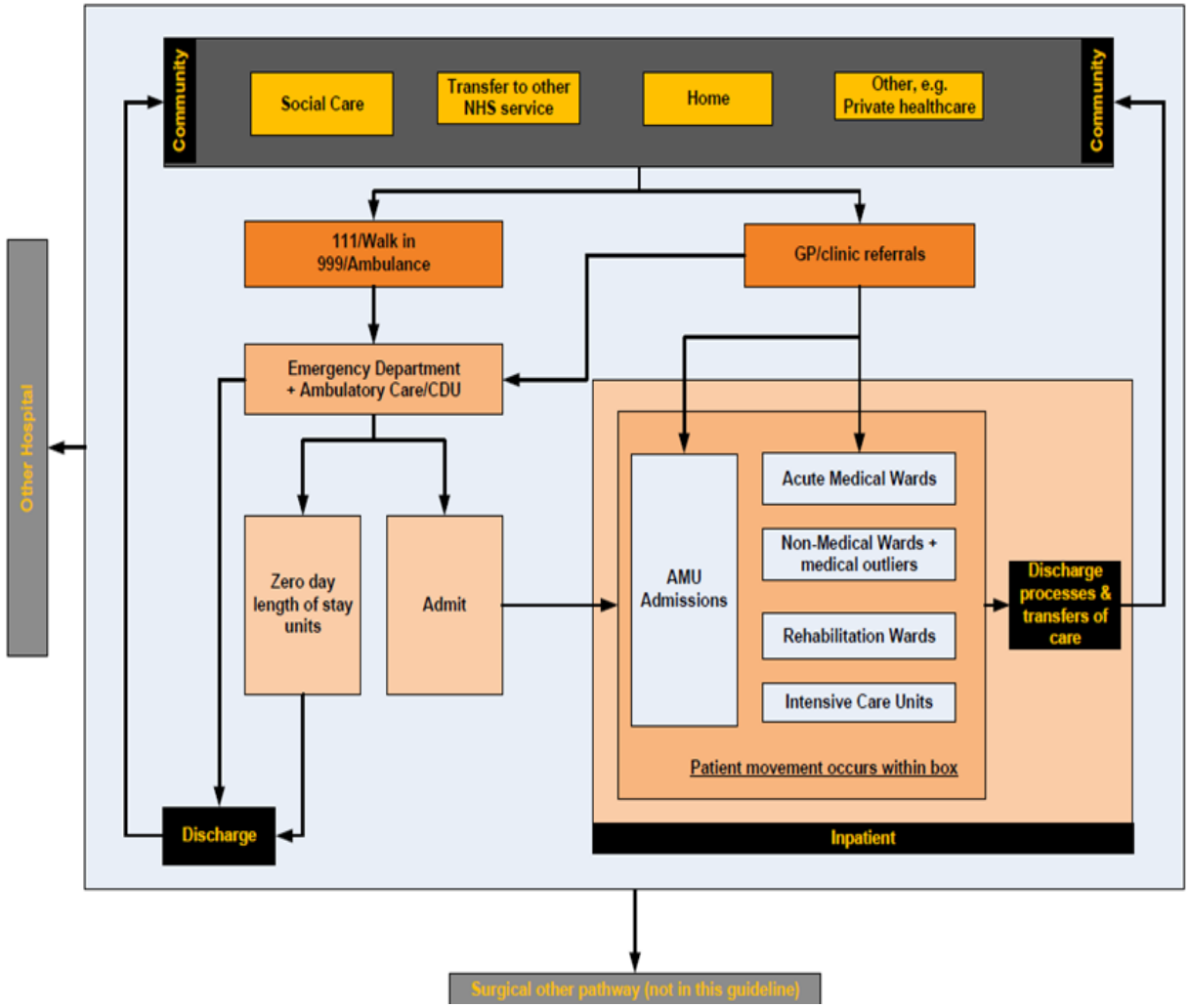
Overlapping published NICE guidance

Stakeholders highlighted the overlaps of emergency and acute care in a number of published NICE guidelines and the need for their further review:

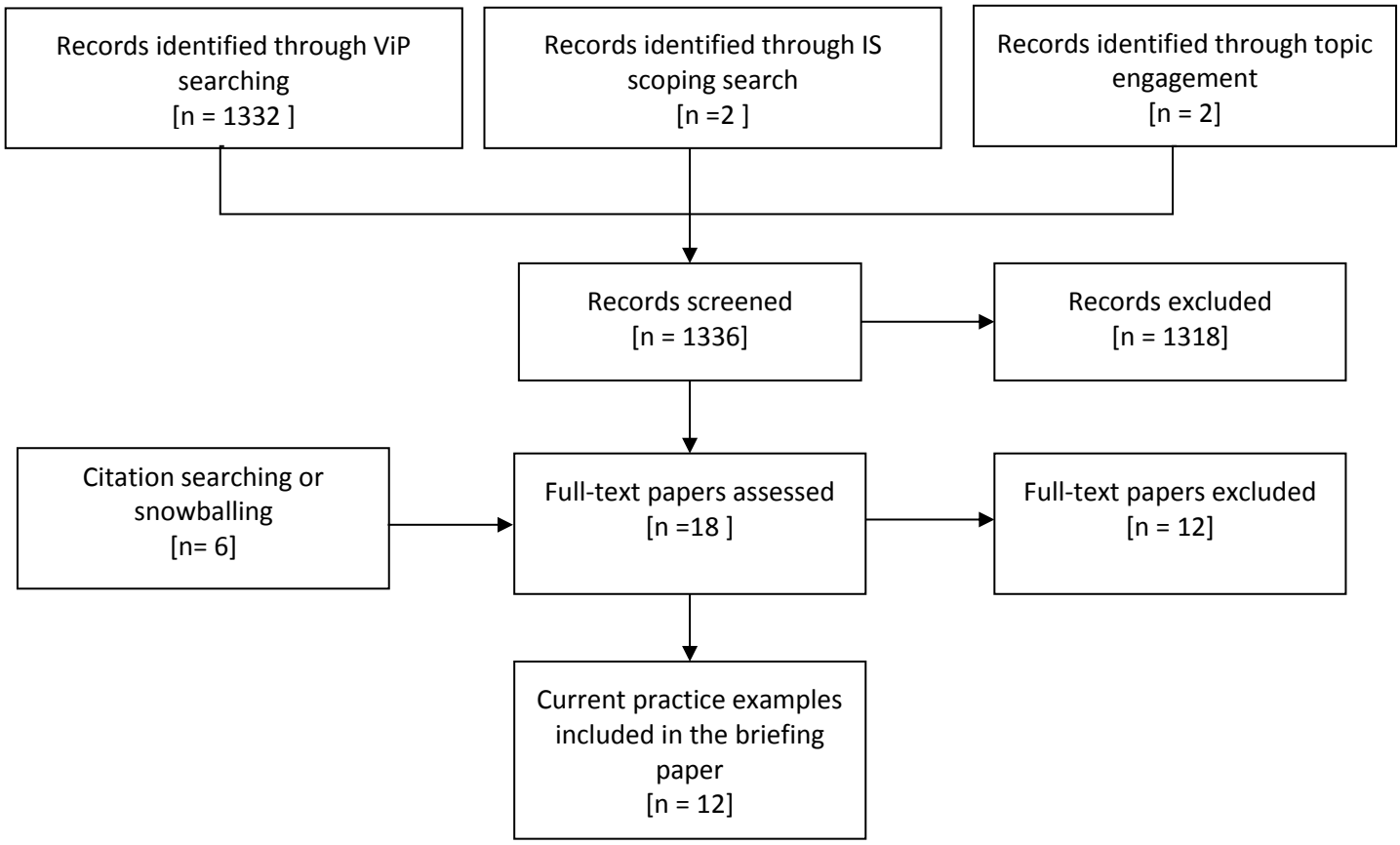
- NICE CG83 guideline on rehabilitation after critical illness in adults
- NICE NG43 guideline on transition from children's to adults' services quality standard
- NICE CG50 guideline on acutely ill adults in hospital: recognising and responding to deterioration
- NICE SG1 guideline on safe staffing for nursing in adult inpatient wards in acute hospitals.

Appendix 1: Additional information

Below shows the emergency and acute medical care pathway.



Appendix 2: Review flowchart



Appendix 3: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Access to diagnostics					
1	British Association of Critical Nurses (BACCN)	Improved access to Point of Care testing (CRP, WBC, D-dimer etc.) and plain x-rays for GPs, Registered Nurses and AHP's in the community setting	The earlier patients are seen and appropriate treatment commenced the more likely they are not to become acutely ill or critically ill are require admission to a hospital	This could avoid patients having to attend hospital for these investigations	

2	British Infection Association	Rapid diagnostics	Timely diagnosis allows earlier isolation or treatment and improved management of clinical pathways.	Universal screening for blood borne viruses in high risk areas on admission to emergency departments and acute medical units – using an opt out rather than opt in approach- have been demonstrated to detect previously undiagnosed infections with high clinical impact.	This will help to determine appropriate treatment for patients, especially those presenting with respiratory infections. Clear accountability and line of communication for transmitting critical results (e.g. blood culture positive). Rapid diagnostics allow early targeted therapy and lower use of unnecessary antibiotics as supported by https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/244058/20130902_UK_5_year_AMR_strategy.pdf A review of tests which may exclude bacterial infection irrespective of source- such as procalcitonin and inflammatory markers as a potential stewardship tool may be effective at the front door. Rapid flu diagnostics at the front door during an outbreak improve patient

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					flow through the acute care pathway.
Multidisciplinary intermediate care					
3	Association of ambulance chief executives	Provide multidisciplinary intermediate care as an alternative to hospital care to prevent admission and promote earlier discharge	Currently patchy and not consistent	Frail elderly patients in particular. It is crucial for ambulance clinicians to be able to leave patients at home to be able to make a robust clinical referral	Needs ambulance service clinicians to access these teams to have clinical discussions and refer patients to

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
4	SCM4	Provide multidisciplinary intermediate care as an alternative to hospital care to prevent admission and promote earlier discharge.	There are inherently more challenges making specific quality standards in relation to intermediate care provisions as they will largely be dependent on local resource and existing services. However, where there is clear advantage to intermediate care, coordination between service providers, creation of such services and communication between providers to make these services accessible is advantageous to the delivery of cost-effective and safe patient care. Hospital admission avoidance and associated mortality are benefits. Evidence appears stronger as compared to Community nursing strategies in isolation (Chapter 9) Again focus on emergency practioners understanding and having access to local alternative services	Community based intermediate care, (e.g. hospital at home, step-up/down care, rapid response schemes and virtual wards) have impact on mortality, length of stay, hospital admissions, ED presentations and patient satisfaction. There is an associated cost saving to the service from admission avoidance and early discharged and moderate to high evidence on Quality of Life, mortality and patient satisfaction. These do vary between conditions treated and it may be more appropriate for a quality standard to suggest local services to target more prevalent or poorly managed conditions in their area. Open communication between primary and secondary services appears to be a critical component in ensuring the correct patient group are selected and the service is then implemented safely.	Table 3 https://www.nice.org.uk/guidance/gid-cgwave0734/documents/draft-guideline-12 Table 4 https://www.nice.org.uk/guidance/gid-cgwave0734/documents/draft-guideline-12

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
5	SCM6	Collaborate with patients to provide multidisciplinary intermediate care as an alternative to hospital care.	Help to achieve earlier discharge from hospital or prevention of hospitalisation in the first instance. Many patients will prefer to be treated outside of the hospital setting.	Types of community-based intermediate care can differ - different services, different names etc. Patient collaboration essential to ensure alternative options to hospital care provide a good outcome for both patients and the healthcare service.	Government case studys: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459196/Countess_of_Chester_ESD_.pdf https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459208/Oxford_Health_EMU.pdf
Advance care planning					
6	Association of ambulance chief executives	Offer advance care planning to people in the community and in hospital who are approaching the end of life and are at risk of a medical emergencies	If plans are not made, an ambulance 999 will often be called and patient may end up in hospital	Lack of data on this, possible data on preferred place of death?	ReSPECT process-see website respectprocess.org.uk

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
7	SCM4	Advance Care Planning offered to people in the community and in hospital who are approaching end of life and are at risk of medical emergency	Dignfied and respectful deaths in accordance with patient's wishes is a core principle of good medical care. These patient's emergency treatment is intimately entwined with their prior wishes, prognosis, social supports and wider medical and mental health. This MDT approach is not available on an emergency basis and Emergency Departments are unlikely to be the best places for these patients to be cared for and are likely to represent an unnecessary resource burden where tests and procedures are performed that are not in the patient's best interests. This is further compounded by long waits on trolleys, admissions to wards and the associated disruption to their ongoing community care.	Advanced care planning can reduce ED presentations. If emergency presentation is required advanced care plans can reduce hospital admission. Overall there is an advantage to patient/carer satisfaction. Data analysis in South West of England suggests cost benefit Addresses priorities of holistic and patient centred care and appropriate utilisation of emergency services although clearly the evidence base is currently small.	Expectations of advanced care planning by healthcare professionals https://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_benefits.asp Improved patient outcomes Table 2 and 3 https://www.nice.org.uk/guidance/GID-CGWAVE0734/documents/draft-guideline-15 Cost effectiveness 15.4 https://www.nice.org.uk/guidance/GID-CGWAVE0734/documents/draft-guideline-15 Low grade evidence
8	Royal College of Emergency Medicine		EDs not used for expected end of life care		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Assessment on admission to hospital					
9	SCMS3	Time to be seen by a competent clinical decision maker on arrival to the AMU.	All patients should be seen by a clinical decision maker who has adequate capabilities within 4 hours of arrival on the AMU. This individual must be able to perform a full assessment and instigate an appropriate management plan. There is no evidence for this standard but it is axiomatic that earlier review and treatment by a capable decision maker should improve patient outcomes.	This is supported by the Society for Acute Medicine – Clinical Quality Indicators and Quality Standards http://www.acutemedicine.org.uk/resources/quality-standards/ Patients should be seen in a timely fashion. The earlier a patient is seen results in earlier treatment. This may enable the patient's condition to improve sooner. It will also hopefully prevent further deterioration from the underlying condition.	
10	Royal College of Physicians of Edinburgh	Standardised assessment pathways	Where appropriate, standardised assessment pathways should be in place, and where that's not possible, the ability for clinicians to talk to each other easily to discuss cases and best way forward.	To ensure patients receive consistently efficient and effective care	
11	SCM5		Standardise admissions to hospital using Risk Stratification Tools.	Evidence suggests the use of Risk Stratification tools does improve – however caution is required (CURB-65 in young people).	Various NICE Guidelines - Gi Bleeding - Pneumonia - Chest pain

12	SCM1		ACUTE ADMISSIONS Admission of patients with acute medical conditions to hospital should be through an Acute Medical Unit under the leadership of a Consultant in Acute Medicine. Assessment of which patients need admission should be done either by a primary care clinician (GP or assistant) or it should be done by a specialist / advanced paramedic. Patients requiring medical admission should not be assessed in the Emergency Department unless they require immediate resuscitation or unless they have self-presented to hospital.	The associated draft guidance recommends admission through an acute medicine department and it recommends using specialist / advanced paramedics to advise on need for admission. When combined, these two recommendations remove the need for medical patients to be assessed in the Emergency Department and then again on a ward.	Putting this in place will drastically reduce the number of patients in the Emergency Department who may become “stuck” there. This has always been worthwhile from the point of view of patient safety and patient comfort. It is particularly prescient now where overcrowding of acute hospitals tends to become concentrated in the corridors of Emergency Departments. Putting this in place will require new investment into acute services to be directed more towards the specialty of Acute Medicine rather than Emergency Medicine. As well as requiring more capacity in general, Acute Medicine Departments will require receiving areas with HDU-type monitoring and treatment facilities. The medical staff are already, through the ACCS programme, trained to work in this higher acuity environment.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
13	SCMS3	Assessment of people with undifferentiated medical conditions requiring admission or further assessment.	All people with undifferentiated medical emergencies that require hospital admission should be assessed and treated in an acute medical unit with a multidisciplinary team. This group should also include those patients whose medical emergency may be managed in an ambulatory fashion.	Effectiveness of acute medical units in hospitals: a systematic review. IAN SCOTT et al. International Journal for Quality in Health Care 2009; Volume 21, Number 6: pp. 397–407. The effectiveness and variation of acute medical units: a systematic review Reid L et al. International Journal for Quality in Health Care, Volume 28, Issue 4, 1 September 2016, Pages 433–446, https://doi.org/10.1093/intqhc/mzw056 Conclusions: AMUs reduce in-patient mortality, length of stay and emergency department access block without increasing readmission rates, and improve patient and staff satisfaction	
Liaison psychiatry					
14	RCGP	Psychiatric emergencies are often neglected and patient distress escalates and risk of harm increases but calm handling can be effective			
15	RCEM		Timely mental health review		
16	RCEM		Timely CAHMS intervention		
17	RCEM		EDs not used as a place of safety for pure mental disturbance		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Discharge planning					
18	Society for Acute Medicine and Royal College of Physicians	Documentation of expected date of discharge	Planning for discharge must start on admission	All patients admitted with an acute medical emergency should have an estimated date of discharge documented within 24 hours of admission	See NHSE/NHSI documentation
19	SCM1		DISCHARGE PLANNING Patients admitted with acute medical problems should have their discharge planned from the day of admission. This should include physical, psychological and functional re-ablement, as well as necessary additional support likely to be needed in the community.	Health services cannot blame social service providers for delayed discharges if the delay in making arrangements originates in hospital. All patients admitted to hospital will leave at some time. Discharge or death are inevitable and each benefits from prior planning. Waiting to see what the outcome of the admission is before starting to plan is unacceptable in an environment with a shortage of beds.	
20	SCM4	Early Discharge Planning for patients admitted with AME although with patient selection a priority.	Increasingly complex patients whose disease process does not start and end with their hospital admission. Doctors not overtly trained in discharge planning – requires MDT input. May be some suggestion that clinical input/follow-up post discharge requires more focus.	Moderate evidence for reduced length of stay. Some evidence for patient satisfaction and adverse events, however with some concerning data on mortality. Implies patient selection and potentially balance of timely discharge vs safe discharge a priority.	Table 3 https://www.nice.org.uk/guidance/GID-CGWAVE0734/documents/draft-guideline-35
Timing and frequency of consultant review					

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
21	Royal College of Anaesthetists	Early senior review of patients with a potential high risk of death, including those who deteriorate.	Whilst there are standards of care regarding 12/14hour consultant review, this is inadequate for those at high risk of death, or those who deteriorate. Waiting until the next scheduled ward round for senior review is inappropriate for such patients. There are no obvious recommendations which will support identifying patients with the most serious and time-dependant conditions prior to the next scheduled ward round, and then expediting care. A risk based approach may be beneficial.	Similar issues have been considered within NELA, in response to the recognition that patients with time sensitive pathology cannot wait until the next scheduled ward round. Standards for consultant input for high risk surgical patients are based on assessment of risk to identify those with >5% risk of death.	RCS Standards for High Risk Surgical Patient are currently being updated, but will continue to emphasis this area. The Higher Risk General Surgical Patient: towards improved care for a forgotten group. RCSEng and DH, 2011 www.rcseng.ac.uk/publications/docs/higher-risk-surgical-patient
22	Royal College of Anaesthetists	Patient Centred Outcomes	Some concern was expressed, including from lay representatives within NELA that patient centred outcomes could be firmed up. Eg there appears to be no mention of patient experience. As a patient "can I please experience a high probability of being given an accurate working diagnosis and can I start definitive (the correct) treatment all within 6-8hrs?"		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
23	Society for Acute Medicine and Royal College of Physicians	Time to assessment by a senior decision maker	Crucial for expert assessment and management	People presenting with an acute medical emergency should be reviewed by a consultant within 14 hours of arrival to hospital (8 hrs if arrived on an AMU 8am-8pm)	Senior decision maker = consultant in this situation AMU= Acute Medical Unit See SAM Quality Indicators document

24	Society for Acute Medicine and Royal College of Physicians	Time to first assessment by a competent decision maker	Crucial for patient treatment	People presenting with an acute medical emergency should be seen by a competent medical decision maker (CMDM) within 4 hours of arrival in the hospital (either ED or another assessment area)	A competent decision maker is someone qualified who can: Perform an ABCDE assessment and take the appropriate resuscitative actions Take a history Perform a full examination Request and perform the appropriate common investigations that are performed in patients presenting as a medical emergency Interpret the appropriate common investigations as above Determine an appropriate initial management plan and ensure it is performed including the prescription of medication Escalate patients who are acutely unstable to their supervising seniors Perform a comprehensive clinical handover Present the patient details in a senior review Perform any further actions or duties that arise as a result of a senior review including onward

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					referral as necessary Speak to the patient/relatives at the appropriate level so they understand what is happening
25	Society for Acute Medicine and Royal College of Physicians	Time to further senior decision maker review	Crucial for ongoing care and planning	People who have presented with an acute medical emergency should be reviewed by a consultant within 24 hours of the first consultant review if they remain an inpatient	
26	SCMS3	Twice daily consultant review on the AMU	All high dependency patients (including acute medical unit, surgical assessment units and intensive care unit) should be seen and their progress reviewed by a consultant twice daily, unless it is determined by a senior decision-maker that this would not affect the patient's care pathway.	Bell D, Lambourne A, Percival F, Laverty AA, Ward DK (2013) Consultant Input in Acute Medical Admissions and Patient Outcomes in Hospitals in England: A Multivariate Analysis. PLoS ONE 8(4): e61476. doi:10.1371/journal.pone.0061476 Consultant presence within the Acute Medicine Unit (AMU, or equivalent) for a minimum of 4 hours per day (65% of study group) had a lower aCFR compared with hospitals that had Consultant presence for less than 4 hours per day (p,0.01) and also had a lower 28 day re-admission rate (p,0.01).	NHS England 7 Day Services – 10 clinical standards https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf Society for Acute Medicine – Clinical Quality Indicators and Quality Standards
27	SCMS3	2. Daily consultant review on the medical ward.			

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
28	Royal College of Emergency Medicine		Timely specialist review		
29	SCMS3	Time to be reviewed by a consultant from arrival to hospital.	Timely consultant review: All emergency admissions should have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital. Observational studies have demonstrated the benefit of consultant review on the AMU.	This is supported by the Society for Acute Medicine – Clinical Quality Indicators and Quality Standards http://www.acutemedicine.org.uk/resources/quality-standards/ McNeill G, Brahmbhatt DH, Prevost AT, Trepte NJB. What is the effect of a consultant presence in 15 an acute medical unit? Clinical Medicine. 2009; 9(3):214-218 The mean length of stay - days in the intervention groups was 1.34 lower (2.67 to 0.01 lower). Proportion of patients discharged on day of admission - 129 more per 1000 (from 71 more to 193 more).	NHS England 7 Day Services – 10 clinical standards https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf Society for Acute Medicine – Clinical Quality Indicators and Quality Standards http://www.acutemedicine.org.uk/resources/quality-standards/
Multidisciplinary team meetings					
30	SCM4	Provide coordinated multidisciplinary care for people admitted to hospital with a medical emergency	There will be multifactorial contributors to acute medical admissions warranting input from multidisciplinary staff. A coordinated effort from the outset is reflective of the complexity of acute medical admissions.	Using an MDT board round there is an estimated saving of £228 per patient and 1.7d reduction in length of stay However no published literature to support cost benefit and the clinical benefits were only weakly evidenced.	Table 5 https://www.nice.org.uk/guidance/gid-cgwave0734/documents/draft-guideline-29

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Enhanced inpatient access to physiotherapy					
31	SCM6	Provide access to physiotherapy 7 days a week for people admitted to hospital with a medical emergency.	Evidence suggests access to physiotherapy can help reduce length of stay and improve quality of life. Immobility after illness can be particularly detrimental to elderly patients. Links with other NICE guidance for specific conditions i.e. Stroke, Hip Fracture, Venous Thromboembolism	Access to 7-day services often found in specialist services but less on general medical wards.	
Structured patient handovers					

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
32	SCM6	Use structured handovers.	Improve patient outcomes/satisfaction and staff satisfaction. Increased patient safety/avoidance of adverse events.	Structured handover of care between transferring and receiving teams is well established within NHS current practice and is reinforced by related NICE guidance (CG50) and the Acute Care RCP Toolkit. However, anecdotal evidence from patients would suggest that structured handovers are not always undertaken. Patient's can experience anxiety with handovers during staff changes or when changing wards/healthcare setting. Patients often left with feeling that information is held with one particular staff member or that they have to constantly repeat the same information to numerous staff members.	

33	The Society and College of Radiographers	Chapter 32 Structured patient handovers Recommendations: 19. Use structured handovers during transitions of care and follow the recommendations on transferring patients in the NICE guideline on acutely ill patients in hospital.	Delayed or missed investigations are referred to in the draft guidance as a measure of relative values of different outcomes. There is no evidence with regards to delayed or missed investigations in terms of statistics. The Society and College of Radiographers does recognise that diagnostic and therapeutic investigations are delayed or incomplete due to inefficient handover. For this reason the recommendation is considered important because of the potential to improve patient care and outcomes. There is evidence that diagnostic radiology services are short staffed with too few radiographers and radiologists https://www.sor.org/sites/default/files/document-versions/appg_a4.pdf http://www.telegraph.co.uk/science/2016/12/31/expensive-nhs-scanners-wasted-shortage-staff-operate/ New models of care may help to improve cost effectiveness.	The committee recognised that “when conducted properly a formal structure for exchanging information would improve outcomes.” Structured handover of care must apply when patients leave the ward environment for example to attend a clinical imaging department. The development will reduce errors associated with inadequate information provided at handover of care to therapeutic and diagnostic radiography departments. Clinical imaging and radiotherapy departments must also use a structured system of handover when returning patients to the care of the ward. The Society and College of Radiographers welcomes research to inform models of care in terms of staffing structures around the clock. The Society and College of Radiographers would suggest that impact on retention of staff of night-time working/length of shifts/shift patterns/work life balance is also considered in order to safeguard succession planning. Evidence suggests that utilising advanced practitioner radiographers benefits the user, the practitioner and the employer. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4175793/	The Society and College of Radiographers welcomes further investigation for the inclusion of reporting radiographers in to diagnostic radiology service configurations. http://www.sciencedirect.com/science/article/pii/S1078817416300499 https://www.ncbi.nlm.nih.gov/pubmed/27008104

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
34	SCMS3	3. Structured patient handovers at any transition of care.			
Additional areas					
35	SCM5		Time to be seen by Senior Clinical Decision Maker for those acutely unwell?	CG50 and CG51 both suggest that people withhigh risk of severe illness or high risk of death are reviewed by a senior clinical decision maker within 1 hour of stratification.	NICE CG50 NICE CG51
36	Royal College of Emergency Medicine		Access to radiology opinions and timely reporting of radiographs and CT scans		
37	Royal College of Emergency Medicine		Access to MR scanning and timely MR scan reports		
38	Royal College of Emergency Medicine		Meeting of the four-hour target for admitted and transferred patients / reduced aggregated patient delays		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
39	NHS England (NCD in Acute Care)		Multiple contacts	One of the major factors that undermines quality is the fact that patients are required to make multiple contacts in order to resolve an urgent healthcare problem. Each contact that does not resolve the problem delays treatment, risks deterioration, undermines patient experience, wastes resources, and reduces quality. An ideal system would resolve all problems on the first or second contact, and a very effective quality standard could focus on reducing the number of healthcare contacts that occur per patient.	
40	Royal College of Physicians of Edinburgh	Quality of data	Fellows have indicated frustration at the lack of quality data available on this topic.	Fellows have stated that trying to build up an accurate picture of what is happening across healthcare boundaries (e.g. primary to secondary care, or between professions like community pharmacy and nursing) is incredibly difficult. There is data on how people entered into secondary care; however there is lack of clarity on how much more data is collected around any healthcare contact pre-admission.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
41	NHS England (NCD in Acute Care)		Access to timely care	Access to timely care is central to quality, and demonstrably improves outcomes. It would therefore be reasonable to recommend a set of core access standards. Examples would include access to an appointment with a GP within 48 hours, access to an emergency ambulance for life-threatening emergencies within 15 minutes, access to discharge, admission or transfer from the Emergency Department within 4 hours, access to a consultant within 14 hours of emergency admission to hospital, access to acute mental health services within 4 hours of referral. There are, of course, many other potential access standards that you may wish to consider.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
42	Royal College of Anaesthetists	Prompt recognition and referral to surgery, of patients admitted under acute medicine who may have acute intra-abdominal pathology	Evidence from the National Emergency Laparotomy Audit has found that ~25% of patients requiring emergency laparotomy are admitted under non-surgical specialties, including acute medicine. Emergency laparotomy is a time-sensitive procedure and delays to diagnosis and treatment are associated with higher mortality. Delays to diagnosis and treatment are likely to be reduced if a) patients are admitted under the correct specialty b) patients receive prompt senior input from the correct specialty. This requires early consideration of potential surgical diagnosis if admitted under medicine. It would help to have a specific section recognising the needs of surgical patients prior to a surgical diagnosis being made. This might include specific pathways for consideration of surgical diagnosis and referral to surgery to minimise time delays.	NELA data shows that ~25% of patients requiring emergency laparotomy are admitted under non-surgical specialties. This varies between providers. Data from the Emergency Laparotomy Network demonstrated that patients admitted under medicine had a higher mortality than those admitted under surgery.	Please see the Second NELA Patient Report – Chapter 8, page 40 and fig 5 (for the trust level variability) http://www.nela.org.uk/Second-Patient-Report-of-the-National-Emergency-Laparotomy-Audit#pt Saunders DI, Murray D, Pichel AC, Varley S, Peden CJ et al. Variations in mortality after emergency laparotomy: the first report of the UK emergency laparotomy network. Br J Anaesth 2012;109(3):368-375

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
43	NHS Improvement Patient Safety Team		This is advice that NICE may want to consider within the QS as relevant to emergency medicine and acute care.	At the time of issuing the Directive Alert in October 2016, NHSI Patient Safety Team were aware that the National Reporting and Learning System (NRLS) had received two reports of fatalities, two of severe harm, and over 200 of incidents resulting in moderate, low or no harm; since January 2013	Please see NHS Improvement Stage 3 Directive Alert - Reducing the risk of oxygen tubing being connected to air flowmeters, published 3 October 2016 https://improvement.nhs.uk/news-alerts/reducing-risk-oxygen-tubing-being-connected-air-flowmeters/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
44	NHS Improvement Patient Safety Team	Supporting the introduction of NatSSIPs	The Alert requires the development and implementation of Local Safety Standards for Invasive Procedures based on NatSSIPs for all invasive procedures with the potential for a never event to occur	The NatSSIPs are developed in response to recommendations to a taskforce commissioned by DH to understand why surgical never events occur. We know from never events data that surgical never events occur in emergency and acute medical care. Development of LocSSIPS will also bring about standardisation in practice across the organisation. One of the NatSSIPs is on handover and determines essential safety requirements for handover. The NatSSIPs also determine the requirement for multiprofessional team training.	Please see NHS Improvement stage 2 resource alert – "Supporting the introduction of the National Safety Standards for Invasive Procedures", published 14 September 2015 https://improvement.nhs.uk/news-alerts/supporting-introduction-national-safety-standards-invasive-procedures/ The NatSSIPs are endorsed by RCP and RCEM

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
45	NHS Improvement Patient Safety Team	Ensuring the QS group is mindful of potential for safety risk related to failure to recognise acute coronary syndromes in Kawasaki disease patients	There is evidence that advanced personalised care plans for patients known to be at risk of potential life threatening conditions can be effective in improving their emergency management with better outcomes.	There is national variance in how these plans are agreed with patients, specialists, ambulance services	Please see NHS Improvement stage 1 warning alert – "Failure to recognise acute coronary syndromes in Kawasaki disease patients" published 11 May 2016 https://improvement.nhs.uk/news-alerts/failure-recognise-acute-coronary-syndromes-kawasaki-disease-patients/
46	NHS Improvement Patient Safety Team	Ensuring the QS group is mindful of potential for safety risk related to use of injectable phenytoin	This is advice that NICE may want to consider within the QS as relevant to emergency medicine and acute care.	At the time of issuing the Warning Alert in November 2016, the NHSI Patient Safety Team had been informed of two recent fatal incidents involving the use of injectable phenytoin in status epilepticus and a search for similar incidents submitted in the preceding three years to the NRLS had revealed 2,200 patient safety incidents including two further deaths, five severe and 121 moderate harm incidents.	Please see NHS Improvement NHS Improvement; Stage one warning alert - Risk of death and severe harm from error with injectable phenytoin, published 9 Nov 2016 https://improvement.nhs.uk/news-alerts/risk-death-and-severe-harm-error-injectable-phenytoin/

47	NHS Improvement Patient Safety Team	Ensuring the QS group is mindful of potential for safety risk related to the inappropriate use of naloxone	This is advice that NICE may want to consider within the QS as relevant to emergency medicine and acute care.	The NHSI Patient Safety Team issued a Warning Alert in Nov 2014 and a Resource Alert in Oct 2015. At the time of issuing the Warning Alert in November 2014, the team had received details of three patient safety incidents describing failure to follow guidance, including two incidents that resulted in death. Work is ongoing with BNF and Toxbase to continue to improve the wording of guidance related to inappropriate use of naloxone.	Stage one warning - Risk of distress and death from inappropriate doses of naloxone in patients on long-term opioid/opiate treatment, published 20 Nov 2014. https://improvement.nhs.uk/news-alerts/risk-distress-death-inappropriate-doses-naloxone-patients-long-term-opioid-opiate-treatment/ Stage two resource alert - Support to minimise the risk of distress and death from inappropriate doses of naloxone, published 26 October 2015 https://improvement.nhs.uk/news-alerts/support-minimise-risk-distress-and-death-inappropriate-doses-naloxone/ Updated UKMi document (Oct 2017) https://www.sps.nhs.uk/articles/what-naloxone-doses-should-be-used-in-adults-to-reverse-urgently-the-effects-of-opioids-or-opiates/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
48	NHS Improvement Patient Safety Team	Ensuring the QS group is mindful of potential for safety risk related to ingestion of button batteries	This is advice that NICE may want to consider within the QS as relevant to emergency medicine and acute care.	The NHSI Patient Safety Team issued a Warning Alert in Dec 2014. At the time of issuing the Warning Alert in December 2014, the team reviewed incident reports from a recent four year period and identified five cases where severe tissue damage occurred after apparent delays in suspecting, diagnosing or treating button battery ingestion in small children; one child died.	Stage one warning alert - Risk of death and serious harm from delays in recognising and treating ingestion of button batteries, published 19 Dec 2014 https://improvement.nhs.uk/news-alerts/risk-death-serious-harm-delays-recognising-treating-ingestion-button-batteries/
49	NHS Improvement Patient Safety Team	Ensuring the QS group is mindful of potential for safety risk related to ingestion of button batteries	This is advice that NICE may want to consider within the QS as relevant to emergency medicine and acute care.	The NHSI Patient Safety Team issued a Warning Alert in Dec 2014. At the time of issuing the Warning Alert in December 2014, the team reviewed incident reports from a recent four year period and identified five cases where severe tissue damage occurred after apparent delays in suspecting, diagnosing or treating button battery ingestion in small children; one child died.	Stage one warning alert - Risk of death and serious harm from delays in recognising and treating ingestion of button batteries, published 19 Dec 2014 https://improvement.nhs.uk/news-alerts/risk-death-serious-harm-delays-recognising-treating-ingestion-button-batteries/

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
50	NHS Improvement Patient Safety Team	Ensuring the QS group is mindful of potential for safety risk if deterioration in a patient's clinical condition is not detected or acted upon in a timely or effective manner	This is advice that NICE may want to consider within the QS as relevant to emergency medicine and acute care.	The NHSI Patient Safety Team issued a Resource Alert in July 2016 in response to research that showed that 26% of preventable deaths were related to failures in clinical monitoring. These included failure to set up systems, failure to respond to deterioration and failure to act on test results (Hogan et al, 2012).1 In addition, in 2015 around 7% of patient safety incidents reported to the National Reporting and Learning System (NRLS) as death or severe harm were related to a failure to recognise or act on deterioration.	Stage two resource alert - Resources to support safer care of the deteriorating patient (adults and children), published 12 July 2016 https://improvement.nhs.uk/news-alerts/resources-support-safer-care-deteriorating-patient-adults-and-children/
51	Royal College of Physicians of Edinburgh	Continue to aim for patients to be referred to the right place to be seen by the right person at the right time.	Avoiding duplication in work and unnecessary delays. Alternatives to inpatient care should be easy to navigate for both clinicians and patients.	To improve patient experience and efficiency of treatment	
52	Royal College of Emergency Medicine		The NICE preliminary report has already cited lack of good quality evidence for many of the areas that are being looking at. These would benefit from more EM academics.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
53	Royal College of Emergency Medicine		With better data now being collected, the rate limiting step for a lot of quality improvement activity will be access to data for organisations like RCEM and researchers, which RCEM is keen to promote.		
54	Royal College of Emergency Medicine		It would help be helpful if NICE could define a standard / expectations for access to Hospital Episode Statistics data for Research / Quality Improvement work etc, for example like a freedom of information request.		
55	Royal College of Emergency Medicine		Good audit systems		
56	Royal College of Emergency Medicine		No crowding of EDs		
57	Royal College of Emergency Medicine		Clean, tidy departments with good hygiene standards and adequate side rooms		
58	Royal College of Emergency Medicine		No GP admissions to come to Eds		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
59	Royal College of Emergency Medicine		EDs not used for readmissions or as a planned / unplanned follow-up system		
60	Royal College of Emergency Medicine		Collocation of services, including community pharmacy and frailty services and oncology		
61	Royal College of Emergency Medicine		Timely access to PCI, stroke, trauma and vascular services		
62	British Association of Critical Nurses (BACCN)	Improved communication; particularly across organisational boundaries. All communications between primary and secondary care should be used using SBAR (Situation, Background, Assessment, Recommendation) or RSVP (Reason-Story-Vital Signs-Plan) communication tool	Effective healthcare delivery depends on this	Unwell patients will often transition through a number of different professionals; research evidence supports that there is often a lack of understanding to provide effective care coordination and continuation	http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/T4I%20%283%29%20SBAR.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
63	MENCAP	Effective systems, processes and staff knowledge to recognise patients who may need reasonable adjustments to care.	Recommendation 1 of the Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD) (2013) was the clear identification of people with learning disabilities on the NHS central registration system and in all healthcare record systems.	CIPOLD found the lack of reasonable adjustments for patients with learning disability was a contributory factor to a significant number of deaths. They found very limited systems for identifying patients with a learning disability, which is vital if reasonable adjustments are to be made. Those systems are still not in place yet across much of the NHS although work is ongoing at NHS Digital and NHS England to improve the situation. Healthcare professionals are still in need of training to be able to use such systems effectively.	Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD) (2013) http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf
64	SCM6	Develop and evaluate integrated care pathways.	Better communication, co-ordination and information sharing between healthcare services can improve health outcomes and satisfaction for patients. Better integration can help to avoid duplication of tests and appointments.	Integrated care already implemented in many services, but still many areas for improvement. In particular shared information systems need development. From a patients viewpoint there seems to be very little in the way of information sharing - service relies on patients being knowledgeable about their condition and care history. Whilst this isn't so bad for patients who are able to provide this information or who have carers who can provide this information, it is worrying that those less able may not receive optimum care.	Consistent with Care Quality Commission programme - 'integration, pathways and place' and NHS Five Year Forward View - 'integrating care locally'.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
65	SCM4	Health and social care systems should develop and evaluate integrated care pathways	Key here is the evaluation. It provokes communication and collaborative thinking between the myriad of complex services that patients may encounter in their journey. Awareness of these services and access can be vital in-patient management in acute/emergency situations; improving both patient and caregiver experience. Clinical focus is key with accessibility of accessing integrated models of working out of hours and on an emergency basis	Reduced length of stay, hospital admissions and ED use with potential for increased quality of life and potential cost effectiveness benefit.	https://www.nice.org.uk/guidance/GID-CGWAVE0734/documents/draft-guideline-38 38.6
66	British Association of Critical Nurses (BACCN)	Improved access to Point of Care testing (CRP, WBC, D-dimer etc.) and plain x-rays for GPs, Registered Nurses and AHP's in the community setting	The earlier patients are seen and appropriate treatment commenced the more likely they are not to become acutely ill or critically ill are require admission to a hospital	This could avoid patients having to attend hospital for these investigations	
67	SCM5		The effectiveness of GP streaming within Emergency Departments.	Are GP's effective in streaming and preventing ED presentations/admissions?	Limited evidence

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
68	Association of ambulance chief executives	Increase in numbers of advanced and specialist paramedics with enhanced competencies in NHS ambulance services	To reduce admissions, more appropriate care closer to home, especially for older and frail patients	Currently very ad hoc picture across NHS,	Needs to link with wider work including HEE, look at rotational models, more measures of data/effectiveness/clinical outcomes
69	SCM2	Provision of Advanced Paramedic Practitioner to manage urgent and emergency care presentations.	There is evidence that many calls to ambulance services relate to patients that are amenable to assessment and treatment in the community. Although paramedics undertake some of this work already, expansion of paramedic skills and knowledge in this area has the potential to further reduce unnecessary hospital admission and improve patient outcomes and satisfaction.	Widespread development of advanced paramedic practice within ambulance services has proceeded at a relative slow pace and where schemes exist these have sometimes not been sustainable. Paramedics have demonstrated that they are capable and motivated to undertake advanced practice roles, and many have now been employed outside the ambulance service thus denuding it of skilled experienced staff. A clear consistent framework for the development of advanced paramedic practitioners within ambulance services is now needed to improve see and treat strategies, reduce unnecessary admission that prioritises such initiatives at ambulance board level. These changes need to be at a national level to ensure that development opportunities and services offered are consistent and sustainable.	Existing evidence regarding the efficacy of paramedic practitioners has already been published with the Emergency Medicine and Acute Care guideline – this provides evidence as to how these roles may be developed and operationalised. In addition, the UK College of Paramedics Clinical Career framework provides comprehensive guidance on the level of education and experience required to fulfil these roles.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
70	British Association of Critical Nurses (BACCN)	Extended hours of opening Emergency Ambulatory Services (EAS)	EAS can reduce the burden in Emergency Departments for a range of patients. NB EAS can be for patients with medical and surgical needs	Only those patients requiring attention in Emergency Departments stay there	Please see the RCP Toolkit at https://www.rcplondon.ac.uk/guidelines-policy/acute-care-toolkit-10-ambulatory-emergency-care and https://www.ambulatoryemergencycare.org.uk for further information about how EAC services can be used
71	British Association of Critical Nurses (BACCN)	National Early Warning Score being used by all healthcare professional across primary and secondary care	To enable all to be using the same language when describing a sick patient	Patient safety	

72	British Infection Association	Sepsis	The reported incidence of sepsis is rising and sepsis is a leading cause of mortality and critical illness worldwide.	Both the UK Parliamentary and Health Service Ombudsman enquiry (2013) and a UK National Confidential Enquiry into Patient Outcome and Death (NCEPOD, 2015) highlighted sepsis as being a leading cause of avoidable death that kills more people than breast, bowel and prostate cancer combined. There remains variability in the management of sepsis and resources provided at emergency and acute care level.	Timely diagnosis and management of this condition, with consideration of previous microbiological results guiding initial antimicrobial prescribing choices is critical. Septic screens are required in all patients who trigger for sepsis (based on local protocols) and completion of key interventions such as sepsis six. Alert systems should be used from ambulance to the emergency department to inform them of a patient in transit with suspected sepsis. Within acute care warning scores such as SOFA score should be used to rapidly prioritise those at high risk of mortality from sepsis. Improve the door-to-needle (antibiotic) time for neutropenic sepsis with early recognition and

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					treatment via PGDs, nurse practitioners and pathways.

73	British Infection Association	Infection control- including isolation unit and facilities availability	The 2014-2016 West Africa Ebola outbreak and subsequent spread to health care workers abroad demonstrated the major impact a lack of appropriate isolation facilities can have on a health service. Outbreak management is a key requirement for any health service to protect both staff and patients.	Protecting patients from communicable diseases and health-care associated infections is a key principle of health-care provision.	http://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf Improve Availability of appropriate isolation facilities for patients with communicable diseases. All attendees to emergency and acute medical departments assessed at triage for the possibility of a communicable disease and isolated appropriately. Where isolation not available review of side rooms to determine best use of side rooms. This document shows that improved cleaning, improved estates management and sufficient bed-space per patient are key interventions in reducing healthcare-acquired infections. https://www.nice.org.uk/guidance/ph36

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Early seeking of travel history to guide appropriate investigations as required.

74	Roche Diagnostics Ltd	NT-proBNP testing for patients presenting with symptoms of Heart failure (as per comments submitted for Emergency and acute medical care in over 16s: service delivery and organisation)	Readmission rates and mortality for patients presenting with heart failure are high. This poses a great burden for the NHS. NT-proBNP testing has not been widely adopted in the NHS however it has been recommended that all Clinical Commissioning Groups should adopt the test. In hospital, the adoption of the test could help to reduce the length of stay in Emergency departments and improve patient satisfaction.	For example, we know that readmissions rates and mortality in patients admitted for heart failure are high. The National Heart Failure Audit reported that 6.4% of patients who survived to discharge died within 30 days, one-year overall mortality was 29.6% and rates have remained unchanged for six years.1 Furthermore, as the median length of stay at readmission is the same as the index admission (8 days), this represents a particular burden to the health system 2. Patients admitted with Acute Decompensated Heart Failure (ADHF) are associated with even higher rates of mortality and frequent readmissions in the first six months after discharge.3 There is a large body of evidence that demonstrates that a lack of reduction in NT-proBNP during admission and higher absolute NT-proBNP levels at discharge significantly predict readmissions and mortality after discharge In ADHF patients.4-8	1. National Institute for Cardiovascular Outcomes Research. National Heart Failure Audit April 2014 - March 2015. July 2016 2. National Institute for Cardiovascular Outcomes Research. National Heart Failure Audit April 2013 - March 2014. October 2015 3. Stienen, S., Salah, K., Eurlings, L. W.M., Bettencourt, P., Pimenta, J. M., Metra, M., Bayes-Genis, A., Verdiani, V., Bettari, L., Lazzarini, V., Tijssen, J. P., Pinto, Y. M. and Kok, W. E.M. (2015), Challenging the two concepts in determining the appropriate pre-discharge N-terminal pro-brain natriuretic peptide treatment target in acute decompensated heart failure patients: absolute or relative discharge levels?. Eur J Heart Fail, 17: 936–944. 4. Bayes-Genis A, Lopez L, Zapico E, Cotes C, Santalo M, Ordonez-Llanos J, Cinca J. NT-ProBNP reduction percentage during

					admission for acutely decompensated heart failure predicts long-term cardiovascular mortality. J Card Fail 2005;11:S3–S8. 5. Bettencourt P, Azevedo A, Pimenta J, Frioes F, Ferreira S, Ferreira A. N-terminal-pro-brain natriuretic peptide predicts outcome after hospital discharge in heart failure patients. Circulation 2004;110:2168–2174. 6. 4 Kubler P, Jankowska EA, Majda J, Reczuch K, Banasiak W, Ponikowski P. Lack of decrease in plasma N-terminal pro-brain natriuretic peptide identifies acute heart failure patients with very poor outcome. Int J Cardiol 2008;129:373–378. 7. Michtalik HJ, Yeh HC, Campbell CY, Haq N, Park H, Clarke W, Brotman DJ. Acute changes in N-terminal pro-B-type natriuretic peptide during hospitalization and risk of readmission and mortality in patients with heart

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					failure. Am J Cardiol 2011;107:1191–1195 8. 6. McQuade CN, Mizus M, Wald JW, Goldberg L, Jessup M, Umscheid CA. Brain-Type Natriuretic Peptide and Amino-Terminal Pro–Brain-Type Natriuretic Peptide Discharge Thresholds for Acute Decompensated Heart Failure: A Systematic Review. Ann Intern Med. 2017;166:180–190. 9. All-party Parliamentary Group on Heart Disease. Focus on Heart Failure. September 2016.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
75	SCM1		CARE HOMES Care homes for the frail elderly should have arrangements in place for managing urgent medical problems that minimise disruption to the lives of the residents concerned, to the ambulance service and to hospital Emergency Departments. Commissioners of health and social care should work together to ensure that: 1. care homes have their own transport systems to bring residents to medical appointments including urgent ones at any time of day and night 2. Care homes have arrangements in place for stepping up the level of care provided for a resident on a temporary basis, so that residents do not generally require hospital admission for nursing only.	Currently, frail elderly people or people with dementia who move into a care home can expect that care to fail if they suffer a minor injury or if they become more than slightly unwell. In such circumstances, they will often find themselves transported by 999 ambulance to a busy Emergency Department where they may have to wait a long time for each aspect of care, in often uncomfortable and always unfamiliar circumstances. When they are finally discharged, their condition is often worse than on admission. The whole procedure results in discomfort and indignity to the care home resident and very significant expense to the most hard-pressed parts of the NHS.	There is probably a lot of evidence now available form NHS vanguards etc that was not around when the original guidance was being written.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
76	SCM1		FRAILTY Since the original guidance was written, much work has been done on the identification of frailty using various indices and the provision of treatments targeted at the frail. We now need to arrange Urgent, Emergency and acute medical services specifically tailored to the needs of the frail. A key concept here is “Diagnosis to determine if admission is needed” rather than “Admission to determine what the problem is”. This means that we need to commission enhanced diagnostic capability (expertise as well as technology): within care settings; shared between care settings; or mobile and available to care settings. Acute hospitals should also consider the provision of Acute Frailty Units alongside Acute Medical Units if local circumstances favour such arrangements.	As the population ages the number of people who are near to the end of their lives without a specific terminal condition increases. The condition of frailty is not new but the numbers are. These patients are identified partly by their poor functional capacity but also by their acceptance, and often wish, that they should be looked after with comfort, dignity and kindness whilst nature gradually accepts them back into its arms. The common presentations of Falls, Delirium and Sudden Immobility each need to have their causes evaluated without admitting the resident to hospital.	There should be plenty of evidence for frailty units now. I am not sure about mobile diagnostics.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
76	Society for Acute Medicine and Royal College of Physicians	Additional developmental areas of emergent practice – Ambulatory Emergency Care		The proportion of those patients referred to hospital for in patient treatment who are cared for by AEC (Ambulatory Emergency Care) should be >20%	See NHSI documentation/SAMBA audit/ECIST work
77	The Pituitary Foundation		Recognition of adrenal insufficiency and crisis by ALL health care professionals working in emergency and acute care. There is good evidence that timely diagnosis and emergency treatment prevents serious illness and death.	No protocol for Hospital emergency departments in dealing with adrenal crisis- experiences of patients vary greatly.	Please see the Society for Endocrinology Adrenal Crisis Information, which highlights the importance of initiating treatment without delay: https://www.endocrinology.org/adrenal-crisis
78	The Pituitary Foundation		It is vital not to confuse diabetes insipidus with diabetes mellitus.	Risk of severe harm or death when desmopressin is omitted or delayed in patients with cranial diabetes insipidus.	Please see NHS England's Patient Safety Alert (reference number: NHS/PSA/W/2016/001)
79	The Pituitary Foundation		Training need for all acute and emergency staff- to better understand diabetes insipidus, recognise it quickly and treat immediately	All acute and emergency staff should be aware of this as a serious condition. Variation in clinical practice currently.	The Pituitary Foundation knows of patients who have died due to being denied desmopressin in hospital, and many more who have become very unwell as a result of missed medication.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
80	SCM1	Additional developmental areas of emergent practice	The value of specific training and assessment in Urgent Care Medicine should be evaluated and recommendations made concerning the skills needed for the practice of Urgent Care Medicine	There are a number of Urgent Care Medicine courses available for doctors, nurse practitioners and physician associates. These clearly have much in common with one another, but there is no accepted curriculum or attainment standard nationally. Recently, the Royal College of Surgeons of Edinburgh have set up a Diploma examination in Urgent Care Medicine within their faculty of Pre-Hospital Care. This could form the benchmark for senior clinicians working in Urgent Care environments, but evaluation would be needed first.	
81	Royal College of Emergency Medicine		More accurate data collection		
82	Royal College of Emergency Medicine		Better computer systems - to help data collection and to save clinical time		
83	Royal College of Emergency Medicine		EDS not used for dental care		
84	SCM5		Are GP Services accessible to the public?	NHS Five Year Forward view identified 40% of people had access to GP Services.	NHS Five Year Forward View (2017)

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
85	SCM5	Additional developmental areas of emergent practice	Paramedic direct referral to Emergency Ambulatory Care	Local audit between East Kent Hospitals and South East Coast Ambulance Service piloted a Direct EAC referral pathway using 6 pathways. 93 referrals, 72 (77.4%) accepted and treated (2.7% admitted).	Poster presentation at Society of Acute Medicine (2017).
86	SCM5	Additional developmental areas of emergent practice	With the launch of Advanced Clinical Practice are we going to include this?	Changes in workforce has resulted in Advanced Clinical Practitioners working on middle grade rota's etc.	http://www.rcem.ac.uk/docs/Training/ACP%20Guide%20to%20the%20Emergency%20Care%20ACP%20Pilot%20Credentialing%20Project%20v2.pdf https://hee.nhs.uk/hee-your-area/thames-valley/our-work/attracting-developing-our-workforce/clinicial-academic-careers/advanced-clinical-practitioners
87	Royal College of Emergency Medicine		Flu vaccination for all staff		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
88	British Society of Interventional Radiology	24-7 access to interventional radiology services	There is good evidence that minimally interventional radiological procedures provide effective and safe outcome, especially in critically ill patients. Interventional radiological procedures such as Embolisation for GI bleeding, pulmonary haemorrhage as well as drainages of obstructed biliary and renal and abscess	The BSIR survey has shown improvement in number of centres providing onc all 24-7 interventional radiology services. However, there is still a wide variation of service provision and local support offered to interventional radiology workforce	24-7 access to interventional radiology services
89	NHS England (NCD in Acute Care)		Agreed IT protocols	The urgent and emergency care system is challenged by an inability to link patient episodes, and view a complete and contemporaneous healthcare record. This means that relevant information is not always available to the clinicians who treat patients in urgent and emergency care. Furthermore, we are unable to accurately track patients through the system, and therefore feedback on outcomes is not available to individual clinicians and those who commission and manage healthcare services. Significant quality gains could be achieved if all healthcare providers were required to collect the NHS number of all patients accessing their services, and share records in real time through agreed IT protocols.	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
90	Royal College of Anaesthetists	Identification and treatment of sepsis	Sepsis is commonly found in patients with surgical pathology. Regardless of admitting specialty, recognition and treatment needs to be carried out as soon as sepsis is suspected, and not left to the receiving specialty if a surgical diagnosis is considered.	Time from admission to administration of antibiotics has shown little improvement in NELA.	
91	Royal College of General Practitioners	First aid training as a compulsory school subject and an essential for employment with regular, free, refreshers	The likely availability of trained first aiders able to resuscitate, use a defibrillator, control haemorrhage, relieve pain and shock etc. and understand telephone instruction	Medical emergencies by definition are unexpected and can happen a long way from skilled medical assistance?	
92	Royal College of Nursing	Transition of care for young people entering Ed (16-18 years)	There is existing evidence surrounding areas of transition and care including previous evidence reviewed by NICE. However, the specific care surrounding transition through emergency and acute care would benefit from further review.	Differing specialities approach this area, mainly for long term conditions and minimal evidence has been reviewed surrounding the actual admission and use of the acute and emergency pathways. Potentials for development from existing evidence is present. Specific consideration of acute and Ed services potentially requires further development	Example: NICE QS140: Transition from children's to adults' services quality standard (2016) Quality standard for quality care. https://www.nice.org.uk/guidance/qs140

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
93	Royal College of Nursing	Work force development	A review of the evidence surrounding the work force tools for emergency care would provide a NICE stance of the evidence.	Facing the 'worst winter yet' Emergency Departments (ED) and acute services are struggling to develop a sound basis on which tool to adopt to review safe staffing levels. Recently published RCN Reports on safe staff levels also set out the challenges for the workforce.	NICE: SG1 Safe staffing for nursing in adult inpatient wards in acute hospitals https://www.nice.org.uk/guidance/sg1 RCN Report (2017): Safe and Effective Staffing: Nursing Against the Odds https://www.rcn.org.uk/professional-development/publications/pub-006415 RCN Report (2017): Safe and Effective Staffing: the Real Picture https://www.rcn.org.uk/professional-development/publications/pub-006195

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
94	Royal College of Nursing	Use of tourniquets in emergency care	With the emerging debates surrounding the use of tourniquets by emergency, first responders and even the public, it would be beneficial to have a review of this process and guidance and quality standard developed.	Specific consideration here should be that the public have now adopted, in light of the recent escalation in terror attacks, the use of the tourniquet. This requires some review of the evidence surrounding first responders.	Wooley T, Round J and Ingram M (2017) Global lessons: developing military trauma care and lessons for civilian practice BJA: British Journal of Anaesthesia, Volume 119, Issue suppl_1, 1 December 2017, Pages i135–i142, https://doi.org/10.1093/bja/aex382 https://academic.oup.com/bja/article/119/suppl_1/i135/4638478
95	Royal College of Nursing	Early utilisation of rehabilitation.	Existing work developed on rehabilitation through critical care and acute care should be further expanded to consider the implications of patients entering EDs and the potential of early action and adoption of rehabilitation principles.	Consideration has been seen for the journey through acute/critical/trauma services, but this has not been seen to consider the emergency admission process and the potential early enactment of these principles mirroring the military models of care which optimise rehabilitation. The NICE CG83 guidance addresses the principles of post critical illness but not early adoption and transition pathways to optimise rehabilitation	Example of existing NICE documentation: NICE CG83: Rehabilitation after critical illness in adults https://www.nice.org.uk/guidance/cg83

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
96	Royal College of Nursing	Carbon monoxide poisoning identification and care pathways	There is existing evidence and work being undertaken on the recognition and treatment of carbon monoxide poisoning in ED. Further NICE review and guidance would link into this and support the further development of the work.	Carbon monoxide poisoning (CMP) has been considered throughout all aspects of health care. However, in acute and emergency care, recognition and treatment is time critical and requires further recognition and development. Evidence of patients suffering with CMP requires further statements to support the development of standardised national care.	Policy connect development of recommendations introducing 26 points for further work. http://www.policyconnect.org.uk/appcog/home
97	Royal College of Physicians of Edinburgh	Clear definition of facilities and signposting for patients	Fellows have been advised by patients that the facilities in emergency in acute and emergency care are difficult to navigate and understand. They have been described as “alphabet soup” with options for patients to attend urgent care for assessment in, for example, UCC, MIU, WIC, CDU, AEC, ED, GP…	This is a key area for improvement as the current situation is confusing for patients and leads to delays in patients attending the correct facilities	
98	Society for Acute Medicine and Royal College of Physicians	Time to first NEWS score	The sooner the patient is assessed in a standardised manner is crucial for identifying those in need of immediate care	As per SAM QI – People presenting with an acute medical emergency should have an early warning score (EWS) measured within 30 minutes of arrival to hospital and also after transfer to the AMU	See SAMBA audits Society and data from Sepsis /COPD studies/audits (eg RCP/BTS COPD, NCEPOD NIV, Sepsis guidelines)

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
99	The Pituitary Foundation		Training need for all acute and emergency staff- to better understand adrenal insufficiency and crisis, recognise it quickly and treat immediately.	Variations in clinical practice currently. Risk of severe harm or death when hydrocortisone is omitted or delayed in patients with primary or secondary adrenal insufficiency.	

100	The Society and College of Radiographers	33 Integrated patient information systems Research recommendations: RR14. What is the clinical and cost effectiveness of different methods for integrating patient information throughout the emergency medical care pathway?	The Society and College of Radiographers commend this recommendation for research and highlight that Radiology Information Systems (RIS) and Picture Archiving Communication Systems (PACS) are available in UK clinical imaging and therapeutic radiography departments. The systems provide timely information with regards to screening, diagnosis and therapeutic procedures. Integration across primary and secondary care is not widespread and we urge research teams to include the review of clinical imaging systems in any proposed research. For patients needing acute care, time is often critically linked to patient outcome and the Royal College of Radiologists have published standards for the communication of critical urgent and unexpected significant radiological findings.https://www.rcr.ac.uk/sites/default/files/docs/radiology/pdf/BFCR%2812%2911_urgent.pdf. The Society and College of Radiographers recognises the	The Society and College of Radiographers supports the need for better integration of patient information in particular about image sharing and report availability. https://www.england.nhs.uk/wp-content/uploads/2016/12/information-sharing-policy-v2-1.pdf	Image sharing between centres may have more of an impact on patient outcome when the emergency or acute medical episode occurs in remote geographical locations. http://www.sciencedirect.com/science/article/pii/S0168851016301270

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			need to implement measures to facilitate urgent reporting.		
101	SCM1		URGENT CARE In the absence of clear evidence favouring any particular configuration of services, local solutions should be commissioned from a combination of primary care, secondary care and novel sources to provide 24/7 availability of advanced modern Urgent Care with both booked appointments and walk-in access (irrespective of presenting complaint). This could, for example, be obtained by extending GP out-of-hours services to 24 hours and adding access to diagnostics, minor injury treatment and selected areas of specialist care. Whatever the particular arrangement, it could be provided from some combination of units close to hospital Emergency Departments and some free-standing units, depending on local geography.	Patients presenting to Emergency Departments with lower acuity problems frequently cite a number of reasons for their attendance there: · Unavailability of convenient GP access. · Belief that hospital diagnostics will be needed. · Think they might be sent there anyway. · Thought problem was worse than it turned out to be. A modern Urgent Care Unit with diagnostics and appropriate staff, and lights on all the time will satisfy this need. Although clearly there are a number of ways to achieve this. N.b. Most UK “Urgent Care Centres” do not come close to satisfying these criteria, which is why UK data is sparse.	Urgent care centres of one sort or another exist in many countries from developing world to the USA. For evidence to be applicable to the UK we need to look to a modern developed country with a largely government funded health service and a similar division between primary and secondary care. The presence of an established network of advanced urgent care centres in Jerusalem (see www.terem.com) is associated with a 30% lower Emergency Department attendance rate than in other cities in Israel. See also: http://bit.ly/2zUgJPu

102	SCMS3	Time to the performance of an early warning score (EWS) on arrival to hospital and transfer to the AMU and the EWS must be linked to an escalation protocol.	All patients admitted to the AMU should have an early warning score measured within 15 minutes of arrival on the AMU. Early warning scores identify patients who have abnormalities in their physiological parameters. The Royal College of Physicians' Acute Medicine Task Force, recommends that the national EWS (NEWS) should be used when patients present acutely to hospital and also in the prehospital assessment i.e. by primary care and the ambulance services.	Acutely ill adults in hospital: recognising and responding to deterioration CG50 July 2007. Adult patients in acute hospital settings, including patients in the emergency department for whom a clinical decision to admit has been made, should have physiological observations recorded at the time of their admission or initial assessment. A graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered local. https://www.nice.org.uk/guidance/cg50/chapter/1-Guidance#physiological-observations-in-acute-hospital-settings This is supported by the Society for Acute Medicine – Clinical Quality Indicators and Quality Standards http://www.acutemedicine.org.uk/resources/quality-standards/	Sepsis: recognition, diagnosis and early management NG51 July 2016. This guidance should be used together with the algorithms organised by age group and treatment location and the risk stratification tools. The risk stratification tools are based on physiological parameters from the EWS. https://www.nice.org.uk/guidance/cg50 Early warning systems when combined with rapid response appear to have the potential to reduce cardiac arrests and unplanned ICU admissions. Impact on reducing in-hospital mortality is mixed. McGaughey J, Alderdice F, Fowler R, Kapila A, Mayhew A, Moutray M. Outreach and Early Warning Systems (EWS) for the prevention of Intensive Care admission and death of critically ill adult patients on general hospital wards. Cochrane

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					Database of Systematic Reviews 2007, Issue 3. Art. No.: CD005529. DOI: 10.1002/14651858.CD005529.pub2. McNeill G, Bryden D. Do either early warning systems or emergency response teams improve hospital patient survival? A systematic review. Resuscitation 2013; 84(12): 1652-1667. Alam N, Hobbelink EL, van Tienhoven AJ, et al. The impact of the use of the Early Warning Score (EWS) on patient outcomes: a systematic review. Resuscitation 2014; 85(5): 587-594.

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
103	SCMS3	1. Time to having a discussion regarding DNAR or having a ReSPECT form completed.			Resuscitation Council - ReSPECT https://www.resus.org.uk/respect/ ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment.

104	MENCAP	Ability of emergency and acute care services to make adjustments to care, in a timely manner, in order to meet the needs of patients with a learning disability.	CIPOLD recommends that two of the main steps to ensuring people with a learning disability do not cotinine to experience such high levels of health inequality are to: -Recognise where health care interventions and diagnostic procedures need to be delivered differently to meet the needs of patients. -Share best practice across the health service. The ability to make reasonable adjustments requires both change in practice from individual members of staff but also change at a systematic level, within departments, trust and the health service in general is vital to allow adjustments to occur. Staff, both clinical and non-clinical need the knowledge to be able to make adjustments to services. Acute services often do not have the ability to plan for a patient's care. They must be able to work with the patient and their supporters, use any resources the patient may have, for example a	At Mencap we continue to see through our engagement, helpline and case work many examples of where reasonable adjustments are not being made and people with a learning disability are not able to access the healthcare they need. Learning disability awareness training, including reasonable adjustments, is very limited. This is essential for any staff coming into contact with patients with a learning disability. Some hospital trusts provide specialist learning disability support by employing a learning disability liaison nurse. However, even in these cases, one or two members of staff are not able to be on site 24 hours a day. This means emergency and acute patients with a learning disability can easily miss out on the support they need to access healthcare. There is, however, some excellent practice dotted around the country, including schemes to ensure that patients readmitted in an emergency go to a ward they are familiar with and special anaesthetic lists for patients who require sedation for general medical procedures/examinations. There is also evidence of very poor practice. Practice differs vastly across trusts and wards within trusts and there does not seem	Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD) (2013) http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			hospital passport and access specialist help if necessary.	to be an effective mechanism to share it at present.	
105	MENCAP	Widespread understanding of the Mental Capacity Act across NHS Emergency and Acute care systems and the ability to put the key principles into practice.	CIPOLD recommendation 12 is that all staff in health and social care receive mandatory training and updates on the Mental Capacity Act.	Mencap continue to see cases where the Mental Capacity Act has not been followed, leading to such issues as the inappropriate issue of Do Not Resuscitate Orders, as flagged by CIPOLD, 4 years ago. One of the fundamental principles of the act is to support individuals to understand information to make their own decisions, however we know that the Accessible Information is still far behind being standard across all services. More training and resources are needed to enable staff to communicate with, and support, people with a learning disability with making decisions.	Confidential Inquiry into the Premature Deaths of People with Learning Disabilities (CIPOLD) (2013) http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
106	The Society and College of Radiographers	Chapter one guideline introduction: Lines 23&24 RR12. What is the optimal configuration in terms of clinical and cost effectiveness of hospital diagnostic radiology services to support 7-day care of people presenting with medical emergencies?	The Society and College of Radiographers recognises the importance of cost effective, efficient and safe quality services. Further research is required to produce a comprehensive evidence-base. The effect of structured handover is likely to vary with different diagnostic imaging pathways. However, the impact to patient care and outcome may vary from minor harm to potentially severe unintended harm due to inaccurate or ineffective handover.	The Society and College of Radiographers would welcome the impact of handover from ward/ICU/ED/AMU based care to diagnostic radiology included in the study.	Example of work in this area https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr1514_seven-day_acute.pdf https://www.hislac.org/images/docs/policy-library/Implementing%207%20day%20working%20in%20imaging%20department.pdf http://www.scin.scot.nhs.uk/wp-content/uploads/sites/3/2015/04/2015-10-28-Recommendations-on-the-Implementation-of-Seven-Day-Working-in-Imaging-in-Scotland-V1.pdf

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
107	SCM5		7 day essential radiology – does it improve patient flow, experience and safety?	Is the service available 24/7.	NHS England. NHS Services, Seven Days a Week Forum, 2013. https://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf

108	The Society and College of Radiographers	Chapter one guideline introduction: Line 8&9 RR5. What is the clinical and cost effectiveness of providing GPs with access to plain-film radiology or ultrasound with same-day results?	The Society and College of Radiographers welcome this recommendation for further research and would like to signpost the committee toward current studies which evaluate the role of advanced practitioner and consultant reporting radiographers in providing same-day results (hot reports). Emergency Department services are under pressure from patients who could perhaps attend a GP service. The Society and College of Radiographers supports research into the effectiveness of better direct access to G.P's supported by the availability of rapid radiology and ultrasound results which may be potentially lifesaving. https://publications.parliament.uk/pa/cm201617/cmselect/cmhealth/277/277.pdf	The Society and College of Radiographers welcomes the inclusion of reporting radiographers in some areas to achieve this and also suggests the consideration of including CT Head examinations into this study. Whilst we acknowledge the groups' decision that more invasive radiological investigations (such as CTPA) would not be included within the research recommendation as such patients would likely need specialist review and expert interpretation of results we do not agree that this is the case for CT Head investigations due to the availability of expert CT Head reporting radiographers.	Please see document AHPs into action for evidence and case studies describing various roles, clinical and cost effectiveness of Advanced Practitioner and Consultant Allied Health Professionals including Radiographers https://www.england.nhs.uk/ourwork/qual-clin-lead/ahp/ The Society and College of Radiographers is interested to see whether the evidence supports the comment made by the committee: "The committee noted that there were likely to be logistical and staffing difficulties in the provision of same day plain film radiology and ultrasound results" as we would argue that these are results that would have been generated anyway via existing pathways rather than additional results. Therefore, it may be that service re-design is

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					required rather than additional resources.
109	British Infection Association	Antimicrobial stewardship	Antimicrobial resistance has been identified as a major threat by the World Health Organisation due to the lack of new antibiotics in the development pipeline and infections caused by multi-drug resistant pathogens becoming untreatable [Goossens et al., 2011; Carlet et al., 2011].	Cautious use of our limited available antibiotics is critical now to prevent further loss of effective antibiotics in the future.	Prescribing needs to occur in accordance with with local guidance wherever possible, with consideration of previous microbiological results guiding initial antimicrobial prescribing choices. Review of antimicrobial therapy within 72 hrs of initial prescription, with consideration of microbiology results needs to occur. To reduce line-associated infections then IV to oral switch policy should occur in a timely and appropriate manner. https://www.gov.uk/government/publications/uk-5-year-antimicrobial-resistance-strategy-2013-to-2018

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
110	NHS England (NCD in Acute Care)		System-wide outcome measures launch	Finally, NICE may wish to consider the system-wide outcome measures that will be launched by NHS England in Spring 2018. These aim to measure the outcome for patients who contact any element of the urgent and emergency care system, and also take account of patient and staff experience. These measures include the case fatality rates for serious emergency conditions, and discharge to normal place of residence, for example. In my view it would be helpful to emphasise the value of patient and staff experience, which have the potential to signal problems with the quality of care at an early stage.	
111	Royal College of General Practitioners	The epidemiology of acute care i.e. time, place, person, morbidity, mortality, effectiveness of interventions, cost, prevention	Best use of resources-skills, training, equipment, best practice	Resource implication and audit	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
112	Royal College of Anaesthetists	Additional developmental areas of emergent practice	We would draw your attention to a recent RCR audit which found higher levels of discrepancy for outsourced reporting.	Additional data from ~25000 patients will be available from NELA when this is analysed in the coming months.	The accuracy of interpretation of emergency abdominal CT in adult patients who present with non-traumatic abdominal pain: results of a UK national audit D.C. Howlett, K. Drinkwater, C. Frost, A. Higginson, C. Ball, G. Maskell http://dx.doi.org/10.1016/j.crad.2016.10.008
113	Royal College of Paediatrics and Child Health	Additional developmental areas of emergent practice	Please will you consider the standards within the revised and updated (due to be published in early 2018) standards for children in emergency care standards. The RCPCH will be sending them out to consultation shortly and hopefully will have a final version in early 2018 which I will be happy to share to ensure alignment with NICE standards development.		
114	Resuscitation Council		We have no specific recommendations at this stage with regard to key area prioritisation.		

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
115	British Association of Critical Nurses (BACCN)	Access to 7 day a week GP services. With consideration of 24 / 7 GP access. This should be in community settings to separate it clearly from hospitals settings.	For many people they attend a hospital seeking medical care as they cannot access a GP	Patients will see the right healthcare professional at the right time and then if needed GP can escalate patients to hospital	