Lincolnshire COUNTY COUNCIL Working for a better future		THE HEALTH SCRUTINY COMMITTEE FOR LINCOLNSHIRE	
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Open Report on behalf of Andrew Crookham,
Executive Director - Resources

Report to	**Health Scrutiny Committee for Lincolnshire**
Date:	**20 January 2021**
Subject:	**Urgent and Emergency Care - Models of Care and Measurement**

Summary

On 15 December 2020, NHS England and NHS Improvement (NHSE/I) launched a consultation on ten proposed indicators for urgent and emergency care, which are detailed in a document entitled: *Transformation of Urgent and Emergency Care: Models of Care and Engagement*.

This item invites the Committee to make arrangements for finalising a response to the 13 questions in *Transformation of Urgent and Emergency Care: Models of Care and Engagement*. **A draft response has been circulated separately to the Committee.**

Actions Required

To authorise the Chairman to approve a response to the consultation on *Transformation of Urgent and Emergency Care: Models of Care and Engagement,* and subject to any amendments, to approve it as the Committee's submission.

1. Background

On 15 December 2020, NHS England and NHS Improvement (NHSE/I) published *Transformation of Urgent and Emergency Care: Models of Care and Engagement.* The Executive Summary is attached at Appendix A to this report and the full document is available at the following link:

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 key point in *Transformation of Urgent and Emergency Care: Models of Care and Engagement* is the proposal to discontinue the four-hour standard. This report summarises the arguments for this proposal, as well as those for the ten proposed measures of how well urgent and emergency care is doing.

The Four Hour Standard

The existing four hour standard provides that no patient should be in A&E for any longer than four hours, measured from the time they arrive in A&E to the time they are admitted to the hospital, transferred to another hospital or service, or they are discharged. The consultation document proposes the existing four-hour standard be discontinued, arguing that since its introduction in 2004 there have been major improvements and changes in how urgent and emergency care are delivered. For example, major trauma centres, heart attack centres and acute stroke units have been created; NHS 111 and urgent treatment centres have been developed; there are new standards for ambulance services; and the use of same day emergency care, to avoid unnecessary overnight admissions to hospital, has been increased.

The consultation document also argues that there are further issues with the four-hour standard: for example, it does not measure total waiting times; it does not take account of a patient's condition; it does not measure whole system performance; and there is significant variation in the proportion of patients, admitted to hospitals, across the country. Questions (1) and (2) of the consultation document refer to the proposal to discontinue with the four-hour standard.

Proposed Measures

Transformation of Urgent and Emergency Care: Models of Care and Engagement sets out the rationale for ten proposed indicators for urgent and emergency care, which are listed in the table below. Sections 2 to 6 of this report provide additional information on each measure. Questions (3) to (9) of the consultation document focus on the new measures.

Service	Measure
Pre-Hospital	Response Times for Ambulances
	Reducing Avoidable Conveyance to Emergency Departments
	Proportion of Contacts via NHS 111 Receiving Clinical Input
A&E	Percentage of Ambulance Handovers within 15 Minutes
	Percentage of Initial Assessments within 15 Minutes
	Average Time in Department – Non-Admitted Patients
Hospital	Average Time in Department – Admitted Patients
	Clinically Ready to Proceed
Whole System	Patients Spending more than 12 hours in A&E
	Critical Time Standards

2. Pre-Hospital Measures

Response Times for Ambulances

In 2017, the Ambulance Response Programme (ARP) introduced new ambulance performance standards, which are summarised below:

- Response to Category 1 calls (life threatening illnesses or injuries) in 7 minutes on average, and response to 90% of Category 1 calls in 15 minutes;
- Response to Category 2 calls (emergency calls, but not life threatening) in 18 minutes on average, and response to 90% of Category 2 calls in 40 minutes;
- Response to 90% of Category 3 calls (urgent calls) in 120 minutes;
- Response to 90% of Category 4 calls (less urgent calls) in 180 minutes.

The consultation document proposes a focus on the 90th centile response time for category 2 calls, on the basis that these calls are emergency calls, excluding those that are immediately life threatening, which typically represent between 7% and 10% of the calls to ambulance services.

Reducing Avoidable Conveyance to Emergency Departments

The document refers to increasing the proportion of 999 calls that can be managed without the conveyance of the patient to hospital, for example, by using 'Hear and Treat' and 'See and Treat' services. There is also reference to increasing the transport of patients to other settings such as urgent treatment centres or same day emergency care services.

This proposed measure focuses on reducing the avoidable transport of patients to A&E departments, as a key contributor to avoiding nosocomial [hospital acquired] infection, and increasing other forms of care, including the patient being treated at the scene; referred to other services; or taken to an alternative care setting. These can all reduce the number of patients being transport to A&E departments.

Proportion of Contacts via NHS 111 Receiving Clinical Input

The consultation document states that it is important that the performance of NHS 111 is reflected in the performance of the overall local health care system. It is therefore essential that there is the right amount of direct clinical advice provided to patients who use NHS 111, so they are directed to the appropriate services for their needs. Clinical advice is important in maintaining both public and professional confidence in NHS 111. For local health systems, the document proposes a measure of the percentage of the patients using NHS 111, who receive clinical advice. The document also refers to an intention to further invest in local clinical assessment services, as well as in NHS 111.

3. A&E Measures

Percentage of Ambulance Handovers within 15 Minutes

There is a proposal to focus on hospital handover delays, as a measure of the flow of patients into A&E departments. The consultation document states that it is essential that patients can be quickly transferred into the care of hospital teams to ensure that treatment can be initiated quickly, and ambulances can be released back onto the road in order to deal with new emergencies

Percentage of Initial Assessments within 15 Minutes

This proposed measure would focus on the percentage patients receiving an initial assessment within 15 minutes. The consultation document states that this would provide assurance that each patient's needs are quickly assessed, so they can be treated in the right place and at the right time.

Average Time in Department – Non-Admitted Patients

This proposed measure is the mean time that patients, who are not admitted to the hospital, stay in the department. The consultation document argues that while there is emphasis on the patients most in need of care, it is also important to ensure that efficient services are provided for patients who do not require admission into hospital. This is important in ensuring departments do not become crowded.

4. Hospital Measures

Average Time in Department – Admitted Patients

This proposed measure is the mean time in an A&E department for admitted patients, who are admitted to hospital. This is a measure of efficiency of hospital services. It is important that those patients requiring ongoing acute hospital care spend no longer in emergency departments than is necessary.

Clinically Ready to Proceed

This proposal would measure the time taken from the time it is agreed that a patient is ‘clinically ready to proceed’ from the A&E department, and when they actually leave A&E. This measure would aim to avoid patients being kept too long in A&E after they are ready to leave.

The consultation document refers to clinicians in acute trusts supporting this measure as a lever to manage patient flow. On the basis it is vital that there is a continuous flow of patients out of A&E departments into acute or general medical and specialty services.

5. Whole System Measures

Patients Spending More Than Twelve Hours in A&E

The consultation document states that there is no valid reason why any patient should spend more than twelve hours in any A&E department. Where any patients spend more than twelve hours in A&E suggests wider system problems, as patients are unable to be transferred to services more appropriate for their needs. For this reason, there is a proposal for a measure of the percentage of patients spending more than 12 hours in A&E.

Critical Time Standards

The consultation document proposes measures for the delivery of specific clinical interventions for patients. For example, this would measure early intervention in stroke, heart attacks, acute physiological deterioration and major trauma.

Clearly making improvements across a number of parts of the pathway is more complex than doing so for one specific point on the pathway. But doing so has clear clinical benefit to patients.

6. Composite Measurement Approach

The consultation document proposes a 'composite measurement approach' as a further means of monitoring performance. In addition to the individual measures, a composite measure would provide at-a-glance information on any A&E department or the urgent and emergency care system. A composite scoring system could reflect the performance of an individual provider or an integrated care system (ICS) footprint. It could also be aggregated at a national level.

The consultation document proposes an aggregated approach with each of the ten proposed measures given a score of 1 (pass) or 0 (fail). Thus a system could achieve a maximum score of 10. Questions (12) and (13) refer to this proposal.

7. Consultation Questions

The consultation, which closes on 12 February 2021, includes the following questions:

(1) Are you aware of the existing Accident and Emergency four-hour standard?
(2) If yes, what do you understand the existing four-hour standard to mean?
(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?
(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? Please explain your answers.

(5) Are there any additional measures that should be included within the bundle?
(6) To what extent do you agree with the recommendation to replace the current measure with the proposed new bundle of measures?
(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 pre-determined timeframe?
(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?
(9) Please explain why you think the measures identified are appropriate or not?
(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?
(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?
(12) Do you support the idea of a composite measurement approach to presenting the effectiveness of urgent and emergency care across a system?
(13) How frequently should this composite be updated and published?

8. Conclusion

The Committee is invited to consider making arrangements for finalising its response to the proposed to the questions on the proposed set of indicators for urgent and emergency care.

9. Appendices – These are listed below and attached to this report

Appendix A	Urgent and Emergency Care - Models of Care and Measurement: Executive Summary *(NHS England and NHS Improvement – December 2020)*

10. Background Papers - No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 07717 868930 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

Transformation of Urgent and Emergency Care: Models of Care and Measurement

(NHS England and NHS Improvement – December 2020)

1. Executive Summary

This report sets out the final recommendations on the urgent and emergency care (UEC) standards from the Clinically-led Review of NHS Standards (CRS) and gives patients, clinicians and the public an opportunity to respond to these findings in a consultation. It also sets out how the proposed measures align with the strategy for transforming urgent and emergency care provision, drawing on the learning from experience through Covid-19 and building on our longstanding vision for the services.

As set out in the Interim Report of the Clinically-led Review of NHS Access Standards (March 2019), the current headline four-hour access standard is used to measure and report performance against one aspect of the urgent and emergency care system. It has proved useful in improving levels of staffing and investment in Emergency Departments (EDs), improving flow through hospitals including improving access to diagnostic services and reducing time spent in ED, and permits comparison of individual healthcare organisations and health systems. However, as the Interim report set out, given the changing nature of urgent and emergency care services, the view of the CRS is that the current single standard offers a limited insight into the care that patients receive, including:

- not measuring total waiting times;
- not differentiating between severity of condition;
- measuring a single point in often very complex patient pathways; and
- hospital processes, rather than clinical judgement, are resulting in admissions or discharge in the immediate period before a patient breaches the standard.

This report considers the recommendations of the CRS alongside the continuing development of urgent and emergency care services. Our ambition is to improve the offer for patients, deliver improved access and outcomes with a better experience of care. The proposed new measures are part of our vision for the transformation of UEC, which combined will support improvements in care by changing the way that the urgent and emergency care system is both perceived and accessed by the patient, as well as reducing the risk to patients by minimising unnecessary healthcare contacts. We continue to build on the success of the Ambulance Response Programme (ARP) and support ambulance services to offer the most clinically appropriate response to patients, including telephone advice or treatment at scene. We also describe the development of NHS 111 to enhance the approach to remote clinical triage with the goal of directing patients to the service that best meets their needs and enables a booked time slot to be made whenever possible, including in

Emergency Departments, Urgent Treatment Centres and primary and community care. This builds on the increased adoption of Same Day Emergency Care to ensure patients get the right care in the right place, at the right time, and avoid unnecessary hospital admissions.

The CRS seeks to align with the ongoing transformation programme of urgent and emergency care by addressing the importance of patient flow into, through and out of emergency departments; good patient flow prevents ambulances queuing outside of hospital EDs, prevents overcrowding of departments and the associated risk of hospital- acquired infection and reduced quality of care for patients, and prevents delays in patients being discharged or admitted to a bed on the appropriate ward for ongoing care.

Finally we look at managing hospital occupancy, with a focus on the steps needed to safely reduce the length of time that patients stay in an acute hospital, and on 'discharge processes' which support the timely discharge of people back home where possible, or into rehabilitation services or residential settings when necessary.

The intention is to enable a new national focus on measuring what is both important to the public, but also clinically meaningful. These indicators have been developed through extensive field testing with a number of acute NHS Trusts and through consultation with an extensive group of clinical and patient representative stakeholders. The CRS has concluded that these indicators are critical to understanding, and driving improvements in urgent and emergency care, and proposes a system-wide bundle of new measures that, taken collectively, offer a holistic view of performance through urgent and emergency care patient pathways. This bundle spans first contact with NHS 111 or 999, right through to admission or discharge from the ED and will enable both a provider and system-wide lens to assess and understand performance. The review findings show how these metrics will enable systems to focus on addressing what matters to patients and the clinicians delivering their care.

We want to get these measures right, and it is crucial that we seek input from a wide array of clinical stakeholders and patients before moving away from current performance standards. This consultation seeks your views on the metrics recommended by CRS, including whether they capture all of the important elements of urgent and emergency care, and if they should replace or complement the existing access standards. Feedback from the consultation will help to inform the development of thresholds appropriate for monitoring performance in the future.

With the support of key national stakeholders we are working with healthcare systems to put in place the critical interventions outlined in The NHS Long Term Plan’s UEC transformation programme, and we look forward to receiving feedback on the measures recommended by the CRS in order to provide continued improvement in care for patients.