National Institute for Health and Care Excellence

Acute Medical Emergencies in Adults and Young People
Scope Consultation Table
16/10/2014- 12/11/2014

ID	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
2	SH	British Geriatrics Society	2	General	There appears to be a lack of recognition of the importance of identifying a discrete flow-stream for frail older people whose needs are not always well deserved by a general acute medical service, but who may well benefit from a more targeted approach reflecting the evidence base for Comprehensive Geriatric Assessment	Thank you for your comment. We understand the frail elderly form a significant proportion of the AME population for whom AME services need to cater and therefore this patient group will be extensively considered in the guideline. We have not included a discrete flow stream for the frail elderly because we see this as a major component of the work for AME. However we have now stipulated in the scope that this group will require special consideration. In addition, a NICE guideline on multimorbidity is also in development and this may supplement our guidance.
56	SH	British Thoracic Society	9	General	We are disappointed to see that guideline development group does not include a respiratory consultant given the central role that the respiratory specialty plays in the acute take and at a number of	Thank you for your comment. The guideline is not focussing on disease-specific medical conditions, but rather the whole

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					the points throughout the patient journey through the hospital after the initial assessment/initial 24 hours. There is documented evidence that approximately one third of the take concerns respiratory patients and respiratory specialists are heavily involved in many early discharge schemes (COPD, pleural effusion, pulmonary embolism) and should therefore be part of the main guideline group. Virtual wards and hospital at home involve the specialties including respiratory; and follow-up is covered, again usually via a specialty. We also note that the patient journey will end on a specialty ward far more often than on ITU, yet the group has one Consultant and a trainee Intensivist.	process. However, we recognise the importance of specialist knowledge and skills and we will ensure that we get advice from disease-specific experts as required.
14	SH	College of Emergency Medicine	1	General	The scope of the guideline is huge and specific questions have not yet been asked within this scope. There is potential for task failure in this context	Thank you for your comment. We agree it is a huge scope, but we are determined to produce a guideline which will assist the delivery of optimal services for AME. We will develop specific questions and work with NICE to ensure we are able to deliver the guideline to agreed timelines.
15	SH	College of Emergency Medicine	2	General	Attempts to recommend one-size-fits-all models of care should be undertaken with caution, since local circumstances, resources and expertise often mean that adaptations of particular models are required, or	Thank you for your comment. We agree and intend to review the evidence and provide recommendations with these

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					that some models will not work	considerations in mind.
16	SH	College of Emergency Medicine	3	General	Crowding in Emergency Departments is one of the most visible consequences of current failure in the system. This has not been mentioned in the scope. Crowding, predominantly due to exit block, is currently harming both patients and staff in the acute sector in the UK.	Thank you for your comment. The guideline will focus on patient flow issues through the whole AME pathway and exit block will form part of these considerations. It is anticipated therefore that the guidance will indirectly mitigate against the causes and consequences of crowding in the ED.
17	SH	College of Emergency Medicine	4	General Section 4.1.2: "Groups that will not be covered" c) People with acute mental health emergencies. d) People with acute	Where the scope considers Emergency Departments, adult medical emergencies cannot be considered in isolation since most departments also deal with children, and non-medical problems. The scope does not also appear to recognise that patients attending ED do not do so as "medical" or "surgical" or "trauma" but as undifferentiated patients requiring assessment and treatments prior to disposition. The scope of this guideline should include these groups as the primary *presentation* is key, rather than the assumed or final diagnosis or subsequent management. Groups (c) and (d) may present with variable symptomology or via variable pathways. "Trauma" (e) in this context must be better defined as this covers a wide spectrum, e.g. minor injury, therefore a large population seeking emergency NHS care.	Thank you for your comment. The scope focus is acute **medical** emergencies but there may be some indirect consequences as a result of other streams and the guideline will attempt to take this into account. Our intention is to consider all patients presenting with an emergency and to include them in analysis until a diagnosis has been made and it is determined that they would be best managed in "other" pathways, for example, surgical/gynaecological/mental health services.

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				surgical emergencies. e) People who have experienced trauma.		We have amended the wording of the section 4.1.2e) for further clarification.
20	SH	College of Emergency Medicine	7	General	To understand/ research/ optimise the treatment of acute medical emergencies, we need to measure presentation and outcome using standardised metrics	Thank you for your comment. The guidance will review and assess the best evidence as systematically as possible.
35	SH	Department of Health	1	General	**I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Thank you for your comment.
65	SH	Intensive Care Society	6	2/General	The remit and scope of this guideline is vast. I am unclear as to what will be the end product as it touches on all aspects of emergency care. It covers the patient pathways if admitted to hospital but equally touches upon the set up for patients who are not admitted.	Thank you for your comment. We agree that the scope is big. The aim is to provide a guideline which improves the delivery of service to patients who present with an acute medical emergency. The aim is to provide guidance so that care is provided in a more structured evidence-based way. Areas that are lacking in evidence will be prioritised for future research.
68	SH	Intensive Care Society	9	General	I have no doubt of the importance of this area in improving medical care. It is difficult to analyse and improve the pathways for more specific groups of	Thank you for your comment. We agree that the scope is big. The aim is to provide a

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					patients in their admission e.g. COPD admissions or admissions to ICU. I worry about the feasibility of this guideline.	guideline which improves the delivery of service to patients who present with any acute medical emergency. We aren't able to go into specifics for each clinical scenario but will take different patient groups into account when we make our recommendations. NICE also has guidelines for specific conditions which should be used for clinical management of specific conditions.
70	SH	Intensive Care Society	11	General	I presume the intention is to produce guidelines with measurable outcome indices so that trusts can embark on quality improvement projects. A lot of the aspects in the document are difficult to define and measure. If you can't measure, it is difficult to improve upon.	Thank you for your comment. This is the purpose of the guidance. In addition, if we find areas where there are gaps in the evidence base, these will be prioritised for research. After the guideline is developed a set of quality standards will be published which will include measurable indicators.
21	SH	Royal College of Nursing	1	General	This is to inform you that the Royal College of Nursing have no comments to submit to inform on the draft scope of the Acute medical emergencies in adults and young people, service guidance. Thank you for this opportunity and we look forward to	Thank you for your comment.

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					participating in the next stage.	
58	SH	Royal College of Paediatrics and Child Health	2	General	This is important guidance for young people and there are significant cancer dimensions too – diagnosis of cancer through presentation as an emergency is now ell recorded and affects young people as it does older adults. The experience of young people presenting with acute complications of their cancer treatment e.g. febrile neutropenia remains frequently dismal despite the introduction of acute oncology services. We think it may be helpful for this to be explicit.	Thank you for your comment. It is the intention of the developers to include the presentation of all acute medical emergencies in the guideline, but we will not cover the clinical management of any specific conditions.
59	SH	Royal College of Paediatrics and Child Health	3	General	The issues around paediatric or adult services admission, transition and / or communication between the two needs to be addressed. Alongside that is the issue of adolescent services and whether a team who manage young people and young adults should be developed, and I feel this should be in scope as well.	Thank you for your comment. We agree that these issues are important and suggest that general principles emerging from the evidence base could be applied to young people and young adults. However, as the scope is already wide, we cannot cover all topics and feel that service provision focussing on admission, transition and communication for adolescents and young adults would be best approached in discrete guidance.
74	SH	Royal College of Physicians	1		The RCP is grateful for the opportunity to comment on the draft scope for this guidance. In doing so, we	Thank you for your comments. Each has been answered

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					have liaised with our Acute Medical Care Committee (AMCC) and our Young Adult and Adolescent Steering Group (YAASG). We would like to make the following comments and also endorse the response submitted by the British Thoracic Society.	separately.
77	SH	Royal College of Physicians	3	Continued from above	Young people attend with new presentations of acute disease or the onset of a chronic disease (25% of cancer diagnoses now occur in the acute setting) or as a result of risk-taking behaviour, including drug and substance abuse, self-harm and unsafe sex. In addition, patients previously seen in paediatric settings are admitted with exacerbations of chronic disease or other intercurrent illnesses. Young people with chronic illnesses are less likely to adhere to treatment regimens and more likely to disengage from medical care a situation exacerbated by the transfer between familiar paediatric to unfamiliar adult services. This is reflected by the fact that the mortality for patients following renal transplant is higher in 18-25 years old than any other group, with similar findings for patients with diabetes mellitus aged 15-35. Patients with severe and complex disabilities also on occasion require admission. Universally, young people and their carers report a poorer experience of care in adult settings. Areas that could be tackled by a NICE guidance:- • Pathways for admission from emergency departments to acute medical units. Currently there is no universal agreement on what the division	The guidance includes young people (aged 16-17) in its analyses, unless young people with a chronic condition are known to paediatric services. Thank you for highlighting these issues. Because of the breadth of the scope we will be unable to cover all aspects of service organisation. The GDG will consider these issues, but they will need to prioritise topics for systematic review so we may not be able to cover everything.

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					between 'paediatric' and 'adult' care is or should be. This results in a lack of uniformity not only between hospitals, but also between departments within hospitals. For example, a patient seen in the paediatric ED catering for young people aged up to 18, may be admitted to an adult ward if the threshold for a paediatric admission is 16 years. • Improved access for young people with chronic conditions to specialist teams to potentially prevent admission and provide expert care during admission and provide a care plan for primary care if the young person is not engaged with specialist services. This specialist input is important as each acute admission is an opportunity to engage the young person and there are differences in management, for example, care of a young person aged 16-19 with diabetic ketoacidosis differs from adults. • Developmentally appropriate environment. There are concerns relating to the AMU environment from the perspective of young people, their carers and staff. There is evidence supporting the role of an adolescent unit. • Specific individuals or team with a remit to support young people and address a range of issues including mental well-being and health promotion in acute settings with strong links with community	

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					services. There is evidence that individuals with a role in supporting young people particularly those with a long term condition undergoing transition with evidence that such an appointment can be cost neutral as the initiative reduced length of stay and readmission rates and improved outcomes. • Staff training. Staff in the acute setting often feel that they lack the skills to deal well with YAA and this is reflected in YAA reporting that their symptoms, particularly pain, as being much less well managed than in adults. Training in developmentally appropriate health care is lacking in most training schemes. • Policy addressing acute medical emergencies for young people undergoing transfer between paediatric and adult services. This would support continuity of the process and close working between paediatric and adult services. This could dovetail into the guidance around transition which is under development. • Policy addressing visiting and accommodation for carers and necessary equipment for a hospital stay for young people with complex needs.	
81	SH	Royal College of Physicians	7	General	We strongly believe that the GDG should include an expert with interest in young people or at least invite an expert in the area for input – elderly care is	Thank you for your comment. We will advertise for a topic specific expert who will be able

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					represented.	to contribute expertise to any analysis relevant to this area.
22	SH	Royal College of Physicians of Edinburgh.	1	General	The College is broadly supportive of this draft scope, which defines what the guideline will cover and to whom it will apply. The draft scope is extensive and covers many important issues such as seven day working; timely access to appropriate expertise; discharge planning; communication over the primary/secondary care interface and care in non-hospital settings. We believe it remains crucial that NICE continue to engage both with the profession and with patient representative groups in the further development of this guidance.	Thank you for your comment. NICE is engaging with the profession and patients in the development of this guidance. During this consultation, NICE advertised for the following full GDG membership roles: 1. GP with expertise in enhanced community care (e.g. community hospitals, hospital at home etc) 2. GP with out of hours experience 3. Director of Ambulance Services 4. Community nursing 5. Senior hospital nurse with responsibility for service quality 6. Community pharmacist 7. Residential Home representative 8. Emergency Medicine physician 9. Elderly Care physician 10. Physician with dual

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						fellowship of Royal College of Anaesthetists and Faculty of Intensive Care Medicine 11. Physician Assistant (a senior representative) 12. Trainee in one of the acute specialities (acute medicine, emergency medicine, intensive care medicine) 13. Senior hospital operations manager 14. Patient/carer 1 15. Patient/carer 2 Following stakeholder comments, NICE will be advertising for an additional 2 full GDG membership roles: 16. Liaison psychiatrist 17. Acute physician
13	SH	Royal College of Radiologists	1	GENERAL	We appreciate that it is necessary to confine the scope of the guidance to a number of specific questions, but given the extent to which modern acute medical care is dependent on imaging, the RCR is surprised and disappointed that the draft	The guidance aims to consider utility and cost effectiveness of investigations and interventions that will be prioritised by the GDG.

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					scope makes no specific reference to imaging and only passing reference to "investigations, diagnostics and interventions". Topical questions include the utility and cost-effectiveness of CT coronary angiography in the acute setting, the necessity for 24/7 availability of MRI in all admitting hospitals and the speed of access to interventions such as percutaneous nephrostomy. Nor does the draft scope contain any reference to the specific needs of cancer patients and the discipline of "acute oncology" which forms an important and growing component of acute medical services.	The draft scope does not cover the requirement of cancer patients specifically as we aim to provide guidance on a service rather focus on the needs of specific patient groups. However, as people with cancer may present with AME and provision of services may obviate the need for presentation in the ED, these patients fall within the population for whom the AME service needs to cater. As such, NICE intends to advertise for an acute oncologist as a topic specific expert, so that the relevant expertise can be brought to the relevant analyses. We will consider access to investigations in the guideline, but won't be able to look at specific clinical management.
82	SH	Royal Pharmaceutical	1	General	We believe that all of the relevant elements for acute medical emergencies are covered in this scope.	Thank you for your comment.

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		Society				
3	SH	St John Ambulance	1	General	Our medical advisor commented; May we suggest that the group make a recommendation to review the emergency medicine exemption list and who can do it, especially on the following 1. Salbutamol nebuliser for VAS/private medical firms (understanding that all operational personnel will need to undertake regular training) 2. Clarify the giving of aspirin – not helping patients to take them but actively administering 3. Clarify the need to prescribe oxygen in pre-hospital environment (contrary to BTS) 4. Clarify duty of all healthcare providers to engage with clinical pathways e.g. VAS taking patients with chest pain to PCI and patients with strokes to neuro centres	Thank you for your comment. The guideline will not consider specific clinical management of acute conditions (1 – 4).
4	SH	St John Ambulance	2	General	The role that the voluntary aid societies could play in this field in the provision of; • Transport of patients on discharge; we already provide these services as part of contracts with NHS Ambulance Trusts • Provision of discharge lounge facilities; we already successfully have contracts to provide a limited number of these services during day time hours and there is potential to expand this	Thank you for your comment. The guidance will consider the utility of these suggestions if prioritised by the GDG.

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					service to provide care overnight in discharge lounges for elderly patients who could be taken home by our ambulances in the morning • Support to NHS ambulance services in extended areas; there is potential for the use of clinical tele-medical support to provide support to non HCP crews of our vehicles which may prevent attendance at A&E.	
97	SH	Monitor	4	General	**Insufficient focus on the patient perspective.** This Guideline may benefit from being positioned from the patient perspective, e.g. considering the services that each of the patient groups outlined below (see comments # 5-7) should receive in the UEC context.	Thank you for your comment. NICE puts patients at the centre of their guidance. Two patient members are included in the GDG to ensure the patient-centred approach.
67	SH	Intensive Care Society	8	4.4/4.5	Given the number of variables and outcome measures identified (both quantitative and qualitative), I am keen to see how analysis of the literature is going to be conducted and analysed.	Thank you for your comment. We agree that the scope is large but are determined to produce a guideline which will assist the delivery of optimal services for AME. The list of outcomes is indicative of those felt to be of overall importance to the guidance. Developers will further refine which outcomes are of importance given the specific focus of the question at hand.
75	SH	Royal College of Physicians	2	1	The current title for the work was felt to be a little cumbersome and could be refined: Acute medical	Thank you for the comment. The title has been changed to

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					emergencies in young people and adults	"Service Delivery and Organisation for Acute Medical Emergencies".
36	SH	Society for Acute Medicine	1	1	This comment applies to the whole scope of the document. As a Society we clearly welcome the guideline. One of our concerns is whether the scope is too wide, particularly as this is a service guideline as opposed to a more traditional disease or technology based guideline.	Thank you for the comment. We agree that the scope is wide but we intend to produce service delivery guidance which is not topic or disease specific.
76	SH	Royal College of Physicians	3	2	We strongly suggest including age and developmentally appropriate care to allow guidance related both to the adolescents and young adults and the elderly. The following comments from our YAASG support this. The YAASG are enthusiastic about the development of this guidance as it could improve care for young people who are currently poorly served by the acute medical emergency services which often focuses on the needs of the elderly eclipsing the needs of the other end of the age span. We therefore strongly suggest that one theme of the guidance would be focussing on developmentally appropriate health care for young people. We suggest that you define young people as 16 to 24 which is keeping with the WHO definition of young people and represents the age range associated with differing social and emotional factors and differences in decision and risk taking. Currently in the document there is an assumption that	Thank you for your comment. The guidance includes young people (aged 16-17) in its analyses, unless young people with a chronic condition are known to paediatric services. Because of the breadth of the scope we will be unable to cover all aspects of service organisation. We will consider these issues, but the GDG will prioritise topics for systematic review. However we hope to recruit a topic specific expert in young people to help inform the GDG.

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					equality of opportunity is the same across the age range. We therefore advise that the overarching theme developmentally appropriate health care for patients aged 16-24 to promote equality of opportunity should be included in the guidance. Previous national initiatives have identified this as an area of need but have been unsuccessful in addressing this. We feel the guidance offers an exciting opportunity to address this. Below we set out the case for including developmentally appropriate care for young people as a theme and some areas that could be explored by the guidance. It is a common perception that young people do not become ill, consume only a small fraction of health care resources and do not pose a particular problem in unscheduled health care settings. The reality is that the number of emergency presentations amongst older adolescents (16-19 years) in England has increased by 31.7% over the past decade, now accounting for 36.3% of emergency department (ED) attendances and nearly 20% of inpatient care. This increase may be explained by their strong preference for using acute services instead of attending the general practitioner. Studies have also shown that the rate of inpatient activity for general medicine has also substantially increased, suggesting that AMUs are not immune from these changing trends.	

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					Young people are a vulnerable patient group with mortality increasing over the same period to the point where deaths in patients aged 10-19 years are now greater than those aged 1-4 years. The healthcare outcomes for patients aged 10-24 in the UK are now amongst the worst in Europe. These striking changes in epidemiology have occurred despite several major governmental initiatives between 1999 and 2009 to reduce inequalities in health status and risk factors in young people.	
110	SH	Monitor		General; 2	**Success of hospital discharge.** While clearly a reduction in delayed transfers of care is beneficial, this should not be considered successful where patients are consequently readmitted within a short period of time because the discharge was poorly considered or rushed. Considering the effectiveness of hospital discharges by also understanding, e.g. the volume and causes of failed discharges or readmissions, may therefore be helpful.	Thank you for your comment. The developers aim to consider evidence to reduce readmissions and provide an informed analysis of the outcomes available.
18	SH	College of Emergency Medicine	5	Section 3	The assumption that 8% of patients attending EDs could have been managed by a pharmacist is incorrect, along with recent assumptions regarding the number of patients attending EDs who could be dealt with in primary care. If such assumptions are being used to underpin the scope of the document, then caution should be exercised	Thank you for your comment. These two points have been deleted from the scope. The best and most recent available data will be sought to support analysis and recommendations which will be generated from these.
78	SH	Royal College of Physicians	4	3.1 c	Young people in particular have been reported as being more likely not have a GP and prefer to attend	Thank you for your comment. The GDG will consider how

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					hospital during episodes of ill health. 16-74 age range is huge. A clear delineation is required we would suggest that 16 to 24 should be described when possible to recognise that this is a group with particular needs as are those 75 and older. By not taking a clear stance this age group will remain invisible	best to analyse the data and make recommendations relevant to this group of patients. We also hope to recruit a topic specific expert in young people to help inform the GDG.
37	SH	Society for Acute Medicine	2	3.1 c	The penultimate bullet point in this section states that short stay and zero length of stay admissions increased by 40% between 2003/04 and 2010/11. One interpretation might be that there are more 'inappropriate' admissions. However, an alternative interpretation might be that the development of acute medical services have improved the efficiency of discharge planning, particularly through the role of acute medical units, acute physicians and ambulatory care services.	Thank you for your comment. The scope states the current figures and does not say that the zero length of stay patients were *inappropriate* admissions.
60	SH	Intensive Care Society	1	3.2.b	"standards varied unacceptably" change to "showed an unacceptable degree in variation in standards".	Thank you for your comment. This change has been made.
61	SH	Intensive Care Society	2	3.2.c/General	The recently published standards in ICM, already stipulates 7 day consultant input with an emphasis on senior input/support. It would be very useful if the guidelines produced identify clear lines of responsibility for the acute medical emergency patient. The document also covers a lot of the issues mentioned be it from an ICM prospective.	Thank you for your comment. The GDG will make recommendations based on the best available evidence. The developers are aware of the published standards in ICM.
62	SH	Intensive Care	3	3.2.d	Heading entitled "consultant review within 12 hours of	Thank you for your comment.

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		Society			admission" and this changed to 14 hours in the paragraph. Is there a reason for this change? Evidence?	The phrase "but at the latest within 14 hours of arrival at hospital" has been deleted. The guidance will investigate whether there is any evidence to support a particular time by which patients should be reviewed by a consultant.
63	SH	Intensive Care Society	4	3.2.e	The care is usually provided by a multidisciplinary team LED by acute	Thank you for your comment, The error has been corrected.
64	SH	Intensive Care Society	5	3.2.g	"The current acute medical emergency service is challenging to navigate through" to "Navigating the current acute medical emergency service is a challenge"	Thank you for your comment. The error has been corrected.
5	SH	National Outreach Forum	1	3.2	Current services does not outline the provision and role of critical care outreach or medical emergency teams in dealing with medical emergencies and discharge planning, where outreach often provide a discharge liaison role. Current services does not outline the provision of therapeutic services in dealing with acute respiratory emergencies as part of or in liaison with Outreach including the discharge rehabilitation / liaison role of physiotherapists and occupational therapists.	Thank you for your comment. The developers intend to look at the delivery of service throughout the pathway. This will include the requirements of staff to provide this.
24	SH	The Royal College of Surgeons of Edinburgh	1	3.2.f	RCSEd note the 14% re-admission rate in patients over 75 yrs who have had a recent inpatient stay and believe this is due in part to the pressures imposed by length of stay targets and the lack of handover planning between the hospital and both community	Thank you for your comment. The guidance aims to review any evidence that might support new service models (some of which you cite) and

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					and primary care. There is an urgent need for integrated care pathways which encompass medical and social care to support these patients and reduce re-admission. The lack of community based rehabilitation; palliative care and intermediate care beds further exacerbates this problem and must be addressed if inroads into these re-admission figures are to be made.	make recommendations based on these data. Palliative care in the community is implicitly covered by existing 2004 guidance on cancer, which will be updated during the lifetime of this guideline to include all patients.
95	SH	Monitor	2	General; 3.2c	**Relation to Keogh work on Urgent and Emergency Care (UEC).** We would find it helpful to understand how this Guideline relates to NHS England's Keogh work on UEC, particularly around service specifications and quality standards. It will be important to join up on this, particularly where the Keogh work can provide an understanding of what good looks like and an insight into real operational issues.	Thank you for your comment. The developers have regular communication with National Directors of NHS England. NICE guidance offers evidence informed recommendations. Where current policy is underpinned by evidence, such evidence will be considered for inclusion in the guideline. NICE hopes that their evidence informed guidance will assist future policy recommendations.
84	SH	Association of Ambulance Chief Executives	1	3.3.2	Our comments are that best practice guidance for UK ambulance services should be mentioned in this section relating to legislation, regulation and guidance. The guidance is 'UK ambulance services clinical practice guidelines 2013' – Association of Ambulance Chief Executives.	Thank you for your comment. We have included this guidance in the scope.
19	SH	College of Emergency	6	Section 4	It should be remembered that children aged 16 and 17 may exercise choice in whether they are treated	Thank you for your comment. The GDG will take this into

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		Medicine			as adults or children, certainly within EDs	account in their deliberations and recommendations.
6	SH	National Outreach Forum	2	4.1	The population does not cover all other medical emergencies, which are dealt with outside of acute medical units, but whom may access emergency medical care via another route.	Thank you for your comment. It is the intention of the developers to consider all patients presenting with an emergency to any part of the service and to include them in analysis until it is determined that they would be best managed in "other" pathways, for example, surgical/ gynaecological services.
85	SH	Association of Ambulance Chief Executives	2	4.1.1	Our comments relate to the scope, and whether there should be mention of the presentation of patients to the ambulance service. It is not clear from this section whether adults and young people that seek primary care or community services includes ambulance services and for patients that seek help via the 999 or NHS 111 systems.	Thank you for your comment. The developers intend to include presentation to ambulance services and 999 and NHS11 services. This has been clarified in the scope.
79	SH	Royal College of Physicians	5	4.1.1 a	While this statement presumably is to reflecting legal description of adult it ignores the developmental aspects. We would suggest that the WHO definition for the definition of young people is adopted which is 15-24 so for adult services 16-24	Thank you for your comment. NICE has its own definition of young people and uses this consistently across its guidance.
38	SH	Society for Acute Medicine	3	4.1.1	We are pleased that this guideline deals with the needs of young people. Teenage patients aged 16 years and above frequently receive care on adult wards. We feel that teenage medicine should be part	Thank you for your comment. NICE will be advertising for a topic specific expert in teenage

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					of the scope of this guideline, although we note that an expert in this field is not being sought for the guideline group. We feel that the guideline should deal with the question of 'what is the best environment to care for an acutely unwell teenage patient?'.	medicine. The guidance includes young people (aged 16-17) in its analyses, unless young people with a chronic condition are known to paediatric services. Because of the breadth of the scope we will be unable to cover all aspects of service organisation. We will consider these issues, but the GDG will prioritise topics for systematic review.
1	SH	British Geriatrics Society	1	4.1.2 (c)	Please clarify that 'people with acute mental health emergencies' does not include people with delirium or dementia and intercurrent acute crisis of any other cause. People with dementia and/or delirium presenting to acute care have poor outcomes and comprise in the regional of 25-30% of the acute medical take.	Thank you for your comment. This patient group will be covered until a diagnosis has been made, as they present as AME. This has been clarified in the scope.
66	SH	Intensive Care Society	7	4.1.2	Colon (:) after "groups"	Thank you for your comment. This amend has been made.
7	SH	National Outreach Forum	3	4.3 4.3.1 (g)	Chain and scope of services should be included, to map what those services can/do/should look like. Inclusion of nursing/residential home and tertiary sector important when looking to address acute medical emergencies/admissions (ie not just patient education but referrer education). (this also pertains	Thank you for your comment. The GDG will consider your suggestions and prioritise the detail of the data to be searched in order to support recommendations.

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					to point 4.5.10)	
39	SH	Society for Acute Medicine	4	4.1.2 c	We accept that this guideline will not focus on patients with acute mental health emergencies. However, many patients presenting to an acute medical unit will have significant mental health issues. Obtaining a timely review of patients with mental health related illnesses can be problematic. We would like to see this guideline express a view regarding the standard of care for acute medical patients with mental health needs, for example deliberate self-harm and acute psychosis.	Thank you for your comment. The guidance will consider patients with a primary acute medical emergency but who have comorbid mental health needs. The scope focus is acute **medical** emergencies but there may be some indirect consequences as a result of other streams and the guideline will attempt to take this into account. Our intention is to consider all patients presenting with an emergency and to include them in analysis until a diagnosis is made and it is determined that they would be best managed in "other" pathways, for example, surgical/gynaecological/ mental health services.
40	SH	Society for Acute Medicine	5	4.1.2 e	People with who have experienced trauma are excluded from the guideline. We agree with this point. However, we note that the guideline group is seeking an expert in nursing trauma. We feel that extra representation from an acute physician as a core group member would be more appropriate, as currently the only acute physician on the group is the	Thank you for your comment. The role for an expert in nursing trauma was advertised in error. We will advertise for an additional acute physician role

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					co-chair.	in the GDG.
100	SH	Monitor	7	4.1.2c	**Exclusion from scope of mental health emergencies.** We agree that those cohorts of patients that present with purely an acute mental health emergency should be out of scope, but might perhaps be considered in a separate Guideline.	Thank you for your comment.
86	SH	Association of Ambulance Chief Executives	3	4.3.1	Our comments are whether there will be consideration to the fact that many patients' access services as a first and often only point of contact for urgent care via a telecare pendant alarm and this may be their only way of accessing help. These telecare monitoring services are not part of the health system, however they link and refer patients to health services on behalf of their clients. We strongly believe that the initial triage systems within these organisations should be reviewed as part of the scope.	Thank you for your comment. We believe that triage systems and alert interventions you highlight fall within the remit of several scope topic areas. We will raise your comment with the GDG who will consider this when prioritising the exact focus of the review questions.
8	SH	National Outreach Forum	4	4.4 (g)	Resource use and costs should extend beyond number of active consultant hours to include critical care outreach/medical emergency team provision/cost.	Thank you for your comment. The GDG will prioritise specific outcomes for specific analyses with the appointed GDG. It is not feasible to include all available outcomes for all reviews.
71	SH	NHS England	1	4.3.1	Standardisation of services must be clear that it is the level of service delivery not how / where that is standardised	Thank you for your comment. Further detail on the proposed focus of this topic is provided in section 4.5.8.

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72	SH	NHS England	2	4.4	Should also include carer / relative experience as this is very relevant in emergencies	Thank you for your comment. The GDG will prioritise specific outcomes for specific analyses with the appointed GDG. It is not feasible to include all available outcomes for all reviews.
25	SH	The Royal College of Surgeons of Edinburgh	2	4.3.1.a	RCSEd fully supports the concept of consistent; high quality; safe seven day care services. RCSEd recognises that timely consultant input does improve outcomes. The seven day care service systems must however ensure rested, alert and safe practitioners who are ready to provide high quality care.	Thank you for your comment. The guidance aims to review evidence that might support new service models and make recommendations based on these data. The GDG will prioritise the exact nature of the reviews.
26	SH	The Royal College of Surgeons of Edinburgh	3	4.3.1.a	Anecdotal evidence from RCSEd's members suggests that most medical units in the UK are performing strongly in the first 24 hours and almost all patients are seen within 12 to 14 hours by a consultant. However, care after this point can be seen as variable. Too often, if admitted on a Thursday night, the patient will be seen on a post op ward round by a consultant on the Friday but then not seen again until the Monday. RCSEd recommend that the guidance should specify that a senior medical review takes places every 24 hours until discharge.	Thank you for your comment. The guidance aims to review evidence that might support new service models and make recommendations based on these data.
27	SH	The Royal College of Surgeons of	4	4.3.1.c	RCSEd strongly believes there is an urgent need to improve access to relevant aspects of the patient's medical records via an open standards interfaces or	Thank you for your comment. The guidance aims to review evidence on continuity of

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		Edinburgh			the equivalent that is available to both primary and secondary care. Although access should always come with the patient's consent, this would be important not only for the upgraded 111 service but also for the major emergency centres.	information (and make recommendations based on these data. The GDG will prioritise the exact nature of the reviews.
28	SH	The Royal College of Surgeons of Edinburgh	5	4.3.1.d	RCSEd notes the improvements associated with specialist trauma centres and major centres for treatment of stroke and myocardial infarction and fully supports the development of major emergency centres.	Thank you for your comment. The guidance aims to review evidence that might support new service models (and make recommendations based on these data.
29	SH	The Royal College of Surgeons of Edinburgh	6	4.3.1.e	RCSEd has a deep understanding of the problems experienced by our Faculty of Pre-hospital Care, particularly in the remote and rural settings. We fully support the development of high specification on scene treatment options for paramedics; nurses and doctors working in the remote and rural environment and would be happy to facilitate their development. These need to be fully supported by intermediate facilities to allow patient stabilisation prior to what can be long transfer times to the major emergency centres.	Thank you for your comment. The guidance aims to review evidence (and make recommendations based on these data. The GDG will prioritise the exact nature of the reviews.
30	SH	The Royal College of Surgeons of Edinburgh	7	4.3.1.e	RCSEd notes the utilisation of standardised post take ward round checklists in the first 24 hours and the associated improved patient outcomes.	Thank you for your comment. We will take this into consideration and the GDG will prioritise the exact nature of the reviews.
31	SH	The Royal College of	8	4.3.1.f	The whole process of handover from acute medical departments to other specialities including surgery	Thank you for your comment. The guidance aims to include

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		Surgeons of Edinburgh			needs to be streamlined with compatible patient documentation to prevent time being wasted with multiple history taking; lost results and repeat investigations. This must include both the medical and nursing records. Medication, often brought in by the patient on admission, is regularly lost or temporarily mis-placed resulting in the unnecessary dispensing of new drugs from the pharmacy and hence additional cost. Processes should be put in place to prevent such waste.	continuity of information as part of the scope. The GDG will prioritise the exact nature of the reviews.
32	SH	The Royal College of Surgeons of Edinburgh	9	4.3.1.g	Frail elderly people's medical conditions can be made worse by being taken from their homes into strange settings where they are exposed to infection and falls. With only a small amount of extra care in the home hospitalisation can be avoided. Social service carers must be supported to reduce pressures which result in their sending clients to hospital.	Thank you for your comment. The guidance aims to include alternatives to acute care in hospitals The GDG will prioritise the exact nature of the reviews.
33	SH	The Royal College of Surgeons of Edinburgh	10	4.3.1.j	The current system for accessing urgent and emergency care is often seen to be confusing and it must be simplified. A guide to good choices should be produced in clear language understandable to all patients and ethnic groups so that the public are clear as to the best way to access appropriate services for their needs.	Thank you for your comment. The guidance aims to review the first point of contact with emergency care. Given the significant workload associated with a meaningful review of how to guide good choices, this topic has been removed from the scope.
23	SH	Royal College of Physicians of Edinburgh.	2	4.3.2	The College suggests that the acute clinical management of a small number of specific medical conditions, such as myocardial infarction, stroke and	Thank you for your comment. The guidance is considering service delivery not disease-

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					pneumonia which require urgent or emergency care are specifically addressed in the guideline, as these are conditions which present regularly as medical emergencies.	specific pathways. Individual disease-specific NICE guidance is available. The service delivery will be transferrable with modifications to the individual areas
34	SH	The Royal College of Surgeons of Edinburgh	11	4.3.2.a	RCSEd notes with disappointment that acute surgical conditions will not be covered by these guidelines. We believe that there are a number of areas of overlap with the terms of reference of these guidelines.	Thank you for your comment. The scope focus is acute **medical** emergencies but there may be some indirect consequences as a result of other streams and the guideline will attempt to take this into account. Our intention is to consider all patients presenting with an emergency and to include them in analysis until it is determined that they would be best managed in "other" pathways, for example, surgical/gynaecological services.
87	SH	Association of Ambulance Chief Executives	4	4.5.1 (c)	Our comments are whether 24 hour access to investigations, diagnostics and interventions should be considered in the pre hospital setting. Certain tests of bloods, lactate monitoring and other diagnostics for example may be of value in managing a patient outside the hospital setting	Thank you for your comment. The guidance will look at the best way to provide services for the AME pathway, therefore access to diagnostics in the pre-hospital setting may be reviewed if the GDG prioritise it

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						as part of integration of services.
93	SH	Association of Ambulance Chief Executives	10	4.5.10 (a) and (b)	We welcome this section, but are hesitant about what evidence there may be for reducing demands on the ever increasing ambulance 999 service and encouraging more appropriate use of emergency services	Thank you for your comment. The developers will systematically search the literature for evidence indicating the most cost effective services and may make consensus recommendations or research recommendations where evidence is lacking.
48	SH	British Thoracic Society	1	4.5.1.c	Timely access to investigations, diagnostics and interventions should also include standards for the "base" wards as timely flow throughout the hospital system ensures improved efficiency at the "front door"	Thank you for your comment. The developers consider "base" ward requirements to affect, but indirectly, the flow of patients. Process outcomes, such as patient flow metrics, will be discussed with the GDG and evaluated where thought appropriate to the topic matter.
9	SH	National Outreach Forum		4.5.1	Consideration of required inclusion of 24 hour access to emergency acute respiratory physiotherapists with 7 day a week access to rehabilitation and discharge physiotherapists and Occupational therapists.	Thank you for your comment. The GDG will prioritise what aspects of 24 hour access to consider because we cannot cover every aspect of service delivery.
88	SH	Association of Ambulance	5	4.5.2 (d)	Regarding timely access to staff with a given competency or skill, potentially the skills and	Thank you for your comment. The GDG will prioritise what

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		Chief Executives			availability of pre hospital practitioners should also be considered as well as the point in (d) relating to paramedics having access to clinical advice. These practitioners could be paramedics with additional skills.	aspects of access to staff with a given competency or skill to consider because we cannot cover every aspect of service delivery.
49	SH	British Thoracic Society	2	4.5.2	Definition of "specialist" or defining competency. From a medical perspective there is much emphasis on consultants but higher trainees as well as specialist nurses and physiotherapists will also have a role in supporting respiratory patients, under the supervision of a specialist consultant.	Thank you for your comment. The developers will agree definitions with the GDG once appointed and will record these definitions in the ensuing guidance.
89	SH	Association of Ambulance Chief Executives	6	4.5.4 (d)	Location of services-In addition to minor injury units in point (d), the role of walk in centres should be considered within the scope as well	Thank you for your comment. It is the intention of the developers to consider this aspect of service location and this has been clarified in the scope.
10	SH	National Outreach Forum	5	4.5.4	Defining acute medical units is important as some will be named differently but may perform the same function (e.g. clinical assessment units; clinical admissions units).(this also relates to Appendix A)	Thank you for your comment. The developers will agree definitions with the GDG once appointed and will record these definitions in the ensuing guidance.
41	SH	Society for Acute Medicine	6	4.5.4	The location of services does include acute frailty units for older people. At the current time, acute frailty units are developing in many hospitals. There a number of models of care. We feel that the acute medical care of older people needs special consideration. There is very little mention of services	Thank you for your comment. Frail elderly patients are a significant patient population of this guideline and will be considered in detail. Also the NICE guidance on

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					for older people in the scope of the guideline and we feel this should be addressed. There is no mention of the 'Silver Book' and 'Frailsafe'.	multimorbidity may also inform delivery of services and care for this group of people.
50	SH	British Thoracic Society	3	4.5.5.c	It is unclear why "General Medical Wards" have been excluded from the scope of the doctor-patient ratio modelling. Again, as for 4.5.1.c comments, the ability of the emergency pathway to "flow" is crucially dependent upon the "base" wards functioning optimally.	Thank you for your comment. NICE is producing separate guidance on this topic, and this may be incorporated in our models if published within a suitable time. Again, as for 4.5.1.c the developers consider "base" ward requirements to affect, but indirectly, the flow of patients. Process outcomes, such as patient flow metrics, will be discussed with developers and evaluated where thought appropriate to the topic matter.
51	SH	British Thoracic Society	4	4.5.5.c	Could we request that the term "general medical wards" is abandoned? It does not reflect the current modus operandi of most medical wards. Most hospitals have "specialist base" wards with an emphasis on having appropriate patients managed by specialist teams eg geriatricians, respiratory physicians, D&E physicians, cardiologists etc.	Thank you for your comment. The developers will agree definitions with the GDG once appointed and will record these definitions in the ensuing guidance. The scope has been amended and now refers to "medical wards".
52	SH	British Thoracic	5	4.5.5.e	Can the document clarify the definition of "generalist"	Thank you for your comment.

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		Society			and "specialist". Geriatrics is a specialty as an example. Many speciality clinicians eg geriatricians, respiratory physicians, D&E physicians still retain roles and skills in acute medicine but it is unclear what a generalist is. Acute physicians manage the first 24 hours or so but do not manage the longer stay patients.	The developers will agree definitions with the GDG once appointed and will record these definitions in the ensuing guidance.
69	SH	Intensive Care Society	10	4.5.5.c	Why are doctor-to-patients ratios in A&E and general medical wards an exception to the analysis? They have immediate and direct effect on the patient population being looked at.	Thank you for your comment. NICE is producing separate guidance on this topic, and this may be incorporated in our models if published within a suitable time.
11	SH	National Outreach Forum	6	4.5.5	Delivery and style of teaching for acute care risk assessment and management to health care staff in hospital/pre-hospital should be included/considered. Inclusion of the appropriate skill mix in wards and Emergency Department including respiratory and rehabilitation physiotherapists, as part of, in liaison with or as a separate service to Outreach services. Consideration of inclusion of discharge coordination occupational therapists.	Thank you for your comment. Delivery and style of teaching was not prioritised by stakeholders at the stakeholder workshop and in a subsequent survey to prioritise topics for inclusion in the scope The GDG will prioritise what aspects of staffing, skills and competencies to consider because unfortunately we cannot cover every aspect of service delivery.
73	SH	NHS England	3	4.5.5	It would be appropriate to see the role of AHPs considered here	Thank you for your comment. It is the intention of the

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						developers to consider this role, as is reflected in the role advertised in the GDG constituency.
83	SH	Royal Pharmaceutical Society	2	4.5.5 (f)	We are pleased to see that the role and scope of community pharmacists are to be included and would like to encourage NICE to consider roles outside of current practice, such as community pharmacists trained as advanced practitioners in urgent and emergency care working in primary care to prevent use of A&E departments.	Thank you for your comment. The "role and scope of community pharmacists" has been removed from the scope - the GDG will prioritise reviews of evidence for community pharmacists and a number of other professionals as well.
53	SH	British Thoracic Society	6	4.5.6.g	The Better Care Together Model proposes increased primary and secondary care integration. One potential consequence of this will be the availability of specialists in primary care ie GPs not being the sole medical practitioners delivering primary care. Can the nomenclature and scope be changed to include this concept ie increased "primary care" access to investigations, diagnostics and interventions	Thank you for your comment. The scope has been amended to refer to "primary care" rather than "GP"s.
55	SH	British Thoracic Society	8	4.5.6	Should there be standards for care in non acute hospitals (community hospitals)? Many patients are transferred from acute hospitals to community hospitals for "rehabilitation" and flow through these hospitals and standards of care are variable and thus impact directly on the emergency care pathway in the acute hospital.	Thank you for your comment. As "non-acute" hospitals are part of the AME pathway, it is the intention of the developers to consider this, if prioritised by the GDG for review. We won't however be covering any clinical aspects of care.
12	SH	National	7	4.5.6	Role and scope of critical care outreach/medical	Thank you for your comment.

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		Outreach Forum			emergency teams in wider context of integration of services should be covered.	The guidance is focussing on the AME pathway and what skills and staff are required to deliver this.
90	SH	Association of Ambulance Chief Executives	7	4.5.7 (a)	Alternatives to acute care in hospital, re. point (a) suggest adding 'access' as well as 'provision', as the ability to admit a patient or to access a community based health care service can be difficult	Thank you for your comment. We anticipate that through evaluation of the benefit of provision, issues around access (i.e. ability to admit or access a community-based health care service) will be considered, and therefore already an implicit part of the scope in this context.
80	SH	Royal College of Physicians	6	5.2	We suggest that the Guidance Transition between paediatric and adult services is also highlighted	Thank you for your comment. We have added this to the scope in section 5.2.
91	SH	Association of Ambulance Chief Executives	8	4.5.8	Can this be enhanced to specifically mention the pre alert process, regarding standardisation of pre alerting an ED or appropriate destination of the forthcoming arrival of an acute medical emergency	Thank you for your comment. It is the intention of the developers to consider this, if prioritised by the GDG for review.
54	SH	British Thoracic Society	7	4.5.8	Could this also include reference to standardisation of care eg use of care bundles?	Thank you for your comment. It is the intention of the developers to consider the use of care bundles in a general way, if prioritised by the GDG for review. Specific care bundles will not be included.

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92	SH	Association of Ambulance Chief Executives	9	4.5.9	It should not matter who a patient calls, but there should be one single consistent outcome	Thank you for your comment. The guideline hopes to be able to determine which service delivery models best provide consistently good outcomes.
47	SH	NHS Choices	1	4.5.9	Comment for NICE: Would it be appropriate to add digital triage to 4.5.9? There is currently a pilot in London whereby a user of the NHS Choices symptom checker can arrange an appointment with the GP without going through the out of hours telephone service. Also, when a user follows a symptom checker, they are referred directly to 999, A&E and various GP outcomes, such as GP urgent or GP routine, but self-care and pharmacy endpoints with appropriate advice serve to keep users away from primary and secondary care services where appropriate. The digital user is often trying to find a way to avoid calling 111 or the GP and is looking for advice to enable them to manage their symptoms. Although only currently commissioned until March 2015, the new 111 digital will replace this with the same outcomes and transfers to urgent care. **4.5.9 First point of contact with urgent care services, including initial triage** a) Single compared with multiple points of patient first contact with acute and emergency care (such as NHS 111 or 999 emergency telephone services, GP	Thank you for your comment. It is the intention of the developers to consider the manner in which a patient accesses the service, if this is prioritised by the GDG for review. The developers welcome any available published evidence.

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					services and emergency departments). b) A consistent and reproducible graded triage system following an emergency call. c) Use of a graded response to emergency calls by call handlers for NHS 111 and/or 999.	
94	SH	Monitor	1	General; 2; 4.6	**Wide-ranging nature of Guideline scope.** To be as effective as possible, this Guideline will need to build on and complement existing work in this area by other bodies such as Monitor and NHS England, particularly considering the wide ranging remit set by the Department of Health, which may prove difficult to manage.	Thank you for your comment. The developers have regular communication with National Directors of NHS England. NICE guidance offers evidence-informed recommendations. Where current policy is underpinned by evidence, such evidence will be considered for inclusion in the guideline. NICE hopes that their evidence-informed guidance will assist future policy recommendations.
104	SH	Monitor		3.3.3; 4.5.11	**The role of the tariff.** Monitor clearly has an interest in the aspects of the Guideline scope relating to the tariff for emergency care and may be able to advise on relevant technical detail. *2014/15 National Tariff Payment System* (Monitor, 2013) sets out two national variations that are designed to incentivise both the sharing of responsibility for managing the care of patients in the most appropriate	Thank you for your comment. The scope of the guideline is wide and the developers will ask the appointed GDG to decide whether targets and incentives will be prioritised for inclusion in the guideline.

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					setting and the prevention of avoidable unplanned hospital stays: • the marginal rate emergency rule; and • reimbursement arrangements for emergency readmissions within 30 days. Both of these rules were introduced to encourage providers and commissioners to better manage emergency admissions through: effective demand management schemes; well-planned discharges; well-organised rehabilitation and support services post discharge; greater involvement of experienced clinicians earlier in the decision-making process; and more collaborative working and better coordination of clinical intervention with community and social care providers. When properly implemented, these should help to create appropriate incentives for whole-system responses to urgent and emergency care planning.	
99	SH	Monitor	6	4.1; 4.1.2	**Inclusion in scope of those with mental health issues presenting as an acute medical emergency.** Those who experience mental health crises upon presentation as an acute medical emergency and need access to psychiatric and dementia liaison should be within scope. Evidence shows that patients with mental health conditions and dementia experience longer lengths of stay in acute trusts and often need much more support on discharge. Additionally, liaison psychiatry and dementia consultants in A&E departments play a crucial role in both preventing admissions (through A&E case finding) and facilitating discharges. There is good evidence of cost effectiveness for this service, such as the specialist multi-disciplinary	Thank you for your comment. The guidance will consider the AME pathway and not specific conditions. However, we acknowledge the importance of mental health conditions in acute presentations. NICE has agreed to advertise for the role of a liaison psychiatrist for full GDG membership.

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					Rapid, Assessment, Interface and Discharge (RAID) model. There is also an argument that alcohol and drug-related A&E attendances would benefit from greater coordination between UEC and substance misuse and alcohol liaison services. You may wish to review the *Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis* (DH, 2014).	
113	SH	Monitor		3.2f; 5.2	**Complementary NICE Guidelines.** We think that this Guideline will also complement the NICE guideline on the coordinated transition between health and social care.	Thank you for your comment. This guidance is listed in section 5.2 of the scope.
101	SH	Monitor	8	4.2a; 4.3.2c	**Clarification regarding transportation.** We are pleased to see that all settings in which NHS is received for acute medical emergencies will be included. We trust that the reference to transportation being out of scope refers to non-emergency patient transport, and that ambulance services and emergency transportation (e.g. hear and treat, see and treat and see and convey) are therefore within scope. Findings from the Keogh Review support the vital role of paramedics in seeing and treating more people at home and/or bringing in community and mental health rapid response teams to avert admissions. The UEC Review looks to be moving towards an 'urgent care' role as well as 'emergency care' role of ambulance services, even when they end up transporting people rather than treating at the scene or by telephone. For example, North East Ambulance Service is considering intermediate-tier transport vehicles and crews (Bands 1-2), supported by	Thank you for your comment. You are correct in your assumption. We have clarified this in the scope.

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					senior rapid response paramedics (Band 7) when needed. They have found that those crews could be despatched to Green category calls where the expectation is transport to an urgent care centre rather than an emergency department.	
57	SH	Royal College of Paediatrics and Child Health	1	Page 9	Odd, opaque and cumbersome title. We see (from page 9!) it is to include care for people aged 16 upwards so very important for our group. Why not say for Acute Medical Emergencies in adults over 16 years for example?	Thank you for your comment. The title has been changed to "Service Delivery and Organisation for Acute Medical Emergencies".
111	SH	Monitor		4.4; 4.6	**Outcomes.** You may also wish to consider measuring supply-induced demand or unmet need as system-wide outcomes in order to help establish the cost effectiveness of services. Analysis of the impact of urgent care centres on reducing demand on A&E as opposed to treating unmet need shows that urgent care centres' activity is approximately equally divided between meeting previously unmet need and acting as substitutes for both A&E and primary care (see *Meeting need or fuelling demand?*, Nuffield Trust, 2014).	Thank you for your comment. The list of outcomes in the scope is indicative and developers will prioritise outcomes (including those of relevance but which may not be listed in the scope, if appropriate) when designing and determining specific review questions.
105	SH	Monitor		4.3.1k; 4.5.11	**Targets and incentives.** However, the tariff is only one financial incentive and payment source for A&E. There is also a significant incentive created by the reliance on winter pressures money and non-recurrent funding from commissioners, and the opportunity to align incentives by using CQUIN across the UEC network.	Thank you for your comment. The scope of the guideline is wide and the developers will ask the appointed GDG to decide whether targets and incentives will be prioritised for inclusion in the guideline.
107	SH	Monitor		4.3.1f; 4.5.6a	**Information-sharing as an enabler.** We are pleased that the Guideline references the importance of information	Thank you for your comment. The guideline aims to assess

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					sharing as a key enabler for person-centred, coordinated care, whether in the care planning process or across the patient's whole experience of care delivery. Ensuring that the right information, particularly clinical information, is collected and effectively disseminated to the right organisations at the right time can play a critical role in ensuring that care is delivered in an integrated way, but is often regarded as a barrier to more integrated care. The management of information should also explicitly look at access to clinical records. For example, the Keogh team has a workstream regarding access to the GP summary care record by A&E, pharmacy and ambulance services.	what effect ways of sharing information have on the delivery of services. The GDG will prioritise which aspects of this to review.
102	SH	Monitor		General; 4.3.1; 4.5.9	**Potential for further, additional related NICE guidance.** We consider that there may be scope for NICE to develop more detailed clinical guidance about, e.g. options for to triaging patients upon arrival at A&E and the role and benefits of, e.g. Medical Assessment Units.	Thank you for your comment. We consider clinical triage to play an integral role in directing patients within the first stages of the AME pathway. However, within the **service** guidance we do not anticipate making recommendations on clinical decision rules. We believe there is opportunity within current scope topic areas (i.e. planning the pathway) for developers to prioritise the evaluation of where triaging decisions are made over other topic areas (i.e. if they believe the topic area would benefit

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						from national guidance).
96	SH	Monitor	3	General; 4.5.6b; 4.5.6c	**Focus on primary and community care.** We welcome the inclusion of end-to-end care across the whole care pathway, as most of the work to avoid hospitalisation, arrange discharges and prevent readmissions takes place in primary and community-based settings. Community, primary, acute and social care bodies (including in relation to prevention and early intervention to avoid exacerbation of long-term conditions) must work together in order to provide the most appropriate care for patients when they leave hospital to help avoid emergency readmissions within 30 days. However, it is important to ensure that the Guideline doesn't focus only on high-end hospital care where we recognise that the relevant data is of better quality and more readily available.	Thank you for your comment. The guidance aims to review evidence that might support new end-to-end service models and make recommendations based on these data. The GDG will prioritise the exact nature of the reviews.
98	SH	Monitor	5	General; 4.1; 4.1.1; 4.1.2	**A review of demand issues associated with UEC may be beneficial and will help to identify relevant population cohorts.** The Guideline may benefit from a greater focus and understanding of demand for UEC as well as the supply issues currently identified. Some localities have stratified and prioritised their patient population, based on defined population risk cohorts. In this way, data is linked across all relevant services such as social, primary, community and mental health care to, e.g. assess population resource consumption and proactively identify those with the greatest needs who might best benefit from new care models. Monitor will shortly be publishing some guidance that you may wish to reference in your final Guideline.	Thank you for your comment and highlighting this interesting work which will provide valuable background to many of the topics we are exploring. Regarding the distinct customer groups you cite, this scope excludes children under 16. The other customer groups will be included in evaluations of the evidence, and special consideration will be given to

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					Such analysis of patient level linked datasets, marginal rate activity trend analysis and the Keogh work on demand modelling suggests that there are a number of distinct customer groups for UEC services – for whom quality considerations may vary. These include: • children and young families (who are frequent users or urgent and emergency care to access advice, reduce anxiety or address minor ailments/injuries); • frail older people (particularly those with long-term conditions and would benefit from continuity of care and early discharge); • Unregistered young people and those working age adults who use A&E instead of visiting a GP; and • Those with underlying mental health conditions (see comment #6-7 for further detail).	frail older people and those with underlying mental health conditions.
106	SH	Monitor		3.2g; 4.3.1f; 4.5.6	**Importance of integrated care.** We agree with the focus on the integration of care, including information sharing, care planning and multi-disciplinary team working to improve patients' outcomes and experience of care.	Thank you for your support.
109	SH	Monitor		General; 3.2g; 4.3.1f; 4.5.6	**Importance of care planning.** Care planning should be coordinated across settings to ensure a system level approach and cover all aspects, including joint working, communications and information sharing. Such an approach can help to ensure that patients do not leave hospital too early and then unnecessarily readmitted as an emergency. In order to provide the most appropriate care for patients when they leave hospital to help avoid emergency readmissions within 30 days, planning may include coordinating with the patient's family and GP regarding	Thank you for your comment. It is the intention of the developers to consider aspects of discharge and readmission as prioritised by the GDG.

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					medication or arranging post-discharge equipment or care by a community or social care provider.	
112	SH	Monitor		3.3; 3.1c; 3.2c; 3.2g	**Additional references.** The following publications may also prove helpful in the development of the Guideline: • *Monitor and NHS England's review of the marginal rate rule* (Monitor and NHS England, 2013) • *Emergency admissions to hospital: managing the demand* (National Audit Office, 2013) • *Reimbursement of urgent and emergency care: discussion document on options for reform* (Monitor and NHS England, 2014) • *Facing the future: smaller acute providers* (Monitor, 2014) • *Walk-in centre review: final report and recommendations* (Monitor, 2014) Additionally, current NHS England research into understanding the impact of seven day services may also be helpful.	Thank you for your suggestions.
103	SH	Monitor		3.1c; 4.5.5b; 4.5.5f	**The role of pharmacy and medicines management.** We are pleased that you reference the role of pharmacists. Evidence (such as by the King's Fund) suggests that medicines management plays a large role in both ensuring: timely discharge of patients (take-home prescriptions are often late); and safe and effective discharge (as many readmissions are due to patients experiencing adverse drug interactions or not taking the medicine as prescribed due to a lack of understanding or	Thank you for your comment. Regarding 4.5.5f, "the role and scope of community pharmacists" has been removed from the scope - the GDG will prioritise reviews of evidence for community pharmacists and a number of other professionals as well.

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					agreement).	
108	SH	Monitor		4.3.1g; 4.5.7c; 4.6	**Alternatives to acute care in hospital.** You may wish to reference care coordination - a targeted, community-based and proactive approach to care that involves case-finding, assessment and care planning. It can be led by clinical staff such as nurses or GPs, or non-clinicians in a named care navigator or coordinator role. Such individuals are often supported by multi-professional teams (including generalists working alongside specialists from health and social care), that are often based in primary or community care settings. These teams will be involved in care planning and co-ordinating care for individuals that have been proactively selected and co-producing personalised care plans that match needs with service provision. Examples include the Virtual Ward model of case management developed in the UK (e.g. Croydon) where the concept of the hospital ward, with its multi-disciplinary team, ward clerk and regular ward rounds, is replicated in the community. Patients at highest risk are identified, assessed and, where appropriate, admitted to the 'ward' and much of the care and care planning takes place in the patient's home. In PACE (USA), case management of older people is organised from daycare centres through multi-disciplinary teams of nurses, physicians, therapists, social workers and nutritionists and has been shown to reduce bed days, admissions and lengths of stays.	Thank you for your comment. The GDG will prioritise what alternatives to acute care in hospital to consider because we cannot cover every aspect of service delivery.

These organisations were approached but did not respond:

Age UK
Alzheimer's Society
Association of Anaesthetists of Great Britain and Ireland
Association of Chartered Physiotherapists in Oncology and Palliative Care
Association of Chartered Physiotherapists in Respiratory Care
Association of Respiratory Nurse Specialists
Barnsley Hospital NHS Foundation Trust
Belfast Health and Social Care Trust
Brahms UK Limited-Thermo Fisher Scientific
Brighton and Sussex University Hospital NHS Trust
Brighton and Sussex University Hospitals Trust
British Association for Counselling and Psychotherapy
British Association of Critical Care Nurses
British Dental Industry Association
British Infection Association
British Medical Association
British Medical Journal
British Nuclear Cardiology Society
British Nuclear Medicine Society
British Orthopaedic Association - Patient Liaison group
British Psychological Society
British Red Cross
Care Quality Commission
Croydon Council
Cumbria Partnership NHS Foundation Trust
CWHHE Collaborative CCGs
Department of Health, Social Services and Public Safety - Northern Ireland
Diabetics with Eating Disorders
East and North Hertfordshire NHS Trust
Faculty of Forensic and Legal Medicine
Faculty of Intensive Care Medicine
Faculty of Sport and Exercise Medicine

False Allegations Support Organisation
Gloucestershire Hospitals NHS Foundation Trust
GP update / Red Whale
Health and Care Professions Council
Health and Social Care Information Centre
Health Foundation
Healthcare Improvement Scotland
Healthcare Inspectorate Wales
Healthcare Quality Improvement Partnership
HIV Pharmacy Association
Humber NHS Foundation Trust
ICU Steps
Imperial College Healthcare NHS Trust
Intensive Care National Audit and Research Centre
Intuitive Surgical
Johnson & Johnson Medical Ltd
Joint Royal Colleges Ambulance Liaison Committee
Kent, surrey and Sussex Air Ambulance Trust
Kingston University and St Georges, University of London
Leeds North Clinical Commisioning Group
Marie Curie Cancer Care
Medical Directorate Services
Medicines and Healthcare products Regulatory Agency
Mencap
Mid Cheshire Hospitals NHS Trust
Ministry of Defence
Monitor
National Clinical Guideline Centre
National Collaborating Centre for Cancer
National Collaborating Centre for Mental Health
National Collaborating Centre for Women's and Children's Health
National Deaf Children's Society

National Institute for Health Research
Neat Projects
NHS Coastal West Sussex CCG
NHS Dorset CCG
NHS Hardwick CCG
NHS Health at Work
NHS Lincolnshire East CCG
NHS Sheffield CCG
NHS South Norfolk CCG
NHS West Cheshire CCG
North of England Critical Care Network
Northern Health and Social Care Trust
Nursing and Midwifery Council
Pan London Acute Medicine Network
Parkinson's UK
Primary Care Diabetes Society
Primary Care Foundation
Proprietary Association of Great Britain
Public Health England
Public Health Wales NHS Trust
Public Health Wales NHS Trust
Randox Laboratories Limited
Resuscitation Council UK
Roche Diagnostics
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of General Practitioners in Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Pathologists

Royal College of Psychiatrists
Royal College of Speech and Language Therapists
Royal College of Surgeons of England
Royal Cornwall Hospitals NHS Trust
Royal Free Hospital NHS Foundation Trust
Royal Mencap Society
Royal National Institute of Blind People
Salford Royal NHS Foundation Trust
Scottish Intercollegiate Guidelines Network
Social Care Institute for Excellence
Sophia Forum
South Eastern Health and Social Care Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health & Social Care Trust
Stockport NHS Foundation Trust
Swansea University
The Anaphylaxis Campaign
The Intensive Care Society
The King's Fund
University Hospitals of Leicester NHS Trust
Welsh Ambulance Services NHS Trust
Welsh Government
Welsh Scientific Advisory Committee
Western Health and Social Care Trust