# Clinically led review of urgent and emergency care standards

 ***Based on the responses to their consultation, NHS England and NHS Improvement (NHSEI) have announced[[1]](#footnote-2) on 26th May their intention to replace the four-hour A&E target by a bundle of new standards and an overall new approach to measuring performance in Urgent and Emergency Care (UEC) services. Any final proposals will however require government sign-off, which has not yet been given.***

## Background

In March 2019, The NHS National Medical Director was asked by the Prime Minister to review the current NHS access standards to ensure they measure what matters most to patients and clinically.

On 15th December 2020, NHS England launched [Transformation of urgent and emergency care: models of care and measurement](https://www.england.nhs.uk/wp-content/uploads/2020/12/Transformation-of-urgent-and-emergency-care_-models-of-care-and-measurement-report_Final.pdf) - a consultation on the recommendations from the Clinically-led Review of Standards (CRS).

The BMA noted at the time that suggested changes set out in the document would have significant implications on how performance of UEC is measured and how patients can access those services in the future. The BMA’s response to NHS England’s original consultation is [here](https://www.bma.org.uk/media/3809/bma-response-to-nhsei-consultation-on-clinical-review-of-standards-feb-2021.pdf).

## What changes are NHSE proposing and why?

NHSEI are recommending replacing the current four-hour access standard with the introduction of a system-wide bundle of measures that taken collectively, they claim, could offer a more holistic view of performance across the range of UEC services.

NHSEI are proposing to introduce **10 new standards** which would allegedly support the transformation of the model of UEC provided and provide system-wide information rather than focusing on one-part of the system. They argue that the current four-hour target focuses on only one part of a now much more complex range of urgent services for patients, including ambulance care, UTCs and NHS 111.

The increased focus on system-wide indicators will, according to NHSEI, drive improvement in the organisation, delivery and access of UEC services.

The new metrics cover the four parts of the UEC system:

**1. Pre-hospital**:

a. Response times for ambulances

b. Conveyance rates to Emergency Departments (EDs) by 999 ambulances

c. Proportion of contacts via NHS 111 that receive clinical input

**2. A&E**

a. Percentage of Ambulance Handovers within 15 minutes

b. Time to Initial Assessment – percentage withing 15 minutes

c. Average (mean) time in Department – non admitted patients

**3. Hospital**

a. Average (mean) time in Department – admitted patients

b. Clinically Ready to Proceed

**4. Whole System**

a. Percentage of patients spending more than 12 hours in A&E

b. Critical Time Standards.

## Key points from NHSE’s announcement on 26th May 2021

*The* [*document*](https://www.england.nhs.uk/wp-content/uploads/2021/05/B0546-clinically-led-review-of-urgent-and-emergency-care-standards.pdf) *published by NHSEI summarises the responses to the consultation and provides some clarification on next steps.*

The recommendations that came out of the CRS were developed with the support of key national stakeholders including patient representatives, clinicians, and healthcare leaders, and have been tested and refined through real experience of using them in 14 test sites since May 2019.

In the document, NHSEI argue that:

* The consultation responses show that at a local level there is agreement with the recommendations that information and performance systems should reflect not just a single point in a pathway, but the wider urgent and emergency care system.

***BMA’s view: The BMA recognises that NHSEI have piloted proposed alternatives and we agree that a better measurement of performance of the whole UEC pathway will prove helpful. We are however concerned that so far there is not sufficient publicly available evidence to demonstrate that the proposed new set of standards will represent an improvement for patients and that potential unintended consequences have been identified.***

***We called on NHSEI to publish the full findings of the pilots it had undertaken and to provide more clarity regarding what threshold will be used to measure performance against the proposed new metrics (particularly the mean waiting time scores).***

* Overall eighty percent of respondents said that a bundle of measures would be more helpful than a single measure to understand UEC performance.

***BMA’s view: The BMA agrees that the four-hour standard does not provide a full picture of how A&E departments are performing and can lead to perverse incentives. However, we also recognise that it has proved instrumental in reducing waiting times in Emergency Departments (EDs) and facilitating patient flow along the UEC pathway.***

* The responses support the proposed model and whilst there is no consensus on a single measure that should be included, there is an agreement that a bundle of measures should be adapted to the different models and pathways that deliver urgent or emergency care to people.
* There is clear support for the move from the current ‘12 hours from Decision to Admit’ to the proposed ‘12 hours from Time of Arrival’ measure. This will be further strengthened when used in conjunction with the ‘Clinically Ready to Proceed’ measure and the average (mean) time in department. **The clinical suitability of an ED for patients beyond six to eight hours has also been raised, and therefore the use of a percentile expectation alongside the average is also being considered.**
* Responses to the consultation also made clear that the proposal to use an average time for all patients in an Emergency Department was more meaningful than the current approach of setting an expectation for a percentage of patients within a pre-determined time frame.

***BMA’s view: we have previously asked for more clarity on how the mean-based target will work in practice in EDs. The current four-hour target may be problematic, but it has the advantage of setting a clear operational standard to work towards for staff in ED, whereas a mean score will be constantly changing throughout the day in a way that will be difficult to keep track of in real time. Targets can act as an operational tool to incentivise patient flow through services, and we would like to see evidence of how targets based on a mean score will affect this in practice.***

* The proposed introduction of Critical Time Standards (CTS) has received extensive support and the responses are helping to inform what should be included within those measures. CTS focus on the delivery of evidence-based clinical interventions for specific cohorts of patients in order to reduce mortality and morbidity resulting from a number of common conditions[[2]](#footnote-3)[[3]](#footnote-4).
* Many respondents have emphasised the importance of a phased implementation given the need to focus on restoring routine NHS services and the technical demands of establishing new data collections and performance analysis systems together with business change to management functions.

***BMA’s view: the new metrics should be implemented through a phased approach and trusts should keep publishing data on their performance against the four-hour target during the transition period.***

* A number of stakeholders and respondents highlighted the need to set appropriate performance expectations against these metrics, which will require agreement with Government.

***BMA’s view: we called on NHSEI to provide more clarity regarding what threshold will be used to measure performance against these new metrics (particularly the mean waiting time scores) and how the performance of each UEC system will be presented.***

Next steps

* NHSE have indicated that they intend to continue to work on the development of a composite measurement approach to present the effectiveness of urgent and emergency care. They are exploring a number of possible uses and audiences that the respondents had anticipated a composite could be used for, from a real time dashboard approach to an annual update.

***BMA’s view: while we understand the potential appeal of a composite measure, we are worried that it would make it difficult for patients or clinicians to understand more clearly why their local UEC system is performing well or poorly. We think a composite measure may not be more accessible for patients and help them to understand the performance of local providers in UEC services and may also fail to shine a spotlight on the parts of these services which would require specific improvements, additional funding or resources.***

***We also believe that breaking the performance score down and highlighting the performance of each individual part of the UEC service to clinicians will also help to ensure accountability in the system.***

* The responses on how best to advise and communicate the proposed new measures to patients and visitors, as well as the opportunities or challenges to implementation, will be considered as part of an implementation plan, subject to Government agreement to implement the proposals.
1. <https://www.england.nhs.uk/2021/05/wide-support-for-more-comprehensive-urgent-care-indicators/> [↑](#footnote-ref-2)
2. NHS England consultation: <https://www.england.nhs.uk/wp-content/uploads/2020/12/Transformation-of-urgent-and-emergency-care_-models-of-care-and-measurement-report_Final.pdf> [↑](#footnote-ref-3)
3. For more information on CTS : <https://www.england.nhs.uk/wp-content/uploads/2020/12/transformation-of-urgent-and-emergency-care-models-of-care-and-measurement.pdf> (p34) [↑](#footnote-ref-4)