NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Emergency and acute medical care in over 16s

Date of quality standards advisory committee post-consultation meeting:
7 June 2018

2 Introduction

The draft quality standard for emergency and acute medical care in over 16s was made available on the NICE website for a 4-week public consultation period between 12 April and 14 May 2018. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 24 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 1: Data collected in The National Audit Office report on NHS Ambulance Services (page 44) suggests that all NHS Ambulance Trusts currently employ advanced paramedic practitioners. Based on this does statement 1 add value for this area of care? If no, what should a statement on ambulance services focus on?

5. Intermediate care as an alternative to hospital care is included within the guideline and we are currently developing a draft quality standard on intermediate care including reablement. Is intermediate care a key area for quality improvement for this quality standard on emergency and acute medical care? If so, please can you specify what should be the focus for quality improvement and how this could be measured?

6. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The quality standard was supported to help reduce critical illness.
- The statements address some very basic components of acute medical services and do not help understand the whole pathway in terms of primary, secondary and ambulance care integration.
- None of the statements directly deal with the delivery of Emergency Care but with Acute Medical Care.
- The role of GPs in providing emergency medical care both during the working day and after hours should be referred to in this quality standard.
- 16-18 year olds attending Acute Trusts should be given the option to be admitted under paediatric services especially when they are already known to the paediatric teams.

Consultation comments on data collection

- General- This is possible for the quality statements but it may simply become a box-ticking exercise rather than a focus on quality.
- Statement 1- Local systems are in place to collect data for people treated in the community versus those conveyed to emergency departments.

- Statement 1- Ambulance services already collect data on activity and some outcomes. More sophisticated measures might however require further investment and development.
- Statement 2- Some Trusts using non-electronic documentation may struggle to consistently collect this data.
- Statement 3- Auditing notes from time of admission to time of review could be achievable.
- Statement 4- Outcome measure on level of staff satisfaction is feasible and achievable.
- Statement 4- At transfer time to another care setting the collection, sharing and transferring of patient information data must comply with the GDPR from May 25th 2018.

Consultation comments on resource impact

- All statements should be achievable with current resources. When unachievable the focus should be on using current staffing and resources more efficiently, rather than recruiting extra resources.
- Statement 1- Additional funding will be needed in order to facilitate the required training and recruitment of these practitioners by both ambulance services and those involved in training (Emergency Departments (EDs) or GPs). However, savings would be gained from reduced hospital admissions and less utilisation of more expensive dual-staffed ambulances.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Ambulance services have specialist and advanced paramedic practitioners.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Current services are not standardised and are patchy. They rely on local pathway development.
- Services having specialist and advanced paramedic practitioners was supported to potentially improve care and deliver care closer to home.
- This statement should encourage the local health services (primary and secondary care) to open alternative referral channels to this group of specialist practitioners (for example, but not limited to, the ability to make direct medical admission referrals) perhaps under the commissioning route.
- Training for these practitioner roles needs to be clarified such as the skills required for working with people with both physical and mental health needs.
- The rationale could state that this statement's focus is on urgent care or primary care presentations.
- Paramedic rotation should be considered including paramedics working in ambulance 999 and 111 control rooms.
- Outcome measure queries were raised and suggestions made.

Consultation question 4

For draft quality statement 1: Data collected in The National Audit Office report on NHS Ambulance Services (page 44) suggests that all NHS Ambulance Trusts currently employ advanced paramedic practitioners. Based on this does statement 1 add value for this area of care? If no, what should a statement on ambulance services focus on?

Stakeholders made the following comments in relation to consultation question 4:

- The statement was supported for contributing to healthcare outcomes such as reducing admissions and improve patient experience.
- A query was raised on the National Audit Office report findings. It was reported that not all NHS Ambulance Services currently employ advanced paramedic practitioners.
- The statement would add more value by:
    - stating how a skill mix should be maintained across all shift patterns with appropriately trained specialist and advanced practitioner paramedics.

- adding detail on what paramedic practitioners should focus efforts on such as attending certain incidents and safely directing patients to the correct care pathway.

5.2 Draft statement 2

Adults admitted with undifferentiated medical emergencies have an initial assessment in an acute medical unit (AMU).

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Support for the use of AMUs with evidence suggesting paramedics can reduce ED pressures by directly referring patients to AMUs.
- A query was raised on the AMU receiving undifferentiated medical emergencies. It was argued that there is no explicit recognition of the role that EDs play in the system. ED run Clinical Decision Units (CDUs) and ambulatory care services were also highlighted as having roles.
- AMUs do not have the capacity to undertake every initial assessment so this may create patient bottlenecks, backlogs and overcrowding.
- The AMU assessment should include access to laboratory diagnostics.
- Additional outcome measures were suggested.

5.3 Draft statement 3

Adults admitted with a medical emergency have a consultant assessment to determine their care pathway.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- A maximum time for assessment and the considerations at weekends and bank holidays was supported.

- Concern raised on this generic statement on the frequency on the consultant review. This should be done in a timely fashion dependent on the condition of the patients.
- 14 hours for a consultant review is too long and appears to match work patterns and not patient need.
- Clarity on consultant assessment needed:
    - Is this the final review/ 'sign off' by a consultant or does it include an assessment and review by a consultant?
    - Is this timing within 14 hours of arrival to hospital, admission or time of decision to admit?
    - What happens when a person is triaged to the wrong specialty – does the 14 hour limit apply from the time of referral to the first specialty before the transfer of care? Does the clock stop when the patient has been seen by the correct specialty consultant?
- People can wait up to 14 hours to see a consultant and so in this time other practitioners can deliver care and implement the care pathway.
- A definition of the consultant is required.

5.4 Draft statement 4

Adults admitted with a medical emergency have a structured patient handover when they transfer between healthcare settings.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Supported for improving patient outcomes and staff satisfaction.
- Suggestion to add specific healthcare setting examples to the supporting information such as pre-hospital setting handover by paramedics and intermediate care.
- Definitional changes were suggested.
- Additional outcome measures were suggested.

Consultation Question 5 on intermediate care

Intermediate care as an alternative to hospital care is included within the guideline and we are currently developing a draft quality standard on intermediate care including reablement. Is intermediate care a key area for quality improvement for this quality standard on emergency and acute medical care? If so, please can you specify what should be the focus for quality improvement and how this could be measured?

Consultation comments

Stakeholders made the following comments in relation to question 5:

- The primary cause of the problem is not a failure to give people good acute care but the lack of available intermediate care. Therefore it would be better to concentrate on solving this through guidance on intermediate care, rather than trying to address it from an acute emergency perspective when it is not an acute emergency.
- Intermediate care quality standards should be separate.
- If intermediate care is going to be included in the guideline there should be a quality statement on this too. Suggestion to focus on the emergency and acute medical team following up the person in the intermediate care within a certain amount of time.
- Suggestion to add this to statement 4 on structured patient handover. Focus on working with intermediate care services to identify and rapidly support the transfer of suitable acute patients into these facilities.
- Multidisciplinary intermediate care is desperately needed especially for the frail elderly. Some paramedics cannot currently refer patients directly. This should be standard practice and primary or community care needs to accept suitable and safe referrals from the ambulance service.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Access to investigations
- Access to liaison psychiatry
- Advance care planning towards end of life
- Ambulatory emergency care
- Nutrition
- Surgical and orthopaedic emergencies.

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	BACCN	General	The BACCN welcome this Quality Statement and to seeing it is action as we believe that this may help reduce patient acuity and thus reduce patients becoming critically ill.
2	BSPED	General	16-18 year olds attending acute trusts should be given the option to be admitted under paediatric services, particularly if they are already known to the paediatric teams.
3	NHS England (NCD for Acute Care)	General	No comments.
4	Resuscitation Council (UK)	General	No. The statements address some very basic components of acute medical services. If emergency medical services do not have these in place, they are not planning use of their resources well, but there are many rather more specific aspects of an acute medical service that could be improved and we believe would result in greater improvement in service quality.
5	Resuscitation Council (UK)	General	We think that these should be achievable within current resources in most organisations and, where they are not already being achieved, the focus should probably be on using current staffing and resources more efficiently, rather than recruiting extra resources and persisting in using them inefficiently.
6	Royal College of Anaesthetists	General	To improve the quality of emergency admissions we must understand the whole process/pathway better, and not just the admission itself. Locally in Nottinghamshire, which is probably a fairly typical UK region, the biggest problems are 1) the inability to discharge patients 2) the delays in 'processing' patients through the system. These then cause backlogs impacting upon the admission of emergency patients. With the increasing population size, increasingly elderly population, and the increasing frailty and co-morbidities these problems are likely to get worse (as has already been demonstrated historically). We don't think that in general the quality standards selected by the committee help understand the **whole** pathway.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
7	Royal College of Anaesthetists	General	Isn't there a case for national documentation for inter-hospital transfer of critically ill patients?
8	Royal College of Emergency Medicine	General	None of the Quality Standards directly deal with the delivery of Emergency Care but rather with Acute Medical Care.
9	Royal College of General Practitioners	General	The statements make no express, explicit reference to integration between primary, secondary and ambulance care. The standards should consider measures of integration and partnership working at a local level (such as through urgent, emergency and acute care delivery partnerships / fora)
10	Royal College of General Practitioners	General	A sensible and workman like approach. The document makes no comment on the work of GP's in providing emergency medical care both during the working day and after hours. The GP can manage safely and effectively medical conditions at home or may make immediate treatment decisions pre-hospital admission. The GP also understands the family/home dynamics and how possible it is to manage care at home. The GP will be aware of hi-risk patients and can give emergency advice by telephone/text and use the primary care team to assist in home emergency management. Examples include paroxysmal nocturnal dyspnoea, asthma, colic, hypoglycaemic coma and stable myocardial infarction over 6 hours since onset, TIA's and psychiatric emergencies.
11	Royal College of Nursing	General	The draft NICE quality standard for Emergency and Acute Medical Care in over 16s seems comprehensive and reasonable. There are no further comments to make at this stage.
12	Royal College of Paediatrics and Child Health	General	Please refer to the new Facing the Future: Standards for children in emergency care settings which are due to be launched on 5 June – chapters include: • An integrated urgent and emergency care system • Environment in emergency care settings • Management of the sick or injured child • Workforce and training • Safeguarding in emergency care settings • Mental health • Children with complex medical needs (new chapter) • Major incidents involvement children or young people • Safe transfers (new chapter) • Death of a child

ID	Stakeholder	Statement number	Comments[1]
			• Information system and data analysis Facing the Future: Standards for children in emergency care settings provides healthcare professionals and service planners with clear standards of care that are applicable to children in urgent and emergency care settings. These standards apply to infants, children and young people up until the age of 18 – and therefore will apply to the NICE Quality Standard for young people aged 16 to 18 years. For more information visit www.rcpch.ac.uk/facingthefuture
13	Royal College of Psychiatrists	General	Not sure how this quality standard will specifically improve the social care-related quality of life.
14	Sheffield Emergency Care Forum	General	Timely reviews for CAMHS and older patients urgent so that early transfer to suitable psychiatric help is received.
15	Sheffield Emergency Care Forum	General	Patient centred outcomes. Yes, patients need a timely diagnosis to have early start to treatment and a date of likely discharge. The patient can then plan ahead. More patient experience/satisfaction needs to be accessed and used to improve patient lives within the hospital setting. There does not seem to be a record of patient experience in structured outcomes.
16	London Ambulance Service NHS Trust	Question 1-statement 1	Statement one does reflect one of the key areas for improvement in the draft quality standard.
17	Royal College of General Practitioners	Question 1-statement 1	Page7: Having specialist and advanced paramedic practitioners in the ambulance organisation is only part of the solution. The standard should also expressly encourage the local health services (primary and secondary care) commitment to opening alternative referral channels to this group of specialist practitioners (for example, but not limited to, the ability to make direct medical admission referrals), perhaps under the commissioning route.
18	Resuscitation Council (UK)	Question 2	Probably, but the likelihood is that any such data collection would simply become a box-ticking exercise, rather than a focus on quality.
19	London Ambulance Service NHS Trust	Question 2-statement 1	In order to measure and evaluate the effectiveness of the role of Advanced Paramedic Practitioners (APP), consideration would need to be given to the time it takes to train new cohorts of practitioners before they become operationally effective. Local systems are in place to collect data relating to key measures such as number of patients treated in the community versus those conveyed to emergency departments. More sophisticated measures might require further investment and development in order to collect more comprehensive data.
20	Royal College of Emergency Medicine	Question 2-statement 1	Ambulance services already collect data on activity and outcomes but I do not think they can accurately capture outcomes e.g if non conveyed patients later attend emergency care. Shared data not yet possible across all services
21	The Society and College of Radiographers (SCoR)	Question 2-statement 4	We are pleased to note that the standard applies to adults who move from one part of a hospital to another. We welcome the definition of a structured patient handover. The point 'tasks still to do' should include informing care

ID	Stakeholder	Statement number	Comments[1]
			providers about outstanding diagnostics and treatment. The rationale behind this point is that when a patient moves from one part of a hospital to another there must be timely updates of local provider software systems - to enable an imaging or radiotherapy department to be able to locate the patient and proceed with diagnosis or treatment in a timely manner. Patient diagnosis and treatment is delayed when patients cannot be located and/or the care provider does not communicate with imaging/radiotherapy departments. The standard is measurable via audit of local Radiology Information Systems / National Radiology Dashboard.
22	BOA Patient Liaison Group	Question 2-Statement 4	At the time of transfer to another care setting the collection, sharing and transfering of patient information data must comply with the GDPR from May 25th.
23	London Ambulance Service NHS Trust	Question 3-statement 1	Yes, it is felt that this statement in this draft quality standard would be achievable. Additional funding might need to be made available in order to facilitate the required training and recruitment of APPs. This would be an offset by savings gained from reduced hospital admissions and less utilisation of more expensive dual-staffed ambulances.
24	Royal College of Emergency Medicine	Question 3-statement 1	Increasing coverage of Paramedic practitioners will need additional investment by both ambulance services and also those services involved in their training (ED's/ GP's etc)
25	Resuscitation Council (UK)	Question 4-statement 1	We doubt it. This requires detailed discussion with hands-on experts from the ambulance services.
26	Royal College of Emergency Medicine	Question 4-statement 1	Perhaps some focus / guidance on what paramedic practitioners should focus efforts on.. e.g. Falls , fits, end of life issues, those where community care is preferable to conveyance. i.e. admission avoidance
27	Royal College of Psychiatrists	Question 4-statement 1	Addressing Question 4 Although the National Audit Office report on NHS Ambulance Services suggests that all NHS Ambulance Trusts currently employ advanced paramedic practitioners, it is still worth stating this as a quality statement should there be a circumstance that might cause this to change. It would appear that this has already been achieved with current resource so there will likely be little additional resource required.
28	The Society and College of Radiographers (SCoR)	Question 4-statement 1	Although data collected in The National Audit Office report on NHS Ambulance Services suggests that all NHS Ambulance Trusts currently employ advanced paramedic practitioners, this quality statement could be extended to add more value by ensuring skill mix with appropriately trained specialist and advanced practitioner paramedics is maintained across all shift patterns.
29	AACE	Question 5	Question 5 discusses intermediate care as an alternative to hospital care. The alternates to admission should not be limited to intermediate care. This restricts the ambition and potential for improving care, patient experience and for reducing costs. Additionally, ambulatory emergency care has been missed as a key objective that would support

ID	Stakeholder	Statement number	Comments[1]
			patient's unnecessary admission. The potential for ambulance systems to contribute to diversion away from admission has been overlooked.
30	Resuscitation Council (UK)	Question 5	This would be relevant as a key area for quality improvement in this QS only on the basis that many people are currently admitted to hospital as acute medical emergencies when they do not have an acute medical emergency but are unable to cope or be cared for at home with a worsening long-term condition. The primary cause of the problem is not a failure to give them good acute care but a lack of available intermediate care, so it would be better to concentrate on solving this through guidance on intermediate care, rather than trying to address it from an acute emergency perspective when it is not an acute emergency. There are plenty of aspects of genuine acute emergencies that require improvement.
31	North West Ambulance Service	Question 5	Question 5 discusses intermediate care as an alternative to hospital care. The alternates to admission should not be limited to intermediate care. This restricts the ambition and potential for improving care, patient experience and for reducing costs. Ambulatory emergency care has been missed as a key objective that would support patient's unnecessary admission. The potential for ambulance systems to contribute to diversion away from admission has been overlooked.
32	Royal College of General Practitioners	Question 5	Intermediate care quality standards should be separate. However, as with the handover of care standard, there should be express inclusion of a standard (or subheading within the handover of care standard) regarding working with intermediate care services to identify and rapidly support the transfer of suitable acute patients into these facilities. There are clear benefits to selected appropriate patients and the healthcare systems locally to having a mechanism to identify and direct suitable patients into this setting direct from the acute medical facility.
33	Royal College of Psychiatrists	Question 5	If intermediate care is going to be included in the guideline, there should be a quality standard around this here too. There could be a standard around someone from the emergency and acute medical team following up the person in the intermediate care within a certain amount of time.
34	Sheffield Emergency Care Forum	Question 5	Multi-disciplinary intermediate care is desperately needed especially for frail, elderly. Some paramedics cannot refer patients directly as yet – this should be standard practice and primary/community care needs to accept suitable and safe referrals from the ambulance service. Many patients would prefer to be treated at home and they should be offered choices. The "falls service" seems to have good links between all the services the patient will require for a susitable, safe recovery/treatment.
35	AACE	1	We welcome the NICE guideline recommendation which advocates the use of specialist and advanced paramedics to reduce conveyance to Emergency Departments. The model of care delivery, using Specialist and Advanced Paramedic Practitioners is one such opportunity that if expanded, could result in systemic change and improvement. However, we would strongly advocate that the operational delivery of these extended trained staff is accounted for in any commissioning arrangements. The commissioning and operational arrangements should allow them to be targeted selectively at low acuity incidents to deliver a safe outcome for their patients whilst working towards the recommended outcomes from the ambulance response programme.

ID	Stakeholder	Statement number	Comments[1]
			We do not think that the statement adds value to the quality standard. Ambulance services supporting specialist and advanced paramedic training does not ensure added value. To add quality to a patient's journey, any specialist or advanced paramedic needs to be involved with the patient's journey. The statement of quality should incorporate the suggestion for them to attend certain incidents; should consider those clinicians in hear and treat roles, or some other measure of their input. There also need to be clarity on the training for this role and the standardisation of the training. There is currently much variation in existence of roles and terms to describe the roles. Also varying despatch models exist, where they don't just attend 999 calls. Recent years have increasingly demonstrated growing system pressures that require all healthcare providers to re-examine their care delivery models and explore opportunities to collaborate together to improve how patients are managed. However these initiatives, whilst extremely effective in their current form, do require further development to ensure they can expand, grow and maximise their full potential. A complete rotational model, with placement in both ambulance and non-ambulance settings, as illustrated above, will allow for mutually beneficial system changes. It is important that the nomenclature and education profile remain as described within the consultation. Dilution of these standards will impact upon the transferability of skills and clinicians and ultimately denigrate patient care. The rationale could be clearer by stating that this refers to urgent care/primary care type presentations. Enhanced level of education should be more detailed – again highlighting type and level (this is important as we move away from the 'traditional' IHCD education format (which gave ambulance services 'control') to under/post graduate education led by universities. The standard should not just focus on reducing hospital admission but safely directing the patient to the correct care pathway: self-care/primary care/walk in centre/ED/medical unit or direct admission etc. It's more about streamlining the service to allow us to distribute the patient cohort to the best facilities for their clinical need. Paramedic rotation should be considered, including paramedics working in ambulance 999 and 111 control rooms. Re-contact rates may not be an appropriate measure. An element of re-attendance can be entirely appropriate e.g. patient seen in early hours with primary care or urgent needs that could be admitted/seen later that day by GP/receiving unit. Could look at delayed 'admission' but also look at length of stay including ITU admission rates post-contact. Much data linkage is required for this. Other areas to measure could include: Number and effectiveness of referral pathways Re-contact beyond 7 days Number of education programmes in place Commissioning of new programmes Availability of Urgent care PGDs/ number of prescribers (and levels of prescribing) Availability/bespoke urgent care clinical guidelines Evidence of ongoing research/audit/evaluation in place to provide assurance

ID	Stakeholder	Statement number	Comments[1]
			The measure of the proportion of incidents resolved without conveyance to an emergency department depends on a number of other factors, including the rates of hear and treat within an ambulance service-this is really important. If more 999 calls are managed over the telephone without sending a resource, this means a larger proportion of the remaining calls will be higher acuity therefore more difficult to manage without conveying to ED. It is alos dependant on the availability of local pathways, and whether they accept the referral for the patient.
36	London Ambulance Service NHS Trust	1	It is questionable whether the figures in the quoted report (page 44 NHS Ambulance Services audit report) reflect the proportions of ambulance service employees in specialist and advanced clinical as opposed to managerial roles such as team leader or operations manager posts. Furthermore, this report suggests that all NHS Ambulance Services currently employ APPs which is not universally the case. When reviewing the NHS Ambulance Services audit report it appears that the table is only representative of NHS Agenda for Change pay banding and not the job role. It is felt that this statement does add a significant value to the area of pre-hospital care. The London Ambulance Service NHS Trust (LAS) is in full support of the statement that ambulance services should have Specialist and Advanced Paramedic Practitioner roles. It is felt that specialist and advanced paramedic practitioner roles can contribute to a reduction in Emergency Department (ED) attendance and hospital admission and improvements in patient and /or carer satisfaction. It also contributes to improved clinical career pathways for paramedics and improved retention of skilled staff within ambulance services.
37	North West Ambulance Service	1	This statement does not add value to the quality standard. Ambulance services supporting specialist and advanced paramedic training does not ensure added value. To add quality to a patient's journey, any specialist or advanced paramedic needs to be involved with the patient's journey. The statement of quality should incorporate the suggestion for them to attend certain incidents; were available for advice or some other measure of their input. There also need to be clarity on the training for this role – emergencies or assessment of patients with a view to safe care closer to home or both. Is this standardised training?
38	Royal College of General Practitioners	1	Page 5: Structure : Data source (b) – It is possible that ambulance services could make meaningful use of specialist and advanced paramedic practitioners in roles other than 'being available to respond to 999 calls' to impact positively on patient care (e.g. based in clinical hubs and providing telephone advice). Evidence of this should be sought, too, and included against this standard.
39	Royal College of General Practitioners	1	Page 5: Outcomes (a) – "proportions of incidents resolved without conveyance to EDs" are dependant on many other factors, and do not – in isolation – necessarily mean that the most appropriate care was delivered. MB

ID	Stakeholder	Statement number	Comments[1]
40	Royal College of Psychiatrists	1	Whilst recommending that specialist and advance paramedic practitioners should be employed by ambulance services, the text should also specify that these practitioners should have skills in working with both physical and mental health needs. Even though mental health is included in the College of Paramedics' Scope of Work, it is not emphasised enough within the Digital Career Framework that specifies these roles, therefore there is a concern that development in skills in mental health might not be considered in the same way as physical health throughout career progression.
41	The Pituitary Foundation	1	This draft quality standard accurately reflects the need for quality improvement in patient safety through training to ensure all paramedic personnel are knowledgeable about pituitary (and other) patients experiencing adrenal crisis so that timely and appropriate treatment can be administered. This may reduce the need for hospital admission, and/or would result in shorter stay in AMU. This corresponds with NHS Framework 2016/17 Domains 4 & 5. Possible to collect data.
42	Royal College of Emergency Medicine	1	Advanced paramedic practitioners do have the potential to improve and deliver care closer to home but current services not standardised and patchy relying on local pathway development
43	Sheffield Emergency Care Forum	1	The links are not well established and extra human and funding resources are necessary to create complete linkage
44	Society for Acute Medicine & Royal College of Physicians	1	About ambulances – we agree
45	UK Clinical Pharmacy Association (UKCPA)	1	Nil to comment.
46	Welsh Ambulance Services NHS Trust	1	Ambulance Services across the United Kingdom face many challenges in respect of continuing to deliver high quality care to the patients they serve. Fundamental in these challenges is the change in patient demographics, complexity of care needs and an ongoing need to work within a restricted fiscal envelope that prevents services from simply growing in size whilst not changing the way in which care is delivered. Recent years have increasingly demonstrated growing system pressures that require all healthcare providers to re-examine their care delivery models and explore opportunities to collaborate together to improve how patients are managed. The model of care delivery, using Specialist and Advanced Paramedic Practitioners is one such opportunity that if expanded, could result in systemic change and improvement. However these initiatives, whilst extremely effective in their current form, do require further development to ensure they can expand, grow and maximise their full potential. A complete rotational model, with placement in both ambulance and non-ambulance settings, as illustrated above, will allow for mutually beneficial system changes. Additionally, it is fundamentally important that the nomenclature and education profile remain as described within the consultation. Dilution of these standards will impact upon the transferability of skills and clinicians and ultlimately denigrate patient care.

ID	Stakeholder	Statement number	Comments[1]
47	East Kent Hospitals University Foundation NHS Trust	2	Proportion of hospital admissions for undifferentiated medical emergencies that were initially assessed in an AMU may be difficult to measure as these patients can also be assessed in ambulatory emergency care, if they do not need obvious admission.
48	East Kent Hospitals University Foundation NHS Trust	2	As well as hospital mortality rates it would be useful to look at readmission rates as a balancing factor to ensure that individual organisations pathways are safe and effective.
49	East Kent Hospitals University Foundation NHS Trust	2	Adults who are referred to hospital with a medical emergency with no exact known cause of their condition are assessed in an acute medical unit. Not all patient are assessed in an Amu with the advancement of ambulatory care services.
50	London Ambulance Service NHS Trust	2	The LAS is broadly supportive of the use of AMUs and there is some evidence that paramedics can reduce ED pressures by directly referring patients to AMUs. But as this is a hospital service/initiative the LAS would be unable to comment further.
51	Resuscitation Council (UK)	2	We are concerned that there is lack of clarity on the role of the Emergency Department (ED) in this statement. The inference is that ALL medical patients should go directly to the AMU and there is no explicit recognition of the role that EDs play in the system. This is implied most obviously in the 'Structure' statement: "Evidence of local arrangements and written clinical protocols to ensure that adults admitted to hospital for undifferentiated medical emergencies have an initial assessment in an AMU." We suggest that the wording is amended to "Evidence of local arrangements and written clinical protocols to ensure that adults admitted to hospital via the Emergency Department or directly from the Primary Care Services for undifferentiated medical emergencies have an initial assessment in an AMU."
52	Royal College of Pathologists	2	The Acute Medical Unit (AMU) should have access to for laboratory diagnostics with timely turnaround, adequate repertoire and appropriate Point of Care testing which comply with UKAS or equivalent quality standards.
53	Royal College of Physicians of Edinburgh	2	Assessment through acute medical units: the initial assessment may actually take place, appropriately, in the Emergency Department or in an ambulatory care setting as well as an acute assessment unit. It may be helpful if the standard is therefore worded towards ensuring all medical admissions go through an acute assessment unit. The standard does however rightly take into consideration the need to exclude those who are admitted straight to specialty units – for example, coronary care, high dependency or acute stroke ward.
54	The Pituitary Foundation	2	Routine tests for low levels of cortisol and adrenal crisis. Timescale essential to avoid coma and possible death. Rapid investigation, initial treatment and management essential. Knowledge of Diabetes Insipidus and how to treat- how it differs from Diabetes Mellitus (Type 1 and 2). Possible to collect data
55	Royal College of Emergency Medicine	2	I take significant issue with the definition of an AMU as receiving undifferentiated medical emergencies. This is the role of the ED and to confuse the two is of no benefit to improving safety and quality in healthcare. AMUs have a

ID	Stakeholder	Statement number	Comments[1]
			fantastic role to play in the management of medical patients requiring admission but this benefit will be compromised by inappropriate definitions entering the current lexicon. Whilst standards discuss and address acute medical emergency care, mention is made of acute surgical care mostly in relation to NELA, however little content re how surgical care addressed in terms of SAU / acute surgical review standards. Is this to be addressed in other guidance? The guideline is quite prescriptive about the use of an AMU. I would question whether the rapid turn-around of patients is related to care being delivered on an AMU or whether the real driver for rapid turnaround is speedy consultant review and rapid access to diagnostics irrespective of location. There is some good evidence relating to the use of a single point of entry for all emergencies with acute specialties all working from the same geographical area which has been effective in driving down admissions e.g. the Cambridge model. This needs to be reflected in the guideline. It's also unclear which specialty the rapid consultant review is aimed at. I would imagine that an acute physician, an acute care of the elderly consultant or an emergency physician may all be willing to take risk and support early discharge of patients. It would be useful to give some examples.
56	Royal College of Emergency Medicine	2	I disagree that all medical emergency admissions need to go through an AMU. Those patients fully assessed in the ED with management plans devised can go direct to specialty wards e.g. Stroke, MI/ACS cases, Confirmed PE, Upper GIB, DKA, those stabilised on NIV to respiratory wards. Duplication of effort, double handling of patients is not cost effective and lengthens stay especially if patients are not reviewed by consultant for up to 14 hours. Also need clarity regarding interface with ED's/ ED run CDU's as many acute medical emergencies are managed in CDU environments by ED clinicians. Up to 15% of local medical emergencies managed by ED clinicians on CDU in my locality [Wales]. Q2: Is this quality measure appropriate given statements above? Should clarification be that all those with undifferentiated medical emergencies have an initial assessment in AMU OR ED run CDU Or have standard that is not 100% to account for those bypassing AMU's such as strokes, AMI etc Quality measures for this statement are blunt mortality rates not best measure as the sicker patients will bypass the AMU's. Better measure would be to look at % with EDD set and number patients who achieve discharge by their EDD Or patient satisfaction or length of stay Q3: Mandating that all patients go to AMU and have to be assessed by the consultant / ACP prior to moving to

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			specialty bed will require AMU's to be rather large if they can wait up to 14 hours for this consultant review. The danger is that the AMUs will be too small and this will create bottlenecks and ultimately backlog in EDs for patients and potentially worsen ED overcrowding.
57	Society for Acute Medicine & Royal College of Physicians	2	We disagree. With many services moving to Acute Physician in-reach into the Emergency Department (ED) this is against the current pattern of care. Our SAMBA 17 (SAM Benchmarking Audit in 2017) showed that most acutely unwell medical patients arrive in ED and a huge chunk of work for these patients is in ED. Most AMUs are designed around at least some of the initial clerkings being done in the ED. This is totally unworkable and would not be achievable and if we went for this most AMUs will just be flooded and fall over.
58	UK Clinical Pharmacy Association (UKCPA)	2	1. It would be good to expand the statement of 'acute physician-led multidisciplinary team (MDT)' in this Quality Standard and recommend the relevant components of such a team, as in Quality Standard 4 (e.g. doctors, nurses, ACP, physio, mental health, pharmacists). Referring to the briefing paper, it is clear that Pharmacy (Pharmacist) input into care of patients in Acute Medical Units can be extremely valuable. Selecting specific examples from Appendix 3; use of IV phenytoin (ID 46), inappropriate use of naloxone (ID 47), antimicrobial stewardship (ID 109) and in addition to these 'end of life care', 'safe use of oxygen', 'cost effective use of medicines' and 'winter pressures / escalation planning and support' are essential patient safety concerns that can be mitigated in part by the input of a highly skilled Pharmacy professional The Carter Report (2016) and subsequent papers including the Model Hospital / Hospital Pharmacy Transformation Plan recommend front-line Clinical Pharmacy as a development for all Acute Trusts. This is further supported by the HEE 'Seven day service clinical standards', which recommends Pharmacy as a key component in the MDT for review of acute inpatients. We would recommend approximately 0.08 – 0.1 WTE Pharmacists (at least one Senior Acute Medicine Specialist) per AMU bed available 8am-8pm 7 days per week to meet this quality standard. This resource can be spread appropriately to support Emergency Departments in times of pressure or escalation and should result in medication reconciliation and optimisation of inpatient therapy being completed for all emergency admission patients in less than 24 hours (and approximately 60-70% within 14 hours). This Pharmacist resource should be supplemented by at least 1 WTE Pharmacy Medicines Management Technician and availability of ancillary Dispensary services and ATO Medicines Management support as a separate but parallel entity to guarantee safe and efficient Pharmacy-led discharge prescriptions and communication. This investment should improve medication (and therefore, patient) safety and optimise both patient flow and handover of critical information. 2. As with other statements, some Trusts operating non-electronic documentation may struggle to consistently collect

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			data to support this standard. 3. Investment will need to be forthcoming to ensure the availability of MDT staff 7 days per week to meet this quality standard.
59	London Ambulance Service NHS Trust	3	Statement three does reflect one of the key areas for improvement in the draft quality standard. Furthermore, the LAS is in support of a Consultant review of adults admitted with a medical emergencies in order to determine their pathway. However, the LAS is unable to comment further on this statement as it does not directly affect services that the LAS provides.
60	Resuscitation Council (UK)	3	We feel that 14 hours for a consultant review is too long and appears to be suggested to match work patterns and not upon patient need.
61	Royal College of Anaesthetists	3	Consultant assessment within 14 hours. Why is 14 hours chosen, and not 12 hours, or 18 hours, etc. for consultant review? We realise that these quality statements are 'generic' and not pathway specific, but there is a real problem with a generic quality statement here. What really matters is that the consultant review occurs in a timely fashion dependent upon the condition of the patients. Certainly, for undifferentiated surgical emergencies this should be much less than 14 hrs. The 'Seven Day Services clinical Standards 2017, page 1 states 'as soon as possible but at the latest within 14 hours from the time of admission to hospital'. It also states 'Consultant involvement for patients considered 'high risk' (defined as where the risk of mortality is greater than 10%, or where a patient is unstable and not responding to treatment as expected), should be within one hour'. This isn't quite the same as in the NICE quality guideline. Having two standards will only create confusion. Isn't it more important that the sick patients are seen promptly rather than everyone is seen within 14 hrs? There is also the issue of which consultant - so there is clear evidence that patients triaged into the wrong specialty have delayed treatment and a worse outcome even though they may have had a consultant review within 14 hours. Just the wrong specialty! We would like clarity on what happens when a patient is triaged to the wrong specialty – does the 14 hour limit apply from the time of referral to the first specialty, before the transfer of care and does the clock stop when the patient has been seen by the correct specialty consultant?
62	Royal College of Anaesthetists	3	Again, there is a real problem with a 'generic' quality standard. Some patients will need a consultant review on a very frequent basis, perhaps hourly in the case of a septic patient. Other patients, perhaps a patient who has had a CVA, has been in hospital many weeks and is awaiting a rehabilitation bed, may only require an occasional consultant

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			review. Indeed the 'Seven Day Services Clinical Standards 2017, section 8, page 9 states 'Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, **unless it has been determined that this would not affect the patient's care pathway.'** The minimum 14 hour time feels rather long, but we understand it is designed to allow for handover and change in shifts. The college feels that some particularly unwell patients will benefit from a much earlier consultant review.
63	Royal College of General Practitioners	3	Page 11: Quality statement: should this consider recommending a consultant-level or GP-specialist medical assessment, recognising that there are a small but significant number of GPs with Special Interest in Urgent and Emergency working in both acute community and hospital settings, with appropriate skillsets and competencies to review some of these these patients and implement appropriate initial plans? It is acknowledged that the source for this statement is – in part – the Society for Acute Medicine benchmarking audit, and that GP-specialist assessment would clearly not be suitable for all patient groups and presentations. However, with GP-specialists working as leading clinicians within acute assessment teams and frailty services, it would be appropriate to include this medical practitioner group in this statement for appropriate patient groups.
64	Royal College of Physicians of Edinburgh	3	Adults admitted with a medical emergency have a consultant assessment to determine their care pathway: there have been calls for that consultant review to be within 14 hours of arrival to hospital, not admission or time of decision to admit (http://www.londonhp.nhs.uk/wp-content/uploads/2016/01/London-Quality-Standards-Acute-medicine-and-emergency-general-surgery-Nov-2015.pdf) for example.
65	Royal College of Psychiatrists	3	Glad to see the specific recommendation around maximum response times for consultant assessment, including variations for daytime working hours and specific mentions for weekends and bank holidays. This is important to set out in writing so that consultants do not leave people waiting to be seen over weekends and bank holidays, so good to see it included within.
66	Sheffield Emergency Care Forum	3	Would like early clinical assessment by consultant on arrival at hospital but resource (human and funding) poor. A geriatrician in ED would be excellent as more frail, elderly are seen.
67	The Pituitary Foundation	3	Consultant review to include liaising with Endocrinologist if pituitary patient hydrocortisone dependent. Procedures in place for early Consultant reviews to avoid potential risk of death.' Expert patient' to be recognised- there are times when their needs and knowledge are ignored by emergency healthcare staff. Possible to collect data.
68	Royal College of Emergency Medicine	3	Yes. Senior clinical input is key to better care.
69	Royal College of Emergency Medicine	3	Measures as time to consultant review is key to improving care and improved quality and safety. The 14 hour timeframe is I feel too long (not sure where this timeframe came from?) and probably reflects the working days that their workforce can currently deliver. However ideally patients should be seen by senior decision maker as soon as possible. Rotas could help but audit of time of review from notes could be achievable. Point out that normal working hours is

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			not defined. Does this include weekends? Daily consultant review is probably not necessary if the initial management plan is done well and patient has not deteriorated. This consultant time would be better spent speeding up the initial review. Perhaps a virtual round / Board round would be better use of time?
70	Society for Acute Medicine & Royal College of Physicians	3	We disagree with aspects of this standard. Patient scan be sent home by non-consultant grade practitioners, if we said it must be consultant our hospitals would be log jammed every morning. Also, the standard is that patients can wait upto 14 hours to see a consultant and so in this time other practitioners can deliver care and implement the care pathway. We understand the sentiment but it needs rewording
71	UK Clinical Pharmacy Association (UKCPA)	3	1. The intent of this statement could benefit from clarification. Does 'consultant assessment' refer to the final review/ 'sign off' by a consultant or does it encompass assessment and review by a consultant? NICE NG 94 (recommendations 1.26 and 1.27) and the Seven Day Service Clinical Standards (Standard 3: MDT review and Standard 8: Ongoing review) emphasise the importance of assessment of adults admitted with a medical emergency for complex or on-going needs within 14 hours by a multi-professional team, which as a minimum will include nursing, medicine, pharmacy, physiotherapy and occupational therapy. This current statement does not outline the role of other allied health care professionals in the patient pathway or recommend the inclusion of these teams in the quality of patient care. We feel the current statement could be broadened to incorporate these recommendations or, alternatively, that an additional quality standard could be formed. 2. Institutions may struggle to collect this data if Consultant review indicators are not available on PAS feed systems. Some may overcome this if utilising electronic notation. Evidence of medicines reconciliation being conducted by a pharmacist within 24 hours for adults admitted with a medical emergency. (Seven Day Service Clinical Standards: Standard 3) Evidence of assessment of adults admitted with a medical emergency for complex or on-going needs within 14 hours by a multi-professional team, which as a minimum will include nursing, medicine, pharmacy, physiotherapy and occupational therapy. (Seven Day Service Clinical Standards: Standard 3; 8. NICE NG 94 recommendations 1.26 and 1.27)

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			3. See "2". May require investment in relevant system.
72	AACE	4	This seems to just relate to handover at hospital. However handover may also take place in the pre hospital setting and by ambulance clinicians which are not mentioned. There is currently no agreed 'gold-standard' tool/process for handover. This could and should be developed.
73	BOA Patient Liaison Group	4	Adults admitted with a medical emergency have a structured patient handover when they transfer between healthcare settings. This should be at the patient bedside – which 1) enables the patient to inter-act with the handover, & 2) improves the quality of information sharing between the patiew t and the carers. 3) Makes complying with the provision of equality and diversity conciderations easier. 4) Should be in the presence of the nominated next of kin when communication with the patient is not possible
74	BOA Patient Liaison Group	4	Adults admitted with a medical emergency have a structured patient handover when they transfer between healthcare settings. Transfers between healthcare setting and discharges should be carried out during "normal working hours" and not at night time or the weekend, when there is a chance that there is innadequate care cover at the patient's new site. This is particularly important when moving from hospital to community based care, or from hospital to a Care Home environment
75	London Ambulance Service NHS Trust	4	Q1 Statement four does reflect one of the key areas for improvement in the draft quality standard. However, there is a limitation to this statement as it only refers to adults who are being moved from one part of a hospital to another or to a new healthcare setting. It is felt that a handover from a paramedic at a first point of contact between the patient and the hospital can play a crucial role when deciding on the next steps of treatment. Q2, Within ambulance services a structured patient handover is already in existence and is a well-practiced process when exchanging patient information between other healthcare providers. Q3, Yes, it is felt that this statement in the draft quality standard could be fully achievable and would contribute to improved patient outcome and staff satisfaction.

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76	Royal College of Anaesthetists	4	Transition points' in patient care are 'high risk' areas where information can easily get lost, and errors can occur. The phrase 'health care settings' seems a bit vague. Within the 'Structured patient handover' we would recommend including patient's allergies (sadly patients still die from being given drugs that they are known to be allergic to) and resuscitation status (DNAR (Do Not attempt Resuscitation) where relevant) in the handover specifications. Often the handovers are verbal, and these will be difficult to capture in any audit. What constitutes a proper 'structure' to the handover?
77	Royal College of Anaesthetists	4	Obviously, the communication with the patient and their next of kin is a basic part of medical care. This NICE quality standard concentrates on the communication with patients and next of kin at times of 'handovers'. Probably more important to the patient and their next of kin are communication on admission, and when the patients' condition(s) changes (either improvement or deterioration). We can understand why the standard committee has gone for written information, but in practice much of this is done verbally. In many ways a mixture of verbal and written is best. The verbal communication allows the patient and next of kin to ask questions that may not be initially apparent, and also for the staff to confirm that the patient/next of kin have understood, whereas written communication allows a record which the patient/next of kin can refer to. Just handing out written pamphlets can very easily become a tick box exercise. We think that this standard would be quite difficult to audit.
78	Royal College of General Practitioners	4	Page 15: Outcome: Level of staff satisfaction should not be the primary outcome. This is not a robust enough justification for the standard, nor is it the most important driving factor. Structured handover should support better identification of deteriorating or significantly unwell patients, fewer adverse events associated with transfers of care, better care planning (including anticipatory planning), better discharge planning and liaison (including medications) and shorter times in acute hospital beds. It should also be associated with fewer errors with delivery or omission of patient-identified preferences (such as inappropriate resuscitation attempts).
79	Royal College of Physicians of Edinburgh	4	Adults admitted with a medical emergency have a structured patient handover when they transfer between healthcare settings: the College agrees this is vital. The College suggests that the standard would benefit from additional detail regarding timings of handover – for all nursing handover it should be done at the time of move, for medical handover, there will be patients who will need it pre/peri move, and for some it may be at a more formal handover meeting the following morning if stable.
80	Royal College of Psychiatrists	4	Glad to see a recommendation around structured patient handovers – think this will help with multi-agency working and improve the patient experience. Also glad to see psychological and emotional needs included in the structured patient handover, and that this needs to be communicated to the person and next of kin. However, handover should explicitly include a formal assessment of the individual's mental health needs with plans to manage these, as would occur with handover of their medical needs. Handover of an individual's psychological and emotional wellbeing, could be simply letting others know that a person is distressed (which happens in many medical emergencies). This is not

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			the same as a more formal understanding that an individual has a longstanding mental health problem for which they receive medication which they have to be prescribed etc.
81	Royal College of Psychiatrists	4	Happy to see that staff satisfaction will be considered.
82	The Pituitary Foundation	4	When patients transfer between healthcare settings- importance of notifying Endocrinologist of acute episode, in addition to GP. Possible to collect data.
83	Royal College of Emergency Medicine	4	Yes
84	Royal College of Emergency Medicine	4	Handover forms in use between Ambulance services/ secondary care and between ED's / inpatient areas in form of SBARs in my experience so this outcome measure is feasible/ achievable
85	Society for Acute Medicine & Royal College of Physicians	4	We agree with his standard about hand over.
86	The Society and College of Radiographers (SCoR)	4	Is staff satisfaction a robust measurement of structured patient handover? SCoR would prefer to see a patient centred measurement based on outcome, such as 'Was sufficient information handed over that the patent was able to proceed to the next stage of care without delay'?
87	UK Clinical Pharmacy Association (UKCPA)	4	General comment: it is great to see specific mention under the heading of 'Health and social care professionals' of the many different professions that contribute to the multi-disciplinary team. Pharmacist to pharmacist handover within the first 24 hours of admission at each location move is particularly critical in order to reduce the risk of accidental omissions of chronic medications and ensure that prescriptions for acute treatments are correct both in terms of clinical and financial impact on the patient / unit. 1. This quality standard may benefit from emphasising that a structured handover of care is applicable both on admission and on discharge from Emergency and Acute medicine care settings. This quality standard does not make reference to the recommendations on transfer of care from NICE NG 27: Transition between inpatient hospital settings and community or care home settings for adults with social care needs (recommendations 1.1.4, 1.1.5, 1.2.1, 1.2.3, 1.3.3, 1.3.4, 1.5.6, 1.5.7) and SIGN 128. Equality and diversity – NG27 also outlines particular populations that would benefit from enhanced structured handover in their transfer of care on admission / discharge. It may be pertinent to preference electronic handover methods at this stage?

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			2. All Trusts should have systems in place that will be broadly similar. Sharing of best practice in this area may lead to improved patient outcomes across the system, this could be recommended? 3. Investment may be required to improve communication systems, in particular with the requirement for all-electronic systems in the near future.
88	UK Clinical Pharmacy Association (UKCPA)	4	To minimise potential variation in the interpretation and measurement of 'evidence of structured handover', the following adaptations to the current definition should include; • A plan for ongoing treatment to 'include clinical indication, reasoning and duration of drugs and therapies which are new, altered, stopped or were received while in hospital. (SIGN 128) • Discussion with patient/carer about Risks and Benefits of each new medication.' (NICE NG 27) Additional measures could include: • Discharge summary is available to the patient's GP within 24 hours of their discharge. • Information provided to patients / carers.
89	The Pituitary Foundation	EIA	All patients should receive the same care, including acute and emergency care. The Pituitary Foundation's mission statement states: 'Every person affected by a pituitary condition has a timely diagnosis and access to the best treatment, information and support'. This is not always the case when pituitary patients are admitted with an acute episode- due to lack of knowledge and expertise amongst emergency healthcare staff- and identifies a training need.
90	Royal College of Anaesthetists	Additional areas	We note the standards are limited to medical patients. We feel this is a missed opportunity and that surgical patients will also benefit from going through an acute surgical assessment unit. The rest of the standards would apply equally to surgical and orthopaedic emergencies.
91	Royal College of Anaesthetists	Additional areas	The quality standards do not appear to consider nutrition.
92	Royal College of Anaesthetists	Additional areas	Access to investigations, including radiology, has not been included. We are surprised by this particularly as it is part of the 'National Emergency Laparotomy Network' standards, and 'Seven Day Services Clinical Standards 2017.'
93	Royal College of Psychiatrists	Additional areas	We note that NICE NGXX Recommendation 1.2.3 is that access to liaison psychiatry should be considered for people with medical emergencies who have mental health problems. We understand that the quality of evidence available regarding liaison psychiatry is weak, however, there is evidence that people with mental health problems who present with medical emergencies do poorly. This indicates that people with mental health problems should be given special consideration when they present with medical emergencies. The presence of co-morbidity makes situations more complex and it is at the point of consultant assessment that such complexity can/should be explored. This does not necessarily mean that each patient must see a consultant psychiatrist, but that the consultant doing the assessment should have sufficient skills to do a mental health assessment.

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94	Sheffield Emergency Care Forum	Additional areas	Advance care planning towards end of life should be a priority. Carers will have a different opinion to the patient and the patient's wishes should be carried out if possible i.e. to die at home rather than in hospital. ReSPECT. GP's could possibly determine patient's wish.
95	Sheffield Emergency Care Forum	Additional areas	End of life patients should not be subjected to procedures and other unnecessary tests (painful for patient and costly for the services) Need more research into end of life optimal care.. ED's are busy, noisy and not the place for end of life.
96	The Society and College of Radiographers (SCoR)	Additional areas	SCoR is concerned that these statements lose value if there is no quality statement related to the 24/7 availability of diagnostics, in particular emergency radiology investigations such as chest x-ray, CT and MRI brain. The outcome of quality statement 3 for example is 'Length of hospital stay for adults admitted with a medical emergency', which is likely to be directly dependent on length of wait for diagnostic radiology.

Registered stakeholders who submitted comments at consultation

- Association of ambulance chief executives (AACE)
- British Association of Critical Care Nurses (BACCN)
- British Orthopaedic Association Patient Liaison Group (BOA)
- British Society for Paediatric Endocrinology and Diabetes (BSPED)
- East Kent Hospitals University Foundation NHS Trust
- London Ambulance Service NHS Trust
- NHS England (NCD for Acute Care)
- North West Ambulance Service
- Resuscitation Council (UK)

- Royal College of Anaesthetists
- Royal College of Emergency Medicine
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Paediatrics and Child Health
- Royal College of Pathologists
- Royal College of Physicians
- Royal College of Physicians of Edinburgh
- Royal College of Psychiatrists
- Sheffield Emergency Care Forum
- Society for Acute Medicine
- The Society and College of Radiographers (SCoR)
- The Pituitary Foundation
- UK Clinical Pharmacy Association (UKCPA)
- Welsh Ambulance Services NHS Trust