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stakeholder organisation	Page Number	paragraph number	Section	Comments Please insert each new comment in a new row	Response - Please respond to each comment
Cambridge University Hospitals NHS Foundation Trust	3	16	The guideline	Point 16 – I would add:- • Model of care – e.g. one front door as opposed to units having MAU's etc • Capacity constraints of organisation	Thank you. We consider these points to be addressed by environmental and organisational factors.
Cambridge University Hospitals NHS Foundation Trust	5	24	box 1	patient factors – I would add :- • Patients requiring specialling • section 136 patients	Thank you. We consider that these concepts are covered by patient dependency and risk factors already included.
Cambridge University Hospitals NHS Foundation Trust	5	24	box 1	department management factors – I would add :- • Data collection requirement • Clinical management of the 4hr standard	Thank you. We consider that these are covered by management structures and approaches and nursing team management, administration approaches and non-clinical arrangements.
Cambridge University Hospitals NHS Foundation Trust	7	25	box 2	other – I would add :- • Re-attendance rate	Thank you. Other outcomes were considered but it was agreed to include only nurse staffing related outcomes at this stage. This list is not definitive and other outcomes may be identified from the evidence review.
Cambridge University Hospitals NHS Foundation Trust	General	General	general	Overall a comprehensive first approach to providing some guidance on safe staffing levels within EDs	Thank you.

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Cambridge University Hospitals NHS Foundation Trust	General	General	general	• 2 final points would be:- • We should not be using the terminology Accident and Emergency – it should be Emergency Department • I could see no mention of recognising professional judgement throughout the document	Thank you for your comment. We have now clarified the settings according to the definitions used for the national clinical quality indicators for A&E. We acknowledge that the terms A&E and ED are used interchangeably and have explicitly stated this in the scope. The Advisory Committee will be considering evidence to inform their recommendations alongside their own professional judgement and that of the Specialist Committee Members. Please note that NICE guidelines do not replace professional judgement.
Chartered Society of Physiotherapy	2	7	Background	The text of the scoping document appears to use 'safe' and 'safe and effective' nurse staffing levels interchangeably, without apparently acknowledging the different meaning of these phrases. It is not clear whether the different usage in different paragraphs is intentional, or whether the intended focus of the planned guideline is defined. (We have made equivalent comments in our response to the NICE draft guideline relating to nurse staffing levels within adult acute in-patient wards.)	Thank you. The NICE team have reviewed this and have updated the scope so that it more accurately and consistently reflects the focus on 'safe staffing'.

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Chartered Society of Physiotherapy	3	16	The guideline	4th bullet point - We are unclear as to the intended meaning of this bullet point, and how the role and contributions of other members of multi-disciplinary teams within A&E services are due to be considered within the scope of the planned guideline. While we understand the planned focus is on nursing staff, it is limiting and partial only to consider patient care from this perspective. The risk is that misplaced assumptions will be made about how the safety and quality of patients' experience and outcomes can best be met; i.e. that this is through addressing nurse staffing levels, when a greater impact for patients may be achieved through looking at all staffing and other factors. These could usefully include considering the wider delivery of services, interventions and public health/patient care messages that could avoid individuals presenting in A&E settings.	Thank you. We recognise the interdependencies of all staff working in A&E but will focus the guideline on core nursing staff to ensure a consistent approach and practical recommendations to support improvement in this area. We have included a review question to take account of the availability of other staff impacting on nursing staff requirements. Wider issues and public health interventions and messages are outside the remit of this guideline and would be best addressed elsewhere.
Chartered Society of Physiotherapy	5	24	Box 1	1st bullet point - We are unsure as to the rationale for the focus on 'minimum' staffing levels and how this fits with the intended focus on 'safe' or 'safe and effective' nurse staffing levels. It is also unclear from the phrasing of the question as to the intended parameters of the question. It seems essential that these are defined, given the multitude of factors (patient needs, environmental and staffing issues) that have a significant impact on how 'minimum' could meaningfully be defined.	Thank you. The review question is included to ensure that all relevant evidence is taken into account, although the intention of the guideline is not to recommend a single ratio for nursing staff to patients. The wording of the review question has been amended to aid clarity.
Chartered Society of Physiotherapy	5	24	Box 1	bullet points 5, 6 & 7 - It would be helpful for the bullet points to include a more explicit emphasis on issues relating to service evaluation and improvement initiatives, including in relation to clinical leadership, engagement in research-related activity, and individual and team professional development activity. Each of these factors is key to ensuring that safe, high-quality and compassionate care is delivered to patients.	Thank you. It is anticipated that these factors will be taken account of in the evidence review and the discussions of the Advisory Committee.

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Chartered Society of Physiotherapy	7	25	Box 2	It is not clear how the title of this box – 'Outcomes of interest' – relates to its content. Almost all that is listed relates to issues of input and process, and not to outcomes relating to quality of patients' experience or outcomes of care.	Thank you. Outcomes have been identified that are specifically related to nurse staffing, rather than outcomes in general. Outcomes related to patient experience have been included in the 'reported feedback' section. It is not however a definitive list and other outcomes may be identified from the evidence review.
Children's Network, Greater Manchester, Lancs & Cumbria Clinical Network	1	6	Background	2nd bullet point - Including in this should be; 'and trend analysis of presentation to A&E' (which is weighted by afternoon and evening clinical presentations) Disproportionally more nursing staff need to work on the 'late shift' mid-afternoon to early evening to cover this peak activity	Thank you. Temporal variations in A&E attendance that affect patient case mix and volume and therefore impact on staffing requirements will be explored as part of the evidence review.
Children's Network, Greater Manchester, Lancs & Cumbria Clinical Network	1	6	Background	2nd bullet point - Changing case mix, including massive rise in children attending A&E	Thank you.

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Children's Network, Greater Manchester, Lancs & Cumbria Clinical Network	1	6	Background	additional bullet points:- • Increase in technology in general working of A&E and impact on nursing staff • Increase in technology dependent therapy for patient in A&E	Thank you. We have now included the increasing use of technology as an additional bullet in this section.
Children's Network, Greater Manchester, Lancs & Cumbria Clinical Network	5	24	Box 1	3rd bullet point: - Professionals education and skilled to care for Babies, Children and young people	Thank you. We consider that this is covered by 'nursing experience, skill mix and specialisms'.
Children's Network, Greater Manchester, Lancs & Cumbria Clinical Network	7	25	Box 2	Serious preventable outcomes:- • Failure to recognise sick child • Failure to recognise the seriousness of injury on the child 'Why Children die' lessons learned from research DH Tarnlet report 'Major Trauma and Children presenting to A&E 2013	Thank you. It is considered that failure to recognise the sick child or the seriousness of injury on the child would be categorised as a serious preventable event and therefore implicitly included.
Department of Health	General	General	general	Thank you for the opportunity to comment on the draft scope for the above clinical guideline. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.	Thank you.

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Guild of Healthcare Pharmacists	3	16	The guideline	We feel that nurses who work in the Emergency Departments (ED) need direct advice, support and input from clinical pharmacists who are directly involved in patient care and work alongside them in the ED i.e. in addition to the dispensary / medicines information / supply roles. The activities include: • Support in writing / reviewing / using Patient Group Directions • Training and support as new prescribers • Medicines administration queries e.g. Intravenous drug compatibilities • Support in medicines use as they develop advanced nurse practitioner roles • Review of medication incidents The following reference provides useful information regarding the role of the clinical pharmacist: Medical and nursing staff highly value clinical pharmacists in the emergency department; Rollin J Fairbanks, James M Hildebrand, Karen E Kolstee, Sandra M Schneider and Manish N Shah; Emerg. Med. J. 2007;24;716-718 Abstract Despite the potential impact that emergency pharmacist (EPh) programmes could have on medication safety and quality of care in the emergency department (ED), very few programmes exist. This descriptive survey study aimed to assess staff perceptions of an EPh programme. A random sample of medical and nursing staff in an academic medical centre ED with a dedicated EPh programme received a 26-item survey (82% return rate). 99% of respondents felt the EPh improves quality of care, 96% feel they are an integral part of the team, and 93% had consulted the EPh at least a few times during their last five shifts. Staff felt that the EPh should be available for consults, attend resuscitations, and check orders. This study reinforced the value of many specific duties of the EPh programme and found that doctors and nurses overwhelmingly favour the presence of an EPh in the ED frequently seek their advice, and feel they improve quality of care. Staff acceptance is clearly not a barrier to implementation of this programme.	Thank you. We recognise the role of pharmacists and other members of the multidisciplinary team working in A&E and their importance in terms of staffing issues in general. This is a staffing factor that will be considered in the evidence review. We will share this reference with the contractors undertaking the evidence review for their consideration.

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Guild of Healthcare Pharmacists	4	24	Box 1	In relation to' Division of activities and tasks between registered nurses, healthcare assistants, specialist nurses and other staff who are part of the A&E team, and Availability of and care provided by other healthcare staff (e.g. emergency medicine consultants, anaesthetists and psychiatry)' we wish to point out that hospital pharmacists in the West Midlands are being specially trained as independent prescribers so that they can manage patients in Emergency Departments. Funding for 70 training places has been secured from Higher Education West Midlands so that pharmacists can be used as frontline clinicians. As a result of shortages of doctors and nurses Birmingham Children's Hospital pharmacists are being asked to take a more hands on role with patients. The hospital is in phase 2 of a study on the initiative and initial results showed that pharmacists could deal with up to 60 per cent of patients who attend accident and emergency. Community pharmacists may also be included in the training, so that they, too, can be brought into Accident and Emergency Departments. The full report on this initiative is available in the PJ Online (part of Pharmaceutical Press, the publishing division of the Royal Pharmaceutical Society), 28th March 2014. We feel that this role of the pharmacist in Emergency Departments would have a significant impact on the 'availability and care provided by other healthcare professionals.' Contact details for the programme have been provided to the safe staffing team	Thank you. We recognise the role of pharmacists and other members of the multidisciplinary team working in A&E and their importance in terms of staffing issues in general. The availability of other healthcare staff and its impact on nurse staffing is included as a factor in the evidence review questions. We will share this reference with the contractors undertaking the evidence review for their consideration.

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Guild of Healthcare Pharmacists	7	25	Box 2	outcomes of interest - In relation to 'Serious, largely preventable safety incidents (also known as 'Never events'), including maladministration of potassium-containing solutions, wrong route administration of oral/enteral treatment, maladministration of insulin, opioid overdose of an opioid-naïve patient, and Serious untoward incidents' as above, clinical pharmacists working alongside nurses in Emergency Departments could provide advice and support in all of these aspects and therefore result in positive reductions of serious preventable events.	Thank you. We recognise the role of pharmacists and other members of the multidisciplinary team working in A&E and their importance in reducing serious preventable events.

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Guild of Healthcare Pharmacists	7	25	box 2	delivery of nursing care - Clinical pharmacists working alongside nurses in Emergency Departments could provide advice and support to prevent drug omissions and errors, review medication that cause patient falls and produce risk assessment tools to prevent falls, and assist in the development of clinical guidelines that cover time to analgesia, fluids and IV antibiotics, and help with their correct implementation. Although a local presentation is currently only available, we have some evidence from Aintree that a clinical pharmacist in a ED reduces time to prescribing and missed doses of critical medicines (i.e. medicines where delays or omissions can cause serious harm or death). Other examples include: 1. Medication supply for specific patients with specifically unusual /complex needs - A personal example involving medication supply of icatibant for ACE induced angioedema / C1 esterase inhibitor. Nurses contact for advice/support. 2. Finance monitoring (though not specifically nurses) (Contact details provided to the safe staffing team) Plus the following abstracts: Pharmacy services to UK Emergency Departments: a descriptive study Ursula Collignon • C. Alice Oborne • Andrzej Kostrzewski_ Springer Science+Business Media B.V. 2009 Abstract: Pharmacy services have developed to support service provision in EDs with similar roles to in-patient pharmacists. Pharmacy services in some EDs are now extensive with funded, full-time pharmacy posts but pharmacy service review is required to optimise ED patient care where there is limited or no current pharmacy input. New pharmacy services must fit with local ED service models and skill mix. Evaluation of these new services is vital to maximise benefit to patients and the NHS. Pharmacist- versus physician-acquired medication history: a prospective study	Thank you. We recognise the role of pharmacists and other members of the multidisciplinary team working in A&E. The NICE team have carefully considered the consultation comments received in relation to which staff groups should be covered by the guideline and the majority consensus is that the guideline should focus on core nursing staff only. Other staff are included on different establishments and are rostered separately. Whilst we recognise the interdependencies of all staff working in A&E, multidisciplinary working is not approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups. We have however included a review question to take account of the availability of other staff groups impacting on nursing staff requirements. We will share this reference with the contractors undertaking the evidence review for their consideration.

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				at the emergency department. Citation: Quality & Safety in Health Care, October 2010, vol./is. 19/5(371-5), 1475-3898;1475-3901 (2010 Oct) Author(s): De Winter S; Spriet I; Indevuyst C; Vanbrabant P; Desruelles D; Sabbe M; Gillet JB; Wilmer A; Willems L Abstract: Recent literature revealed that medication histories obtained by physicians and nurses are often incomplete. However, the number of patients included was often low. Study objective: In this study, the authors compare medication histories obtained in the Emergency Department (ED) by pharmacists versus physicians and identify characteristics contributing to discrepancies. This large prospective study demonstrates that medication history acquisition is very often incomplete in the ED. A structured form and a standardised method is necessary. Pharmacists are especially suited to acquire and supervise accurate medication histories, as they are educated and familiar with commonly used drugs.	

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Health Education England	1	2	Background	The scope of the guideline is nursing but within the A&E setting the nurse staffing requirements are impacted by the wider inter-professional team. HEE would welcome the scope of this guideline being extended to include medical staff, pharmacists, AHPs, paramedics, Physician Assistants. Advanced Clinical Practitioners and others.	Thank you. The NICE team have carefully considered this issue in light of the consultation comments received, and the majority consensus is that the guideline should focus on core nursing staff only. Other staff are included on different establishments and are rostered separately. Whilst we recognise the interdependencies of all staff working in A&E, multidisciplinary working is not approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups. We have however included a review question to take account of the availability of other staff groups impacting on nursing staff requirements. Please see the notes of the scoping engagement workshop for further detail of the discussion around this issue.

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Health Education England	2	6	Background	Other reasons include: The impact of shortages in other professional groups for example Emergency Medicine Physicians and the increased opportunities for nurse / AHP led work Service reconfigurations and changes in access to specialist services (centralisation of services) will have implications for attendances which will increase in specialist centres and reduce in DGHs 4th bullet – caution when interpreting variation in attendances per whole time equivalent nurse as the case mix will vary between A&E depts. (some hospitals will be regional centres for trauma, burns, neurosciences etc whilst others will be limited to district general services). This will also be influenced by potential for differences in nursing roles in different A&E depts for example nurses may take on work usually undertaken by medical staff in some A&E depts particularly where there are challenges recruiting medical staff 5th bullet suggest amending this to 'increasing A&E waiting times'	Thank you. These additional suggestions have been considered and this section updated accordingly. Service reconfiguration is referred to, although the list of reasons for review is not intended to be exhaustive. The guideline will primarily be focussed on core nursing staff, but the impact of availability of and care provided by other healthcare staff will be reviewed in the evidence, recognising the interdependencies of staff groupings (box 1).
Health Education England	2	13	The guideline	Suggest using terms Registered and Non Registered Nurses. Assistant / Associate Practitioners should also be included. Paediatric and Mental Health nurses within A&E teams will not always be employed as specialist nurses instead these may be Registered Nurses at staff nurse level with specialist skills. The guidance provides an opportunity to ensure that the range of skills is provided in A&E departments to meet the breadth of patient needs particularly those relating to mental health, older adults and learning disabilities.	Thank you. We have tried to broadly include the core nursing staff, and it is anticipated that the subtleties of distinction will be picked up during Advisory Committee discussions. We have however amended the wording in this section to aid clarity.
Health Education England	3	14	The guideline	Will the guidance cover nurse led minor injury units? Some of these are stand alone units and not part of an A&E dept for example in a community setting. How will this be considered in the guidance?	Thank you for your comment. We have now clarified the settings according to the definitions used for the national clinical quality indicators for A&E. Minor injury units, as type 3 units, will

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					therefore be excluded.
Health Education England	3	16	The guideline	Suggest also including: - safeguarding role of nurses - impact of paramedics on admissions / stability of patient's condition - impact of admission avoidance schemes - escort duties for example RNs will be required to escort patients to radiology, theatres, wards / departments and other hospitals - non-direct patient care nursing needs for example communications with other professions / family for example discharge planning - extent of independent nurse prescribing - dealing with sudden deaths -impact of impending nursing re-validation	Thank you. Box 1 contains more detail on all factors that will be considered as part of the evidence review.
Health Education England	3	19	The guideline	Although these departments are not considered in the guideline their impact on the A&E attendances and case mix needs to be taken into account. This also relates to comment 2 above (pg 2 line 6).	Thank you. We recognise the interdependencies of different service availability impacting on A&E attendance. Patient case mix and volume has been included as a patient factor that impacts on nursing staff requirements. It will be considered as part of the evidence review.

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Health Education England	5	24	box 1	Bullet 1 – not clear why the question 'is there evidence that demonstrates a minimum staffing threshold for safe nursing care?' is included when NICE has previously been clear that it will not be setting minimum staffing levels Bullet 2 suggest including presenting condition Bullet 3 – include travel times related to escort duties within and outwith hospital Bullet 5 - availability of other professional groups in the A&E department will also impact upon the number and skill set of Registered Nurses for example high medical vacancies may require greater levels of nursing substitution Bullet 6 – consider also impact of supervisory status of lead sister / charge nurse and impact of nursing revalidation Attendance at mandatory training and continuing professional development should also be included	Thank you. The review question is included to ensure that all relevant evidence is taken into account, although the intention of the guideline is not to recommend a single ratio for nursing staff to patients. The wording of the review question has been amended to aid clarity. We consider the additional points suggested to be covered in this section.
Health Education England	7	25	box 2	Delivery of nursing care should include - - assessment of care needs, monitoring and record keeping - safeguarding duties - resuscitation - sudden death	Thank you. This has been considered and the outcomes list amended accordingly.
Health Education England	7	25	box 2	Other – Consider: - appropriateness of attendances / admissions - impact of local events for example high profile sporting events / music festivals – potential for increased admissions during these periods and staffing will need to be increased in response - include staff turnover rates	Thank you. We believe that these aspects are related to A&E attendance patterns which impact on nursing staff requirements. We have included reference to seasonal variation and trends in attendance (such as local and national events). We consider that staff turnover rates may be covered by the inclusion of 'nursing vacancy rates'.

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Health Education England	8	28	Related NICE guidelines	Are there any NICE guidelines relating to mental health or maternity care that could also have implications for A&E staffing	It is noted that many published guidelines will be related to this guideline as it 'cross-cuts' many aspects of care delivery. The wording in this section has therefore been amended to reflect this.
Healthwatch Enfield	General	General	general	The paper presents relevant factors for consideration of staffing levels for the Board, however the paper may fail to miss the input of other members of the multi disciplinary team e.g. family liaison and chaperoning of patients may be done by others. There is a danger that by focussing only on individual professions that other members of the MDT will be compromised and innovations around skill mix stalled.	Thank you for your comment. The NICE team have carefully considered the consultation comments received in relation to this issue and the majority consensus is that the guideline should focus on core nursing staff only. Other staff are included on different establishments and are rostered separately. Whilst we recognise the interdependencies of all staff working in A&E, multidisciplinary working is not approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all staff groups. We have however included a review question to take account of the availability of other staff groups impacting on nursing staff requirements. The evidence review will also examine any evidence found in relation to skill mix factors and their effect on nursing staff requirements.

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Hearing Link	2	15	The guideline	In order to fully meet the needs of patients with sensory loss, effective nursing team staffing requirements include appropriate provision of staff able to meet their communications needs. This includes deaf awareness training and regular updates for staff.	Thank you for your comment. The need for staff training on various aspects of care will be included as part of the considerations of the Advisory Committee in developing the guideline.
Hearing Link	5	24	Box 1	Patient and environmental factors needs to be considered for those with hearing loss.	Thank you. We consider sensory impairment to be covered by patient dependency.
Hearing Link	7	25	Box 2	Delivery of nursing care should also include addressing the needs of patients with sensory loss.	Thank you. We have included addressing the needs of patients with disabilities in the list of outcomes.
North Tees and Hartlepool NHS Foundation Trust	General	General	General	From looking at the scoping guideline there seems little discussion in regard to continuous development of nursing staff. Historically little time has been given to regular nurse training and in particular inter professional training once qualified especially in the pressured environment of the Emergency Department. Given the nature of A&E a wide variety of cases arrive some of which require immediate action it is therefore essential that all staff are up to speed not only with knowledge and skills but also working together as a team. In any discussion of safe staffing levels account must be taken of the need for training beyond that of mandatory training to ensure that patients remain safe and staff do not suffer undue stress. Once the basics have been learnt this should be in the form of regular interprofessional simulation type training within the working environment where staff can be safely challenged not to simply produce competent care but to develop true expertise this only comes with Deliberate Practice. Human Factors issues related to patient care can only be solved by ensuring there is sufficient staffing and time to do this regularly. ALS type courses do not offer a solution to this problem as the attrition rate is too fast and those attending are not working with their normal team or in their own environment	Thank you. Staff training has been identified as an organisational factor which will be included in the review questions. The evidence review will examine any evidence found in relation to staff training factors and their effect on nursing staff requirements.

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North Tees and Hartlepool NHS Foundation Trust	General	General	General	In regard to Paediatric nursing there is great variation throughout the country in numbers of children's nurse in a department. With the advent of child and adult branch training there can be difficulties in a mixed department with surges of adult and child attendances at different times. This needs to be recognise and taken into account in staffing. It is also essential that some new method of training is introduced so that an adult trained nurse can develop their children's skills and vice versa at the current time there is nothing of a realistic time frame	Thank you. Registered nurses with specialist skills are within the scope of the guideline.
North Tees and Hartlepool NHS Foundation Trust	General	General	General	In regard to mental health nursing we have 24 hour liaison mental health cover with the staff being present in the A&E most of the time out of hours but also seeing patients on acute wards in hours. We do not employ this team they are provided by the local mental health trust. They are invaluable to providing appropriate care to the patient and the smooth working of the department	Thank you. Registered nurses with specialist skills are within the scope of the guideline, and availability of and care provided by other healthcare staff are included as factors to be considered in the evidence review.
North Tees and Hartlepool NHS Foundation Trust	General	General	General	Not all duties provided by the nursing team require the skills of a qualified nurse or a trained health care assistant (our non qualified staff are well trained both HAs and Associate Practioners and are invaluable to caring for patients) other roles that can be carried out are administrative controlled by our patient process facilitator – ensures patients beds booked, checks results are back etc and a hostess who ensures that patients and often relatives have something to drink and eat in addition they provide someone else to talk to	Thank you. Non-clinical arrangements are included as a nursing team management factor to be considered as part of the evidence review.
North Tees and Hartlepool NHS Foundation Trust	General	General	General	Again not nursing staff but insufficient porter numbers has a direct impact on nurse staffing if there aren't enough porters the patient stays in the department for a longer period of time requiring nursing care. If we have a fifteen minute delay in portering for half of our admitted patients this will amount to 2125 extra hours a year or 40 hours a week which is more than one extra nurse	Thank you. Non-clinical arrangements are included as a nursing team management factor to be considered as part of the evidence review.

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North Tees and Hartlepool NHS Foundation Trust	General	General	General	If we transfer a patient out of the department to a tertiary care facility elsewhere in the region we lose that nurse for three to four hours which must be taken into account	Thank you. This factor has been included.
Ovarian Cancer ACtion	General	General	General	Ovarian cancer can be challenging to diagnose in primary care. 32% of patients are diagnosed in emergency admission. We would ask for nurses working in A&E to be aware of the symptoms and to work alongside A&E doctors in recognising these. There should be sufficient levels of experienced nurses working alongside junior nurses who can bring their knowledge and experience to bear in treating patients in A&E.	Thank you for your comment. Staffing factors such as experience and skill mix will be explored as part of the evidence review.
RCN Emergency Care Association (RCN ECA) & RCN	1	6	Background	As well as considering changing case mix, members highlighted the importance of considering temporal and seasonal variations in attendance patterns. This in turn should take account of the specification of the individual department (trauma units, major trauma units and specialist centres). We also think that it is important that local and regional variations in service provision are catered for (mental vs. physical health, adults and children's services, remote and rural departments).	Thank you for your comment. The review questions contained in box 1 include reference to factors impacting on nursing staff requirements and includes patient case mix and volume as determined by, for example, demographics and seasonal variation, which impact on A&E attendance patterns.
RCN Emergency Care Association (RCN ECA) & RCN	1	6	Background	Our members felt that the two additional bullet points shown below should also be included within this section: • Increase in technology in general working of A&E and impact on nursing staff • Increase in technology dependent therapy for patients in A&E	Thank you. We have now included the increasing use of technology as an additional bullet in this section.

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RCN Emergency Care Association (RCN ECA) & RCN	2	13	The guideline	It should be carefully considered whether or not the same workforce planning and staffing recommendations can be made to the general emergency nursing workforce as well as the advanced nursing roles (ENP/ANP nurse consultant). Any decision should be based on the evidence review and a pilot of any intended recommendation.	The NICE team have carefully considered this issue in light of consultation comments received, and the majority consensus is that Advanced Nurse Practitioners and Emergency Nurse Practitioners should be excluded as they are generally included on the medical establishment and would therefore be rostered separately. As you point out, it would be difficult to make recommendations that would apply to different staff groups. It has been agreed that the scope should cover core registered nursing staff and healthcare assistant requirements only. We have however included a review question to take account of the availability of other staff impacting on nursing staff requirements.

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RCN Emergency Care Association (RCN ECA) & RCN	2	13	The guideline	Emergency nurse practitioners (ENP) and advanced nurse practitioners (ANP) are not usually seen as a part of the general nursing establishment or the medical establishment. It would be prudent to consider that: • Where ENP/ANP are employed from within a department's existing nursing establishment, this loss to the general nursing establishment is partly or wholly 'back-filled' in order that general nursing numbers are not adversely affected by role development • That departments draw up separate establishments for general ED nurses and ENP/ANP and that these are maintained independently of each other to neither group's detriment • Given the role that ENP/ANP and other non-medical practitioners play it may be advisable, in terms of avoiding some of the problems outlined here, to consider placing them within the medical establishment, whose role they now replicate to some extent, whilst not losing the nursing focus within the specialist role. It is also worth acknowledging that where ENP/ANPs are absent for any reason (e.g. sickness) they will need to be replaced by a nurse or often a doctor with equal competency. The numbers needed by any one department would be dependent on the medical workforce available.	Thank you for your comments; for the reasons you state it has been agreed that the scope will cover core registered nursing staff and healthcare assistant requirements only.
RCN Emergency Care Association (RCN ECA) & RCN	2	13	The guideline	Consideration should be given to making this an 'Emergency Department Workforce Guide' and include all members of the multi-disciplinary team as the numbers needed for each profession/role are very much linked interdependently.	A workforce guide is outside the remit of this NICE guideline.

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RCN Emergency Care Association (RCN ECA) & RCN	2	13	The guideline	The roles of the 'nurse consultant' and the 'matron' should also be considered in this guide.	The issue of which specific staff requirements should be included in this guideline has been carefully considered in light of consultation comments and the scoping engagement workshop. The majority consensus is that groups who form part of staffing establishments outside of general nursing or are rostered separately to general nursing should be excluded. We recognise the interdependencies of all staff working in A&E but as multidisciplinary working is not approached in a consistent way across all hospitals it would be difficult to develop recommendations that apply to all. It has been agreed that the scope should cover core registered nursing staff and healthcare assistant requirements only. We have however included a review question to take account of the availability of other staff groups impacting on nursing staff requirements.
RCN Emergency Care Association (RCN ECA) & RCN	3	14	The guideline	Clarity needs to be given to the terms "resuscitation facility" and "emergency medical unit" as this may be considered to be a medical assessment unit. In line with the National Review, the term should be "Major Emergency Department" and "Emergency Department"	Thank you. The unclear terms have now been removed and the settings clarified according to the definitions used for the national clinical quality indicators for A&E.

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RCN Emergency Care Association (RCN ECA) & RCN	3	16	The guideline	In addition to Nursing Team Management factors consideration should also be given to the Nursing Leadership of a department.	Thank you. It is anticipated that leadership is incorporated in management approaches and organisational factors, and, evidence permitting, we would hope to cover in the guideline.
RCN Emergency Care Association (RCN ECA) & RCN	4	21	The guideline	As noted for section 13, consideration should be given to making this an 'Emergency Department Workforce Guide' and include all members of the multi-disciplinary team as the numbers needed for each profession/role are very much linked interdependently.	A workforce guide is outside the remit of this NICE guideline.
RCN Emergency Care Association (RCN ECA) & RCN	5	24	Box 1	2nd bullet point - When considering patient acuity it would be helpful to look at the NEWS (National Early Warning Score) tool and how teams are recording patients moving through the department. NEWS (Majors/Resus stream) can be then used to evaluate the acuity of the department. The tool should now have been rolled out nationally so it would be good to use as a benchmarking tool, both internally and externally. It should be noted that the impact of caring for patient's families and relatives in the department is another patient factor that affects nursing staff requirements.	Thank you. Following publication of the guideline NICE will seek to accredit any existing tools that aim to support safer staffing in A&E. We have considered including additional factors to be addressed in the evidence review and have updated the review questions accordingly.

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RCN Emergency Care Association (RCN ECA) & RCN	5	24	Box 1	3rd bullet point - Other department level factors that have an effect on nursing staff requirements include: • The time of day of clinical presentation of patients - there are certain predictable variances in demand for emergency services based on time of day and day of the week that are well evidenced and established • Trend of patient presentation and seasonal variation i.e. medical vs trauma, winter vs summer Other department level factors that have an effect on nursing staff requirements include: • The time of day of clinical presentation of patients - there are certain predictable variances in demand for emergency services based on time of day and day of the week that are well evidenced and established • Trend of patient presentation and seasonal variation i.e. medical vs trauma, winter vs summer	Thank you. The review questions include reference to patient factors impacting on nursing staff requirements and includes patient case mix and volume as determined by, for example, demographics, seasonal variation and trends, which impact on A&E attendance patterns.
RCN Emergency Care Association (RCN ECA) & RCN	5	24	Box 1	5th bullet point - Safe nurse staffing of the emergency department is not simply numerical but linked to skill mix. That skill mix includes the degree to which the nursing staff are skilled in the provision of emergency care to children and young people. It is also worth considering factors such as triage (i.e. who is triaging and at what time of day), whether units give nurses the tools and skills to request diagnostics (i.e. x-rays/bloods) and whether the nurse in charge on nights can also work as an emergency nurse practitioner and stream away some of the minor injury cases. It is these factors which work to make the skill mix of the nursing team just as important for departments seeking to manage its caseload effectively as the actual number of staff on duty. Skill mix is also an important aspect to consider when determining safe	Thank you. We have included reference to skill mix, nursing experience and specialisms and models of nursing care including triage.

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				staffing levels on observational wards and clinical decision units i.e. what additional skills do the nurses need who are allocated to work within these units?	
RCN Emergency Care Association (RCN ECA) & RCN	7	25	Box 2	serious preventable events - It was suggested by members that NICE may wish to consider adding the following two points to the list of serious preventable events: • Failure to recognise the sick child and/or the seriousness of injury on the child The panel might want to consider the following pieces of evidence as outlined in 'Why Children die' lessons learned from research, DH and the Tarnlet, report 'Major Trauma and Children presenting to A&E 2013'	Thank you. It is considered that failure to recognise the sick child or the seriousness of injury on the child would be categorised as a serious preventable event and therefore implicitly included.
RCN Emergency Care Association (RCN ECA) & RCN	7	25	Box 2	delivery of nursing care - It was suggested by members that NICE may wish to consider adding the following points to the list of delivery of nursing care outcomes: • Safeguarding Concerns Considered (and acted upon if necessary) • Cared for in Suitable Environment e.g. Child friendly or Mental health friendly • All children weighed in KGs • Cared for by a nurse with appropriate competence e.g. competence in care of child or young person • Assigned appropriate triage category / given appropriate priority	Thank you. These have been considered and the outcomes list amended accordingly.

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RCN Emergency Care Association (RCN ECA) & RCN	8	28	Related NICE guidelines	Members highlighted that other published guidelines related to this guidance include: • Self Harm (CG16) • Violence (CG25) • Stroke (CG68) • Diarrhoea and Vomiting in Children under 5 (CG 84) • When to suspect child maltreatment (CG 89) • Chest pain of Recent Onset (CG 95) • Alcohol-use disorders-physical complications (CG 100) • Sedation in children and Young People (CG112) • Anaphylaxis (CG134) • Acute Upper GI Bleeding (CG 141)	It is noted that many published guidelines will be related to this guideline as it 'cross-cuts' many aspects of care delivery. The wording in this section has therefore been amended to reflect this.

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RCN Emergency Care Association (RCN ECA) & RCN	General	General	General	It was encouraging to find our comments at the first scoping workshop were given due consideration and we hope that the attached comments will further inform the ongoing process. The RCN ECA has extensive experience of workforce planning for Emergency Departments. We use a model of workforce planning that is responsive to individual departmental demand on an hourly basis and this is available, free of charge, as the Baseline Emergency Staffing Tool (BEST). Once the NICE guideline development process has finished we look forward to engaging with you in the tool endorsement process. During the guideline development it is important to consider variations in demand not only over the 24 hour period, but also day to day and seasonally – no two emergency departments are operationally the same. This means that the approach to workforce planning must combine existing methodologies in ways which are dynamically responsive and non-prescriptive. The RCN and RCN ECA recommend that emergency departments should use evidence based workforce planning tools which take account of local requirements and that the departments are facilitated to implement the outputs of such tools in their workforce model by boards and commissioners. Finally, as the largest professional body for emergency nursing in the UK, we have an in-depth knowledge of the nursing care needed by ED patients - and the range of nursing roles employed to deliver that care. Further to our discussion at the workshop we would like to make this knowledge and experience available to you by occupying a specialist seat on the steering committee.	Thank you. Engagement feedback and consultation comments are essential to NICE's work to ensure that the guidelines produced are accurate, relevant and can be practically implemented. We welcome your input. Specialist Advisory Committee members are appointed as individuals with the required knowledge and expertise rather than representatives of any organisation. We have however forwarded your expression of interest to colleagues involved in the recruitment of the Committee.

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RCN Emergency Care Association (RCN ECA) & RCN	General	General	General	The Royal College of Nursing was invited to comment on the draft guideline for safe staffing for nursing in accident and emergency departments. The document was circulated to RCN staff and members working in this area of practice for their comments. Please find below comments received from the reviewers.	Thank you.
RCN Emergency Care Association (RCN ECA) & RCN	General	General	General	In line with inter-collegiate recommendations the RCN advise that the correct terminology is Emergency Department rather than Accident and Emergency and ED rather than A&E.	Thank you for your comment. We have now clarified the settings according to the definitions used for the national clinical quality indicators for A&E. We acknowledge that the terms A&E and ED are used interchangeably and have explicitly stated this in the scope.
RCN Emergency Care Association (RCN ECA) & RCN	General	General	General	When considering staffing levels of specialist and advanced emergency nursing roles (emergency nurse practitioners, consultant nurses), it should be remembered that advanced practice and emergency care is in fact multi professional. For example, the advanced care practitioner role (ACP) currently being developed by Health Education England (HEE) does not require a specific professional registration.	Thank you. This has been considered when updating the scope in light of consultation comments.
RCN Emergency Care Association (RCN ECA) & RCN	General	General	General	Members highlighted the importance of considering existing research and workforce planning tools e.g. the RCN/FEN baseline emergency staffing tool (BEST).	All relevant and appropriate existing research will be considered in the evidence review. Following publication of the guideline NICE will seek to endorse any existing tools used to support safe staffing which are assessed to be consistent with the guideline recommendations.

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RCN Emergency Care Association (RCN ECA) & RCN	General	General	General	In developing this guideline members point out that the opportunity should be taken to review the competencies required by nurses in the emergency department as part of the skill mix recommendations	Reviewing competencies required by nurses in A&E is outside the remit of this guideline but skill mix will be included in the evidence review and considered as part of the Committee's deliberations.
RCN Emergency Care Association (RCN ECA) & RCN	General	General	General	It should be noted that the document should refer to registered children's nurses and not paediatric nurses.	Thank you. We have now amended this section to reflect the correct term.
Royal College of Physicians (RCP)	2	8	Background	It is reassuring that the scope explicitly states that the guidelines 'will not set a single ratio for nursing staff to patients'. We strongly agree with this approach as no one size fits all. However, the evidence section then goes on to say 'What patient safety activities and outcomes are associated with staffing of the nursing team? Is there evidence that demonstrates a minimum staffing threshold for safe nursing care?' which appears to contradict the original statement.	Thank you. The review question is included to ensure that all relevant evidence is taken into account, although the intention of the guideline is not to recommend a single ratio for nursing staff to patients. The wording of the review question has been amended to aid clarity.
Royal College of Physicians (RCP)	5	24	box 1	**'What environmental factors affect safe nursing staff requirements? These include:** Physical and temporal availability of alternative primary/minor care providers (e.g. on-site out of hours GP services) Physical and temporal availability of alternative social care and mental health care services' With regard to temporal availability we would suggest that further detailed analysis of Bank Holiday weekends and the impacts on the days preceding and following long weekends is required. Local data suggests that surges pre and	Thank you. The review questions include reference to patient factors impacting on nursing staff requirements and includes patient case mix and volume as determined by, for example, demographics and seasonal variation, which impact on A&E attendance patterns. It is anticipated that issues around

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				post long weekends present a significant concern which requires solutions. **'What department management factors affect nursing staff requirements? These include:** Nursing team management and administration approaches (e.g. shift patterns)' We would suggest that this analysis needs to be fairly detailed and should cover seasonal variations and diurnal variations (which are at this time showing a trend towards later and later attendances) to address staffing appropriately. We believe it would be helpful for the guidance to promote a more fluid and responsive workforce and include ways of ensuring availability of sufficient staff to be drawn upon at times of escalation. It might become necessary to actively consider leave and other professional activities in what one would hope to be the quieter summer period. However, current trends of attendances are showing unrelenting numbers even at this time. **'Staff and student supervision and teaching'** We believe that the practice of advanced nurse practitioners in accident and emergency departments should be reviewed regularly. Support and education should also be given in a timely manner (depending on experience and pre-existing capability) as the feedback is that they do very well in process/pathway driven scenarios but less well in complex scenarios. As such, their resources should be utilised appropriately. At times of escalation, overnight 'bedded' areas in EDs tend to become predominantly filled with medical patients and the bedded area starts to function very much like an acute medical ward. This will not be familiar to most ED nurses as the pace and roles are different. Therefore, it would be worthwhile considering some rotational posts through an acute medical unit to support skill mix to cover this eventuality.	responsiveness, flexibility and leave planning etc to be part of the considerations of the Advisory Committee when reviewing the evidence for suitability to develop recommendations.

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Royal College of Physicians (RCP)	General	General	General	The RCP is grateful for the opportunity to respond to the above consultation. Overall, our experts felt that the draft scope was fairly broad in its outlook and appeared to consider all the variables that would impact on Emergency Department (ED) staffing. We have had sight of the comments from the College of Emergency Medicine and wish to highlight that submission to NICE. In addition, we would like to make the following comments.	Thank you.
Royal College of Physicians (RCP)	General	General	General	The RCP would be particularly interested: • to see NICE's decisions on which outcomes should be used as indicators of safe staffing • in how NICE will estimate the costs of any recommendations which are made	Thank you. As with all NICE guidance the decision-making process will be transparent, and will be documented in the guideline.
Salford Royal NHS Foundation Trust	1	6	Background	Of particular concern at SRFT is the acuity of patients attending. We have carried out audits that show that in the last 2 years we have had a 43% increase in "standby" calls from NWAS. These patients at present will all go into our Resus. Some of this is due to reconfiguration (regional Stroke Centre and Trauma Centre). Many of the factors listed combine, as one of our solutions is a planned rebuild that will give us 2 levels of "Majors" but this expansion will in itself require further staffing due to the expanded footprint of the dept	Thank you for your comment. Patient acuity will be one of the key factors reviewed in the evidence and considered by the Advisory Committee.

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Salford Royal NHS Foundation Trust	2	13	The guideline	(a) We are presently considering if it is desirable to have different grades of staff carrying out different layers of duty ie B2 to provide support to clinical staff in the dept and the use of ancillary staff ie B1 non-clinical, to carry out "non-clinical" duties presently carried out by RN/HCA. There is presently no agreement as to what the non-clinical duties will be and the supervision element that will be required. (b) Also need to consider that ENPs take part of the medical team's duties ie clinical decision making. This is even more significant for the ANPs, who form a large (10 in main ED and 6 in Paeds ED) and key part of the medical rota	Thank you. Division of activities and tasks between registered nurses, healthcare assistants, specialist nurses and other healthcare staff is included in the review questions as a staffing factor and will therefore be considered in the evidence review. The issue of ENPs and ANPs has been carefully considered in light of consultation comments and the majority consensus is that the guideline should focus on core nursing staff only. As you point out, ANPs and ENPs are included on different establishments and are rostered separately.

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Salford Royal NHS Foundation Trust	3	16	The guideline	As 6 above, a present filter of acuity is the paramedic (NWAS) pathfinder and while this is a useful tool consideration of the potential for over-triage and subsequent perceived higher usage of Resus is required SRFT in liaison with and in agreement of the CCG use a deflection model. This allows the use of own GP appointments. Co-location of out-of-hours GP makes streaming easy High skill-mix ensures higher quality care and improved flow. At SRFT we have a high B6/7 ratio, however what is really key is the skills of the RNs and not their grade. We are nearing the point where we have exhausted our pool of suitable staff to be promoted and all departments will have to ensure that the long-term supply of skilled nurses continues to avoid just changing RNs grade with minimal change in quality Managers need to be allowed to manage and the traditional model of one senior RN manager may no longer be appropriate. For example, the threshold for safety concerns has rightly changed, however this now takes a much greater part of a manager's time and commitment. Managerial circumstances have changed and an assessment of these changing duties would be highly beneficial	Thank you. Following publication of the guideline NICE will seek to endorse any existing tools that aim to support safer staffing and are ssessed to be consistent with the guideline recommendations. Division of activities, balance of tasks, and availability of other units or assessment models will be considered as part of the evidence review.
Salford Royal NHS Foundation Trust	3	17	The guideline	Managers need to be allowed to manage and the traditional model of one senior RN manager may no longer be appropriate. For example, the threshold for safety concerns has rightly changed, however this now takes a much greater part of a manager's time and commitment. Managerial circumstances have changed and an assessment of these changing duties would be highly beneficial	Thank you. Managerial factors are included in the evidence review questions and these issues may form part of the Advisory Committee discussions.

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Salford Royal NHS Foundation Trust	4	21	The guideline	The scope discusses how patient flow affects safety, and how staffing levels make a difference to flow. However MDT roles (including community in-reach, rapid discharge teams, etc) are a simultaneous variable playing a part. The structure of bed management and bed flow systems, electronic records/prescribing are other factors that will make a difference	Thank you. We recognise the interdependencies of different staff and systems impacting on the operation of A&E but will focus the guideline on core nursing staff to ensure a consistent approach and practical recommendations to support improvement. Staffing factors such as the availability of other multidisciplinary team members and models of nursing care, and organisational factors such as the availability of other assessment models are included in the review questions although it is outside the remit of this guideline to address service design and reconfiguration matters.

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Salford Royal NHS Foundation Trust	4	24	box 1	Some A&Es are fundamentally too small with inevitable overcrowding. Patient flow processes and other interventions may alleviate this to a lesser or greater extent, so overcrowding may in part be a factor of something else and not just size/layout As 13, would be useful to assess the breakdown of RN tasks in those that could be carried out by B3/2/1/clerk. Possibility of multiple grades to avoid staff drift away from fundamental but less "sexy" care ie cleaning, stocking up, paperwork, by clearly delineating roles by grade? 12hr shifts vs traditional shifts: 12hr create more time but is there a subsequent reduction in concentration and efficiency. The effect of documentation on nursing time – in essence documenting care is a safer thing to do, however there is a tipping point where extending the amount of documentation takes makes the whole ED less safe. RCN Baseline Emergency Staffing Tool has been used to assess acuity vs staffing at SRFT	Thank you. We have moved the crowding item to the organisational factors section. Division of activities and tasks, as well as skill mix, will be reviewed in the evidence and discussed by the Advisory Committee. Shift patterns will also be considered as part of nursing team management and administration approaches as well as demands on nurse time. Following publication of the guideline NICE will seek to endorse any existing tools to support safe staffing and are assessed to be consistent with the guideline recommendations.
Salford Royal NHS Foundation Trust	7	25	Box 2	Agree with never events, but also need to consider "incidents" that happen outside A&E but as a consequence of A&E care. There may also be different thresholds for "Serious Incidents" and SUIs at different hospitals	Thank you. The evidence review will include reference to serious incidents which may or may not have occurred within A&E. We acknowledge the different thresholds for reporting SUIs at different hospitals.
Salford Royal NHS Foundation Trust	7	25	Box 2	Delivery of Nursing Care - I like the inclusion of evidence that is usually normal care as this will be a key variable affected by staffing	Thank you.

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Salford Royal NHS Foundation Trust	7	25	Box 2	Reported Feedback - Complaints may have different thresholds and need to note PALs involvement/numbers. Friends and Family test is greatly affected by wait times, which may be a variable of availability of clinical decision makers (ENP/ANP/Medical staff)	Thank you. We acknowledge the interdepencies of different staff working in A&E and have tried to identify outcomes that are most closely related to nurse staffing issues.
Salford Royal NHS Foundation Trust	7	25	Box 2	other - These variables are significant but cannot be relied on individually as other factors beyond staffing may affect them	Thank you. It is considered that these outcomes are nurse staffing related but agree that they are subject to confounding factors, and these will be assessed as part of the evidence review.
The College of Emergency Medicine	1	1	Guideline title	The guideline must be relevant and useful in practical terms to those with responsibility for nurse staffing levels in Emergency Departments (EDs) at a local level.	Thank you. This is very much a part of the Advisory Committee's considerations, and we will make available any implementation tools that may be developed to support the implementation of the guideline.
The College of Emergency Medicine	1	6	Background	The reasons for reviewing should also consider the considerable changes to the nature of the clinical work in recent years. For example time critical interventions, invasive monitoring and non-invasive ventilation all have an impact on nursing care and skill mix requirements	Thank you. We have included reference to increasing use of technology which we believe covers an element of this point. The list is not intended to be exhaustive.
The College of Emergency Medicine	2	8	Background	Tools for determining nurse staffing levels in EDs that the College are aware of include the Royal College of Nursing's Baseline Emergency Staffing Tool (BEST), work undertaken by the Shelford Group and work undertaken by NHS Scotland.	Thank you. Following publication of the guideline NICE will seek to endorse any existing tools used to support safe staffing which are assessed to be consistent with the guideline recommendations.

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The College of Emergency Medicine	2	13	The guideline	Emergency Nurse Practitioners and Advanced Nurse Practitioners work as clinical decision makers and should be excluded from the guideline. Although from a nursing background, they work largely to a medical model and in practical terms they are often rostered with medical staff as part of a combined clinical decision maker workforce. The guideline should focus on 'core' nurse staffing levels.	The NICE team have carefully considered this issue in light of consultation comments received, and the majority consensus is that Advanced Nurse Practitioners and Emergency Nurse Practitioners should be excluded from the scope for the reasons you have set out. It has been agreed that the scope should cover core registered nursing staff and healthcare assistant requirements only. We have however included a review question to take account of the availability of other staff impacting on nursing staff requirements.
The College of Emergency Medicine	2	13	The guideline	The College welcomes the inclusion of specialist nurses in the guideline as they are core members of ED nursing teams.	Thank you.
The College of Emergency Medicine	2	13	The guideline	Patients with psychiatric / mental health problems can be particularly challenging and access to timely liaison psychiatric / mental health services can be particularly poor in EDs. The College strongly advocates that all EDs employ specialist psychiatric liaison mental health nurses.as part of a liaison psychiatry service.	Thank you. Mental health nurses who are members of the A&E nursing team are included in the scope of the guideline.
The College of Emergency Medicine	2	13	The guideline	The College welcomes the inclusion of appropriate skill mix in the guideline. This should take into consideration recommendations in relevant national documents.	Thank you.

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The College of Emergency Medicine	2	13	The guideline	The College strongly advocates that all EDs implement the nursing staff recommendations made in the guidance 'Standards for care of children and young people in emergency care settings' published by the Royal College of Paediatrics and Child Health intercollegiate committee. The guidance recommends nursing leadership on safeguarding and paediatrics with one registered sick children's nurse (RSCN) on duty each shift. All nurses in EDs who care for children must have appropriate competences.	Thank you. Relevant contextual reports and national policy and guidance will be taken into account during development of the guideline.
The College of Emergency Medicine	3	14	The guideline	Section 14 should be truncated to 'The guideline will cover all nursing care provided to adults and children in all secondary care Emergency Departments in hospitals'. Some of the terminology used in the second sentence is unfamiliar / incorrect, such as 'resuscitation facility' and 'emergency medical units', and is therefore unnecessary and likely to lead to confusion. In essence the guideline should apply to any area where the '4 hour target' is applied, with the exception of those exclusions listed at 20. The College agrees that the guideline should exclude areas, such as clinical decision units, which fall under the governance of EDs but which would ordinarily be staffed along a ward model.	Thank you for your comment. We have now clarified the settings according to the definitions used for the national clinical quality indicators for A&E. The guideline will cover type 1 A&Es only, with other types subject to the 4 hour wait (e.g. minor injury units), therefore excluded.
The College of Emergency Medicine	3	16	The guideline	If historical demand is used to predict future nurse staffing levels, then this should not be based on mean or median values, but on a minimum of a 75th or 80th centile. Nurse staffing levels must allow the delivery of safe, effective, high quality nursing care in all areas and to all patient groups at times of peak demand, with the ability to 'flex' to accommodate surges in activity.	Thank you. Evidence relating to calculating nurse staffing requirements will be reviewed and considered by the Advisory Committee.
The College of Emergency Medicine	3	16	The guideline	Nurse staffing levels must encourage sustainable working (acceptable workload and shift patterns) to support and facilitate the wellbeing, recruitment and retention of nursing staff.	Thank you. We anticipate that this will be part of the considerations of the Advisory Committee when assessing the evidence for suitability to make recommendations.

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The College of Emergency Medicine	3	16	The guideline	Nurse staffing levels must allow appropriate cover for annual leave, sick leave, maternity leave, study leave etc. to ensure that the delivery of safe, effective, high quality nursing care is not compromised to accommodate these.	Thank you. We anticipate that issues of responsiveness, flexibility and leave planning etc will be part of the considerations of the Advisory Committee when assessing the evidence for suitability to make recommendations.
The College of Emergency Medicine	3	16	The guideline	Nurse staffing levels must allow appropriate cover for any unpaid and / or paid breaks during shifts 24/7 to ensure that the delivery of safe, effective, high quality nursing care is not compromised to accommodate these.	Thank you. We anticipate that issues of responsiveness, flexibility and leave planning etc will be part of the considerations of the Advisory Committee when assessing the evidence for suitability to make recommendations.
The College of Emergency Medicine	3	16	The guideline	Factors that impact on nurse staffing levels also include the number of attendances to the Emergency department and the case mix.	Thank you. Patient factors affecting nurse staffing have been included as a review question, which includes patient case and volume.
The College of Emergency Medicine	3	16	The guideline	Consider replacing the term 'social complexity' with 'psychosocial complexity'.	Thank you. We have amended this term as suggested.

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The College of Emergency Medicine	3	16	The guideline	In many EDs inadequate nurse staffing levels frequently results in 'carve out' i.e. nursing staff are reallocated from one area to support another, to the detriment of the former. For example a nurse may be reallocated from delivering care to patients in the 'majors' area to support the delivery of care to a patient in the resuscitation room, but this consequently compromises the delivery of safe, effective, high quality nursing care to patients in the 'majors' area and impacts on patient flow. Nurse staffing levels must allow the delivery of safe, effective, high quality nursing care in all areas and to all patient groups at times of peak demand, with the ability to 'flex' to accommodate surges in activity.	Thank you. It is anticipated that issues around responsiveness and flexibility will be part of the considerations of the Advisory Committee when reviewing the evidence for suitability to develop recommendations.
The College of Emergency Medicine	3	16	The guideline	Differences in local models of care may impact on nurse staffing levels. For example, paediatric work up in the ED v paediatric work up on admission to the paediatric ward. Other examples include paediatrics, stroke, cardiac, drug/alcohol, liaison psychiatry, mobility assessment, frail elderly, service navigation – how such services are configured will impact on what ED nurses do and the requirements for safe, effective staffing levels.	Thank you. Factors relating to availability and phyiscal proximity of other separate units will be considered as part of the evidence review.
The College of Emergency Medicine	3	16	The guideline	Nurse staffing levels must allow effective 'shop floor' nursing leadership by sisters / charge nurses 24/7.	Thank you. It is anticipated that leadership will be included in the evidence review as a management approach and/or organisational factor.
The College of Emergency Medicine	3	16	The guideline	Senior nurse staffing levels must be sufficient for providing appropriate supervision of junior nursing staff (particularly newly qualified nurses), delivering training and development for all nursing staff.	Thank you. Supervision and teaching will be considered as part of the department management factors.
The College of Emergency Medicine	3	16	The guideline	Nurse staffing levels must be sufficient to accommodate nursing contribution to governance and service development (e.g. infection control, managing risk, addressing complaints, leading clinical areas etc.)	Thank you. The wider roles of the nurse will be considered in the evidence review and when making recommendations.

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The College of Emergency Medicine	6	25	Box 2	There are risks associated with the use of nursing staff that are unfamiliar with the ED they are working in and/or the specialty. Other outcomes of interest might therefore usefully include the proportion of shifts covered by bank and/or agency nursing staff or the proportion of shifts covered by non-substantive nursing staff.	Thank you. We updated the review questions to include consideration of proportion of temporary staff as a factor, and the outcomes include 'nursing vacancy rates' which may also address this.
The College of Emergency Medicine	9	general	Appendix A	Box 1 - Replace the term 'overcrowding' with 'crowding'.	Thank you. This has now been amended.
The College of Emergency Medicine	General	General	General	There are complex inter-relationships between nursing staff and all other clinical and non-clinical staff groups in ED. Careful consideration must be given to how the recommendations in the guideline might impact on these relationships.	Thank you. This will form part of the Advisory Committee's considerations when developing recommendations.
The College of Emergency Medicine	General	General	General	Consideration should be given to adding the descriptor 'high quality' to 'safe and effective' nursing care throughout the guideline.	Thank you. The guideline is primarily focussed on recommendations for establishing safe levels of nurse staffing. Although safety is a component of quality we will not explicitly be covering the broader concept of high quality nursing care.
The Patients Association	2	8	Background	The Patients Association accepts that there is "no single nursing staff to patient ratio that can be applied to all A&E wards". There are staffing levels that have been developed and are in use in ITU and Pediatric departments. These have been developed by the Department of Health and with input from professional bodies.	Thank you for your comment.

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The Patients Association	2	13	The guideline	We agree with the coverage of nursing staff requirements including all levels of registered nurses, emergency nurse practitioners, advanced nurse practitioners and healthcare assistants. This is important to ensure that the care delivered in the A&E departments is safe and joined up. We do believe that Healthcare Assistants play a key role in non-clinical nursing activity and an adequate provision of this group of staff is essential to ensure that the clinical staff are able to focus on their duties.	The NICE team have carefully considered this issue in light of consultation comments received, and the majority consensus is that Advanced Nurse Practitioners and Emergency Nurse Practitioners should be excluded as they are generally included on the medical establishment and would therefore be rostered separately. It has been agreed that the scope should cover core registered nursing staff and healthcare assistant requirements only. We recognise the interdependencies of all staff working in A&E but as multidisciplinary working is not approached in a consistent way across all hospitals it would be difficult to develop recommendations that apply to all staff groups. We have however included a review question to take account of the availability of other staff groups impacting on nursing staff requirements. Please see the notes of the scoping engagement workshop for further detail of the discussion around this issue.

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The Patients Association	3	16	The guideline	While we are in agreement with all the factors listed as those impacting on safe nursing requirements we would like to emphasise that the focus should always be on the patient first. It is vital that factors such as acuity, dependency and social complexity are decided with meaningful involvement from the patients. Any decision about patients should be for the benefit of the patients rather than that for staff or the systems. It is also very important that nursing staff are available to offer nursing care to patients. We have been concerned for many years that skilled nurses are spending too much time dealing with paperwork and non-clinical duties. It is important that when establishing the required skill mix on an A&E ward, that the appropriate numbers of registered and suitably trained nurses are available. The clinical needs of the patient must come first and this must be reflected in planning. It is very important that when planning staffing numbers, managers do not underestimate the time that is required for nursing staff to communicate effectively with patients and their families. Communication is a key issue that continues to emerge from our Helpline. Patients and their families expect (and deserve) to have adequate time devoted to an explanation of the issues surrounding their treatment. It is therefore essential that adequate numbers of trained staff are available to provide this level of care. For many patients, communication is just as important as the clinical treatment that they receive. Furthermore, a lack of communication can be very distressing for patients and their families. Finally while we agree that sometimes patients may have to wait in the A&E however, we do believe they should be informed the current status and how long the wait would be. We hear from callers to our Helpline many times about inordinate delays in the emergency units without any information or attention.	Thank you for your comments. Patient factors are key to safe staffing and are included in the evidence review questions. Please note that NICE has patient representation on all its Advisory Committees and these aspects of care will be considered by the Committee as part of its deliberations.

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The Patients Association	3	16	The guideline	Staff factors - Ensuring that A&E units are staffed by competent and skilled staff is essential to enable the delivery of a safe and high quality care to patients. The Patients Association would like to comment particularly on the role of the healthcare assistants; as covered in the Cavendish Review into valuing and supporting healthcare assistants and care assistants in the NHS and care settings We are worried at what appears to be an imbalance between the utilisation of healthcare assistants in the place of registered nurses. We are concerned that as healthcare assistants are cheaper to recruit and pay, many Trusts and hospitals are becoming increasingly reliant upon them to bring up staff numbers in A&E. However, they lack even basic regulation and have minimal training. Many, it is reported, pick up skills (and indeed bad habits) as they go along rather than undergoing any rigorous training. Despite this, we are increasingly hearing that healthcare assistants are undertaking tasks which should only be performed under supervision from a trained and registered nurse. Indeed, even some more complex tasks like taking blood have been reported to have been performed by healthcare assistants. We have heard from many patients who struggle with distinguishing between different nursing roles and healthcare assistants. We would reiterate our support for the proposals put forward by the Willis Commission with regards to its recommendations for the on-going professional development of nurses should be applied to the healthcare assistant profession also. We would want to take this opportunity, supported by Health Education England (and in association with the Royal Colleges) to ensure that the training offered was of an applicable standard, and of a correct focus; to ensure that the skills of healthcare assistants was such that they complemented, and ultimately supported, the skills of registered nursing staff.	Thank you. It is outside the remit of this guideline to address healthcare assistant training, but the role of healthcare assistants and the skill mix of the nursing team are included as key factors in the evidence review.

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The Patients Association	3	16	The guideline	nursing team management - We believe that it is vital that senior and experienced staff are available in A&E or at least accessible to ensure that decisions made are based on good guidance and benefit the patients. We have recently heard about experienced staff particularly doctors leaving A&E which puts patients at risk as they are being cared for less experienced and junior staff.	Thank you. Staff factors impacting on safe staffing will be included in the evidence review.
The Patients Association	3	16	The guideline	Environmental factors - This is a vital area particularly concerned with discharge from the A&E. We hear many calls to our Helpline where patients have been sent home from A&E without adequate support in the community. This has meant that patients have been put at risk or have been readmitted to A&E.	Thank you for your comment.
The Patients Association	3	16	The guideline	General - This is a vital area particularly concerned with discharge from the A&E. We hear many calls to our Helpline where patients have been sent home from A&E without adequate support in the community. This has meant that patients have been put at risk or have been readmitted to A&E.	Thank you for your comment.
The Patients Association	7	25	box 2	outcomes of interest general - In principle we agree with the list of Outcomes of interest as listed in Box 2. All these outcomes are very relevant to ensuring high quality safe care. However we would like to emphasise that there is a need to place stronger focus on the experiences of patients and their carers in terms of dignity, communication and other non-measurable factors which can be picked up by observations particularly for those patients who have cognitive or language difficulty and feel unable to express their concerns.	Thank you. We recognise the importance of patient experience as an outcome, which is included in the Reported Feedback section.

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The Patients Association	7	25	box 2	outcomes of interest serious preventable events - While we agree that deaths and 'Never events' are the ultimate indicators of the quality of care in A&E however we would like to stress that ideally the 'Never Events' must never happen or should be kept to minimum.. A clear audit trail of the cause of such incidents and the associated accountability must be ascertained. It needs to be recognised that some of the 'Never Events' may have long term effects on the patients and may impact on the quality of their daily life. We also believe that many of the patients who are admitted to the A&E are frail and vulnerable and such 'Never Events' may cause emotional distress with lasting effects.	Thank you. It is intended that the implementation of guidance will be part of a number of iniatives that contribute to reducing the occurrence of never events.
The Patients Association	7	25	box 2	outcomes of interest reported feedback - While we agree that this is an important indicator of quality of care in the A&E and the tools such as complaints, Friends and Family Test would be a good mechanism to seek information on patient experiences, however, we are concerned that in practice there are challenges for patients in reporting substandard care in A&E units. Firstly many patients are in extreme distress or even unconscious so may find it difficult to remember the quality of nursing care received by them while in an emergency situation. Furthermore many patients particularly with life threatening episodes and their relatives who visit A&E would consider being saved as an excellent outcome and may not wish to complain about non-clinical nursing factors due to a sense of gratitude. Finally we know from our Helpline evidence that complaints process in the NHS is complex and lacks adequate patient focus. We believe that at the heart of patient-centred care, there should be the requirement that patients be informed of how they can make a complaint if they wish to do so. It is obvious that inadequate staffing levels and inadequately qualified and trained staff are going to have a direct bearing upon the quality of patient care. Patients therefore should have the right to complain if they feel that safe staffing standards are not being met. As	Thank you. NICE acknowledges the importance of patient-centred care and the provision of information to support this. We will produce a version of the guideline for the public which will provide patients with the necessary information to support them.

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				patients are at the centre of healthcare (and it is they who ultimately benefit or suffer as a result of poor staffing), they have an important role to play in assessing and commenting upon the adequacy of staffing levels.	
The Patients Association	7	25	box 2	outcomes of interest reported feedback - Every year we receive many calls to our helpline from patients who are confused about the complaints procedures in health and social care settings. Many patients are either not aware that they are "allowed" to make a complaint or are reluctant to complain, particularly as they fear that the quality of the care that they receive may decline if they do so. Furthermore, those who did complain have had to deal with complex, bureaucratic systems and are unhappy with the response that they have received; and are even more confused about how to take the matter further. We believe that the NHS needs to do more to raise the awareness of the complaints procedure. We also feel that the NICE guidelines should make specific reference to the rights of a patient, as expounded in the NHS Constitution - as we have argued for in many previous consultations.	Thank you. We would anticipate that any guidelines developed on safe staffing would complement and support other work being done within the NHS to address the important issues you raise with regard to complaints. The NHS Constitution applies to everyone.
The Patients Association	8	26	economic aspects	The guidelines should include the longer term economic benefits from improved patient safety, quality and effective and efficient use of resources as well as a happy workforce	The economic evidence will be reviewed to identify all relevant factors impacting on nursing staff requirements and associated outcomes, and modelling undertaken to calculate associated costs and benefits.

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The Patients Association	General	General	General	The Francis inquiry made 290 recommendations which set out a clear blueprint for the creation of a care system which ensures that the safety, dignity and well-being of patients is paramount. The Patients Association made it very clear at the time that it was vital that the recommendations were implemented swiftly and in full. In order to ensure high quality patient care and safety, the recommendations must be taken seriously and acted upon. Whilst we welcome the findings of the various reviews and reports (Berwick, Keogh, Cavendish, Clwyd-Hart and the appointment of Professor Sir Mike Richards as the Chief Inspector of Hospitals by the Care Quality Commission), it is now time for action. It is becoming increasingly apparent that hospital managers are reluctant to take the radical steps demanded by the Francis inquiry. We need to see regulation of healthcare assistants, a reformed complaints system, improved training and a properly funded and structured regulatory system. We have been saying for many years now that the need to listen to patients, involve them in their care, value our NHS staff and for trusts to work together (rather than in isolation), are all key elements to ensure that standards improve and unnecessary deaths are avoided.	Thank you. We anticipate that evidence-based guidelines on safe staffing will contribute to the work to implement the recommendations from the Francis Inquiry.

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The Royal College of Psychiatrists	2	13	The guideline	This guidance concerns nursing (including HCAs, Advanced Nurse Practitioners etc.) only. Guidelines on safe staffing levels for EDs are welcome and timely, and starting with the largest professional group is reasonable. However, it may help stabilise the ED staffing environment if NICE published its intent to produce safe staffing guidance for other professional groups and specialties too in ED and elsewhere. These groups might include admin staff, the allied professions and doctors such as liaison psychiatrists. We welcome the mention of mental health nurses and are supportive their recognition as being core members of the ED team. However, the best evidence of effectiveness of mental health services in EDs supports there being a Liaison Psychiatry service consisting of a mix of professionals (most of whom are nurses) based in the ED, led by a liaison psychiatrist.	Thanks for your comment. NICE has not currently been commissioned to produce guidance on staffing levels in A&E for other professional groups. We recognise the interdependencies of all staff working in A&E, but as multidisciplinary working is not approached in a consistent way across all hospitals and it would be difficult to develop recommendations that apply to all, therefore we have focussed on core nursing staff. We have however included a review question to take account of the availability of other staff groups impacting on nursing staff requirements.

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The Royal College of Psychiatrists	3	16	The guideline	We suggest some additional patient factors which may impact on safe nursing requirements: 1) mental health problems; 2) mental and physical health problem co-morbidity; 3) more general multi-morbidity; 4) use of alcohol and drugs. We would like to suggest some additional environment factors which may impact on safe nursing requirements: 1) The effectiveness of any local primary care/minor care providers (in addition to their existence and notional availability); 2) The variability of workload of the department. Some departments are likely to be much more variable in their workload than others. Determining the staffing level from a 'mean workload' or similar in a highly variable department may not be suitable. 3) The degree deprivation of the catchment area, which is likely to have a large effect on workload.	Thank you. We consider these factors to be covered by patient acuity and patient dependency. Whilst we acknowledge that the effectiveness of alternative providers will have an impact, assessing the effectiveness of other providers is outside the remit of this guideline, although it may form part of the Advisory Committee's deliberations with regard to the recommendations. Patient case mix and volume, as determined by demographics, will be considered as part of the evidence review.
The Royal College of Psychiatrists	General	General	general	We note this guideline development is happening at the same time as the Urgent and Emergency Care Review and trust this guidance will feed and/or be fed by the Review as appropriate.	Thank you. NICE is aware of the Urgent and Emergency Care Review and has arrangements in place for liaison as necessary.

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The Royal Pharmaceutical Society	5	24	Box 1	Review question: What environmental factors affect safe nursing staff requirements? - Minor ailments have been recognised to contribute to significant pressures on urgent care delivery and pharmacists within the community setting as highly qualified medicine experts can provide advice and support on self management and healthy interventions. Commissioning of pharmacy to deliver a proportion of first line diagnosis for minor ailments, advice and care to form a core part of local out of hours care networks could address this. In addition new models of care in community settings as outlined in the Royal Pharmaceutical Society Now or Never report have provided examples of pharmacists providing care in innovative ways including identifying patients at risk of admission and reducing the risk.	Thank you. This section has been amended to ensure reference to pharmacists is included.

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The Royal Pharmaceutical Society	5	24	Box 1	Review question: What staffing factors affect safe nursing staff requirements? - Pharmacists are experts in medicines use both at operational and strategic level hence their involvement within the accident and emergency setting is key in the redesign of services or new care pathways and meeting outcomes related to medication and never events. Data shows that between 5 to 8 % of unplanned hospital admissions are due to medication issues and pharmacists sited at the correct place within the system have been demonstrated to have a beneficial impact on outcomes such as hospital admissions and prescribing errors. The King's Fund report on polypharmacy and medicines optimisation recommends that multi-morbidity and polypharmacy increase clinical workload hence the need for doctors, nurses and pharmacists to work collaboratively with a balanced skill mix. Health Education England has also recognised the merit in having trained pharmacists in the emergency department 24/7 "in view of the complexity of many older patients in terms of multiple medications, the delays in discharging patient awaiting prescriptions and the risk of prescribing". Health Education West Midlands has already initiated a study involving independent pharmacist prescribers working in a clinical capacity within the emergency department of the Birmingham Children's hospital as one of their strategy schemes for addressing workforce shortages. We believe that this skill mix should be fully utilised across hospitals with pharmacist prescribers and pharmacy teams being fully integrated into accident and emergency departments and the delivery of pharmacy services seven days a week. The Royal Pharmaceutical Society is currently working on a report to outline key principles and recommendations for progressing seven day services in pharmacy to support pharmacists in this area.	Thank you. We recognise the role of pharmacists and other members of the multidisciplinary team working in A&E and their importance in terms of staffing issues in general.

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United Lincolnshire Hospitals NHS Trust	3	16	The guideline	How will the layout of departments be considered in calculating the number of staff on duty?	This will depend upon the results of the evidence review which will determine whether there is evidence available in relation to this factor. The nature of the evidence available and the considerations of the Advisory Committee will determine whether it is possible to make a recommendation on how this factor is considered when calculating the number of staff required.
United Lincolnshire Hospitals NHS Trust	5	24	box 1	What consideration will be made regarding the age profile of the population attending the department ?	Age may be considered as part of the patient factors and case mix affecting staffing requirements.
United Lincolnshire Hospitals NHS Trust	7	25	box 2	What considerations will be made regarding the time it will take to collect information required, as this will have an impact on the staffing levels?	Thank you. Data collection aspects will be considered by the Advisory Committee when developing recommendations.