NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Emergency and acute medical care in over 16s

NICE quality standard

Draft for consultation

April 2018

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

It is for commissioners, service providers, health, public health and social care practitioners, and the public.

This is the draft quality standard for consultation (from 12 April to 14 May 2018). The final quality standard is expected to publish in September 2018.

Quality statements

Statement 1 Ambulance services have specialist and advanced paramedic practitioners.

Statement 2 Adults admitted with undifferentiated medical emergencies have an initial assessment in an acute medical unit (AMU).

Statement 3 Adults admitted with a medical emergency have a consultant assessment to determine their care pathway.

Statement 4 Adults admitted with a medical emergency have a structured patient handover when they transfer between healthcare settings.

NICE has developed guidance and a quality standard on patient experience in adult NHS services (see the NICE pathway on patient experience in adult NHS services), which should be considered alongside these quality statements.

Other quality standards that should be considered when commissioning or providing emergency and acute medical care services for over 16s include:

- Rehabilitation after critical illness in adults (2017) NICE quality standard 158
- End of life care for adults (2011, updated 2017) NICE quality standard 13

A full list of NICE quality standards is available from the quality standards topic library.

Questions for consultation

Questions about the quality standard

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

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

Question 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.

Questions about the individual quality statements

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?

Question 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?

Local practice case studies

Question 6 Do you have an example from practice of implementing the NICE guideline that underpins this quality standard? If so, please submit your example to

NICE local practice case studies on the NICE website. Examples of using NICE quality standards can also be submitted.

Quality statement 1: Ambulance services

Quality statement

Ambulance services have specialist and advanced paramedic practitioners.

Rationale

Paramedics with an enhanced level of education may potentially reduce emergency department attendance, hospital admission and improve patient and/or carer satisfaction.

Quality measures

Structure

a) Evidence of ambulance services supporting specialist and advanced paramedic training.

Data source: Local data collection, for example, personal development plans (PDPs) and training plans. The College of Paramedics and Health Education England's 2017 Digital career framework details the levels of experience and education required to undertake specialist and advanced level paramedic practitioner roles.

b) Evidence of ambulance services having specialist and advanced paramedic practitioners who can respond to 999 calls for suspected medical emergencies.

Data source: Local data collection, for example, service protocols and staff rotas.

Outcomes

a) Proportion of incidents resolved without conveyance to an emergency department.

Data source: Local data collection, for example, audit of electronic case records. The National Audit Office report on NHS ambulance services includes details on resolved incidents without conveyance to an emergency department.

b) Re-contact rates within 7 days of discharge from the emergency scene.

Data source: Local data collection, for example, audit of electronic case records. The National Audit Office report on NHS ambulance services includes details on re-contact rates.

What the quality statement means for different audiences

Service providers (ambulance services) have specialist and advanced paramedic practitioners to assess and treat adults with suspected medical emergencies. They should have local arrangements in place to provide education and training for paramedic staff with sufficient post-qualification experience so that these staff can undertake specialist or advanced paramedic practitioner roles. Models of service delivery for paramedic practitioners need to take into account of local geography, population demographics, and availability of and access to other health and social care services. They also have effective coordination and dispatch systems within ambulance services to maximise the benefits of specialist and advanced paramedic practitioners.

Healthcare professionals (specialist and advanced paramedic practitioners) attend to selected adults with suspected medical emergencies who need urgent care in the community. They provide enhanced assessment and treatment to decide whether the person can be discharged or needs further treatment and if so, where they should be taken for further treatment.

Commissioners (such as clinical commissioning groups and NHS England) ensure that they commission ambulance services that have specialist and advanced paramedic practitioners to provide enhanced assessment and treatment. They also ensure effective coordination and dispatch systems within ambulance services to maximise the benefits of specialist and advanced paramedic practitioners.

Adults who have a medical emergency and who call 999 are treated by services that employ paramedics with specialist and advanced training who might be able to treat the suspected medical problem without needing to take them to hospital.

Source guidance

Emergency and acute medical care in over 16s: service delivery and organisation (2018) NICE guideline NG94, recommendation 1.1.1

Definitions of terms used in this quality statement

Specialist paramedic practitioner

A paramedic who has undertaken, or is working towards a post-graduate diploma (PGDip) in a subject relevant to their practice. They will have acquired and continue to demonstrate an enhanced knowledge base, complex decision making skills, competence and judgement in their area of specialist practice.

[The College of Paramedics and Health Education England's 2017 Digital career framework]

Advanced paramedic practitioner

An experienced paramedic who has undertaken, or is working towards a master's degree in a subject relevant to their practice. They will have acquired and continue to demonstrate an expert knowledge base, complex decision making skills, competence and judgement in their area of advanced practice.

[The College of Paramedics and Health Education England's 2017 Digital career framework]

Question for consultation

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?

Quality statement 2: Assessment through acute medical units

Quality statement

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

Rationale

An AMU provides rapid assessment, investigation and treatment for medical emergencies, which are often undifferentiated and may involve multiple medical pathologies. Assessment in an AMU can reduce length of stay and improve patient and/or carer satisfaction.

Quality measures

Structure

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.

Data source: Local data collection, for example, clinical protocols.

Process

Proportion of hospital admissions for undifferentiated medical emergencies that were initially assessed in an AMU.

Numerator – the number in the denominator in which an initial assessment in an AMU is carried out.

Denominator – the number of hospital admissions of adults for undifferentiated medical emergencies.

Data source: Local data collection, for example, audit of electronic case records.

Outcome

Hospital mortality rates for adults admitted to hospital for undifferentiated medical emergencies.

Data source: Local data collection, for example audit of electronic case records.

What the quality statement means for different audiences

Service providers (such as emergency departments) ensure that local referral pathways are in place for adults with undifferentiated medical emergencies that need hospital admission to have an initial assessment in an AMU. Service providers also ensure that staff are aware that when there is clear pathology and a clear pathway (for example, for resuscitation or treatment of specific conditions such as a heart attack), AMU admission may not be appropriate.

Healthcare professionals (such as acute physician-led multidisciplinary AMU teams) carry out an initial assessment for adults who have been referred to an AMU with undifferentiated medical emergencies that need hospital admission. The timescale of this initial assessment is based on the person's condition, and the assessment initiates ongoing care.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission AMUs with sufficient resources and expertise to carry out initial assessments for adults who have been referred to hospital with undifferentiated medical emergencies.

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.

Source guidance

Emergency and acute medical care in over 16s: service delivery and organisation (2018), NICE guideline NG94, recommendation 1.2.2

Definitions of terms used in this quality statement

Undifferentiated medical emergencies

Acute medical conditions with no exact known cause and no clear, predetermined clinical pathway.

[Expert opinion]

Acute medical unit (AMU)

An acute medical unit (AMU) (also called an acute assessment unit [AAU] or medical admissions unit [MAU]) is the first point of entry for people with a medical emergency who are referred to hospital by their GP or need admission from the emergency department. Its primary role is to provide rapid assessment, investigation, initial treatment and definitive management.

[Adapted from NICE's guideline on emergency and acute medical care in over 16s: service delivery and organisation, evidence review on assessment through acute medical units.]

Quality statement 3: Consultant review

Quality statement

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

Rationale

Timely assessment by a consultant is associated with reduced length of stay for people admitted to hospital with a medical emergency.

Quality measures

Structure

a) Evidence of the availability of a designated consultant who has responsibility to assess adults who have a medical emergency within 14 hours of the time of admission.

Data source: Local data collection, for example, from staff rotas and service specifications.

For measurement purposes the timeframe of first consultant review within a maximum of 14 hours from the time of admission is based on NHS England (2017) Seven Day Services Clinical Standards and Society for Acute Medicine (2017) Benchmarking audit.

b) Evidence of the availability of a designated consultant who has responsibility to review adults who have a medical emergency at least daily.

Data source: Local data collection, for example, from staff rotas and service specifications.

Process

a) Proportion of admissions of adults with a medical emergency in which a consultant assessment is carried out within 14 hours of the time of admission.

Numerator – the number in the denominator in which a consultant assessment is carried out within 14 hours.

Denominator – the number of admissions of adults with a medical emergency.

For measurement purposes the timeframe of first consultant review within a maximum of 14 hours from the time of admission is based on NHS England (2017) Seven Day Services Clinical Standards and Society for Acute Medicine (2017) Benchmarking audit.

Data source: Local data collection, for example using Hospital episode statistics from NHS Digital.

b) Proportion of admissions of adults with a medical emergency in which daily consultant review is carried out after the initial consultant.

Numerator – the number in the denominator in which daily consultant review is carried out.

Denominator – the number of admissions of adults with a medical emergency in which an initial consultant assessment was carried out.

Data source: Local data collection, for example, local audit of patient records.

Outcome

Length of hospital stay for adults admitted with a medical emergency.

Data source: Local data collection, for example using Hospital episode statistics data from NHS Digital.

What the quality statement means for different audiences

Service providers (including emergency departments and acute medical units) ensure that consultants are available to assess and review adults with a medical emergency within a maximum of 14 hours of the time of admission to determine the care pathway. Current local staffing models, the case mix presenting and the severity of illness are all considered to ensure early consultant involvement. Staff

rotas may have to be reconfigured to support this consultant review in terms of timing and frequency.

Healthcare professionals (consultants) assess adults with a medical emergency face to face as soon as possible and always within a maximum of 14 hours of the time of admission. During daytime working hours a review should normally occur within a maximum of 6 hours of the time of admission. The frequency of consultant review is based on clinical need. It should happen at least daily, including at weekends and bank holidays.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services using a service specification that states that there are consultants available to assess adults with a medical emergency within a maximum of 14 hours from the time of admission. The frequency of consultant review is based on clinical need. It should happen at least daily, including at weekends and bank holidays. Commissioners monitor contracts and seek evidence that service providers have these available.

Adults who are admitted to hospital with a medical emergency are seen by a consultant within 14 hours of admission, and at least once a day while they are in hospital.

Source guidance

- Emergency and acute medical care in over 16s: service delivery and organisation (2018), NICE guideline NG94, recommendation 1.2.5
- For measurement purposes the timeframe of first consultant review within a maximum of 14 hours from the time of admission is based on NHS England (2017) Seven Day Services Clinical Standards and Society for Acute Medicine (2017) Benchmarking audit.

Quality statement 4: Structured patient handovers

Quality statement

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

Rationale

Structured patient handovers for exchanging information between healthcare settings are associated with improvement in patient outcomes and staff satisfaction.

Quality measures

Structure

Evidence of structured (verbal and written or electronic) handover processes when transferring adults between healthcare settings who have been admitted with a medical emergency.

Data source: Local data collection, for example, ward transfer protocols. NHS England's NHS standard contract 2017/18 and 2018/19 technical guidance and Seven Day Services Clinical Standards include patient handover processes.

Process

Proportion of transfers of adults who have been admitted with a medical emergency in which a structured handover of care is carried out when transferring between healthcare settings.

Numerator – the number in the denominator who have a structured handover of care.

Denominator – the number of transfers of adults between healthcare settings who have been admitted with a medical emergency.

Data source: Local data collection, for example, local audit of patient records.

Outcome

Level of staff satisfaction with the structured handover of care when adults who have been admitted with a medical emergency transfer between healthcare settings.

Data source: Local data collection, for example, local audit of staff surveys.

What the quality statement means for different audiences

Service providers (primary, secondary and community-based intermediate care) have processes in place to ensure that a structured handover of care (verbal and written or electronic) is carried out when adults who have been admitted with a medical emergency transfer between healthcare settings. The current care provider shares complete and up-to-date care information with the new care provider, who documents and acts on this information. Roles and responsibilities between the current and new care providers are also clearly defined at transferral. Service providers ensure that healthcare professionals have training in structured patient handovers and supervision with monitoring of competency.

Health and social care professionals (such as doctors, nurses, advanced clinical practitioners, physiotherapists, mental health teams and pharmacists) work together to deliver a structured handover of care (verbal and written or electronic). They share complete and up-to-date information when adults who have been admitted with a medical emergency transfer between healthcare settings so that patient safety is not compromised. Roles and responsibilities between the current and new care providers are also clearly defined at transferral.

Commissioners (clinical commissioning groups and NHS England) ensure that they commission services that enable coordination and continuity of care, and sharing of information, when adults who have been admitted with a medical emergency transfer between healthcare settings.

Adults who move from one part of a hospital to another or to a new healthcare setting have information about their condition and any special needs passed on to their new care provider. They are given information about their condition and encouraged to be involved in making decisions about their care.

Source guidance

- Emergency and acute medical care in over 16s: service delivery and organisation (2018) NICE guideline NG94, recommendation 1.2.11
- Acutely ill adults in hospital: recognising and responding to deterioration (2007) NICE guideline CG50, recommendation 1.15

Definition of terms used in this quality statement

Structured patient handover

A handover of care that uses the approach outlined in the SBAR (situation–background–assessment–recommendation) tool. It includes:

- a summary of the stay, including diagnosis and treatment
- a monitoring and investigation plan
- a plan for ongoing treatment, including drugs and therapies, nutrition plan, infection status and any agreed limitations of treatment
- a discharge plan
- physical and rehabilitation goals
- psychological and emotional needs
- specific communication or language needs
- tasks still to do.

The plan also needs to be communicated to the person or their next of kin.

[Adapted from NICE's guideline on acutely ill adults in hospital, recommendation 1.15, the NHS Institute for Innovation and Improvement's Safer care SBAR implementation and training guide, and expert opinion]

Equality and diversity considerations

Adults admitted with a medical emergency who are transferring between care settings should be provided with handover information that they can easily read and understand themselves, or with support from their next of kin if appropriate. This can help them to communicate effectively with healthcare services. Information should be in a format that suits their needs and preferences. It should be accessible to people

who do not speak or read English, and culturally and age-appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard.

About this quality standard

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

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

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

See quality standard advisory committees on the website for details of standing committee 1 members who advised on this quality standard. Information about the topic experts invited to join the standing members is available on the quality standard's webpage.

This quality standard will be included in the NICE Pathway on emergency and acute medical care, which brings together everything we have said on emergency and acute medical care in an interactive flowchart.

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

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and

Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Improving outcomes

This quality standard is expected to contribute to improvements in the following outcomes:

- health-related quality of life
- social care-related quality of life
- length of hospital stay
- emergency readmissions following discharge from hospital
- deaths attributable to problems in healthcare
- severe harm attributable to problems in healthcare
- patient safety incidents.

It is also expected to support delivery of the Department of Health and Social Care outcome frameworks:

- Adult social care outcomes framework 2016–17
- NHS outcomes framework 2016–17
- Public health outcomes framework for England, 2016–19.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the baseline assessment and resource impact tools for the NICE guideline on emergency and acute medical care to help estimate local costs.

Diversity, equality and language

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

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

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