# Emergency and acute medical care in over 16s: service delivery and organisation

## Consultation on draft guideline
## Stakeholder comments table

## 03/07/2017 to 14/08/17

***Comments forms with attachments such as research articles, letters or leaflets cannot be accepted.***

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| British Geriatrics Society and the Acute Frailty Network | Specific need of older people | | | Older people, especially those with frailty, are increasingly becoming the main users of urgent care services, yet their needs appeared to be somewhat underrepresented. Older people accessing urgent care often present with a combination of cognitive impairment, multiple co-morbidities, polypharmacy and functional impairment, making assessment and management challenging. This did not feature strongly in your guideline.<br>Comprehensive Geriatric Assessment is a useful evidence based, overarching framework to guide assessment and management of older people with frailty presenting with crises[1-3]. It is a process of care which includes management not just assessment, yet this too was underrepresented.<br>There was a lack of information on the training required to manage older people with acute care needs – for example, falls, delirium and polypharmacy assessments. Specifying these skills at key points in the patient pathway such as pre-hospital, emergency and acute care settings could help improve outcomes for older people.<br>For older people with frailty, patient/family derived, value driven goals of care may be more important than protocol driven standards of care – we missed a section on patient centred care. | Thank you for your comment. We are sorry that you believe older people have been underrepresented across this guideline. This guideline covered topics prioritised during a stakeholder consultation and by guideline committee members. We have included the question on elderly care assessment units and the needs of older people were considered within all the other questions covered.<br>The committee developed a research recommendation on elderly care assessment units as there was not strong evidence to support it. The committee discussed this alongside their expert opinion and agreed a research recommendation should be made. This reflects the fact that these are relatively new units which vary across sites and would benefit from further research. We hope that future research in this area will help inform future updates of this guideline.<br>Unfortunately, training is outside the scope of this guideline.<br>At the start of the recommendations in the short version of the guideline we include a link to document about joint decision making. Please see https://www.nice.org.uk/about/nice-communities/public-involvement/your-care |
| British | Terminology | | | We would strongly encourage NICE to avoid using the word | Thank you for your comment. We have changed the |

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| Geriatrics Society and the Acute Frailty Network | | | | 'elderly' a term which homogenises and ascribes a general state to older people which we know is not true. 'Frail older people' or more recently 'older people living with frailty' is the preferred term as it immediately asks the question 'what is frail' – and we can start a conversation about frailty; or it asks 'older than what' which introduces relativism rather than absolutism and encourages thinking about individuals. This is about attitude/behaviour and role modelling, all of which are crucial to improvement. | term 'elderly' to 'frail older people' wherever we have referred to this population in the narrative. We have not changed the term 'elderly' where it appears as part of the name of an intervention for example 'elderly care assessment units' as this is the most commonly known term for the service. |
| British Geriatrics Society and the Acute Frailty Network | *Specific issues* | | | **Intermediate care**<br>We broadly support the recommendations on hospital at home, but would draw your attention to the following trial, due to report in 2018:<br>https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/1220966/#/<br>**Rehabilitation**<br>We broadly support the recommendations on hospital at home, but would draw your attention to the following on-going trial:<br>https://www.journalslibrary.nihr.ac.uk/programmes/hta/154307/#/<br>**Risk stratification tools to inform clinical decisions about hospital admission**<br>We are anxious about this as a general recommendation, as it appears not to have taken account of non-specific presentations, seen frequently in older people (e.g. immobility or delirium) that can arise from an acute medical condition. Frailty is an independent predictor of falls, delirium, disability, hospitalisation and care home admission[4-6]. Yet there was relatively little mention of incorporating frailty assessment into acute care pathways as a means of enhancing risk assessments such as early warning scores[7]. Identifying frailty can help mitigate possible under-recognition of acute illness when someone presents non-specifically or with an acute frailty syndrome (under triage).<br>**Admission units** | Intermediate care and rehabilitation<br>Thank you for your comments. NICE have also recently published a guideline on Intermediate care including reablement (2017).<br>The NIHR studies are unpublished but we will highlight them to the NICE surveillance team so they can be tracked.<br><br>Standardised hospital admission<br>The committee are not aware of any validated predictive tools for frailty. The committee have recommended the use of validated risk stratification tools to inform clinical decisions about hospital admission.<br><br>AMU and ECAU<br>The evidence for acute medical units and ECAU were both from observational studies reporting very low quality evidence. The committee were aware that despite this, one resulted in a research recommendation while the other was a positive recommendation.. AMU already exists in most centres and is well established. However, ECAUs are not widespread and their set up is varied across the country which makes it difficult to assess their effectiveness. Therefore, the committee believed that it was essential that this was a research |

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| | | | | The recommendations about Acute Medical Units (AMUs) were based upon low quality evidence, and acknowledged that RCTs were not possible. Yet a similar evidence base was reviewed for geriatric admission units but the committee made a research recommendation. Moreover, the evidence review appears to conflate liaison services and acute geriatric units, which Cochrane reviews analyse separately due to the relative strengths of the models[8]. A summary of the literature is shown here: https://academic.oup.com/ageing/article/doi/10.1093/ageing/afx104/3920268/New-horizons-in-comprehensive-geriatric-assessment?guestAccessKey=7649c909-1c07-493e-a17b-c56356c3c533 and appears to include multiple trials not cited in your review, for reasons which are not clear.<br>In addition, we would respectfully draw your attention to this on-going NIHR funded research that might be relevant: https://www.journalslibrary.nihr.ac.uk/programmes/hsdr/125000302/#/<br>We would also note that it is highly unlikely that an RCT of acute geriatric units could be undertaken, for the same reasons cited in in your guidelines pertaining to acute medical units.<br>**References**<br>1. Ellis G, Whitehead M, O'Neill D, et al. Comprehensive geriatric assessment for older adults admitted to hospital. . Cochrane Library 2011.<br>2. Fox MT, Persaud M, Maimets I, et al. Effectiveness of Acute Geriatric Unit Care Using Acute Care for Elders Components: A Systematic Review and Meta-Analysis. Journal of the American Geriatrics Society 2012;**60**(12):2237-45.<br>3. Baztan JJ, Suarez-Garcia FM, Lopez-Arrieta J, et al. Effectiveness of acute geriatric units on functional decline, living at home, and case fatality among older patients admitted to hospital for acute medical disorders: meta-analysis. BMJ | recommendation to explore how effective they actually are. We hope that research in ECAU will help inform future recommendations in any update of this guidance.<br><br>In addition, the purpose of our ECAU review was to assess the effect of admission through ECAU on patient outcomes and hospital resource usage. Interventions that were not focussed on admission were therefore excluded. The article cited in your comment includes trials of ward based acute care and interventions across ward boundaries, which commenced after patients, had been admitted to hospital. Trials of interventions based in the ED (other than the 2 included in our review) did not meet our inclusion criteria for reasons which have now been added to the excluded studies list. Unfortunately, the link to the NIHR study was not working but we hope that ongoing trials will be able to feed into updates of this guideline.<br><br>Further information on the ECAU research recommendation can be found in the Appendix. We have suggested that the research uses a RCT design in a DGH or a large observational study. Therefore, if an RCT is not possible then we have also suggested an alternative study design. |

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| | | | | 2009;**338**(jan22_2):b50-.<br>4. Clegg A, Young J, Iliffe S, et al. Frailty in elderly people. The Lancet 2013;**381**:752-62.<br>5. Fried L, Tangen C, Walston J, et al. Frailty in Older Adults: Evidence for a Phenotype. Journal of Gerontology: Medical Sciences 2001;**56A**(3):M146-56.<br>6. Boyd C, Xue Q, Simpson C, et al. Frailty, hospitalization, and progression of disability in a cohort of disabled older women. The American Journal of Medicine 2005;**118**(11):1225-31.<br>7. Romero-Ortuno R, Wallis S, Biram R, et al. Clinical frailty adds to acute illness severity in predicting mortality in hospitalized older adults: An observational study. Eur J Intern Med 2016;**35**:24-34.<br>8. Ellis G, Whitehead MA, O'Neill D, et al. Comprehensive geriatric assessment for older adults admitted to hospital. Cochrane Database of Systematic Reviews 2011(7). | |
| British HIV Association | FULL | - | - | BHIVA welcomes the draft NICE guidance "Emergency and acute medical care in over 16s: service delivery and organisation." As the specialty society representing clinicians providing clinical care to people living with HIV (PLWHIV), our patients demand and depend upon the highest quality unscheduled inpatient care. Recognising that HIV infection is now a manageable long-term condition, PLWHIV are increasingly managed in general medical settings, and the recommendations laid out here are highly relevant to their care needs. The PICO questions are sound and pertinent, the methodology robust and transparent, and the recommendations valid and well intentioned. We have no specific concerns regarding the draft recommendations or evidence summaries. We would like to take this opportunity to highlight the recommendations laid out in NG60 (HIV testing: increasing uptake among people who may have | Thank you for your comment and support of the recommendations.<br><br>The guideline remit focussed specifically on generic conditions hence we did not to go into the detail for specific diseases/conditions. Unfortunately we do not think that it is appropriate to cross refer to a NG60 as we are unable to cross refer to all the NICE guidelines relevant to acute care. |

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| | | | | undiagnosed HIV) that are relevant to the delivery of emergency and acute medical care, most notably the recommendation to offer routine HIV testing to all patients accessing unscheduled care settings in high prevalence areas. Might there be the opportunity to cross-reference this guidance in the final document? | |
| British Infection Association | Short | General | | We recommend inclusion of mention of infection in this document. If this were included we would generally support the short guideline with a hope that sufficient resources can be provided to achieve these aims. | Thank you for your comment.<br>We undertook a comprehensive scoping exercise with stakeholders to identify and prioritise key areas for inclusion in the guideline.Infection was not prioritised for this guideline.<br>However, NICE has issued guidance on antibiotic use on a number of occasions; please see: https://www.nice.org.uk/guidance/conditions-and-diseases/infections/antibiotic-use |
| British Infection Association | Full | General | | With 40 chapters of over 40 pages each our members have not had the time available to read the document in full however there is a clear absence of a chapter on infections or diagnostic microbiology. | Thank you for your comment. We were unfortunately unable to cover all areas and focused upon those that stakeholders and guideline committee members initially prioritised. |
| British Infection Association | Full | General | | Our members were unable to find mention of infection or microbiology within the document. We recommend a chapter on this area or inclusion in the full guideline given the high numbers of emergency and acute medical patients with infections, high rates of inappropriate antibiotic use and antimicrobial resistance in this population. | Thank you for your comment. We were unfortunately unable to cover all areas and focused upon those that stakeholders and guideline committee members initially prioritised. Please see the NICE guidance on antibiotic use: https://www.nice.org.uk/guidance/conditions-and-diseases/infections/antibiotic-use |
| British Infection Association | Full | General | | Co-location does not appear to have been considered and we encourage NICE to look at what associated services are required to support acute medicine. http://www.secsenate.nhs.uk/files/5514/2255/2355/The_Clinical_Co-dependencies_of_Acute_Hospital_Services_SEC_Clinical_Senate_Dec_2014.pdf?PDFPATHWAY=PDF | Thank you for your comment and the hyperlink. We undertook a comprehensive scoping exercise with stakeholders to identify and prioritise key areas for inclusion in the guideline.<br>However, we did cover some of the aspects of co-location that are mentioned in the report you cite. For example we have chapters on GPs in the ED, minor injury and walk in units, and liaison psychiatry. |
| British | | 8 | 2 | We strongly support the use of risk stratification tools to | Thank you for your comment. |

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| Thoracic Society. | | | | inform clinical care. This includes decisions regarding admission, hospital at home/ early discharge, level of care and readmission avoidance. Exacerbation of COPD (ECOPD) is the second commonest reason for emergency hospital admission, and up to 43% of patients are readmitted within 90 days. Consequently, ECOPD warrants specific attention, but this is currently lacking. The DECAF score was developed in 2,645 patients across 6 UK hospitals to predict acute mortality risk, is simple to score at the bedside, outperforms alternative tools (Thorax 2012 and 2016) and is included in the National COPD Rolling Audit. Of note, ~50% of patients triaged for admission are low risk (mortality 1%) thus admission may be avoided, length of stay reduced or care provided within hospital at home. High risk patients warrant early escalation / more intensive intervention. The current published evidence supports use of DECAF. Clinical implementation of such tools is rarely supported by RCT evidence; an RCT showing hospital at home selected by low risk DECAF score is safe, clinically and cost effective and preferred by 90% of patients has been presented at the BTS and paired papers are under review; this will further strengthen the evidence base. PEARL predicts risk of readmission within 90 days and outperforms alternative tools (Thorax 2017, n = 2,417). Use to select patients for readmission avoidance services (as recommended in 1.1.3; 1.1.5; 1.1.9) may help ensure most efficient use of resources. | The committee have recommended the use of validated risk stratification tools to inform clinical decisions about hospital admission. The committee are not recommending specific scores as this guideline did not cover specific conditions. |
| British Thoracic Society. | | 8 | 5 | We support this recommendation, however the term "undifferentiated" is open to interpretation and we suggest rewording to support triage directly to the most appropriate speciality based on the dominant reason for admission (accepting that most patients have one or more comorbidities), if supported by a 7 day specialist consultant service. The Northumbria Specialist Emergency Care Hospital (NSECH) opened in June 2015. Patients are triaged to acute speciality wards according to the dominant reason for admission, supported by a 7 day specialist consultant | Thank you for your comment. After careful consideration, the guideline committee do not agree that 'undifferentiated' should be removed from the recommendation. It is used to distinguish the early stage of admission when there is uncertainty. This is opposed to when patients have clearly defined conditions that can be managed on specific pathways. Thank you for feedback on local data. We look forward to ongoing research in this area which could help inform future updates of this guidance. |

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| | | | | service, with a minority managed through acute medicine when appropriate. Data on 6,291 consecutive ECOPD admissions spanning introduction of this model of care was presented at the NCEPOD NIV report launch. NSECH was associated with a substantial fall in in-hospital mortality (to 3.8% overall, and 9.2% for those requiring ventilation) from a strong baseline. Most patients had one or more co-morbidities. Care is influenced by DECAF score (low and high risk groups). Many other hospitals offer direct speciality admission for certain specialities/ conditions. | |
| British Thoracic Society. | | 8 | 16 | Compared to 12 hours, consultant review within14 hours is more achievable for patients admitted late evening / overnight and has been cited in other reports. | Thank you for your comment and feedback. The committee discussed your comment and agreed. Recommendation 1.2.5 has been updated changing '12 hours' to '14 hours'. |
| British Thoracic Society. | | 8 | 18 | It is unclear whether daily consultant review applies to all patients, which would be difficult to achieve, or to new admissions until clinically improving (and any patients showing unexpected deterioration or requiring senior review regarding discharge). Prompt assessment of the latter group by a consultant, particularly the most appropriate specialist, is more achievable and should improve outcomes. | Thank you for your comment. The committee agree that frequency of review should be dependent on clinical need and this is made explicit in the recommendation (third bullet – 'based on clinical' and final sentence – 'severity of illness'. |
| British Thoracic Society. | | 12 | 1 | We support the research recommendations. Consider implementation studies assessing the clinical and cost-effectiveness of use of risk stratification tools to inform clinical decisions (ideally RCTs, but acknowledging the challenges and that other trial designs should also be considered). | Thank you for your comment. Further detail on the research recommendations can be found in the Appendix including study designs suggested by the guideline committee. |
| College of Paramedics | 3 | 5 | 10 | The College of Paramedics supports the enhancement of competencies for paramedics but as noted in general comments, cannot overstate the challenge to ensure this is achieved in a consistent and standardised way across the UK.<br><br>Ambulance services should all take note of the guidance provided by the professional body for paramedics in regards education, competencies and career progression. | Thank you for your feedback. A link to the paramedic postgraduate curriculum will be inserted into the narrative supporting this recommendation. |
| College of | 3 | 13 | Gener | The College of Paramedics agrees that not all paramedics | Thank you for your comment and for the link to the |

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| Paramedics | | | al | should be trained to specialist and advanced paramedic level. It also fully agrees that the opportunity for paramedics to progress their careers to advanced paramedic level will be a significant factor in retention of paramedics within the UK ambulance services.<br><br>The College of Paramedics has also produced the Paramedic Post Graduate Curriculum Guidance which details the requirements of Specialist, Advanced and consultant paramedics and is available at https://www.collegeofparamedics.co.uk/downloads/1703020ParaPostGradCurricGuide17FinalNew.pdf | paramedic postgraduate curriculum which we shall insert into the narrative supporting this recommendation. |
| College of Paramedics | 3 | 14 | General | In its submission to the HEE's Workforce Planning and Strategic Framework (Framework 15) 2015/16 Call for Evidence document the College of Paramedics recommended that of the 12,500 paramedics working for NHS England Ambulance Trusts, there should be a minimum of:<br>6,000 Specialist Paramedics Urgent and Emergency Care<br>2,000 Specialist Paramedics Critical Care<br>1,000 Advanced Paramedics<br>And pro-rata figures for the devolved nations; Northern Ireland, Scotland and Wales.<br><br>The figures noted above would need to be reviewed since the Health and Care Professions Council's website shows there are now 24,285 paramedics registered in the UK.<br><br>This would present significant challenges for the NHS ambulance services and commissioners and have significant cost implications. | Thank you for this feedback and for the recommended figures. The committee agree that the provision of paramedics with enhanced training would have initial resource implications. These may be offset by future savings to the wider system in terms of fewer ED attendances, fewer admissions and fewer ambulance call-outs. The committee support the ongoing training and career opportunities across the NHS. |
| College of Paramedics | 3 | 15 | General | Paramedic vacancies and retention are major issues for UK ambulance services. The College of Paramedics believes there has been insufficient attention given to career development and career opportunities and has addressed this in its Post-Registration Career Framework. | Thank you for your comment. The guideline committee believe that this has the potential to offer career progression and, in turn, to promote better staff retention. The initial resource implications are acknowledged. The benefits of advanced paramedics |

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| | | | | There will be challenges for NHS ambulance services and commissioners and there would be significant costs involved to ensure that career development opportunities have a positive impact of the current retention issues | practice may not be immediately realised until trainee advanced paramedics are sufficiently educated and experienced. |
| College of Paramedics | 4 | 7 | General | The College of Paramedics is concerned to note the implication that an advanced nurse practitioner and a consultant paramedic are of equal standing. Standardised career and competencies frameworks should ensure that each level equates to its counterpart positions in other professions such as the Careers in Allied Health Professions document which can be accessed at https://www.healthcareers.nhs.uk/sites/default/files/documents/Careers%20in%20the%20allied%20health%20professions_0.pdf | Thank you for your feedback. It was not the intention of the Guideline Committee to imply that an advanced nurse practitioner and a consultant paramedic are of equal standing in the sentence relating to the cost implications of a 24-hour remote support service ("…a GP, advanced nurse practitioner or consultant paramedic…"); it was simply listing some of the potential alternatives for remote support that might be appropriate. However, we have now changed 'consultant paramedic' to 'advanced paramedic' for consistency, in line with the document that you have cited. |
| College of Paramedics | 3 | 5 | General | In part the approach/background research seems a bit dated. More recent work on various projects involving the College of Paramedics along with other organisations (for example on education with HEE support and prescribing by Advanced Paramedics with NHS England) may be helpful and informative. | Thank you for your comment. The committee considered randomised and observational studies that meet the study protocol for this review. One randomised and one non randomised controlled trial was identified for inclusion. The committee did not believe that it would be useful to search for lower levels of evidence. Please see Appendix G for further information on studies that were excluded and the reason for exclusion. The committee were confident that the evidence alongside expert opinion was sufficient to support the recommendation |
| College of Paramedics | Short version | General | General | Specialist and advanced paramedics are already working in a wide range of health settings and may have an impact in other guidelines relating to: Extended access to GP Services; GP practices located near or in Emergency Departments; GP - led home visits; Extended opening of Emergency | Thank you for this comment; we recognise and acknowledge that advanced paramedics are already working in a variety of healthcare settings. This has the potential to offer career progression and, in turn, to promote better staff retention. The initial resource |

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| | | | | Departments; and Urgent Care and Walk-in centres.<br><br>The attractiveness of specialist and advanced paramedics to other health providers and the attractiveness of those providers to the paramedics will have negative impact on the retention ability of NHS ambulance services. This is an area that may require research to fully understand why and when paramedics leave the ambulance services. | implications are acknowledged. |
| College of Paramedics | Short version | 12 | General | Research is needed for hear-and-treat services including what standardised training should be adopted for specialist and advanced paramedics undertaking such roles in ambulance control centres | Thank you for your comment. This was not an area reviewed by the guideline. We hope that training requirements will be considered by the appropriate bodies. |
| College of Paramedics | Short version | 6 | 12-13 | Paramedics have a role to play here by being part of an integrated team, they are particularly useful in joint patient assessment alongside OTs, pharmacists etc and can undertake on the spot ECGs and provide treatment such as wound care or antibiotic therapy where indicated. This approach will then allow the patient to receive a truly holistic assessment by a multi-disciplinary team that manages to avoid admissions by the right care in the right place which should probably be the main focus with hospital avoidance being a desirable bi-product of this model of care.<br>Although the available evidence is limited, there is strong opinion that specialist and advanced paramedics are most effective when working as part of multi professional team and in a setting that makes best use of their education training and experience gained from working in the out-of-hospital environment. | Thank you for your comment. The guideline committee agreed that appropriate use of current resources is important particularly to avoid unnecessary duplication. A multi professional or multidisciplinary team would be an important part of delivering this service. It would be important to measure and record outcomes to develop the evidence to direct the best way of working and how services should be configured. |
| College of Paramedics | Short version | 10 | General | Putting Guideline into Practice – there needs to be targeted funding for NHS ambulance services to educate their clinicians through advanced practice programmes and for NHSE and CCGs to provide funding to deliver SPs and APs as part of the core workforce. The former emergency care practitioner schemes were needed at that time, but they were piecemeal and there now needs to be longer-term workforce planning to provide stability for service-provision and | Thank you for your comment. We hope that our recommendations are implemented. |

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| | | | | retention of staff.<br><br>There will be significant challenges and funding for commissioners. | |
| Department of Health | General | Full | Full | I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation. | Thank you for participating in the consultation process. |
| East Midlands Ambulance Service NHS Trust | Short version | General | General | The Trust agrees with the notion that enhanced roles for Paramedics (and other ambulance clinicians) will contribute to the management of patients being cared for in more appropriate settings than the Emergency Department. It is acknowledged that there is a paucity of evidence but there are a number of schemes operating across the UK that evidence improved quality of care and patient experience. | Thank you for your feedback. |
| East Midlands Ambulance Service NHS Trust | Short version | General | General | The guideline whilst dealing with acute and emergency care, the focus is upon management in community or non-ED settings. There is little reflection of acute care pathways for the sickest of patients, for example sepsis. Whilst other guidance does address such issues this should be referred to in the guidance. For example recommended triage tools to ensure that those who need emergency care in an ED setting receive it in a timely manner. | Thank you for your comment. Sepsis is covered in a separate NICE guideline published 2016. Please see Sepsis: recognition, diagnosis and early management (https://www.nice.org.uk/guidance/ng51). We do not believe that it should be referenced in this guideline as we have not covered any disease specific conditions. |
| East Midlands Ambulance Service NHS Trust | Chapter 3 | General | General | The isolated reference to Paramedics as the only pre-hospital clinicians is not reflective of the breadth of practitioners in out of hospital care and does not drive the multi disciplinary team agenda. It is recognised that this section may be based upon the group as a specified has been identified. | Thank you for your comment. The initial scope for this topic was related specifically to paramedics. The majority of pre-hospital care is provided by paramedics. The search terms used for the interventions studied under the umbrella of "paramedics with enhanced competencies" included "specialist and advanced paramedics, paramedic practitioner or emergency care practitioner". |
| East Midlands Ambulance Service NHS Trust | Short version | 6 | 9 | Reference is made to Nurse-led services. This would ideally be Nurse or AHP led to recognise the role of other specialities in community care. | Thank you for your comment. This review question was focused on community nursing and the services that nurses will lead in specialist services and their role in long term care. We recognise that allied health professionals undertake critical roles in community care but this question was not covered in the |

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| | | | | | evidence review for this guideline. |
| East Midlands Ambulance Service NHS Trust | Chapter 4 | General | General | We welcome the identified role for remote support and the need for further evidence to establish the benefits of such interventions. | Thank you for your comment. |
| East Midlands Ambulance Service NHS Trust | Chapter 3 | General | General | The role of commissioning and strategic workforce planning requires consideration within guidance to ensure that variability across regions is minimised (accepting that localisation of elements may be necessary to meet demographics and clinical need). The enabler of funding mechanisms to provide advanced practice education schemes cannot be underestimated. This would enable advanced competency clinicians to be a part of a core workforce. | Thank you for your comment. We acknowledge that models of service delivery for paramedic practitioners needs to take account of local geography, population demographics and availability of and access to other health and social services within the chapter (section 3.6 other considerations).<br>We have added a link to the appropriate post graduate training schemes into section 3.6. |
| East Midlands Ambulance Service NHS Trust | Short version | General | General | We welcome to recommendations for improved advanced care planning, alternatives to hospital care and the role of 24/7 services. For ambulance services care provision to be effective, systems need to be in place to support pathays of care. | Thank you for your response. |
| London Ambulance Service NHS Trust | Ch 3 | General | General | We support the recommendation to provide specialist and advanced paramedic practitioners who have extended skills in assessing and treating people with medical emergencies.<br><br>This is likely to have a significant impact on practice; however, will be challenging to implement especially for ambulance services that have yet to develop specialist and advanced paramedic practitioners within their career structures. The recommendation will be challenging for ambulance services from a financial perspective, in that this would require significant investment in education and training, and associated back-fill of 'standard' paramedic vacancies. There may be implications for academic providers in terms of capacity, and the maintenance of quality | Thank you for your response. The committee acknowledge that there will be resource and training issues associated with this recommendation within the chapter linking evidence to recommendation section. We acknowledge that there are challenges implementing this recommendation. The committee hope that this recommendation will be implemented. |

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| | | | | in terms of delivery. Successful training in specialist and advanced practice roles also requires support from the wider healthcare system in terms of placements, which may require additional funding.<br><br>Successful deployment of advanced and specialist practitioners may also require changes to ambulance dispatch models, which may require financial support to develop. Additionally, rotational working models may aide support clinical safety.<br><br>In order to realise the investment required, ambulance services may be able to modify existing models of service delivery to make finances available. In addition, investment from bodies such as Health Education England may be able to access funds to support the delivery of academic education. | |
| London Ambulance Service NHS Trust | Ch 12 | General | General | The Trust supports alternatives to hospital in principle and is keen to work with providers to support patients closer to home where possible. We would highlight the need to engage with providers to ensure accessibility for ambulance service staff to make referrals. From the perspective of paramedics, and specialist and advanced paramedics, the ability to avoid admissions for more complex patients often rests on the availability of local pathways to provide the support needed to manage patients in the home with acute medical crisis. Providing sufficient capacity for reliable and responsive services will require system and financial input. | Thank you for your comment. Direct referrals by ambulance staff to secondary care services are already happening but it is variable. The guideline committee agree that credible alternatives to hospital are required to deliver equivalent processes of care to patients in their own homes and such services require funding. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 5 | 14 | The CRG supports this recommendation | Thank you for your comment. |

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| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 5 | 18 | The CRG supports this recommendation | Thank you for your comment. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 6 | 8 | The CRG supports all of the recommendations in this section and would anticipate " value for money" if implemented | Thank you for your comment. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 8 | 2 | The CRG supports this recommendation but advise that this will not be comprehensive | Thank you for your comment and feedback. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 8 | 5 | The CRG supports this recommendation but would like to see a comment about " pull" through from AMU to medical specialities | Thank you for your comment. The same principle applies throughout the system and into the community. However, this was not reviewed and we are unable to make recommendations where we have not searched for the evidence. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 8 | 8 | The CRG's opinion is that this is a must and not an optional recommendation | Thank you for your comment. The Committee proposed that its consultation wording of the recommendation should be retained due to the lack of supportive evidence, i.e. 'consider providing access to liaison psychiatry services for people with medical emergencies who have mental health problems.' Final approval prior to publication is required from |

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| | | | | | NICE.<br>NICE noted that stakeholder comments received on the committee's draft wording advocated strengthening it and gave reasons for this.<br>NICE also noted that NHS England's seven day service standards require that:<br>*Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.*<br>Accordingly, NICE decided to strengthen the wording of the recommendation by changing it to 'provide access to liaison psychiatry services for people with medical emergencies who have mental health problems.' |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 8 | 14 | The CRG's opinion is that this is a must and not an optional recommendation as may be interpreted by using the word "consider" | Thank you for your comment. After careful consideration, the guideline committee did not agree that this recommendation should be strengthened. The clinical and cost effectiveness evidence is not strong enough to support a strong recommendation. |
| NHS England Adult Critical Care Clinical Reference Group. | Short version | Page 8 | 24 | The CRG support all of the recommendations in this section | Thank you for your comment. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 9 | 11 | The CRG support all of the recommendations in this section | Thank you for your comment. |

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| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 9 | 19 | The CRG supports this recommendation and would like to draw attention to the recommendations of the AAGBI (Association of Anaesthetists of Great Britain and Ireland ) and Intensive Care Society where detailed evidence relating to standards for transfer of critically ill patients is written. These publications are not listed in the full version. | Thank you for your comment. We have noted that there is already guidance in place in the 'other considerations' of the linking evidence to recommendations section for this chapter. We have now edited this to include references to the AAGBI safety guidelines for inter-hospital transfer and Inter-hospital transfer of the critically-ill patient. Some of the references in the AAGBI safety guideline for inter hospital transfer have already been included in our review; however other references could not be included as they did not meet our protocol criteria to be included in our evidence review. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 10 | 14 | The CRG supports this recommendation and would recommend that this includes matching patient need to medical staffing within the ED | Thank you for your comment and feedback. We are unable to add this to the recommendation as it is outside the scope of this guideline. |
| NHS England Adult Critical Care Clinical Reference Group. | Short Version | Page 16 | 19 | The CRG supports research involving Hospital Radiology services : both configuration to support 7 day diagnostic imaging/reporting and would wish to see interventional radiology included in this theme as it is pivotal to delivery of optimal emergency care. | Thank you for your comment. This review question was prioritised by the guideline committee and did not include interventional radiology. |
| North West Ambulance Service NHS Trust | 2.12 | 27 | General | RR1 – NHSE workforce deployment work (which is developing layers of advisors within the 111 setting) would further help/complicate this.<br>It's a commonly quoted statement that the algos are "risk adverse" – however there is no evidence for this statement. Also the 5YFV is 30% calls receiving clinical assessment by Oct 2017 and 40% by March 2018. | Thank you for your comment.<br>It was the consensus opinion of the guideline committee that the algorithms were risk averse. Although an observational study, there is some evidence supporting this view. 'Potential for advice from doctors to reduce the numbers of patients referred to emergency department by NHS 111 call handlers: observational study by Anderson and Roland |

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| | | | | | (http://bmjopen.bmj.com/content/5/11/e009444). The next steps on the NHS five Year Forward view plans to increase the proportion of 111 calls receiving clinical assessment to 30% by March 2018 and this is quoted in the linking evidence to recommendation section. |
| North West Ambulance Service NHS Trust | 4 | General | General | Agree with research suggestions. NWAS has extensive experience with funded GP referral scheme as mentioned in the guideline as being too expensive.<br>Blodgett JM, Robertson D, Ratcliffe D, Rockwood K. An alternative model of pre-hospital care for 999 patients who require non-emergency medical assistance, International Journal of Emergency Services, 2017: 6(2),99-103 | Thank you for your comment and information on GP referral schemes. The committee did not conclude that such schemes are too expensive, rather that there is not yet good evidence to show if they represent good value. We hope that the recommendation for research will provide further evidence on clinical and cost effectiveness of paramedic remote decision support for future updates of this guideline. Thank you for referencing the paper which we have looked at. However the study cannot be included in this review as it did not meet the inclusion criteria. |
| North West Ambulance Service NHS Trust | 3 | General | General | This chapter is rather restrictive in perspective of the ambulance service. Specialist and advanced paramedics, plus urgent care or emergency care practitioners have roles across the spectrum of the patient pathway. This chapter focuses on decision making face to face, with a small mention of triage. If we consider prevention, then managing the initial call in a more clinically accurate system (enhanced by paramedics), followed by targeted specialist and advanced paramedic or urgent and emergency care practitioner face to face review, then the scope for safe 'hear and treat' and 'see and treat' can be considered.<br><br>A key area in respect of paramedic practice is to establish a critical understanding of the decision making skills and capability of ambulance clinicians. A piece of work was carried out in 2010/11 to assess unsupported differentiation skills and identified significant risk in certain clinical areas Cardiac v MSk Chest Pain, Primary presentations of | Thank you for your feedback. The distinction between face-to-face and triage systems is acknowledged within the narrative supporting the recommendation as is the potential scope for "hear and treat" systems. A crucial part of safe implementation will include an understanding of the decision-making skills and capabilities of individual paramedics. However, paramedic advanced competencies was prioritised for inclusion in the scope and this was the focus of our question.<br><br>Thank you for referencing the paper which we have looked at. However, the study cannot be included in this review as the intervention is not covered on our protocol. |

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| | | | | headache, and urinary retention. On the basis of a specific and overall under triage rate of 13%, an alternative approach was taken that harnessed the ability to identify symptoms with a system that promoted reductive approaches to decision making. This improved the sensitivity and specificity of decision making tools and by design, the clinical safety. NWAS study in 2014; Newton M, Tunn E, Moses I, Ratcliffe D, Mackway-Jones K. Clinical navigation for beginners: the clinical utility and safety of the Paramedic Pathfinder Emerg Med J 2014;31:e29-e34 | |
| North West Ambulance Service NHS Trust | 12 | General | General | 'Rapid response' services that exist to 'deflect' patients away from the ED need to be 24 hour, 7 days and cover a sufficient geographical area to enable the ambulance services to use them appropriately. There also needs to be formalised feedback regarding outcomes to ensure ongoing clinical development of staff. | Thank you for your comment. The review of evidence did not find sufficient evidence to make a separate recommendation on rapid response schemes.<br><br>The guideline committee agreed that there was a need for communication between all providers who are involved in alternatives to hospital admission; hopefully this should be incorporated into emergency care networks. Time for reflections and measuring and recording data are also important.<br><br>Formalised feedback would be helpful for all referrers, irrespective of their professional training, in order to continue to develop skills. This is a generic issue for all healthcare provision, rather than specific to referral into services that are alternatives to hospital admission. |
| North West Ambulance Service NHS Trust | 17 | General | General | Paucity of evidence to the standard that NICE would consider robust enough to include in recommendations. | Thank you for your comment. There was a lack of good quality evidence in the area and this was the basis for the recommendation for further research. |
| North West Ambulance Service NHS Trust | 32 | General | General | Consider structured handover for out of hospital referral too. | Thank you for your comment. This particular question covered structured handover between healthcare professionals between shifts in any acute care setting. It did not cover handover from one setting to another |

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| | | | | | and therefore we have not searched for that evidence. However, the chapter on hospital transfer (Chapter 34) covered patient handover from one hospital to another and from one department to another within the same hospital. |
| North West Ambulance Service NHS Trust | Overall | General | General | The scope of the guidance is too large and too many of the areas of the topic lack appropriate evidence for NICE to be able to make any recommendations. | Thank you for your comment. The specific areas included were prioritised by the guideline committee and stakeholders. The committee have made recommendations when there was sufficient evidence to support them and where there was no or limited evidence the committee has made research recommendations. |
| Roche Diagnostics Ltd | 35 | General | | We support the recommendation that discharge planning should start at the time of admission for a medical Emergency. However, we are concerned that to limit of focus of the research question to "early" discharge planning, fails to take into account the need for "effective" discharge planning.<br><br>For example, we know that readmissions rates and mortality in patients admitted for heart failure are high. The National Heart Failure Audit reported that 6.4% of patients who survived to discharge died within 30 days, one-year overall mortality was 29.6% and rates have remained unchanged for six years.[1] Furthermore, as the median length of stay at readmission is the same as the index admission (8 days), this represents a particular burden to the health system [2].<br>Patients admitted with Acute Decompensated Heart Failure (ADHF) are associated with even higher rates of mortality and frequent readmissions in the first six months after discharge.[3] There is a large body of evidence that demonstrates that a lack of reduction in NT-proBNP during admission and higher absolute NT-proBNP levels at discharge significantly predict readmissions and mortality after discharge In ADHF patients.[4-8]<br><br>Therefore, we would ask the Committee to consider widening | Thank you for your comment. The guideline committee agreed that the discharge plan should be made on admission in order to enable adequate time to make the necessary arrangements. Our focus here is not on specific risk indicators for specific diseases, which are evaluated under disease-specific NICE guidance, but on the general principles of service organisation.<br>We included several outcomes in our review which considered the effectiveness of discharge planning. Our outcomes included:<br>• Readmission up to 30 days<br>• Mortality<br>• Avoidable adverse events<br>• Quality of life<br>• Patient and carer or family satisfaction<br>• Length of stay<br>• Delayed transfers of care<br>• Staff satisfaction |

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| | | | | the scope of the review question to "Does discharge planning facilitate earlier and more effective hospital discharge", and review evidence in cardiology and other disease areas to assess this.<br><br>1. National Institute for Cardiovascular Outcomes Research. National Heart Failure Audit April 2014 - March 2015. July 2016<br>2. National Institute for Cardiovascular Outcomes Research. National Heart Failure Audit April 2013 - March 2014. October 2015<br>3. Stienen, S., Salah, K., Eurlings, L. W.M., Bettencourt, P., Pimenta, J. M., Metra, M., Bayes-Genis, A., Verdiani, V., Bettari, L., Lazzarini, V., Tijssen, J. P., Pinto, Y. M. and Kok, W. E.M. (2015), Challenging the two concepts in determining the appropriate pre-discharge N-terminal pro-brain natriuretic peptide treatment target in acute decompensated heart failure patients: absolute or relative discharge levels?. Eur J Heart Fail, 17: 936–944.<br>4. Bayes-Genis A, Lopez L, Zapico E, Cotes C, Santalo M, Ordonez-Llanos J, Cinca J. NT-ProBNP reduction percentage during admission for acutely decompensated heart failure predicts long-term cardiovascular mortality. J Card Fail 2005;11:S3–S8.<br>5. Bettencourt P, Azevedo A, Pimenta J, Frioes F, Ferreira S, Ferreira A. N-terminal-pro-brain natriuretic peptide predicts outcome after hospital discharge in heart failure patients. Circulation 2004;110:2168–2174.<br>6. 4 Kubler P, Jankowska EA, Majda J, Reczuch K, Banasiak W, Ponikowski P. Lack of decrease in plasma N-terminal pro-brain natriuretic peptide identifies acute heart failure patients with very poor outcome. Int J Cardiol 2008;129:373–378.<br>7. Michtalik HJ, Yeh HC, Campbell CY, Haq N, Park H, Clarke W, Brotman DJ. Acute changes in N-terminal pro-B-type natriuretic peptide during hospitalization and risk | |

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| | | | | of readmission and mortality in patients with heart failure. Am J Cardiol 2011;107:1191–1195<br>8. 6. McQuade CN, Mizus M, Wald JW, Goldberg L, Jessup M, Umscheid CA. Brain-Type Natriuretic Peptide and Amino-Terminal Pro–Brain-Type Natriuretic Peptide Discharge Thresholds for Acute Decompensated Heart Failure: A Systematic Review. Ann Intern Med. 2017;166:180–190. | |
| Roche Diagnostics Ltd | 7 | General | | We appreciate that point-of-care BNP cardiac marker testing could not be recommended due to lack of evidence. However, as the "Focus on Heart Failure" report pointed out, access to BNP testing is variable across the country with one-third of GPs and hospital trusts without any access.[1] We would remind the committee that as well as standard NT-proBNP testing, "STAT" (nine-minute turnaround time) NT-proBNP testing is also available, though not widely adopted within the NHS. The abovementioned report recommends that all clinical commissioning groups should commission cost-effective NT-proBNP testing. Wider adoption of the "STAT" or the standard NT-proBNP test even in hospital, while not reducing the referrals to secondary care, could facilitate reducing the length of stay in Emergency Departments and improve patient satisfaction.<br>1. All-party Parliamentary Group on Heart Disease. Focus on Heart Failure. September 2016. | Thank you for your comment. The guideline committee agree that access to BNP testing is an important consideration for people with heart failure and inflammatory illnesses, and searched for evidence on the clinical and cost-effectiveness of BNP tests including STAT/standard NT-proBNP tests to address this. However, little evidence was available to inform a recommendation for clinical practice, and it was the consensus of the committee not to make any recommendation for BNP testing. This has been noted in 'Trade-off between benefits and harms' section of the linking evidence to recommendations'. |
| Royal College of Anaesthetists | Chapter 4 | General | General | Supportive of research suggestion. This recommendation should be extended to include other practitioners such as Physicians Associates and Advanced Critical Care Practitioners working in remote or distant situations accessing telemedical support. | Thank you for your comment. These populations were not included in the review question drafted by the committee. The research recommendation must reflect the population within the review question as we did not look for evidence on other populations and there may already be evidence available. |
| Royal College of Anaesthetists | Chapter 15 | General | General | Supportive. The availability and transfer of relevant information is very important, advance directive documents are often not available during an emergency admission leading to potential inappropriate treatment being offered. It is noted that many patients would choose to die at home | Thank you for your support.<br><br>We have edited the section on Trade-off between costs and health effects:<br>"The wider implementation of advanced care planning |

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| | | | | rather than in hospital but other work has shown that relatives may not be comfortable with this. The document makes no comment about the cost of providing care and support in the community to both the dying and their relatives. | would require more input from community based palliative care services for patients and their families. However, the committee felt that for many patients it would be less resource intensive to die at home. ACP reduces hospital admission and emergency department visits which might be translated into cost savings. The committee also noted that none of the studies assessed hospital length of stay as an outcome.<br>Additionally, evidence considered in the review of community palliative care (Chapter 14) suggests that this service was cost saving.<br>Based on their collective experience, the committee believed that caring for terminally ill people at home can release hospital beds for other patients and this would allow the hospital to use its available resources more efficiently".<br>The clinical evidence for advance care planning suggested a benefit for family satisfaction (reported as a dichotomous outcome) in one study and no difference (when reported as a continuous outcome) in another study. |
| Royal College of Anaesthetists | Chapter 20 | General | General | Supportive of call for research into clinical and cost effectiveness of physician extenders. The use of these new groups of workers particularly PAs and ACCPs has increased in the UK and new research within the UK health economy and culture is needed. | Thank you for your comment. |
| Royal College of Anaesthetists | Chapter 22 | General | General | Not sure a research recommendation is helpful. Expert opinion is available from Royal College of Radiologists and Royal College of Physicians among others on what investigations or interventions are necessary to provide an optimal acute medical service. Matching of workload and referral patterns to service configuration will be dependent on population density and geography. Would be appropriate for NICE to support expert opinion. | Thank you for your comment. There was no evidence identified for this review question. After careful consideration, the guideline committee decided that they could not make a positive recommendation without any evidence to support this. The value of radiology support to acute clinical services was clearly recognised as was the current widespread provision of elements of 7-day radiology service. This is why the |

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| | | | | | focus of the research recommendation was not so much the absolute presence or absence of a service but rather its optimal configuration. |
| Royal College of Anaesthetists | Chapter 24 | General | General | Support the pragmatic though poorly evidence based recommendation that patients should be assessed and have initial management in AMUs. We echo the recognition that it is important to have appropriate levels of staffing, use established best practice guidelines and defined pathways of care. | Thank you for your comment. |
| Royal College of Anaesthetists | Chapter 27 | General | General | We recognise that the evidence base is lacking and applaud the decision to support CCOT by recommending that they be considered we would of course have welcomed stronger support, based on the clinical experience and expertise of the committee. We do wish to support the experience based comment of the committee that CCOT provide an important support and link system within hospitals contributing to earlier recognition of and response to deterioration and overall integration of patient services between ward and critical care. We note that the evidence for AMUs is no stronger but they are recommended based on expert opinion. We recognise this is a difficult area for research particularly given the wide variation in design, function and staffing of these services. We would welcome and support prospective studies examining the optimal system for providing education, support, early recognition of deterioration and intervention for acute medical patients. In particular, step change interventions such as that used by Jung (93) would enable fine tuning of models for CCOT and provide support for particular models of service. | Thank you for your feedback and broad support for the recommendation. There was much discussion within the guideline committee highlighting the conflict of positive personal experience of committee members related to CCOT against the lack of robust positive RCT or economic evidence. It was also recognised that, irrespective of a recommendation being published, the majority of NHS acute provider trusts already possess the equivalent of a CCOT, although the composition and standard operating policies vary significantly. It was acknowledged that a research recommendation might allow more formal evaluation of the efficacy of CCOT and specifically the composition and remit of such systems. However, on balance, it was felt that a "consider" recommendation best reflected the views of the committee and allowed some flexibility in individual institutional implementation of CCOT. The committee wanted to encourage evaluation and therefore included a statement in the recommendation that if the service is provided it should be accompanied by local evaluation. We acknowledge that the evidence for acute medical units was from observational studies reporting very low quality evidence. However, after careful consideration the committee agreed on a positive recommendation for AMUs as they already |

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| | | | | | exist in most centres and are well established. |
| Royal College of Anaesthetists | Chapter 29 | General | General | Support the recommendation for coordinated multidisciplinary care, this model works well in surgery and critical care and whilst the evidence base is deficient it would be expected to improve care of acute medical patients too. | Thank you for your response. |
| Royal College of Anaesthetists | Chapter 32 | General | General | Support the strong recommendation despite the absence of quality evidence. Handovers between shifts and at break points in care e.g. primary to secondary care or vice versa, or between teams (such as discharge from intensive care to ward) should be recognized as requiring different emphasis and amount of information. We welcome the recognition of good handovers requiring training. | Thank you for your comment. A comment has been added to the 'other considerations' of the linking evidence to recommendation section, stating that handovers between primary and secondary care may require different emphasis and amount of information. |
| Royal College of Anaesthetists | Chapter 34 | General | General | Strongly support the recommendation. Only very limited mention is made of the possible implications of service reconfiguration driven either via STPs or evidence supporting regionalisation of services. We have seen changes in trauma, burns, ECMO for severe respiratory failure, and stroke, each of which has demonstrated improvements in outcome for patients and it maybe that similar centralisation of care will be seen in other disease processes. Increases in transfers for upgrade care or driven by a reduction in the numbers of hospitals providing 24/7 acute services driven by STPs may change the balance towards specialist transfer services. Particular problems of distance or difficulty of transfer may require bespoke solutions, a general statement recognising the downside of inadequate transfers would be helpful. | Thank you for your comment. The guideline committee made a strong recommendation to use standardised systems of care when transferring critically ill patients. The committee do not think it would be useful to include a statement of the downside of inadequate transfers as it is implicit in this recommendation that an absence of standardised systems are harmful to patients and staff. |
| Royal College of General Practitioners | full | Chapter 2 | General | There is a specific need to differentiate between non-GP 'clinical' call-handling, GP 'clinical' call-handling and non-clinical call-handling models. Research priorities in this area also need to focus on which software tools are most applicable to which setting. There is a notable body of qualitative work looking at what purpose/function the | Thank you for your feedback. These specific issues will need to be addressed as part of any research evaluating the use of clinical call handlers and their supporting software tools. We have added this information into the research recommendation in the Appendix. |

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| | | | | telephone contact serves in the lives of callers, that suggests for many the telephone call for help serves as a 'complex consultation'. The development of tools & training of both clinical and non-clinical call-takers around this matter needs to be a core aspect of service development. This is not fully reflected in this chapter. | |
| Royal College of General Practitioners | full | Chapter 3 | general | This chapter is rather restrictive in perspective of the ambulance service. Specialist and advanced paramedics, plus urgent care or emergency care practitioners have roles across the spectrum of the patient pathway. This chapter focuses on decision making face to face, with a small mention of triage. If we consider prevention, then managing the initial call in a more clinically accurate system (enhanced by paramedics), followed by targeted specialist and advanced paramedic or urgent and emergency care practitioner face to face review then the scope for safe 'hear and treat' and 'see and treat ' can be considered.<br><br>A key area in respect of paramedic practice is to establish a critical understanding of the decision making skills and capability of ambulance clinicians. A piece of work was carried out in 2010/11 to assess unsupported differentiation skills and identified significant risk in certain clinical areas Cardiac v Muscloskeletal Chest Pain, Primary presentations of headache, and urinary retention. On the basis of a specific and overall undertriage rate of 13%, an alternative approach was taken that harnessed the ability to identify symptoms with a system that promoted reductive approaches to decision making. This improved the sensitivity and specificity of decision making tools and by design, the clinical safety. EMJ 2014 31, 1e. Clinical navigation for beginners: the clinical utility and safety of the Paramedic Pathfinder. | Thank you for your feedback. The distinction between face-to-face and triage systems is acknowledged within the narrative supporting the recommendation as is the potential scope for "hear and treat" systems. The guideline committee believe that a crucial part of safe implementation will include an understanding of the decision-making skills and capabilities of individual paramedics. However, paramedic advanced competencies was prioritised for inclusion in the scope and this was the focus of our question.<br><br>Thank you for referencing the paper which we have looked at. However, the study cannot be included in this review as the intervention is not covered on our protocol. |
| Royal College of | full | Chapter 4 | general | The research suggestions appear appropriate. North West Ambulance Service NWAS has extensive experience with | Thank you for your comment and information on GP referral schemes. We hope that the recommendation |

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| General Practitioners | | | | funded GP referral scheme as mentioned in the guideline as being too expensive. Blodgett JM, Robertson D, Ratcliffe D, Rockwood K. An alternative model of pre-hospital care for 999 patients who require non-emergency medical assistance, International Journal of Emergency Services, 2017: 6(2),99-103 | for research will provide further evidence on clinical and cost effectiveness of paramedic remote decision support for future updates of this guideline. |
| Royal College of General Practitioners | full | Chapter 5 | general | This questions the value of GP led home visits. The perspective is that of a hospital A and E clinician looking at what GP do and comparing it with their practice, an interesting question is asked, they miss a key question as to whether it is the equipment and access to testing that prevents recognition of acute medical illness or training and skills of the GP undertaking the assessment. Rarely is a decision made on the result of a test or lack of access to a test in the home.<br><br>The advent of portable near patient testing and monitoring could be an alternative pathway as could be enhanced training for GPs on recognition of medical emergencies etc rather than more assessment in hospital.<br><br>If research is going to be conducted into if GP visiting works for deteriorating or sick patients, it is important not prejudge what the alternative outcome is. | Thank you for your comment. Our committee consisted both of clinicians working in A and E and GPs. It is hard to know whether skills of the GP or access to equipment and tests are the most important factors for success and we have recommended further research. Access to diagnostic testing is certainly important in the rapid assessment of a suspected medical emergency, including point of care testing.<br>We have discussed these points in the trade-offs and harms section of the write up and have amended this to make it clearer. Credible alternatives to acute hospital assessment can be provided in the community and this has been discussed in more detail in our section on alternatives to hospital care. We needed to specify outcome measures for further research, but we do not prejudge the results and we hope that the research is conducted. |
| Royal College of General Practitioners | full | Chapter 5 | 2-23 | This repeats the above comments regarding GP extended hours, and assumes extending GP hours schemes provide access to the patients usual GP team This is isn't how it works in many areas. The GPs are not seeing their own patients but an agglomeration of local practices patients for who they have no personal prior knowledge. Any comments must reflect the reality of extended hours | Thank you for your comment. The guideline committee discussed the fact that this is how extended GP access works in many areas and this has been further clarified in the introduction (section 5.1). However, the review question prioritised at scope development focuses on whether extended access to your usual GP is more clinically and cost effective. |
| Royal College of | full | Chapter 5 | 1 | The decision not to make a recommendation in this area is appropriate given the above comments and the poor quality | Thank you for your comment. |

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| General Practitioners | | Page 11 | | of available evidence to support one. | |
| Royal College of General Practitioners | full | Chapter 5 11 | | The Continuity of care question drawing GPs back to providing an early evening and weekend cover sounds like describing the systems many GPs faced in the 1990s. to 2000. It was ultimately exhausting and unstainable in the face of unrestricted demand from patients and an aging population. There are considerable concerns that this is an attempt to describe a bygone system | Thank you for your comment. The purpose of this guideline was to look at how services could be provided. This may include the way services had been previously delivered. Review questions were prioritised by guideline committee following a stakeholder meeting and consultation. However, the committee chose not to develop a practice recommendation given the limited evidence available and chose to develop a research recommendation on this topic. |
| Royal College of General Practitioners | full | General 6 | General | The document regarding GP led home visits does not specifically mention hybridised models, e.g. GPs nested within ambulance services or Acute Response Teams. These services are emerging nationally and are subject to local evaluation. A more centralised, cohesive evaluation of these pilots should be an explicit recommendation. Has the panel considered recommending a centralised registry of such pilots, to enable a much more robust dataset to be generated? | Thank you for your comment and information. The guideline committee is aware that there are GPs nested within ambulance services that support an ambulance trust in its work rather than an out of hours primary care provider. However, the guideline committee prioritised this review question to assess the function of contracted out of hours primary care rather than innovative pilots of services that have employed GPs in addition to their core staff. |
| Royal College of General Practitioners | Full | | 1.3.1 diagnostic hubs | Many practices within primary care provide spirometry and bronchodilator reversibility as a near patient test. How much additional diagnostic accuracy is gained by introducing FeNO testing over and above spirometry and BDR? What is the evidence that diagnostic hubs as proposed would produce better patient outcomes and be cost effective considering the resources they would consume, the diagnostic delay that would be introduced and the inconvenience to the patient? | Thank you for your comment. We are sorry, but we cannot understand what your comment refers to. The 'fractional exhaled nitric oxide' (FeNO) test to help diagnose asthma maybe of use but was not part of the scope of this guideline on acute medical emergencies. |
| Royal College of General Practitioners | Short | 12 | 19-20 | The research question suggests that it wants to look at extended weekday and weekend access to their usual primary care team might reduce unscheduled use of secondary care emergency services. Many extended access | Thank you for your comment. The review questions were prioritised by the guideline committee following a stakeholder meeting and consultation. The committee were aware that not all the 'extended access' |

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| | | | | schemes don't provide access to the usual team but to a GP or nurse unfamiliar with the person. It would advisable to study what is there, not what is thought is there. The whole of this paragraph does not describe services many GPs recognise or can conceive of GPs being able to provide. It is unclear the right question is being asked in a way that is transferable to what is happening in reality. | schemes are delivered by the usual primary care team. We have amended the introduction (section 5.1) to reflect this. |
| Royal College of General Practitioners | full | Chapter 12 | general | 'Rapid response' services that exist to 'deflect' patients away from the ED need to be 24 hour, 7 days and cover a sufficient geographical area to enable the ambulance services to use them appropriately. There also needs to be formalised feedback regarding outcomes to ensure ongoing clinical development of staff. | Thank you for your comment. The review of evidence did not find sufficient evidence to make a separate recommendation on rapid response schemes.<br>The guideline committee agreed that there was a need for communication between all providers who are involved in alternatives to hospital admission; hopefully this should be incorporated into emergency care networks. Time for reflections and measuring and recording data are also important.<br>Formalised feedback would be helpful for all referrers, irrespective of their professional training, in order to continue to develop skills. This is a generic issue for all healthcare provision, rather than specific to referral into services that are alternatives to hospital admission. |
| Royal College of General Practitioners | | 15 | General | The document notes that paramedics with enhanced competencies may actually result in identification of more subtle or complex underlying pathology, and see a rise in subsequent health service use. This is a vital point to articulate much more clearly in the research priorities and general guidance. If the outcome measure of 'success' is built solely around hospital attendance or health service utilisation immediately after to the contact, then improved quality of care and potential long-term savings will fail to be captured. Advanced paramedic practitioners with integration into primary care may actually increase costs short term, but this may be offset by longer term savings. | Thank you for your comment. Paramedics with enhanced education and competence could increase the conveyance rate to hospital due to identification of more subtle or complex underlying pathology. We have already discussed this within the linking evidence to recommendations section (Section 3.6). We also acknowledge that this may be a beneficial outcome. The committee made a positive recommendation for this question and not a research question. Outcomes considered included quality of life, patient and /or carer satisfaction, staff satisfaction, adverse events as well as hospital |

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| | | | | | admission, mortality, and conveyance rates. |
| Royal College of General Practitioners | Long Chapter 7 | 18 | | There is a case for CRP testing based on evidence. However there is an opportunity to decide whether research into POCT in out of hours or GP delivered urgent care has a value. This is important and seems to have been overlooked as a gap | Thank you for your comment. POCT in out of hours or GP delivered urgent care was not the focus of this particular review question and we did not look for the evidence on this topic. |
| Royal College of General Practitioners | Long Chapter 8 | 7 | | Most GPs are unfamiliar with admitting adults simply to access radiography or ultrasound. The need is usually for an assessment which is supported by a test because most Gps do not have the opportunity to get a emergency hospital test and then decide if that means the patient need to go back to the hospital they have just come from to have an intervention. This cause delay and distress to patients. | Thank you for your comment. The review question was to assess whether GP access to radiology with same day results improve outcomes. The committee wanted to determine if there was scope to modify existing radiology provision to allow for improved access (same day) to minimise patient disruption and safe management in the community by differentiating patients with an AME to those safe to manage at home. There would be an increased need for staff training and we have added a comment to the linking evidence to recommendation section to reflect this.. |
| Royal College of General Practitioners | 17 | General | General | It is noted that the only evidence included in this review is more than 20 years old. There have been a substantial number of local trials, pilots and service-level evaluations of such schemes over the last two decades. There is also a substantial body of qualitative research evidence looking at the issue. The over-riding general consensus is that the evidence for GPs in Emergency Departments EDs suggests a complex array of localised nuances, demographics, service structure issues, staff attitudes, working systems, organisational policy and social landscape mean that it is almost impossible to recommend a model that is nationally applicable in this regard. There is a concern that simply prioritising 'more research' in this area is unlikely to move this situations forwards, and could result in a continued cycle of short term local-level pilots. Could this document suggest a more centralised strategy for understanding the outcomes of these local-level initiatives much more comprehensively? | Thank you for your comment. Whilst we appreciate the point we were limited by the research available and not able to make a practice recommendation. With regard to further research, we were aware whilst writing our recommendations that there are currently two NIHR funded studies being undertaken in the area (please see links below), and we chose to prioritise research in this area, as we hope these will inform a future update to the guideline. We will refer these references to the NICE surveillance programme.<br>http://www1.uwe.ac.uk/hls/research/gpedproject/studysummary.aspx<br>GPs in EDs Study: Protocol May 2016: NIHR HS&DR System |

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| Royal College of General Practitioners | 21 | 17 | General | The document notes that the stratifications tools were derived from secondary care settings, and suggests that some may be useful in a pre-hospital context. This statement requires much more qualification than it is presently afforded in the document. Many risk stratification tools are being used, unvalidated, out of hospital. If local pathways to conform to national guidelines, there must be clear community validation of risk-stratification tools. A potential recommendation for research might include determining which tools are valid in this setting, before moving on to look at developing local pathways (according to national guidance) to respond to these. | Thank you for your comment. Risk stratification tools for admission to hospital must be validated, which is why we stated in the recommendation that validated tools should be used. Validated tools include validation in the appropriate population and patient setting. |
| Royal College of General Practitioners | full | Chapter 32 | general | Consider structured handover for out of hospital referral as well. | Thank you for your comment. This particular question covered structured handover between healthcare professionals between shifts in any acute care setting. It did not cover handover from one setting to another and therefore we have not searched for that evidence. However, the chapter on hospital transfer (Chapter 34) covered patient handover from one hospital to another and from one department to another within the same hospital. |
| Royal College of General Practitioners | General | | | There needs to be consideration of System incentives which like it or not do have an influence on individual clinical behaviour if for no other reasons the system does not facilitate managing people out of hospital.<br><br>Integrated care for older people with frailty: innovative approaches in practice (24 November 2016) a joint report from the Royal College of GPs and the British Geriatrics Society showcased how GPs and geriatricians are collaborating to design and lead innovative schemes to improve the provision of integrated care for older people with | Thank you for your comment and information. System incentives are important but unfortunately was not prioritised by the guideline committee and stakeholders.<br>We believe our recommendations many of the issues you raise including advance care planning, community support by nurses, pharmacists and social care and hospital flow. |

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| | | | | frailty.<br><br>There are three critical system factors<br><br>• Advanced care planning for those who are complex/vulnerable<br>• Enhanced community teams supporting general practice<br>• Streamlining flows in hospital starting off at the point of entry usually A&E.<br><br>All of these components need to be in place not only to reduce admission but also to facilitate discharge<br><br>The NHS May 2017 AE statistics show a drop-in attendances in the last month but an overall increase in the last 12 months by 2% with emergency admissions increased by 2.7%.<br><br>• The total number of attendances in May 2017 was 2,069,000, a decrease of 0.1% on the same month last year. Of these, attendances at type 1 A&E departments were 0.4% lower. Attendances over the latest twelve months are higher than levels in the preceding twelve-month period (an increase of 2.0%).<br><br>• There were 508,000 emergency admissions in the month, 3.0% higher than the same month last year. Emergency admissions via type 1 A&E departments increased by 3.3% over the same period. Emergency admissions over the last twelve months are up 2.7% on the preceding twelve-month period.<br>• 27.6% of patients that attended a type 1 major A&E department required admission to hospital, which | |

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| | | | | compares to 26.6% for the same month last yea<br><br>What brought A&E to near breaking point last winter, and will again this winter, is not people turning up with minor problems but the rise in those with frailty, multi-morbidities (including mental health) and complexity of all ages. This combined with the cuts in social care to support the frail elderly in the community, the lack of timely social care to enable hospital discharges and the lack of residential and community beds available to NHS patients will continue to put a considerable strain on our limited primary and secondary care NHS resources. | |
| Royal College of General Practitioners | Full | General | General | A number of chapters refer to GP-delivered aspects of the urgent care service. None of the chapters provide explicit, detailed recommendations for training and education in urgent care. This is presently a small part of the GP training curriculum. The Full guideline suggests the direction of travel is for Primary Care involvement in a much broader context to 'urgent' presentations. This requires specific training and development. Post-graduate formal training opportunities for GPs are few and far between, qualifications sparse and not always nationally recognised, supervision arrangements ad-hoc and limited undergraduate exposure to urgent care curriculum items. This guideline is an opportunity for formal recommendations around training and skills development to be expressly communicated. | Thank you for your comment. We are aware that some of the recommendations will require additional training. Unfortunately, it is out of the scope of this guideline to make recommendations on training. The guideline committee hope that the relevant professional bodies will address this appropriately. |
| Royal College of General Practitioners | General | | | Other points this guidance could consider<br><br>1.The changing role of the GP in working with but managing and supervising a team of professionals trained in acute care most of which can be dealt with within agreed algorithms. It may be that in future emergency medical care could become no longer a GP role in the same way as did intra-partum | Thank you for your comment. We are unable to cover all areas and focused upon those that stakeholders and guideline committee members initially prioritised. We hope that new initiatives are evaluated properly so that new evidence can be incorporated into future updates of this guideline. |

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| | | | | obstetrics<br><br>2. The advent of IT and monitoring devices in the person/patient's home with the ability of Primary care/Secondary Care to monitor. i.e. telemedicine,<br>a. environmental e.g. temperature, hygiene<br>b. behavioural monitoring-eating, sleeping, excreting, movement<br>c. biological BP, PEF, blood sugar,<br><br>3. The uncertainty around Out of Hours care and its variation across the country may call for a standardised, salaried service with access to the patient record at all times.<br><br>4.The possibility of enabling GP's to provide telephone triage after hours-particularly (18.30-12 midnight and 6-8.00) and then liaising with the OOH service as necessary as part of a new contract (Telephone call is significantly less stressful than full on call and might be better value for money than extended opening)<br><br>5.The role of the Ambulance service/paramedic team in best dealing with medical emergencies (skills, resources, drugs near patient testing etc.)-i.e. treat at home or transport. | |
| Royal College of Paediatrics and Child Health | Short | 8 | 25 onwards | Would suggest addition of:<br><br>*Provide access to liaison psychiatry 7 days a week for people admitted to hospital with medical emergencies related to self-harm and suicide attempts.*<br><br>This will help to alleviate potential threat of bed blockages. | **Thank you for your comment.** The committee felt that the recommendation should be open, applying to all people with mental health problems and not limit it to self-harm and suicide attempts. The document 'Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care – Part 2: Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults – Guidance' provides support for enhanced services for mental health emergencies, including self-harm. |

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| | | | | | The Committee proposed that its consultation wording of the recommendation should be retained due to the lack of supportive evidence, i.e. 'consider providing access to liaison psychiatry services for people with medical emergencies who have mental health problems.'<br>Final approval prior to publication is required from NICE.<br>NICE noted that stakeholder comments received on the committee's draft wording advocated strengthening it and gave reasons for this.<br>NICE also noted that NHS England's seven day service standards require that:<br>*Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.*<br>Accordingly, NICE decided to strengthen the wording of the recommendation by changing it to 'provide access to liaison psychiatry services for people with medical emergencies who have mental health problems.' |
| Royal College of Paediatrics and Child Health | | | | Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why.<br><br>Children with varying needs (and particularly those with complex needs) will be going through transition to adult services in the period before and after turning 16 years in age. Clarity is required over who lead, with whom they communication to and how this process is backed up by operating procedures which have robust accountability and governance arrangements. | Thank you for your comment. We are unable to prejudge which areas will have the biggest impact. However, we have prioritised our top 5 research recommendations as the ones that we feel are the most important to inform future updates of the guideline.<br><br>Each recommendation represents a complex intervention. The interaction between multiple interventions is outside the remit of this guideline. Please see NICE guideline on Transition from children's to adults' services for young people using health or social care services |

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| | | | | | (https://www.nice.org.uk/guidance/ng43) for further information. |
| Royal College of Paediatrics and Child Health | | | | What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)<br><br>We note that nomenclature and service models will vary in paediatrics More broadly, the RCPCH Intercollegiate Standards for Children and Young People in Emergency Care Settings are applicable to children up to 18 years old and a revision of this document will be published towards the end of 2017. We have produced standards for short-stay assessment units, standards for acute general paediatrics and for the unscheduled care pathway (which we are currently auditing) and we align with 3 out of 4 of the NHSE 7 day prioritised standards. A consideration for these pieces of work will help to support clinicians to implement recommendations. | Thank you for your comment. There is a large literature available on techniques for overcoming barriers to implementation of complex interventions. For example The Health foundation website provides range of resources. We have referred to the standards for short-stay assessment units, standards for acute general paediatrics and for unscheduled care pathway into the chapter on integrated care (chapter 38). |
| Royal College of Paediatrics and Child Health | General | - | - | We have looked at many of the papers in the document describing innovative plans which have been implemented to greater or lesser extent in many localities. There has been a diversion of funds away from specialist emergency departments without strong evidence, particularly young people age 16-18 or 16-25 have been poorly researched, evidenced and targeted. This seems a major omission in this NICE clinical guideline. | Thank you for your comment. We undertook a comprehensive scoping exercise with stakeholders to identify and prioritise key areas for inclusion in the guideline. Unfortunately, targeting young people was not prioritised as a key area for this guideline |
| Royal College of Physicians of Edinburgh | Full: 24 | General | General | This chapter on the Acute Medical Unit does identify the lack of quality research into acute medical unit (AMU) impact: Fellows of the College have noted that the recognition of a gap in this knowledge may drive further research of higher quality, which would be a positive development. This chapter does not provide enough detail to influence the day to day practices of acute medical work streams: College Fellows felt that this guideline's biggest legacy may be as the catalyst to improve quality outcome data and research. | Thank you. We acknowledge your comment and the differences in the wordings of the recommendations. NICE guidelines do not duplicate recommendations from other guidelines and are based on clinical and cost effectiveness. The recommendation for AMU is based on current evidence and the consensus opinion of guideline committee members. |

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| | | | | Overall, Fellows commented that there was accepted practice in this chapter which would be regarded as common sense – however it was suggested that the AMU specific recommendations are better summarised in other documents such as RCP Acute Care Taskforce 2007 document and the Society for Acute Medicine standards (which are referenced by NICE). | |
| Royal College of Physicians of Edinburgh | Short | General | General | Fellows commented that a significant omission from the document is any detailed analysis of Emergency Departments – a significant part of the acute medical emergency pathway, but almost no mention of them other than in opening hours. | Thank you for your comment. We have referred to emergency department workings in many chapters throughout the guideline including: Standardised criteria for admission (Chapter 21), AMU (Chapter 24), Elderly care assessment units (Chapter 25), GP co-located to EDs (Chapter 17). |
| Royal College of Physicians of Edinburgh | Short | 7 | 8 | Concern was expressed that liaison psychiatry input is not recommended due to a lack of evidence. This is due to the fact studies have not yet been done: Fellows commented that patients with mental health problems pertinent to their emergency admission would benefit from liaison psychiatry input and the NCEPOD report Treat as One would suggest that liaison psychiatry is not integrated enough into general hospitals to the detriment of these patients. | Thank you for your comment. The committee made a positive recommendation for liaison psychiatry given the improved patient satisfaction and reduced length of stay and cost savings.. The Committee proposed that its consultation wording of the recommendation should be retained due to the lack of supportive evidence, i.e. 'consider providing access to liaison psychiatry services for people with medical emergencies who have mental health problems.' Final approval prior to publication is required from NICE.<br>NICE noted that stakeholder comments received on the committee's draft wording advocated strengthening it and gave reasons for this.<br>NICE also noted that NHS England's seven day service standards require that:<br>*Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days* |

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| | | | | | *a week.*<br>Accordingly, NICE decided to strengthen the wording of the recommendation by changing it to 'provide access to liaison psychiatry services for people with medical emergencies who have mental health problems.' |
| Royal College of Physicians of Edinburgh | Short | 8 | 14 | The College would agree that an increase in consultant review of patients with medical emergencies is important, although these recommendations will be very challenging for many Trusts to deliver. | Thank you for your comment. Since it is a weak (consider) recommendation, this will allow Trusts to prioritise this based on their local circumstances. |
| Royal College of Psychiatrists | Full and short | General | | The Royal College of Psychiatrists is pleased to be able to comment on the draft chapter 23, relating entirely to Liaison Psychiatry. We appreciate the recognition that is given to the high levels of mental health morbidity experienced by patients in the in the emergency and acute medical care pathways. We believe that the extent of this morbidity is evidence in itself for the universal provision of Liaison Psychiatry services to meet the level of need.<br><br>We would like to draw to panel's attention to a number of recent documents that might support the development of recommendations, in particular:<br>• The replacement for the cited 2003 report by the RCPsych and CEM - *Liaison psychiatry for every acute hospital: Integrated mental and physical healthcare,* RCPsych Council Report CR183, 2013.<br>• Reviews highlighting the benefits of Liaison Psychiatry, such as that by the Kings Fund, *Bringing physical and mental health together,* 2016.<br>• The NCEPOD report, *Treat as One*, 2017. This report specifically notes the finding that good mental health care in general hospitals is positively associated with the provision of a Liaison Psychiatry service.<br><br>We are concerned that the review appears to have been | Thank you for your comment and for referencing the papers which we have looked at. However, they cannot be included in this review as they are not of a study design that we included this review.<br><br>We note your point about the complexity of these interventions. However, this review identified seven randomised controlled trials and therefore we did not go down to lower levels of evidence.<br>We agree that training in recognition and management of mental illness is important. Unfortunately, we are unable to recommend training as it is outside the scope of this guideline.<br><br>The Committee proposed that its consultation wording of the recommendation should be retained due to the lack of supportive evidence, i.e. 'consider providing access to liaison psychiatry services for people with medical emergencies who have mental health problems.'<br>Final approval prior to publication is required from NICE.<br>NICE noted that stakeholder comments received on the committee's draft wording advocated strengthening it and gave reasons for this. |

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| | | | | limited by reliance on RCT evidence, with which it is unreliable to demonstrate the effectiveness of complex interventions such as the provision of a whole service. Of note, the lead researcher in the quoted LP-MAESTRO study (currently underway) has noted that their research will examine outcomes and possibly economics but 'will only be able to say something quite limited about the association between service configurations and ED waiting times'.<br><br>As well is providing a clinical service, it is recognised that Liaison Psychiatry staff have a valuable role in the training of general hospital colleagues in the recognition and management of mental illness, including in the emergency care pathway (e.g. see the *Psychiatric Liaison Accreditation Network Standards 5th Revision*, RCPsych, 2017). We suggest that this work be emphasised in the final recommendations.<br><br>Overall, we are concerned that there is an expectation that Liaison Psychiatry must provide an evidence base for its effectiveness based upon RCTs in order to merit inclusion in these recommendations. Whereas this would not be asked of many areas of health service provision that are seen as necessary on the basis of morbidity and clinical experience. | NICE also noted that NHS England's seven day service standards require that:<br>*Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.*<br>Accordingly, NICE decided to strengthen the wording of the recommendation by changing it to 'provide access to liaison psychiatry services for people with medical emergencies who have mental health problems.' |
| Royal College of Psychiatrists, | Short | 8 | 8 | The Faculty of Liaison Psychiatry is concerned that the recommendations should adequately reflect the health service priority to ensure parity of esteem, whereby patients with mental health needs are afforded the same access to specialist care as patients with any physical condition whilst in the general hospital. We therefore suggest the recommendation in this area (1.2.3) is amended to say Liaison Psychiatry services should be provided for people with medical emergencies where mental health needs are significant, concurrent with the physical emergency or require specialist assessment or management in the hospital or | Thank you for your comment. The Committee proposed that its consultation wording of the recommendation should be retained due to the lack of supportive evidence, i.e. 'consider providing access to liaison psychiatry services for people with medical emergencies who have mental health problems.'<br>Final approval prior to publication is required from NICE.<br>NICE noted that stakeholder comments received on the committee's draft wording advocated strengthening it and gave reasons for this. |

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| | | | | emergency department. | NICE also noted that NHS England's seven day service standards require that:<br>*Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.*<br>Accordingly, NICE decided to strengthen the wording of the recommendation by changing it to 'provide access to liaison psychiatry services for people with medical emergencies who have mental health problems.' |
| Royal Pharmaceutical Society | Short | 6 | 5 | Please see point 13 below. There is evidence that medicines reviews in community pharmacies are beneficial as published in the Community Pharmacy Clinical Services Review which recommends *that the current medicines use reviews should be redesigned to include on-going monitoring and regular follow-up with patients as an element of care pathways. This redesign should ensure that they are an integrated part of a multifaceted approach to helping people with long-term conditions that includes medicines optimisation, providing advice and helping people stay well. Such a service should be able to utilise transfer of care and referral schemes and electronic repeat dispensing (ERD), and have a focus on patients at high risk and those with multiple co-morbidities as well as those with single conditions that are clinical priorities such as diabetes, hypertension and COPD where evidence is already strongest. It should also include consideration of appropriate prescription duration to optimise outcomes and convenience for patients. Ultimately MURs should evolve into full clinical medication reviews utilising independent prescribing as part of the care pathway. For these to be safe and effective they would require access to a patient's full medical record which may not be possible immediately in all situations.* | Thank you for your comment. This particular review was not specifically evaluating the role of medication use reviews (MURs). However, the committee recognise that this may be a part of the intervention of a community or clinical pharmacist. This review is supportive of MURs in community pharmacy. However, the evidence for pharmacist home visits for those at risk of an acute medical emergency was weak and often showed these visits were detrimental compared to usual care and made a negative recommendation for commissioning these services. |
| Royal | Short | 6 | 12 | As experts in medicines and their use, pharmacists are a key | Thank you for your comment. The guideline |

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| Pharmaceutical Society | | | | element of the multidisciplinary intermediate care team as medicines are often a factor of hospital admission. If a patient takes their medicine as intended they are less likely to be admitted for an acute episode of care. | committee agree that pharmacists are a key element of the multidisciplinary intermediate care team. Please see the Community Pharmacy (Chapter 10) for further information on Medicines Use Reviews. |
| Royal Pharmaceutical Society | Short | 6 | 20 | Pharmacists are a key component of the multidisciplinary community-based palliative care service. As well as providing timely access to medicines they can advise on doses and combination of medicines. | Thank you for your comment. This has now been added in the 'other considerations' section of the community palliative care chapter. |
| Royal Pharmaceutical Society | Short | 7 | 13 | Under the recommendations for Emergency and acute medical care in hospital we were surprised that there was no recommendation for the undertaking of pharmacy-led medicines reconciliation as this is supported by previous NICE guidance and quality standards on medicines optimisation. Quality statements 4 and 5 reflect medicines reconciliation in acute settings and medicines reconciliation in primary care | Thank you for your comment. We have added a footnote in the recommendations to cross refer to the NICE Medicines Reconciliation guideline. |
| Royal Pharmaceutical Society | Short | 10 | 20 | The integrated care pathways should include the transfer of information between secondary and primary care. Helping make care more seamless for patients by integrating hospital and community pharmacy and ensuring effective clinical handover and pre-admissions medicine support and reconciliation for patients at risk; providing medicines use reviews following hospital discharge; and providing the new medicine service for patients started on a new medicine in hospital. Pharmacists can speed up discharge by ensuring medicines are understood by patients prior to discharge and by following this up via community pharmacy when patients return to primary care. Examples of electronic transfer 7between hospital and community pharmacy can be found at http://bmjopen.bmj.com/cgi/content/full/bmjopen-2016-012532?ijkey=IzR9HpzxpbKTdzh&keytype=ref or www.elht.nhs.uk/refer. The report on the Evaluation of the Discharge Medicines Review Service also shows positive results | Thank you for your comment. The review question on integrated care looked at integrated care between primary (community) and secondary care. It is multidisciplinary and involves all professional groups, including pharmacists. We also made specific recommendations about community pharmacists in chapter 10 "For people who are at increased risk of developing a medical emergency:<br>- provide advanced community pharmacy-based services<br>- consider providing advanced pharmacist services in general practices".<br>In addition, we made a specific recommendation to "Include ward-based pharmacists in the multidisciplinary care of people admitted to hospital with a medical emergency." We think these recommendations taken together address your important points and should improve care for patients. |
| Royal Pharmaceuti | Short | 12 | 9 | Part of the research around extended access to GP services should consider the role of community pharmacies in the | Thank you for your comment. The committee do not think that this research recommendation should |

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| cal Society | | | | locality to support this. The research should also consider the development of a nationally commissioned minor ailment scheme to relieve pressure from GP services. | include the role of community pharmacies as this is covered in a separate chapter in the guideline (Chapter 10 Community Pharmacists). We did not review evidence on minor ailment schemes so cannot make recommendations for practice or research on this area but agree that future research on this would be interesting. |
| Royal Pharmaceutical Society | Short | 13 | 23 | This recommendation for research should also include community pharmacies located in or near emergency departments. The RCEM has also recommended that 'every clinical commissioning group ask their local A&E department to have a pharmacy on site, open 16 hours a day, 365 days a year. Placing community pharmacies in emergency departments circumvents a whole load of obstacles when a patient needs a prescription. Creating a hub [of health professionals], allows people to share their expertise and minimise the risk and inconvenience to the patient. Pharmacists also have an important role to play in managing patients on multiple medications, the pharmacist is much better trained to look at the potential risks and benefits of drugs," | Thank you for your interesting comment. Unfortunately community pharmacies located in or near emergency departments was not an area prioritised for inclusion in the scope and therefore we did not review the existing evidence. |
| Royal Pharmaceutical Society | General | | | Some of the recommendations mention structured handovers and standardised systems of care. Any electronic standards used in the clinical care of patients should be aligned to the clinical standards published by the Professional Record Standards Body to ensure consistency and interoperability. | Thank you for your comment. We have added a reference to this in the chapter on structured patient handovers (Chapter 32) within the Linking Evidence to Recommendation section. |
| Royal Pharmaceutical Society | 2 | General | General | NHS England have recently commissioned a national urgent medicines supply advanced service pilot from community pharmacy and this should be taken into account as part of access to urgent and unscheduled care | Thank you for your comment. The committee are aware of the urgent medicines supply advanced service pilot for community pharmacy and that the pilot runs from December 2016 to March 2018. This guideline does not include unpublished evidence but the committee hope that this pilot provides useful information for future updates of this guideline. We have added information about this ongoing pilot into the linking evidence to recommendations section of the chapter. We will refer this study to the NICE |

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| | | | | | surveillance team for tracking. |
| Royal Pharmaceutical Society | 10 | 6 | 4 | All pharmacists are clinicians and it is not helpful to distinguish pharmacists working in GP practices as clinical pharmacists – we would recommend using the term practice pharmacist | Thank you for your comment. After careful consideration, the guideline committee do not agree that the term 'clinical pharmacists' should be changed. The reason for using clinical pharmacist is to highlight that there is now a pharmacist in primary care who has additional clinical training. This is the Clinical pharmacist in GP practices as defined by NHS England https://www.england.nhs.uk/gp/gpfv/workforce/building-the-general-practice-workforce/cp-gp/ Furthermore this is supported by The national learning pathway which is titled - Developing clinical pharmacists in general practice - https://www.cppe.ac.uk/wizard/files/developing_career/cppe-hee-general-practice-pharmacist-learning-pathway-current-edition.pdfThese roles are defined in the LETR section of this chapter. |
| Royal Pharmaceutical Society | 10 | 53 | 13 | The following section is based on low quality evidence and we would query why this evidence is deemed acceptable to include. It would be useful to see if there is data where pharmacists went into a patient's home as an additional service, rather than as a replacement service for a GP visit, to check the patient is taking their medicines to the best effect.<br><br>We believe this should be removed.<br>*Three studies comprising 1254 participants evaluated the role of community pharmacists (patient's 13 home strata) for improving outcomes in adults and young people at risk of an AME, or with a 14 suspected or confirmed AME. The evidence suggested that home visits from a community pharmacist 15 were associated with higher mortality (2 studies, low quality) and more hospital admissions (3 16 studies, low quality) but no effect on quality of life (2 studies, low quality).* | Thank you for your comment. This question identified 7 randomised controlled trials which were considered sufficient to make a recommendation for community and clinical pharmacists in the patients home strata. The committee do not think it is appropriate to remove this evidence.<br><br>After careful consideration and discussion, the committee agreed that the evidence was weak and often showed these visits were detrimental compared to usual care and made a negative recommendation for commissioning these services. However, we have added the population (people at risk of an acute medical emergency) to the recommendation to clarify who this is relevant for.<br><br>Pharmacists visiting patients at home as an additional service was not prioritised for inclusion in the scope. |

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| Royal Pharmaceutical Society | 10 | 55 | 1 | We are concerned that the recommendation that pharmacists should not be commissioned to conduct medication reviews in patients homes unless needed for logistical or clinical reason is misleading. The document itself states that there is a lack of evidence in this area so rather than including this negative recommendation we feel that the recommendation should be that more research is required in this area. | Thank you for your comment. This question identified 7 randomised controlled trials which were considered sufficient to make a recommendation for community and clinical pharmacists in the patients home strata. After careful consideration and discussion, the committee agreed that the evidence was weak and often showed these visits were detrimental compared to usual care and made a negative recommendation for commissioning these services. It is worth noting that our recommendation covers patients who are an increased risk of an acute medical emergency (as the remit of the guideline). The recommendation does not include medication use reviews in patients who are not at risk of an acute medical emergency. We have amended the recommendation to include the population so that this is clearer. |
| Royal Pharmaceutical Society | 30 | General | General | Whilst we recognise this is focused on pharmacists working in secondary care it should take into account the transfer of care between secondary and primary care and also outreach services provided by pharmacists working in secondary care. | Thank you for your comment. This particular review question did not cover outreach services provided by pharmacists working in secondary care as this was not included in the scope for the guideline. However, the guideline does address community pharmacists in Chapter 10. |
| Royal Pharmaceutical Society | 35 | General | General | Early discharge planning should include the consideration of clinical handover between the hospital and community pharmacy to ensure continuity of care on discharge. | Thank you for your comment. The guideline committee agree that this is important but it was not covered in this particular review question. The guideline can only make recommendations based on evidence. The importance of coordinated communication between secondary, primary and community care is well understood, and reflected in our research recommendations on integrated patient information systems and integrated care. |
| Royal Pharmaceuti | Short | General | General | Innovative practice should be reflected in this guidance. For example, ambulatory care units / centres are improving flow | Thank you for your comment. We have made several research recommendations that we hope will spark |

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| cal Society | | | | through A&E departments as patients can be referred to the ambulatory care units instead of to A&E. The role of the pharmacist in ambulatory care centres in ensuring the appropriate use of antibiotics, reducing DVTs and supporting medicines optimisation is being explored and evaluated in some areas.<br>Also, many A&E or urgent / emergency departments are now employing pharmacists as part of the team to improve flow through the urgent care pathway.<br>We have examples of good practice that we can share in these areas. | innovation. We have passed it on to the NICE implementation team to inform their support activities for this guideline. |
| Society for Acute Medicine | | genera l | gener al | Though we realise the constraints of the methodology we are disappointed in the lack of evidence quoted around AMUs | Thank you for your comment. The guideline committee were also disappointed by the lack of evidence in this area. There were no randomised controlled trials and the committee agreed to look for observational studies. We included three observational studies that supported the recommendation alongside the committee members' expert opinion. |
| Society for Acute Medicine | | Gener al | Gener al | Apart from a chapter on opening hours there is no reference to Emergency Dept workings | Thank you for your comment.<br>We have referred to emergency department workings in many chapters throughout the guideline including: Standardised criteria for admission (Chapter 21), AMU (Chapter 24), Elderly care assessment units (Chapter 25), GP co-located to EDs (Chapter 17). |
| The Royal College of Emergency Medicine | Short | Gener al | Gener al | Recommendations as made seem sensible, however all recommendations maintain the artificial split between "hospital" and "community" services that might be better served if each could in reach/outreach into the other. | Thank you for comment and support of the recommendations. We have made a recommendation to develop and evaluate integrated care pathways (recommendation 1.3.2 from Chapter 38 on integrated care). |
| The Royal College of Emergency Medicine | Short | Gener al | Gener al | There's no mention that strategies that work well in urban areas are not necessarily transferable to rural areas (as an example, there are 18,000 people per square mile in Hammersmith cf 93 people per square mile in Anglesey and Gwynedd, which impacts greatly upon logistics of community- | Thank you for your comment. The guideline committee took these factors into consideration when making our recommendations and were aware that one size doesn't fit all. This partially led to us developing 'consider' recommendations in some |

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| | | | | based service delivery). | cases to allow local providers to take into account their own circumstances. |
| The Royal College of Emergency Medicine | Short | 8 | 5 | Section 1.2.2<br><br>As this is stated 'undifferentiated medical emergencies' should be assessed and admitted though a 'Medical Admission Unit' is unclear pragmatically speaking, and could lead to duplication. Suggest changing to adding 'all patients referred by community services, and those streamed from acute services'; otherwise large number of Emergency Department patients could be included in this group. | Thank you for your comment. After careful consideration, the guideline committee do not agree that 'undifferentiated' should be removed from the recommendation. It is used to distinguish the early stage of admission when there is uncertainty. This is opposed to when patients have clearly defined conditions that can be managed on specific pathways. |
| The Royal College of Emergency Medicine | Short | 8 | 8 | Section 1.2.3<br><br>'Consider providing' ought to read 'Must provide' Mental Health Liaison services.<br><br>Evidence of low or very low quality as defined by NICE.<br><br>Shortened length of stay (but no economic analysis) (and patient satisfaction); however, evidence of increased mortality and reduced Quality-Adjusted Life Year. When reviewed this recommendation appears to support an intervention than worsens and shortens life, while (possibly expensively) reduces length of stay. This is questionable, as would suggest is a research recommendation rather than clinical recommendation. | Thank you for your comment.<br>There was an economic analysis reviewed as part of the evidence – see 23.4. However, this focused on the resource cost savings and not the health outcomes.<br><br>As noted in 23.6 the differences in deaths and QALYs were not statistically significant and the committee felt that there was not a plausible mechanism for these trends. We noted that there is ongoing research on this topic, which can inform a future update of this guideline.<br><br>In the meantime, given the improved patient satisfaction and reduced length of stay and cost savings, the committee decided to make a positive recommendation, albeit a weak one due to the limited evidence.<br><br>We are confused as to whether you feel this should be a strong recommendation, as indicated by your first sentence or a research recommendation, as indicated by your last sentence.<br>The Committee proposed that its consultation wording of the recommendation should be retained due to the |

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| | | | | | lack of supportive evidence, i.e. 'consider providing access to liaison psychiatry services for people with medical emergencies who have mental health problems.'<br>Final approval prior to publication is required from NICE.<br>NICE noted that stakeholder comments received on the committee's draft wording advocated strengthening it and gave reasons for this.<br>NICE also noted that NHS England's seven day service standards require that:<br>*Liaison mental health services should be available to respond to referrals and provide urgent and emergency mental health care in acute hospitals with 24/7 Emergency Departments 24 hours a day, 7 days a week.*<br>Accordingly, NICE decided to strengthen the wording of the recommendation by changing it to 'provide access to liaison psychiatry services for people with medical emergencies who have mental health problems.' |
| The Royal College of Emergency Medicine | Short | 9 | 19 | Section 1.2.12<br><br>Medical Assessment Units should have a standard operating policy which also details the conditions that need to be met for closure and diversion of certain patient groups to other healthcare settings (eg. Emergency Department, Hyper-Acute Stroke Unit (HASU). | Thank you for your comment. We have considered escalation measures in chapter 40. |
| The Royal College of Emergency Medicine | Short | 9 | 25-27 | The Royal College of Emergency Medicine would have a particular interest in informing and being involved in this research. | Thank you for your comment and interest in the research recommendations. The committee have made 17 research recommendations that they hope will be taken up to help inform future updates of this guideline. |
| The Royal | Short | 10 | 14 | Local Measures: time from Emergency Department referral to | Thank you for your comment. These may be useful |

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| College of Emergency Medicine | | | | arrival at Medical Assessment Unit, Medical Assessment Unit Length of Stay. | metrics to collect locally. We were unable to go into that level of detail in the recommendations as there may be many other locally useful measures. |
| The Royal College of Emergency Medicine | Short | 12 | 1 | Research recommendations<br><br>Several times in the detailed documents the authors candidly refer to the shortage of doctors in both primary and secondary care. We have some concerns regarding where the GP resource will come from to do the evaluation work required to look at a) GPs in ED and b) extending full-service GP access. | Thank you for your comment. The committee were aware that the government is planning to increase number of GPs through overseas recruitment and increase in medical school places. |
| The Royal College of Emergency Medicine | Full | General | General | Little mention is made of organisation within an emergency department. A review of the various service models that exist would be greatly welcomed. Integrating acute medicine with the emergency department has led to significant reductions in mortality and improved many aspects of care quality<br>http://bmjopen.bmj.com/content/2/4/e000930<br>http://emj.bmj.com/content/25/2/78.short<br>http://emj.bmj.com/content/29/3/208 | Thank you for your comment and information. The guideline committee did not prioritise the organisation of the ED within the scope of the guideline. However the committee did include questions on GPs within or on the same site as emergency departments (Chapter 17) and ED opening hours (Chapter 18). |
| The Royal College of Emergency Medicine | Full | General | General | Overall our concern is that these documents do not mention the issue of how to provide emergency and acute medical care AND provide effective training for the clinicians who will be providing it. There was also concern about the proportion of Emergency Medicine representation in the committee drafting the guidance. | Thank you for your comment. Training issues were outside of the scope of the guideline.<br>The guideline committee was made up of 20 committee members that represented different roles within emergency and acute medical care. For a full list of the guideline committee please refer to Chapter 1 Guideline introduction. We believe that the proportion of emergency medicine representation was appropriate for a guideline that covered a varied range of services. |
| The Royal College of Emergency Medicine | Full | General | General | Training the next generation of clinicians is, by its very nature, a long term and population concern. There may be little or no clear value for the individual patient who has an initial assessment from a junior or is involved in bedside teaching or WPBAs. However, the population of patients needing acute care in the future will gain value. This balance | Thank you for your comment. The committee hope that training will be addressed adequately by the appropriate bodies. Unfortunately it was outside the scope of this guideline. |

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| | | | | between a short-term individual patient approach and a long-term population approach is extremely important to acknowledge as we battle the crisis of trainee recruitment and retention. | |
| The Royal College of Emergency Medicine | 2 | 5 | 2.1 | Non-emergency telephone access and call handlers<br><br>"The Out-of-Hours GP services are separate to these services" Since the announcement from Barbara Hakin in 2015, the Out-of-Hours service will be integrating with the NHS 111 providers to become the new Integrated Urgent Care service (IUC) which is now for national roll-out and has already been established within a number of regions in England. | Thank you for your comment. We have added this information to the introduction of this chapter (Section 2.1). |
| The Royal College of Emergency Medicine | 2 | 5 | 2.2 | Non-emergency telephone access and call handlers<br><br>Typo: 999/112 should be 111 | Thank you for your comment. The sentence has been corrected. |
| The Royal College of Emergency Medicine | 2 | 14 | 2.7 | Non-emergency telephone access and call handlers<br><br>NHS 111 uses non-clinical call handlers with a Clinical Decision Support Software System (CDSS) which is currently NHS Pathways, which uses a tree-based algorithm to reach a disposition, rather than a diagnosis. The dispositions include advice to attend A&E (DX02/DX03). Within the new specification of Integrated Urgent Care, an increased number of calls will be transferred to a Clinical Advice Service(CAS). This is a locally procured and delivered service that will have access to a wide range of clinicians including Dental, Primary Care, Mental Health and Pharmacy. | Thank you for your comment. We have updated the introduction of this chapter to include this information (Section 2.1). |
| The Royal College of Emergency Medicine | 4 | General | General | Paramedic remote support<br>Regarding supporting paramedics, there may be an opportunity that can be mutually beneficial. Prehospital training is becoming increasingly common within EM training and a significant draw into the specialty. There are | Thank you for your comment and feedback. We recognise your point but these examples are not remote support and so we have not included this. Unfortunately, training issues are outside of the remit of our guideline. |

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| | | | | programmes developing in which EDs facilitate their senior trainees to support paramedics in the community on scene with patients (e.g. the Physician Response Unit from the Royal London Hospital in London). Clearly it is important to distinguish between giving remote advice and providing on-scene support, and have appropriate training and supervision. Training programmes such as this may assist in rates of non-conveyance, improve working relationships between the ED and our prehospital colleagues and provide a much needed incentive and variety in the final years of training. | |
| The Royal College of Emergency Medicine | 16 | General | General | Emergency Department opening hours<br>Any measures to limit the out-of-hours burden of the ED would be welcomed. However many see this associated with a downward trend including reliance on locums/ difficulty staffing, leading to reduced hours.<br>Currently in most EDs it is the senior trainees who are managing the shop floor overnight with remote EM consultant support. In a relatively short period we have seen the numbers of patients out of hours increase to the point that the ED is proportionally busier per treating clinician than during the day. This going alongside the well-known decision fatigue and susceptibility to cognitive error we all suffer while tired<br>The intensity of these long overnight shifts for these junior doctors cannot be overstated and it should be recommended that anything that can feasibly and safely wait until the next day should be encouraged and supported to do so. | Thank you for your comment. We recognise the points you make however we did not look at these issues as our review questions. We therefore cannot make recommendations on these topics. We have however added a comment about workforce shortages to the discussion. |
| The Royal College of Emergency Medicine | 16 | 5 | General | Emergency Department opening hours<br>We have seen recent ED overnight closures laid at the door of workforce shortages rather than low demand. However, the document does not seem to consider this as one of the factors affecting opening hours. There are concerns that by basing this guidance on published research it may be out of date, given the long lead times for such research. Is NICE aware of whether the NIHR-funded trial is considering | Thank you for your comment. Four recent observational studies were identified between 2011 and 2014. The committee agreed that the direction and quality of the evidence currently identified was not sufficient to make a recommendation limiting ED opening hours. The committee were aware of the NIHR funded study (Impact of closing emergency departments in England). We are unaware of whether |

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| | | | | workforce supply side issues and their effects? | the NIHR trial is considering workforce supply as they have not published this information to date. We will refer this study to the NICE surveillance team so that it is tracked.<br>Thank you for drawing our attention to the issue of workforce shortages. We have added a comment into the linking evidence to recommendation section to note that whilst not the subject of this review, recent overnight closures may be due to workforce shortages. |
| The Royal College of Emergency Medicine | 18 | General | General | Minor injury units<br><br>It is the view of the Emergency Medicine Trainees' Association (EMTA) that an emergency doctor should be able to deal with the spectrum of emergency injuries and illnesses. The curriculum still emphasises the core skills gained by treating minor injuries. We welcome any efforts to streamline the efficiency for these patients who often face disproportionally long waits considering how rapidly they could be treated and discharged. We would like to emphasise the value that comes from having EM doctors formally trained with this cohort of patients. Given their expertise, there also should be no barrier for EM trainees getting trained by Advances Nurse Practitioners in this area. | Thank you for your comment. We would agree that training of emergency medicine trainees in the management of minor injuries is an important issue and it is specifically acknowledged in the supporting narrative for the research recommendation (in the linking evidence to recommendations section) that any research should "…assess the impact on staff training…". |
| The Royal College of Emergency Medicine | 19 | General | General | Early vs late consultant review<br><br>The evidence does seem to support front loaded decision making for patients however, depending on how this implemented, there can be an impact for trainees. EMTA is aware that relatively junior trainees (e.g. ST3) are frequently given the role of RAT although they are unlikely to have the expertise to effectively make safe decisions rapidly. They are clearly even less likely to perform with the added pressure to see patients as fast as they can. Similarly the pressure on senior doctors to see patients rapidly in that role may inhibit any training opportunities and may anchor trainees, | Thank you for your comment. However, the evidence was not very strong and therefore the committee felt that immediate consultant assessment, such as RAT, could not be recommended. |

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| | | | | assessing the patients later, to the previous working diagnosis, further inhibiting their ability to make their own plans and decisions. We would encourage that any recommendations regarding frontloading senior decision making are tempered with<br>1) allowances for training, support and supervision in that role when the department is less busy<br>2) a recommended model which emphasises expertise in that role and a team alongside to assist execution of the rapid decisions. | |
| The Royal College of Emergency Medicine | 19 | 21 | | Early vs late consultant review<br><br>Regarding Early Consultant Review - The NICE Guideline Template Document says "In settings where patients are presenting with often unclear disease processes (for example, in an emergency department), the benefit of early consultant involvement might be realised if consultants' greater knowledge results in earlier diagnosis, or diminished if the diagnostic process is complex."<br>The Royal College of Emergency Medicine recently published the findings of a clinical audit of 24,341 patients in 180 Emergency Departments looking at consultant sign-off of four high-risk patient groups. The full national report can be accessed from<br>http://www.rcem.ac.uk/docs/QI%20+%20Clinical%20Audit/RCEM%20Consultant%20Sign-Off%20National%20Audit%20Report.pdf | Thank you for your comment and for the link for the national report evaluating 'Consultant sign-off'. The audit is interesting but has not been included in this review as it does not meet the protocol criteria for inclusion. |
| The Royal College of Emergency Medicine | 19 | 22 | | Early vs late consultant review<br>Regarding Early Consultant Review - A poor view is taken of Rapid Assessment and Treatment (RAT) as not being cost-effective per QALY gained. The outcomes RAT has been measured against are not the outcomes it is intended to impact. The primary outcome of RAT is to increase flow and help achieve the four-hour standard, rather than to directly improve QALY. | Thank you for your comment. We have amended this typo in the response below.<br><br>Thank you. The committee were aware that the main aim of RAT was to improve flow, especially to meet the four hour target. For this reason, we attempted to model the impact of RAT on patient flow using our simulation model to see if this would impact on patient and resource outcomes. |

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| | | | | | The model suggested no improvement in QALYs and an additional cost of £8 for every presenting acute patient. The number of 4-hour breeches fell from 10% to 8%.<br><br>The committee did not feel this was strong enough evidence to support a positive recommendation. However, they did not make a recommendation against RAT, so that Trusts can use it to improve patient flow if they wish. However, the evidence that RAT does improve flow was limited. |
| The Royal College of Emergency Medicine | 20 | General | General | Physician extenders<br><br>It is clear that there is enough work to go around. There are, however, limited access to training opportunities. It is unclear of the impact that these practitioners have on EM trainees. EMTA are currently surveying trainee experience in this regard. It is also still unclear for many trainees as they develop where the roles and responsibilities for these clinicians lie. The process of moving from a supervised trainee to a supervising trainee is already stressful without such added uncertainty.<br>The evidence gathered in the review seems to focus on specialist nurses in very narrow spheres of practice i.e. diabetes. An EM extended roll practitioner has a much broader band of operation and therefore the generalisability of any of these studies is very poor for them.<br>Recommendations should emphasise transparency in level of responsibility for giving clinical advice to physician extenders along with protection of training opportunities for trainees.<br>Emergency nursing is now in a crisis and the number of senior nurses leaving nursing to enter clinical practice (on a predominantly in hours, supervision heavy rota) cannot have helped. | Thank you for your comment. Although there are several types of physician extender, randomised controlled trials have only evaluated diabetes specialist nurses, nurse care co-ordinators and nurse practitioners focused on pathway management and improving compliance with best practice. The committee noted the difficulty in making a recommendation without having a broad spectrum of evidence available and decided to make a research recommendation. We hope that further research will address some of your concerns about the impact of these professionals in the system. |
| The Royal | 21 | Gener | Gener | Standardised criteria for hospital admission | Thank you for your comment. The linking evidence to |

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| College of Emergency Medicine | | al | al | Development of standardised admission pathways is beneficial in many ways for trainees. There is an opportunity to immerse trainees in creating quality improvement projects which ultimately result in improved decision making and admission pathways. When agreed locally, these standardised protocols reduce the conflict inbetween specialties that is such a potent source of trainee distress and poor job satisfaction. In this regard recommendations should emphasise cross professional engagement in formation of local admission criteria, stating the utility of trainee literature reviews and quality improvement projects. They should also express the ambition that adherence to standards reduces inter-speciality conflict.<br>While not directly training related, where EDs do not have any access to first fit clinic or rapid access chest pain, all those patients were admitted overnight to AMU. It is examples like that are where NICE guidance on what should be available and admission avoidance might have a positive impact. | recommendations section discusses the benefits of using validated risk stratification tools as standardised criteria for admission. |
| The Royal College of Emergency Medicine | 24+25 | General | General | MAUs and Elderly care assessment units<br><br>While EMTA strongly support the concept of AMUs and Elderly care (or frailty) assessment units it should be noted that there is a potential for dilution of trainee experience and that opportunities should be explored for senior EM trainees to work on these units with close ties to the ED, further improving breadth of training and improving relationships across professional boundaries. | Thank you for your comment. We note your point and agree that training is important; however it is outside the scope of this guideline. |
| The Royal College of Emergency Medicine | 40 | General | General | Escalation Measures<br>When experiencing an event related surge (such as a terrorist attack) then the system responds well, but a general ongoing slow build up in demand is less easily dealt with. We suggest that the research recommendation includes this, and a measure of political pressure to avoid declaring incidents due to 'winter pressures'. | Thank you for your comment. The evidence identified evaluated interventions used in response to specific increases in demand and could not necessarily be generalised to other situations. We didn't specifically look for evidence on a general build-up of demand. So whilst this is a challenging area the committee have specifically developed the research |

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| | | | | | recommendation to include surges due to excess demand. |
| The Royal College of Nursing | 1:2:9 | General | General | There is a concern that the guideline states 'consider providing critical care outreach teams access.' The word consider does not support the referral systems held within many hospitals Trusts which advocates early referral of the acutely unwell. This may be because of the low quality of evidence within this area. Would this be a further area considered for research? | Thank you for your comment. There was much discussion within the guideline committee highlighting the conflict of positive personal experience of committee members related to CCOT against the lack of robust positive RCT or economic evidence. It was also recognised that, irrespective of a recommendation being published, the majority of NHS acute provider trusts already possess the equivalent of a CCOT, although the composition and standard operating policies vary significantly. It was acknowledged that a research recommendation might allow more formal evaluation of the efficacy of CCOT and specifically the composition and remit of such systems. However, on balance, it was felt that a "consider" recommendation best reflected the views of the committee and allowed some flexibility in individual institutional implementation of CCOT; a research recommendation on its own would not have given the overall "positive" message that was felt to be appropriate. The committee wanted to encourage evaluation and therefore included a statement in the recommendation that if the service is provided it should be accompanied by local evaluation.<br>The term 'consider' in this recommendation is to encourage providers to consider setting up CCOT, which allows the hospitals with CCOT already in place to continue working this way and services without a CCOT to consider implementing one. The guidance to 'consider providing' is aimed at the people planning and commissioning services rather than clinicians 'considering' an individual patient. |
| The Royal College of Nursing | | General | General | There is concern that the guideline does not full address the issues surrounding present ED staffing. Indicating the need for development of out-of-hours and consultant care of | Thank you for your comment. Staffing levels were not part of our scope. However, the combination of positive and research recommendations provides |

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| | | | | patients should be streamlined to the new ways of working and the utilisation of more advanced nurse practitioners within the ED environment. Therefore further work should be advocated on the impact on patient outcomes from this. | strong platform for further research along the lines proposed by RCN. |
| The Royal College of Nursing | 1.2 | | | This is where Ambulatory Care needs to be explored when discussing managing hospital admissions 1.2.1 and Providing services within the hospital 1.2.6. In the recommendations for research there could also be discussion around the use and effectiveness of Ambulatory Care in monitoring safety and improved flow. I am happy to be involved in this if this is taken forward. | Thank you for your comment. This review question was specifically focussed on the use of standardised criteria for hospital admission as this was identified by stakeholders as an area of high priority. We are therefore unable to comment on ambulatory care in this chapter, having not looked for the evidence. |
| The Society and College of Radiographers | | Chapter one guideline introduction | Line 8&9 RR5. | *What is the clinical and cost effectiveness of providing GPs with access to plain-film radiology or ultrasound with same-day results?*<br>The Society and College of Radiographers welcome this recommendation for further research and would like to signpost the committee toward current studies which evaluate the role of advanced practitioner and consultant reporting radiographers in providing same-day results (hot reports). | Thank you for your comment. |
| The Society and College of Radiographers | | Chapter one guideline introduction | Lines 17&18 RR11. | *What is the clinical and cost effectiveness of providing 'physician extenders' such as advanced nurse practitioners, 'physician associates' and advanced clinical practitioners in secondary care?*<br>Please see document AHPs into action for evidence and case studies describing various roles, clinical and cost effectiveness of Advanced Practitioner and Consultant Allied Health Professionals including Radiographers<br>https://www.england.nhs.uk/ourwork/qual-clin-lead/ahp/ | Thank you for your comment. We acknowledge that there are a range of roles undertaken by advanced and consultant practice allied health professionals. However, this review was specifically looking at physician extenders and specialist nurse roles and not all allied health professionals listed in this report. |
| The Society and College of Radiographers | | Chapter one guideline introduction | Lines 23&24 RR12. | *What is the optimal configuration in terms of clinical and cost effectiveness of hospital diagnostic radiology services to support 7-day care of people presenting with medical emergencies?*<br>Example of work in this area<br>https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr1514_seven-day_acute.pdf | Thank you for your comments and information. We have referenced these reports in the 'other considerations' section of the linking evidence to recommendation section (Chapter 22, Section 22.6) for further information. |

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| | | | | https://www.hislac.org/images/docs/policy-library/Implementing%207%20day%20working%20in%20imaging%20department.pdf<br>http://www.scin.scot.nhs.uk/wp-content/uploads/sites/3/2015/04/2015-10-28-Recommendations-on-the-Implementation-of-Seven-Day-Working-in-Imaging-in-Scotland-V1.pdf | |
| The Society and College of Radiographers | | Chapter 8 access to radiology | | *RR5. What is the clinical and cost effectiveness of providing GPs with access to plain-film radiology or ultrasound with same day results?*<br><br>This should include a distinction between the costs of reporting of these investigations by radiographers against reporting costs by radiologists. | Thank you for your comment. The purpose of the question was not to look at who is reporting the imaging. It will be assumed that the decision on who reports will be decided by the local provider and competency of the staff. However, we have now noted in the section on 'trade-off between net effects and costs' that 'The costs, effectiveness and cost-effectiveness of same day results might be influenced by the equipment used and the type of staff (including the ratio of radiologists to radiographers used in reporting results),' |
| The Society and College of Radiographers | | Chapter 8 access to radiology | Line 4 | With an acute medical emergency (AME). This can range from simple imaging, such as plain film.<br>'Film' is an outdated term with computerised or digital radiography now employed in clinical imaging departments. | Thank you for your comment. We have removed the term film and updated to plain x-ray radiology. |
| The Society and College of Radiographers | | Chapter 8 access to radiology | | *8.2 Review question: Does GP access to radiology with same day results improve outcomes?*<br>The Society and College of Radiographers are pleased that the committee noted likely logistical and staffing difficulties in the provision of same day plain film radiology and ultrasound results. Increased provision for staff training at undergraduate and postgraduate level would be required for such a service. | Thank you for your comment. We have added a comment to the linking evidence to recommendation section. |
| The Society and College of Radiographers | | Chapter 16 Emergency depart | | *RR8. What is the clinical and cost effectiveness of limiting emergency department opening hours, and what effect does this have on local healthcare provision and outcomes for people with medical emergencies?* | Thank you for your comment. We have added these variables to the research recommendation (Appendix C8). |

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| | | ment opening hours | | This should include a measure of the time patients present with acute medical emergencies. Justification for closing a service can only be made if it can be shown that patients do not present with these conditions during this period. It should also take into account the availability of diagnostic imaging services at these sites, i.e. would a patient have had to go to another centre for imaging regardless of time of the day or day of the week. | |
| The Society and College of Radiographers | | Chapter 17 GPs within or on the same site as emergency departments | Lines 13-15 E. | *The evidence suggested that GPs working within the ED may provide a benefit in reduced number of diagnostic investigations (2 studies, very low quality).*<br>The benefit to patients and population safety in terms of reduced radiation dose should be considered. | Thank you for your comment. This benefit has now been added in the 'trade-off between benefits and harms' section. This is an additional benefit of the same outcome and does not change the quality of the evidence associated with that outcome. Therefore, the committee decided not to change their recommendation for research. |
| The Society and College of Radiographers | | Chapter 17 GPs within or on the same site as emergency departments | | *17.6 Recommendations and link to evidence: Trade-off between benefits and harms; Even if the reduction in diagnostic tests was found to persist, the committee did not consider this benefit alone to be sufficient to justify a recommendation.*<br>The benefit to patients and population safety in terms of reduced radiation dose should be considered. | Thank you for your comment. This benefit has now been added in the 'trade-off between benefits and harms' section. This is an additional benefit of the same outcome and does not change the quality of the evidence associated with that outcome. Therefore, the committee decided not to change their recommendation for research. |
| The Society and College | | Chapter 20 | Lines 4-6 | *The roles include Advanced Nurse Practitioners, Physician Associates and Advanced Clinical Practitioners who may be* | Thank you for your comment. We acknowledge that there are a range of roles undertaken by advanced |

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| of Radiographers | | Physician Extenders | | *Physiotherapists and Paramedics with extended training.* The Society and College of Radiographers urges the committee to recognise the full range of roles undertaken by advanced and consultant practice allied health professionals including radiographers: https://www.england.nhs.uk/ourwork/qual-clin-lead/ahp/ | and consultant practice allied health professionals. However, this review was specifically looking at physician extenders and specialist nurse roles and not all allied health professionals listed in this report. We don't think it is appropriate to link to this report as some of the professions listed are not relevant to an ED setting. |
| The Society and College of Radiographers | | Chapter 20 Physician Extenders | | *20.2 Review question: Do physician extenders (for example, physician assistants and emergency nurse practitioners) improve outcomes in secondary care?*<br>*Research recommendations: RR11. What is the clinical and cost effectiveness of providing 'physician extenders' such as advanced nurse practitioners, 'physician associates' and advance clinical practitioners in secondary care?*<br>Please acknowledge and include the roles of the Allied Health Professionals in this research. | Thank you for your comment. We acknowledge that there are a range of roles undertaken by advanced and consultant practice allied health professionals. However, this review was specifically looking at physician extenders and specialist nurse roles and not all allied health professionals listed in this report. |
| The Society and College of Radiographers | | Chapter 22 7 day diagnostic radiology | | *RR12. What is the optimal configuration in terms of clinical and cost effectiveness of hospital diagnostic radiology services to support 7-day care of people presenting with medical emergencies?*<br><br>Risk/benefit, The Society and College of Radiographers would argue against the statement:<br>*There are no anticipated harms in providing 7 day diagnostic radiology except for the potential increase in resource costs (although these may be offset by potential benefits such as reduced length of stay)*<br>Radiographer and radiologist shortages have not been considered here. Extending a service increases the number of staff required. If the workforce is not available to be employed, cost becomes almost irrelevant. Consequently harm may result from shortages transferred to a different part of the service or a different time of the day or night as the same number of staff are stretched more thinly.<br>Extended hours needs defining as this is variable and can mean 11,12,16 hours etc. | Thank you. We have revised this sentence as follows:<br>"There are no anticipated harms in providing 7-day diagnostic radiology, if it is fully resourced. However, if shortages in radiology and radiography staff persist then there is potential for harm through spreading staff more thinly across the week."<br>We have also added the following to the section on 'Trade-off of net effects and costs':<br>"The current shortage of trained radiology and radiography staff means that the opportunity cost of expanding services is likely to be higher than that suggested by salary levels, since there is a need to recruit or train additional staff." |

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| The Society and College of Radiographers | | Chapter 22 7 day diagnostic radiology | | Recommendations and links to evidence: Trade-off between net effects and costs; This would include additional staff time and investment in radiology equipment and machinery where there is currently little provision.<br>Investment in staff training at undergraduate and postgraduate level with provision for preceptorship and career development, recruitment and retention are also required. | Thank you for your comment. The guideline committee have acknowledged the potential need for increased resource to support a 7-day service in the narrative supporting this research recommendation (Appendix C11). |
| The Society and College of Radiographers | | Chapter 22 7 day diagnostic radiology | | The interventional radiologist workforce would need to grow to provide this service throughout England.<br>In addition interventional radiographers and interventional nursing staff must be considered. | Thank you for your comment. The guideline committee have acknowledged the potential need for increased resource to support a 7-day service in the narrative supporting this research recommendation. We have referred to radiographers staffing in the research recommendation (Please see appendix C11). However, the committee focused on diagnostic radiology in this review question and have therefore not referred to interventional radiology specifically. |
| The Society and College of Radiographers | | Chapter 28 Structured ward rounds | | *Recommendations: 15. Use standardised and structured approaches to ward rounds for example, with checklists or other clinical decision support tools. Other considerations, a willingness to adopt greater standardisation of processes amongst team members, and a flattening of hierarchies.*<br>The Society and College of Radiographers agree with this recognition of the influence of team working and culture with regards to the adoption of change. Has the document any recommendations with regards to implementation. | Thank you for your response. The guidance does not include recommendations on implementation. Your comments will be considered by NICE where relevant support activity is being planned. |
| The Society and College of Radiographers | | Chapter 29 Multidisciplinary team meetings | | *Recommendations: 16. Provide coordinated disciplinary care for people admitted to hospital with medical emergency. Other considerations, It is often assumed that this form of working is easy and simple to implement. To achieve effective MDT working some training is required to ensure members understand and value the roles of each other and develop an ethos of working as a member of a team, particularly focusing on providing the best possible outcomes for patients.* | Thank you for your comment.<br>We have added a statement in the linking evidence to recommendation section that the multidisciplinary team should value and understand the roles and remit of the wider healthcare team. |

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| | | | | In additions to the understanding and value the roles of each other (team members) it is essential that the multidisciplinary team value and understand the roles and remit of the wider healthcare team e.g. diagnostic and therapeutic radiographers in order that multidisciplinary care may be effective and timely; the full skill set and expertise of the wider healthcare team must be recognised and staff enabled to contribute fully to care. | |
| The Society and College of Radiographers | | Chapter 31 Enhanced inpatient access to physiotherapy and occupational therapy | | *Recommendations: 18. Provide access to physiotherapy and occupational therapy 7 days a week for people admitted to hospital with a medical emergency.*<br>Trade-off between benefits and harms, there was no evidence for occupational therapy but the committee considered that the evidence for physiotherapy was likely to be applicable to occupational therapy as well.<br>Given the lack of evidence with regards to the role of occupational therapists in this area, The Society and College of Radiographers would expect a recommendation for further research to evidence or discard the notion that occupational therapy is accessed seven days per week. The statement that evidence from two physiotherapy RCTs is likely to be applicable to occupational therapy is unsubstantiated. There is no evidence of the outcome for patients or of the costs and implications of the recommendation for the profession of occupational therapy. | Thank you for your comment. The committee decided to link physiotherapy and occupational therapy as we believe that both are essentially part of a package. Physiotherapy is concerned with physical function and occupational therapy follows on/is the application of that function. These services are becoming increasingly integrated with staff frequently having a mixture of both sets of skill and the committee wanted to reflect this in its recommendation. We have edited the guideline to reflect this. |
| The Society and College of Radiographers | | Chapter 31 Enhanced inpatient access to physiot | | Trade-off between net effects and costs: The committee noted that the cost of the intervention could be reduced if conducted partly by a therapy assistant or as part of an exercise class where multiple people are being treated together. They also noted that physiotherapy and occupational therapy are usually delivered by a team of staff with mixed skills and therefore, it is not appropriate to evaluate the two separately.<br>Despite this assertion the recommendation is based upon | Thank you. We have edited this section as follows: "All evidence identified was for physiotherapy access only but the committee considered that physiotherapy and occupational therapy services are closely linked with the former concerned with physical function and the latter focused on the application of that function. These services are becoming increasingly integrated with staff frequently having a mixture of both sets of skills and the committee wanted to reflect this in its |

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| | | herapy and occupational therapy | | just two RCT studies each of which did in fact evaluate the role of physiotherapy separately; occupational therapy was not evaluated at all. There should be a recommendation for further research based upon a lack of robust evidence. | recommendation."<br>This does not preclude research into the exact skill-mix and set up necessary to deliver a cost effective service at the local level. |
| The Society and College of Radiographers | | Chapter 32 Structured patient handovers | | *Recommendation: 19. Use structured handovers during transitions of care and follow the recommendations on transferring patients in the NICE guideline on acutely ill patients in hospital.*<br>Delayed or missed investigations are referred to as a measure of relative values of different outcomes. There is no evidence with regards to delayed or missed investigations. The Society and College of Radiographers recognises that diagnostic and therapeutic investigations are delayed or missed in clinical imaging departments due to errors in handover. The committee recognised that "when conducted properly a formal structure for exchanging information would improve outcomes." Structured handover of care must apply when patients leave the ward environment to attend for clinical imaging and therapeutic radiography procedures. Conversely medical imaging and radiotherapy departments must also use a structured system of handover when returning patients to the care of the ward. | Thank you for your comment. This particular question covered structured handover between healthcare professionals between shifts in any acute care setting. It did not cover handover from one ward to another. The chapter on hospital transfer (Chapter 34) covered patient handover from one hospital to another and from one department to another within the same hospital. |
| The Society and College of Radiographers | | Chapter 32 Structured patient handovers | | The committee noted that it is important to provide a structured handover between primary and secondary care as this is a point of escalation. Therefore, there was scope for further research in this area covering the bridge between secondary and primary care. Similarly there is a perceived need to bridge the gap when transferring patients between the ward and diagnostic imaging and radiotherapy departments. | Thank you for your comment. Structured handover between primary and secondary care was not an area prioritised in scoping and therefore we are unable to make a research recommendation in this area as we did not look for the existing evidence. The committee did however agree that it is important to provide a structured handover between primary and secondary care, and this is noted in the narrative. The chapter on hospital transfer (Chapter 34) covered patient handover from one hospital to another and from one department to another within the same hospital. |

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| The Society and College of Radiographers | | 33 Integrated patient information systems | | *Research recommendations: RR14. What is the clinical and cost effectiveness of different methods for integrating patient information throughout the emergency medical care pathway?*<br>The Society and College of Radiographers commend this recommendation and stress that it should be recognised that Computerised Radiology Information Systems and Picture Archiving Communication Systems are employed universally in UK clinical imaging and therapeutic radiography; the systems provide timely information with regards to screening, diagnosis and therapeutic procedures. Integration across primary and secondary care is not widespread however, and we urge research teams to include the review of clinical imaging systems in any proposed research. | Thank you for feedback. We have added a comment in the research recommendation to include the review of clinical imaging systems in any proposed research. |
| The Society and College of Radiographers | | Chapter 35 Discharge planning | | General comment: When planning discharge it is important to consider the availability of imaging services. Where imaging is required this should not prohibit the discharge of patients; discharge of inpatients introduces the potential for error – where patients are discharged prior to their imaging examination contingency must be in place to ensure that outpatient appointments or instructions for walk-in attendance are handed over to patients, carers and their families. | Thank you for your comment. The guideline committee believe that that post-discharge imaging investigations should be planned and arranged before discharge. This is implicit in the guidance, which focuses on the general principles of services organisation rather than on specific diseases or investigations. |
| The Society and College of Radiographers | | Chapter 36 Standardised discharge criteria | | General comment: standardised discharge criteria should also take into the account the capacity, values and opinions of the patient, family and carers. | Thank you for your comment. This has been added to the 'Recommendations and link to evidence' section of the chapter. |
| CURE – University of Sheffield | Chapter 2 – Telephone access | General | General | The chapter draws extensively on our published research on the evaluation of the NHS 111 pilot sites. The evidence is interpreted and presented as a comparison of NHS Direct and NHS 111. The evaluation of NHS 111 was designed to assess the impact of NHS 111 on the wider emergency care | Thank you for your comment. We were aware that your published research was intended as an evaluation of NHS 111 and not as a comparison with NHS Direct. We have added this information into the summary of studies included in the review (Table 2, |

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| | | | | system. It was not designed to "compare" NHS 111 with NHS Direct, nor were any such comparisons or conclusions made and reported. The purpose and findings of this research have been taken completely out of context and the conclusions are therefore unreliable as the research has been used for a purpose that was never intended. I will happily clarify the actual purpose of the evaluation of NHS 111 pilot sites for the authors if they would find that helpful. There is also a large evidence base on telephone triage summarised here https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr03430/#/abstract | Section 2.3) to clarify that this data was used as indirect evidence in our review. As some of this research was before and after the introduction of NHS 111 (before was NHSD so although it did not directly compare it did observe the situation before and after the introduction of the 111 service) we were able to use this in our review with the caveat that it was indirect evidence.<br><br>We have recommended that there should be further research in this area as the evidence in our review was not strong.<br>We have checked the hyperlink for references and have added some papers to our excluded studies tables. We did not find any extra includable studies. |
| Resuscitation council UK | Short version and full guideline | General | | We congratulate all those who worked on this large and complex piece of guidance.<br><br>Much of the guidance addresses aspects of service delivery and organisation that are outside our specific areas of expertise. However, we were disappointed that the guideline does not appear to have addressed service delivery and organisation in response to and following the 'ultimate' acute medical emergency, namely cardiac arrest.<br><br>The Resuscitation Council (UK), working in collaboration with a range of national professional organisations, publishes quality standards for cardiopulmonary resuscitation service delivery and training in a range of clinical settings (https://www.resus.org.uk/quality-standards/introduction-and-overview/).<br><br>We recognise that, even when attempted resuscitation is initially successful, leading to return of spontaneous circulation, there is considerable variation in the further care of patients provided by individual healthcare professionals | Thank you for your comment. The aim of this guideline was to look at generic and not disease specific guidance for emergency and acute medical care. Therefore, we do not agree that these reports should be referenced in this guideline. We have made a positive recommendation for critical care outreach services (Chapter 27) that was based on reduction in cardiac arrest rates. |

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| | | | | and provided in different hospitals. Together with other members of the Community Resuscitation Steering Group for England, representatives of the Resuscitation Council (UK) contributed to the document 'Resuscitation to Recovery. A National Framework to improve care of people with out-of-hospital cardiac arrest (OHCA) in England' (https://www.resus.org.uk/publications/resuscitation-to-recovery/), Like NICE guidelines, the recommendations in this document are based wherever possible on current evidence, and otherwise on consensus.<br><br>In the current draft guideline, NICE appears to be missing an opportunity to promote excellence in health care, in line with these two documents. | |
| RCP | General | General | General | The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Young Adults and Adolescents Steering Group (YAASG) and would like to make the following comments. | Thank you for comment. We will respond to your comment below. |
| RCP | General | General | General | Younger people aged 16 to 24 have recognised differing health needs and experiences of healthcare from younger children and older adults, this issue is frequently unrecognised by the health service and the data hidden in large age bands. There has been little research into what is the most clinically and cost effective way of managing this age group. We therefore suggest that this age group should be a focus of a research recommendation. | Thank you for your comment. Unfortunately, this age group was not the prioritised for a specific question and therefore we cannot make a research recommendation when we have not looked for the evidence.<br>NICE have published a guideline on Transition from children's to adults' services for young people using health or social care services (https://www.nice.org.uk/guidance/ng43). |