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RCEM Response to the Clinical Review of Standards consultation

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The Urgent and Emergency Care system is under considerable strain. Over the past few years, we have witnessed steady increases in attendances to Emergency Departments and increased numbers of patient admissions against a reduction in the numbers of available staffed beds in hospitals. This has contributed to a period of unacceptable crowding and corridor care in Emergency Departments.

We welcome the explicit recognition of the harms associated with crowding and the stated ambition of transforming the Urgent and Emergency Care system. The system has been in crisis for some time now and there is a pressing need for change. RCEM has been consulted in the formulation of the new standards and some of our thinking is reflected in the consultation document. For many years, we have argued that crowding is mainly caused by exit block and inadequate hospital acute bed capacity, along with insufficient staffing, poor physical infrastructure in Emergency Departments, and a lack of alternatives to admission. We support a performance framework that illustrates this more explicitly. Long stays in Emergency Departments are bad for patients, resulting in increased mortality and morbidity. The patients who suffer the longest stays are people who need admission to a hospital bed.

We are in favour of the introduction of a bundle of new measures which allow us to view hospital and system performance more holistically. Whilst a single measure, such as the four-hour standard makes drawing comparisons between departments easy, it oversimplifies a complex system. Multiple measures have the added benefit of nuance and reducing gaming and perverse incentives.

The proposed measures recognise that a problem identified in one part of the system can be caused by issues elsewhere. For example, delayed ambulance handovers are part of Emergency Care measures, while the mean time for admitted patients is recognised as a hospital wide problem. We are reassured to see the move to a new metric which measures 12-hour length of stay, rather than the misleading 12-hour decision to admit metric. This is a simpler, patient-centred measure, which brings performance measurement in England in line with the rest of the devolved nations. We recommend that a strong communications exercise is conducted with patients and the public to ensure the 12-hour metric is not perceived to be a replacement for the four-hour standard. We will continue to argue that no one should be spending 12 hours in an Emergency Department.

Our response identifies some difficulties in defining measures such as Time to Initial Assessment and Ready to Proceed. The latter will help to illuminate the problem of exit block and issues occurring in the wider hospital system. Moreover, thresholds need to be

defined and there is no indication of how they will be used to compare different Emergency Departments. The lack of transparent reporting in the pilot sites has made it hard to maintain adequate operational grip and subsequently compromised performance. New measures must be reported fully, so that good performance in one area does not disguise poor performance in another area. If implemented, these measures should transfer performance ownership away from individual clinicians to a service level.

We recognise that it would be wrong to deal with crowding in Emergency Departments by pushing the problem 'down the corridor' to other assessment areas in the hospital. There should be joined up working with the national Same Day Emergency Care programme and admission standards to beds from Medical or Surgical Assessment Unit type facilities.

Some of the measures – especially those relating to time – can be implemented and reported very quickly. Other measures with complex definitions will require more development to allow data collection and reporting. The operationalisation of the proposed metrics was not outlined in the consultation document. We believe this will be a very complex area of work, especially as there are some legitimate concerns about implementing a major performance management programme in the middle of a pandemic. We strongly recommend a phased approach to implementation as this is more likely to be successful.

Measurement alone does not improve performance or quality of care. Global comparisons of bed availability data reveal that England has one of the lowest numbers of hospital beds per capita in comparison to other OECD nations[1] and we have long campaigned for increasing acute bed capacity in hospitals, and improvements in social care to tackle the harms associated with crowding and exit block. There are currently too few alternatives to admission for primary care, prehospital and Emergency Department teams, meaning that too many patients end up in hospital. Regardless of how we measure and define the problem, transformation of the Urgent and Emergency Care system cannot take place without additional investment and resources.

The winter of 2020/21 has been like no other. We recognize that the NHS faces significant challenges ahead in recovering from the pandemic. These new models of measurement proposed by NHS England represent a first step towards improving the Urgent and Emergency Care system. We have concerns that without a clear performance framework, associated scrutiny, and operational grip, organisations may take their foot off the gas and matters will get worse rather than better. Our consultation response aims to enhance the effectiveness of the proposed measures. If the right range of metrics are implemented correctly and are accompanied by additional investment for implementation and increasing capacity in the Emergency Care system, there could be an improvement in performance and patient flow. The Clinically Led Review of Standards is an ongoing, long-term programme, and we look forward to continuing our engagement in this process.

[1] OECD (2019) Health at a glance: hospital beds. Available here.

Consultation response

1. Are you aware of the existing Accident and Emergency four-hour standard?

Yes.

2. If yes, what do you understand the existing four-hour standard to mean?

The four-hour standard was introduced to the NHS in England in 2004 as a measure to combat crowding and Exit Block in hospital Emergency Departments. The standard requires 95% of patients to be seen, admitted, transferred, or discharged within four hours of arrival in Emergency Departments. In 2009, the standard was included as a pledge set out in the NHS constitution.

Since its introduction there is no doubt that waiting times have been reduced, however in recent years they have risen again. The four-hour standard has not been met nationally in English hospitals since 2015 and only sporadically in a few hospitals more recently, and there is a recognition that the standard has ceased to work in driving improvement.

This suggests that metrics alone are not the answer to Emergency Department performance, but that there are other issues are at play such as increasing demand from patients, lack of availability of primary care, workforce and physical capacity in Emergency Departments, lack of alternatives to admission, limitations of hospital bed capacity, and a lack of adequate social care, all of which put pressure on hospital bed capacity.

The operational focus on the four-hour standard has overshadowed the experiences and the reality of long waits for admitted patients, who are more likely to be the oldest and sickest.

3. Which would help you understand how well urgent or emergency care is doing: A single measure or a wider range of measures across your urgent or emergency care journey?

A wider range of measures across the Urgent and Emergency Care journey.

Although the four-hour standard has been used as the 'canary in the coalmine' to signal pressures in the system, we think that the exclusive focus on the four-hour target has created disproportionate attention on a single metric. Analysis of the pressures requires a broader set of metrics to understand the components of the wider situation and how the different parts of the urgent or emergency care patient journey are performing. The four-hour target has lacked the nuance needed to expose the root causes of overcrowded Emergency Departments and so in recent years crowding has increasingly become a significant issue affecting patient safety, where remedies have been slow to be applied.

4. Please rate how important you think each of the measures are based on a scale of 1-5, where 1 is not important and 5 is extremely important.

	1	2	3	4	5
Pre-Hospital					
Response times for ambulances					**X**
Reducing avoidable trips (conveyance rates) to EDs by 999 ambulances					**X**
Proportion of contacts via NHS111 that receive clinical input					**X**
A&E					
Percentage of ambulance handovers within 15 minutes					**X**
Time to initial assessment – percentage within 15 minutes					**X**
Average (mean) time in Department – non-admitted patients					**X**
Hospital					
Average (mean) time in Department – admitted patients					**X**
Proportion of patients admitted within one hour of it being safe to do so (clinically ready to proceed)					**X**
Whole system					
Percentage of patients spending more than 12 hours in A&E					**X**
Critical Time Standards					**X**

Please explain your answers

It is important for all measures to have equal weighting and attention. Please refer to annex 1 for more information about each measure.

5. Are there any additional measures that should be included within the bundle?

We previously proposed the following additional measures during the development of these standards:

- A standard that identifies the need for infection control within 15 minutes of arrival. This was important before the coronavirus pandemic for flu, measles, and norovirus; it is much more important now.

- The time to see a decision-making clinician, with the threshold set to less than one hour.
- The six-hour admitted patient delay - which measures patients who have been admitted who stay beyond six hours - is evidenced by GIRFT to be informative and useful.[2]

We support the recommendation for a separate clinical standard for the urgent review of children under 28 days of age with a fever, as put forward by the Association of Paediatric Emergency Medicine and the Royal College of Paediatrics and Child Health.

There is currently a disproportionate managerial focus on the four-hour target, so NHS England and Trusts must ensure that the proposed new metrics are prioritised. It is important that we learn the lessons from the last time new measures were introduced – when Professor Matthew Cooke was National Clinical Director of Urgent and Emergency Care, he introduced a wider set of indicators to create a more balanced picture of performance. However, 'intense performance management of the four-hour target' negated the impact of a balanced set of measures.

6. To what extent do you agree with the recommendation to replace the current measure with the proposed new bundle of measures?

1- Strongly Disagree	2	3	4	5 – Strongly agree
			X	

7. To what extent do you agree that measuring the average time for all patients is a more appropriate or meaningful performance measure than the percentage of patients treated within a predetermined timeframe?

1- Strongly Disagree	2	3	4	5 – Strongly agree
		X		

8. To what extent do you agree that the bundle of indicators adequately measures the elements of the Urgent and Emergency Care pathway that are important to you?

1- Strongly Disagree	2	3	4	5 – Strongly agree
			X	

[2] Getting It Right First Time (2020) Emergency Care. Available here.

9. Please explain why you think the measures identified are appropriate or not?

Please see annex 1 for an analysis of the proposed metrics against the requirements of NHS standards.

Disaggregating the mean time for admitted and non-admitted patients will make it possible to find out how much bed delays and exit block affects the oldest and sickest patients.

Pre-Hospital

The measures are appropriate; however, detail about what the thresholds are will be important, especially for clinical input. We advise that clinical validation before referral to an Emergency Department should be over 80%.

A&E

The A&E measures should be renamed to Emergency Department measures.

Exit block causes entrance block. GIRFT data reveals the hospitals with the greatest number of 12-hour lengths of stay from time of arrival, are those that have the greatest delays in ambulance handovers.[3] It can be argued that this is a hospital metric, rather than an Emergency Department metric.

These measures are important but are incomplete and must include the time to a clinician. The time thresholds are also important, the methodology for calculating the thresholds should be made explicit.

Hospital

These are sensible measures, but the time thresholds should be defined.

Clinically Ready to Proceed additionally requires careful definition. We propose that this should be defined as the first time the ED clinician (authorised to discharge patients from the ED) is satisfied that the patient no longer requires ongoing care in the ED (as judged by the most senior clinician in the Emergency Department) and is therefore 'Clinically Ready to Proceed' to one of the following:

- an inpatient ward OR
- a designated department / clinical service area outside the ED - staffed and configured to safely deliver all immediately necessary care OR
- transferred to another provider for continuation of their care OR
- discharged from the Emergency Care facility

Measuring Clinically Ready to Proceed for admitted patients only, risks neglecting the patients who have been referred – and local arrangements which have allowed patients to be seen by a specialty team in the Emergency Department – along with those who are

[3] Getting It Right First Time (2020) Emergency Care. Available here.

referred and never get admitted because of exit block and consequent very long length of stay. Organisations should make sure Interprofessional Standards are rigorously applied.

We know from GIRFT data that there is considerable variation in the percentage of emergency admissions that come through the Emergency Department, reflecting the variation in alternative access points.[4] The lack of measures identifying this means that there is a risk that there will be less incentive for the development of extended hours, 7 days services, which are designed to offer more appropriate models of care for patients who do not need admission.

Whole system

We welcome the proposal to measure the 12-hour length of stay from arrival. No patient has a clinical need that requires them to wait for 12 hours in an Emergency Department.

The proportion of patients is not defined, but we advocate that this should be a very unusual event, and certainly less than 1%. In addition, no patient should ever be receiving clinical care in corridors. We know that harm increases with increased length of stay and this harm is apparent even at six hours.

There is not currently a standard specifically for children outside major trauma and this important group should be supported with a recommendation. We recommend a separate clinical standard which urgently reviews children under 28 days of age with fever.

10. What do you think are the best ways to advise and communicate the proposed new urgent and emergency care measures to patients and visitors to Urgent and Emergency Care departments?

There should be strong engagement with patient groups to help inform the communications strategy for the proposed new metrics. The media should be briefed on how to interpret the new set of measures and it should be made explicit that all measures are important. We have legitimate concerns that these multiple measures will be distilled down to one headline catching measure, which is likely to be the 12-hour measure. Additionally, it must be made explicit to the public and the media that the 12-hour measure is not a target and does not replace the four-hour standard.

The performance figures should be published monthly and be clearly visible and accessible to all on the hospital's website. The performance dashboard should indicate monthly figures in each of the four domains - good performance in one domain should not hide poor performance in another. Data should be published and made available by hospital, rather than NHS Trust.

[4] Getting It Right First Time (2020) Emergency Care. Available here.

11. What are the key issues/barriers that should be taken into account for implementation of the bundle of measures and establishing thresholds for performance? What additional support might providers need for implementation?

Key principles to be taken into account for implementation:

- Good performance in one domain should not be used to hide poor performance in another domain.
- Type 1 departments should be reported without adding Type 2 or Type 3 units.
- Trusts that run multiple Emergency Departments should report departmental performance, not trust performance.
- Emergency Department staff have been significantly stretched during the pandemic and have had to adapt their working practices to a considerable extent. An additional transformation project may not be welcome.

Evaluation

In 2017, the Ambulance Response Programme introduced new time-based targets, following the largest clinical ambulance trial in the world. NHS England commissioned Sheffield University to independently monitor, analyse and evaluate the Ambulance Response Programme. This formed a two-year study with staff, patients, and clinicians participating in the evaluation, helping the programme to address any issues arising from the implementation of the new metrics. Any introduction of new measures should follow the same pattern of robust evaluation and learning from the findings. The evaluation should be published in full to ensure transparency.

Barriers

Some time-based measures can be collected and reported quite easily, yet there are others which require further work, for example those where there are issues regarding definition or clinical standards.

We advocate a phased implementation where the time-based standards are implemented first. These cannot be successfully implemented without investment in both implementation and capacity in the Urgent and Emergency Care system.

Accountability

The consultation document did not identify clear lines of accountability for the performance management of the new measures. We would like to know who is accountable for each domain and how will they be held to account.

12. Do you support the idea of a composite measurement approach to presenting the effectiveness of Urgent and Emergency Care across a system?

No. A composite measure could result in good performance in one area overshadowing poor performance in another.

13. How frequently should this composite be updated and published?

We welcome the intention to move away from a single summary statistic to the reporting of performance in each domain. This should be published monthly by hospital, rather than by NHS Trust.

Annex 1: Comparison of proposed Urgent and Emergency Care metrics versus requirements of NHS Standards

	Percentage of Ambulance Handovers within 15 mins	Time to Initial Assessment – percentage within 15 mins	Average (mean) time in Department – non-admitted patients	Average (mean) time in Department – admitted patients	Clinically Ready to Proceed	Patients spending more than 12 hours in A&E	Critical Time Standards
Promote safety and outcomes	Yes	Yes	Not clear.	Yes – this should reduce length of time for the sickest and oldest patients, who are those admitted	Potentially. This may be helpful in reducing crowding and free up nursing time.	Yes. Over 500,000 patients spent more than 12 hours in EDs in 2019 and this was reported as 9000 DTA breaches.	Yes, these are based on respected national clinical audits and are clinically meaningful.
Drive improvements in patients' experience	Yes	Yes	Yes –Friends and Family data (all non-admitted patients) consistently cite waiting time as a matter of concern.	Possibly by reducing target associated flow. This may allow some patients to go home after a slightly longer stay. This would clarify responsibility to individual services within hospitals.	Yes, as long as this is owned by ED this should reduce the length of stay in an ED.	Yes, better than 12hr DTA but need to ensure the 12 hours does not become the new 4-hour.	Yes, these are based on respected national clinical audits and are clinically meaningful.
Are clinically meaningful, accurate and practically achievable	Yes	Yes	Not clinically meaningful but it is easy to measure	It is clinically meaningful and easy to measure. Risk to referred, not admitted patients.	Yes	Yes	Yes, these are based on respected national clinical audits and are clinically meaningful. The RAPID standard will need more development. There should be a paediatric standard.
Ensure the sickest and most urgent patients are given priority	Perhaps	Often	No	No	Potentially	No	Yes
Ensure patients get the right service in the right place	Indirectly	Indirectly	Yes – may encourage use of Type 3 EDs	No. Although this might drive improvements in Same Day Emergency Care	Yes, by admitting a patient to a hospital bed in a ward and this might drive improvements in Same Day Emergency Care.	No	Potentially, system wide focus is welcome to ensure equality of access to urgent, specialist care.
Are simple and easy to understand for patients and the public	Yes	Yes	With the right communications, yes	With the right communications, potentially	Yes	Yes, this is a transparent measure and a considerable improvement on the 12-hour DTA metric.	In terms of measures, yes. In terms of the complexity of the diagnosis, then measure is likely an over-simplification
Not worsen inequalities	We cannot see that this will worsen inequalities	We cannot see that this will worsen inequalities	Potentially but less so than the four-hour standard - focus on the quick uncomplicated win at expense of the more complex patient	We cannot see that this will worsen inequalities	We cannot see that this will worsen inequalities	We cannot see that this will worsen inequalities	There is no question if there are inequalities already, this could shine a light on inequalities and trigger improvements.