Quality standards advisory committee 1 meeting

Date: 1 February 2018

Location: NICE office, Level 1a City Tower, Piccadilly Plaza, Manchester, M1 4TD

Topic: Emergency and acute medical care in over 16s – prioritisation of quality improvement areas

Minutes: Draft

Attendees

Quality standards advisory committee 1 standing members:

Bee Wee (chair), Simon Baudouin, Gita Bhutani (vice-chair), Phillip Dick, Tim Fielding (vice-chair), Zoe Goodacre, Ruth Halliday, Nicola Hobbs, Rhian Last, Tessa Lewis, Anita Sharma, Hazel Trender, Hugo Van Woerden, Alyson Whitmarsh

Specialist committee members:

Emergency and acute medical care in over 16s:

Daniel Albert
Tim Edwards
Mike Jones
Amar Mashru
Oliver Phipps
Debra Quantrill

NICE staff:

Nick Baillie, Sabina Keane, Julie Kennedy, Nicola Bodey, Jamie Jason (notes)

Apologies Teresa Middleton, Ian Reekie, Sunil Gupta, John Jolly, Philip Dyer (SCM)

1. Welcome, introductions objectives of the meeting
The Chair welcomed the attendees and the quality standards advisory committee (QSAC) members introduced themselves. The Chair informed the committee of the apologies and outlined the objectives of the meeting, which was to prioritise areas for quality improvement for the emergency and acute medical care in over 16s quality standard. The Chair confirmed that this would be a closed committee meeting with no public observers joining the meeting as this QSAC would be discussing the areas in the Emergency and acute medical care in over 16s: service delivery and organisation, which is a NICE draft guideline consultation version.
2. Confirmation of matter under discussion and declarations of interest
The Chair confirmed that, for the purpose of managing conflicts of interest, the matter under discussion in the morning session was the emergency and acute medical care in over 16s, specifically: • First points of contact with healthcare services • Alternatives to hospital care • Managing hospital admissions • Timing and frequency of consultant review • MDT care • Organising handovers The Chair asked standing QSAC members to declare verbally any interests that have arisen since the last meeting and all interests specifically related to the matters under discussion. The Chair asked the specialist committee members to verbally declare all interests. Interests declared are detailed in Appendix 1.
3. Minutes from the last meeting
The committee reviewed the minutes of the last QSAC1 meeting held on 4 January 2018 and confirmed

them as an accurate record.

4. QSAC updates

NB informed the committee that there is a new board-approved policy for recording and collecting declarations of interest and this will be in effect from April 2018.

5. Prioritisation of quality improvement areas – committee decisions

SK provided a summary of responses received during the emergency and acute medical care in over 16s topic engagement, SK referred the committee to the full set of stakeholder comments provided in the papers and the committee then discussed each of the areas in turn. The committee discussed the comments received from stakeholders and specialist committee members at topic engagement **(in bold text below)**.

General note

SK advised the committee that the scope of this quality standard will not include areas specific to 7-day working.

The following areas were not prioritised for inclusion in the draft quality standard.

First points of contact with healthcare services

- **Access to diagnostics** – Not prioritised.

The committee agreed:

- There was significant cost associated with the point-of-care C-reactive protein (POC CRP) testing compared to other available tests not included in the draft guideline.
- It was not felt to be an area within the top 5 priorities for this quality standard so should not be prioritised.

Alternatives to hospital care

- **Advance care planning –** Not prioritised

The committee agreed:

- Patient choice is important and should be handled respectfully.
- This care planning can be just a form filling exercise as opposed to taking action.
- The whole infrastructure which is wider than emergency care needs to be addressed for this planning to be effective so it should not be prioritised as part of this quality standard.

ACTION: NICE team to review whether similar wording within the published multimorbidity quality standard (QS153) can be added to the introduction of this quality standard in relation to patient experience, shared-decision making and coordination of care.

Managing hospital admissions

- **Liaison psychiatry** – Not prioritised

The committee agreed:

- Some hospital have better access than others so the impact of a statement on this was queried.
- The current guideline recommendation is limited to psychiatry and does not apply to wider mental health. Therefore it was felt a statement could not be progressed based on this terminology.

- **Discharge planning –** Not prioritised

The committee agreed:

- Early discharge plans are beneficial to patient experience.
- There is a risk of this planning being a tick box exercise.
- It is currently a well-established practice so the impact of a statement on this was queried.
- It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.

- **Standardised criteria for hospital admission–** Not prioritised

The committee agreed:

- Validated risk stratification tools are useful when people are in hospital but there are associated risks when using this for hospital admission.
- Other criteria alongside these tools must be considered with clinical judgement.
- It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.

- **Multidisciplinary team meetings-** Not prioritised

The committee agreed:

- Not to prioritise this area as it assumes that all patients need this. As it is not appropriate for all measurability will be difficult.
- To incorporate MDT care in other appropriate statements within the supporting information.

The following areas were prioritised for inclusion in the draft quality standard.

Alternatives to hospital care

- **Multidisciplinary intermediate care –** Prioritised

The committee agreed:

- This area is important to promote early discharge and prevent unnecessary admissions, as long hospital stays can often be detrimental to the patient.
- This area should also include social care.
- The population for this area relates particularly to elderly and frail people but the focus must be kept as broad as possible.
- This area is supported, however the NICE team will have to review the statement's focus with potential questions needed at consultation.

ACTION: NICE team to investigate progressing a structural statement based on service as the population will be difficult to measure.

- **Managing hospital admissions** – Prioritised

The committee agreed:

- This area is important to improve care and reduce hospital admissions.
- Most hospitals have an acute medical unit but the capacity is too small for the intake needed so people then present at A&E.
- The care pathway is also important so that patients are directed to the appropriate place.
- Undifferentiated medical emergencies will need to be defined.

ACTION: NICE team to progress a statement on assessment through acute medical units.

- **Timing and frequency of consultant review** – Prioritised

The committee agreed:

- Both timing and frequency are important as these could lead to early discharge and better outcomes. Currently both are not carried out well so are they are areas for quality improvement.
- Consultant review timing- should be within 14 hours in line with the recommendation. Timings can differ during the day which can be included in the supporting information or measures. Consultant review must be face to face and not only a board review.
- The consultant review frequency- should be more frequent (e.g. twice daily) depending on clinical need which SCMs can advise on.

ACTION: NICE team to review progressing 2 separate statements on timing and frequency of consultant review.

- **Structured patient handovers** – Prioritised

The committee agreed:

- This area is very important as patients are at risk if this handover is not done properly.
- There is a risk of this planning being a tick box exercise.
- Include team working in the audience descriptors as this is not just from A&E but between transferring and receiving teams.
- Handovers to cover all places and all teams.

ACTION: NICE team to progress a statement on structured patient handovers.

- **Providing access to specialist and advanced paramedics as first point of contact** – Prioritised

The committee agreed:

- This area is very important as specialist and advanced paramedics with extended training could reduce hospital admissions and have patient benefit.
- Paramedics are widely used across an array of functions.
- The population would be difficult to measure as the population is significantly high for people who dial 999. NICE team will review and investigate this as a possible structural statement.

ACTION: NICE team to investigate a structural statement on providing access to specialist and advanced paramedic practitioners on first contact to assess and treat people with medical emergencies.

NICE team to liaise with NICE resource impact team when constructing the statement.

6. Additional quality improvement areas suggested by stakeholders at topic engagement

The following areas were not progressed for inclusion in the draft quality standard:

- Training- Stakeholders highlighted extended training for specialist and advanced paramedic practitioners needs to be considered. Quality statements however focus on actions that demonstrate high quality care or support, not the training that enables the actions to take place. For specialist and advanced paramedics the focus has now changed to their access.
- Care access- Stakeholders highlighted access to a number of healthcare services needs to be considered. There are no recommendations on these areas (other than research recommendations) within the draft guideline consultation version .It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.
- Infection control- Stakeholders highlighted the need to protect patients from communicable diseases and healthcare associated infections as a key principle of healthcare provision. They specifically highlighted antimicrobial stewardship and flu vaccination as priority areas. There are no

recommendations on this area within the draft guideline consultation version. It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.

- Integrated patient information systems and facilities signposting- A number of stakeholders supported the need for integrated care through integrated patient information systems across care settings and organisations to resolve problems by the first or second healthcare contact. It was however felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.
- Admission through elderly care assessment units- A stakeholder highlighted the importance of care home arrangements to manage urgent medical problems and minimise disruption to the residents, ambulance service and emergency departments. The provision of Acute Frailty Units was also suggested. There are no recommendations on this area (other than research recommendations) within the draft guideline consultation version. It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.
- Specific conditions, treatments and procedures- This quality standard will not cover acute clinical management of specific medical conditions requiring urgent or emergency care as this will be addressed within the quality standards for the relevant conditions. Also there are no recommendations on this area (other than research recommendations within the draft guideline consultation version. It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.
- Patient safety- A stakeholder highlighted a number of patient safety risks on emergency medicine and acute care. There are no recommendations on these specific risks within the draft guideline consultation version. The committee discussed patient safety as a general issue but it was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.
- National early warning scores (NEWS) - Stakeholders supported NEWS to be used by all healthcare professionals across primary and secondary care for consistent communication and patient safety. The committee discussed NEWS as a general issue but there are no recommendations on this area within the draft guideline consultation version. It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.
- Immediate decisions on care and treatment- Stakeholders raised the importance of time to having a discussion regarding resuscitation needs or having a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form completed. There are no recommendations on this area within the draft guideline consultation version. It was felt not to be an area within the top 5 priorities for this quality standard so should not be prioritised.

7. Resource impact and overarching outcomes

The committee considered the resource impact of the quality standard. NICE team will liaise with NICE resource impact team on the progressed statements which may not be achievable by local services given the resources required to deliver them, for example, providing access to specialist and advanced paramedic practitioners.

The committee confirmed the overarching outcomes are those presented in the draft quality standard.

SK requested that the committee submit suggestions to the NICE team relating to the overarching outcomes of the quality standard when it is sent to them for review.

8. Equality and diversity

The committee agreed the following groups should be included in the equality and diversity considerations:

Age	Disability
Gender reassignment	Sex
Pregnancy and maternity	Race
Religion or belief	Sexual orientation
Marriage and civil partnership	

It was agreed that the committee would continue to contribute suggestions as the quality standard was developed.

9. AOB

Appendix 1: Declarations of interest

Name	Membership	Declaration
Daniel Albert	Specialist member	Daniel provides services to Cumbria Health on Call, a social enterprise provider of urgent care. Daniel has no financial interest in the company and is not a director. Daniel has recently worked for United Hospitals of Morecambe Bay NHS Trust and Cumbria Partnership NHS Trust. In a clinical capacity only.
Tim Edwards	Specialist member	Recent submission (July 2017) of PhD thesis/dissertation – observational study addressing out of hospital airway management in resuscitated patients transferred directly to specialist heart attack centres.
Mike Jones	Specialist member	Mike is a Director of Standards at the Royal College of Physicians of Edinburgh
Amar Mashru	Specialist member	Amar is an Emergency Medicine Higher Specialist Trainee with London Deanery (Doctor in Emergency Medicine) Amar holds an executive position on the Emergency Medicine Trainees' Association – an unpaid and unfunded organisation advocating for Emergency Medicine Trainees' in the UK to the Royal College of Emergency Medicine.
Oliver Phipps	Specialist member	Oliver is Chair of the Advanced Nurse Practitioner Forum, Royal College of Nursing. Oliver is a member of the Advanced Clinical Practice Group, Health Education England.
Debra Quantrill	Specialist member	Debra has shares held in Futura Medical plc, pharmaceutical group that develops products for the consumer healthcare market.
Zoe Goodacre	Standing member	Zoe as Network Manager advises the Welsh Government on the adoption of advanced care planning as a national priority for critically ill patients in Wales.
Bee Wee	Chair	Bee is the National Clinical Director for End of Life Care for NHS England and was the Chair of the Topic Expert Group for the NICE Quality Standard for End of Life Care (2011) which included the area of advanced care planning.