12 February 2021

NHS Providers response to NHS England and NHS Improvement's *Transformation of urgent and emergency care: models of care and measurement consultation*

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. NHS Providers has all trusts in voluntary membership, collectively accounting for £92bn of annual expenditure and employing more than one million staff.

NHS Providers welcomes the opportunity to respond to NHS England and NHS Improvement's Transformation of urgent and emergency care: models of care and measurement consultation. Our response is based on engagement with the sector before the pandemic (including a roundtable which informed a briefing setting out our initial thoughts), as well as more recent feedback from our members and key stakeholders.

Unfortunately, due to the consultation period coinciding with the extreme operational pressures facing the provider sector, we could not undertake a full engagement process with our members. Given the operational and clinical nature of the proposals, we had hoped to seek the views of all chief executives, chief operating officers/directors of operations, and medical and nursing directors across all trusts. Instead we have had to carry out a lighter touch engagement exercise with a smaller group of trusts and, as such, our response does not address those areas that would have required in-depth clinical input. We must therefore highlight the risk that the timing of the consultation will prevent full and proper engagement with NHS organisations, stakeholders and the public on a significant policy change with far reaching implications clinically, operationally, and in terms of public accountability.

Overview of our position

1 NHS Providers agrees with the overall strategic direction of the clinically-led review of access standards. It is right to review access standards on a regular basis to ensure they reflect current clinical practice, meet the public's expectations of access to services, and support patient safety.

2 NHS Providers believes trust leaders will support changes to the standards, as they did with the ambulance standards and the introduction of mental health standards, if five key conditions are met:

- there is a strong, clear, and widely supported, clinical case for change;
- new standards are meaningful to patients and the public;
- trust leaders are fully involved in the design, consideration and implementation of any changes;
- implementation planning is realistic and honest about what resource and time is needed to make any change, taking full account of the current operationally challenged context;
- it is demonstrably clear the changes are not an attempt to abandon the inherent performance in the current standards and that there is a credible, fully funded, agreed plan to recover those inherent performance levels.

3 The way care is provided across the urgent and emergency care pathway has significantly changed and NHS Providers agrees that this pathway needs transformation to reflect modern clinical practice.

4 The mismatch between demand and capacity across the health and care system is played out each winter through significant seasonal pressures which are evident in demand and performance figures for ambulance service and acute hospitals. These pressures are linked to, and have a knock-on effect for, community and mental health services. Transforming the urgent and emergency care pathway is therefore one pillar, required alongside the expansion of hospital, community, and mental health beds, and workforce capacity, to address this mismatch.

5 Trust leaders broadly support the proposed bundle of measures and the direction of travel as set out in the consultation. Trusts welcome the focus on the entire patient journey and feel that some measures, including the percentage of patients spending more than 12 hours in A&E and the critical care standards, will deliver real improvements for patients.

6 However, in line with our tests, our members have some reservations around the timing and implementation of the new bundle. These concerns, which have been exacerbated by the pandemic, fall into five categories:

- current uncertainty around the sector's priorities for COVID-19 recovery;
- workforce challenges, particularly viewed through the COVID-19 lens;
- digital and technical capacity and capability across the provider sector;
- data sharing and information governance;
- the incomplete picture of the relationship between:

- how the measures will be used in any performance management and oversight framework;
- what the thresholds will be to drive real tangible improvements in patient care; and,
- how the measures align with system working.

7 Therefore, while supporting the overall direction of travel and the new bundle of measures, we would recommend a phased approach to implementation that allows the sector to transform the urgent and emergency care pathway in conjunction with other service priorities. A phased introduction of the measures will allow for some improvements ahead of winter 2021/22, as well as a longer-term focus on getting the full transformation of the pathway right for patients within the COVID and post-COVID context.

Context

The mismatch between demand and capacity across the health and care system is played out each winter through seasonal pressures which are evident in demand and performance figures for ambulance service and acute hospitals. Over the last ten years, there has been a significant reduction in the number of beds which has only widened the demand/capacity gap. Transforming the urgent and emergency care pathway is one pillar, alongside the need for an expansion of hospital, community and mental health beds, and workforce capacity, to help address this mismatch.

COVID-19 has significantly changed the NHS, requiring heightened infection control measures, affecting how services are delivered and potentially impacting the expectations of the public. The clinically-led review of NHS access standards was a welcome pillar of the long term plan, but it is important to acknowledge that much of the work, including the piloting of potential measures, was carried out before the pandemic. The consultation for the proposals is being carried out during the peak of the current wave of the pandemic from December 2020 to February 2021 – a peak that has seen considerably more patients in hospital than during the first wave. The timing has therefore inevitably limited sector engagement with the proposals for this key national policy change.

There is a lot of uncertainty across the sector. Understandably, there is currently ambiguity over the priorities for 2021/22 and the next phase of the COVID-19 response and subsequent service recovery. Planning and contracting arrangements have been rolled over, meaning the financial framework is still largely unknown. The statutory tariff consultation has also rightly been delayed due to the limited clinical input available at present. Furthermore, there is still uncertainty around future waves and the impact they will have on the NHS.

Trust leaders expect 2021/22 and 2022/23 to be dominated by COVID-19 and the recovery of services. Elective care recovery, dealing with the significant increases in mental health demand, delivering a world class COVID-19 vaccination programme, implementing the patient safety incident management system and quality metrics, and further embedding system working are just a few of the priorities trust leaders expect to be in the upcoming operational plans. Any recommendations from the review across all workstreams must be aligned and balanced alongside the evolving priorities for the service.

As the number of patients in hospital begins to fall and we exit the current peak, the operational pressures and priorities of the next delivery phase must take the workforce context into consideration. Frontline staff and NHS leaders alike have worked incredibly hard since the outbreak last year, navigating the first wave, restoring services over the summer and autumn, and responding to the latest peak through winter – with many trusts having no option other than to cancel staff annual leave. As the latest COVID pressures ease, staff wellbeing must be paramount. Trust leaders are extremely concerned about the high levels of stress and burnout across their workforce. Any significant policy changes or asks, such as changing long established waiting time access standards, or COVID recovery expectations, need to be balanced alongside workforce support and recovery.

Consultation questions

The four-hour standard

Are you aware of the existing Accident and Emergency four-hour standard? If yes, what do you understand the existing four-hour standard to mean?

Yes, we are aware of the existing Accident and Emergency four-hour standard.

Before the pandemic, parts of the NHS in England were experiencing the worst performance against waiting times targets since the targets were set. Performance has steadily deteriorated over the past six years. This includes the highest proportion of people waiting more than four hours in A&E departments since 2004, with the sector failing to hit the 95% target nationally since 2015.

From a clinical perspective, there is a strong argument that the existing standard no longer reflects modern clinical practice. For example, the way care is provided in acute settings has changed with significant growth in same-day emergency care. NHS 111, urgent treatment centres and A&E front door GP triaging have facilitated the care of lower acuity patients outside of A&E departments – patients who would have typically been counted within the four-hour standard. Trusts therefore have a higher proportion of more complex presentations, which take longer to assess, and this has contributed to a decline in performance against the four-hour target. This is the case even though

the treatment provided to those patients attending may be just as good as it has been in the past, potentially even better. We also know there is a spike in emergency admissions just before the four-hour mark in A&E to enable clinicians more time to make the decisions they need which also 'stops the four-hour clock' for the patient concerned.

Trust leaders therefore acknowledge that it is right to review the four-hour standard from a clinical standpoint. However, as we set out in our 2020 briefing, Setting good standards for NHS patient care, NHS England and NHS Improvement should also acknowledge that the four- hour standard has fulfilled a number of purposes including:

- service level oversight – for clinicians and patients. Informed by clinical practice, the standard acts as an expression of the responsiveness of the care and patient experience the NHS should be providing;
- service level operational information – for clinicians and service managers the standard acts as a key organising principle of service provision;
- trust level planning, performance measurement and governance – for trust senior leaders and boards;
- trust, system and regional level oversight, support and regulation – for the arm's-length bodies;
- national system level oversight and accountability – for the public, politicians and the media.

Removal of the established four-hour standard must be accompanied by further information around how the new bundle of measures will or will not fulfil the roles set out above. For example, it is not currently clear what role the new bundle of measures will have from a regulatory and oversight perspective. NHS England and NHS Improvement must ensure there are no unintended consequences or gaps left in existing or future accountability structures.

In line with our suggestion of a phased approach, careful consideration needs to be given to the timing and removal of the four hour target. We recommend that double running or a clear transition period is identified to help providers and the public have some continuity in reporting while implementing the new standards. Particularly following the latest wave of the pandemic, it is possibly more important than ever to be able to provide some continuity and be able to track performance in a comparable way, at least in the short term.

A single measure or a wider range of measures across your urgent or emergency care journey?

Overall, trust leaders from across the acute, mental health, community and ambulance sectors support the introduction of a wider range of measures across the urgent and emergency care pathway. It is encouraging to see the inclusion of measures which cover the patient journey across the pathway and join up with the new metrics in emergency departments. This is a positive step towards measuring performance across systems, although trusts feel the proposals do not go far enough in terms of system accountability.

Some members felt that the existing target was a blunt measure which something that is inherently complex to potentially unhelpful simplicity – for example:

- there have been occasions when performance at 0.1% above standard is seen as good and 0.1% below standard as bad, when the difference between the two are essentially the same in terms of performance; and
- when performance against the standard has been regarded as the sole responsibility of a trust when it is significantly affected by wider local or national system conditions.

While a broader range of measures is welcome, trust leaders felt some are easier to implement than others – with 'time to initial assessment', 'ready to proceed', and the critical time standards proving more complex. This should be a key factor in establishing a phased implementation approach which ensures consistent and national reporting for the public, regulators, and the government. It will also support effective media scrutiny of NHS performance.

New bundle of measures

The provider sector broadly supports the new bundle of measures. Trusts from all sectors, including the ambulance service, community and mental health, welcome the expansion of measures to cover the entire patient pathway.

Members are clear that simply changing the measurement of performance across the urgent and emergency care pathway will not drive improvements for patients in isolation. Although there is broad agreement about the need to a step away from a single measure, our members have emphasised the need for detailed consideration around implementation, and an honest conversation regarding the level of investment required to drive a marked improvement in patient care, and how these changes should be balanced with other priorities in the ongoing COVID-19 context.

Average time

There was mixed feedback from trusts on the introduction of a measure of average time spent in an emergency department. It is positive that the findings from the pilot sites show the switch to an average wait reduces admissions and removes the spike just before four hours. It is also positive that this approach means every patient counts towards the performance of the standards.

There is an acknowledgement that the average wait may be understandable to the public. However, there is also a concern that by, definition, half of attendees will receive care below the standard which may make managing the expectations of those in emergency departments more difficult. Again, without knowing the thresholds or a target average wait, trusts feel it is not possible to know what real improvements to patient experience and patient outcomes will be achieved.

Feedback from our trusts also suggests that, as the average wait will constantly change, the extent to which the measure can be used as an operational leaver to maximise patient flow is diminished - as an average wait cannot ascribe a mean wait to an individual patient. Therefore, the future work for the review around thresholds and setting the standard of care a patient can expect is a key element of the reviews proposals.

Other measures

Due to the limited clinical engagement we were able to undertake during the consultation period, we are not in a position to provide quantitative ratings or rank the importance of the individual measures. However, we did receive some feedback about the individual measures as follows:

- We welcome the prominence given to the entire patient journey, the existing ambulance waiting time standards, and the percentage of ambulance handover within 15 minutes. By bringing ambulance handover delays to the forefront we hope this drives improvement in this area. However, the reference to 'right vehicle' should be replaced with 'right clinician' to reflect the changing multidisciplinary approach the ambulance service now uses.
- We agree that disaggregating the average (mean) time in department by admitted and non-admitted patients is a positive move and will help separate out the waiting times by acuity. As a result, it will be clear how long those who need inpatient treatment had to wait in the department.
- Respondents felt that the 'time to initial assessment' and 'ready to proceed' measures were going to be more difficult to implement, given the ambiguity around definitions. Some felt that

the time to initial assessment metric could drive the wrong behaviours as it places an emphasis on an assessment, not necessarily by the appropriate clinician.

- The introduction of a measure of the percentage of patients spending more than 12 hours in A&E is positively received, with a strong view that this is a marked improvement on the current 12 hours after decision to admit metric. It was felt this metric is vital in safeguarding against long waits and was needed alongside an average (mean) wait time.
- The critical care standards are well received but there are concerns about the time and additional resource needed to carry out data entry and clinical coding for these individual and detailed data sets.

Additional measures

Alongside our concerns that most of the measures are still focused on individual organisations and are not truly system measures, others flagged the need for the metrics to focus on quality. While the remit of the review was to look at existing access standards, the measures need to be accompanied by an increased focus on patient outcomes and quality. Without these thresholds – such as what does a 'good' average mean time in emergency departments might look like – it is hard to gauge the quality or level of service that is being built inherently in the new bundle. Waiting times are only one aspect of patient experience and good quality care. We know that patients are also concerned about communication and the quality of service they receive, so it is vital that any changes to standards also bring about a positive improvement in clinical outcomes and patient experience.

Some members felt that COVID-19 has had such a large impact on the urgent and emergency care pathway, particularly with enhanced infection prevention and control measures in ambulances and emergency departments, that the measures should be reviewed through that lens. One suggestion included having an additional metric for overcrowding in emergency departments.

A composite measure?

Our engagement was not wide enough for us to draw a firm conclusion on whether there should be a single composite measure for the entire pathway. We acknowledge the usefulness of this, particularly for simplicity, but there is a risk that this too would become a blunt instrument and merely replace the four-hour target.

Trust leaders emphasised that system partners must be collectively held to account for effective service delivery across the entire urgent and emergency care pathway: performance should not be seen solely as the responsibility of an individual provider, such as one acute hospital or ambulance service. More

information about how the proposed bundle will align with system metrics and any future system oversight framework is also needed.

Mental health

Although the urgent and emergency mental health standards are being addressed in a different workstream within the clinical review of standards, many of our members flagged their ongoing concerns for mental health patients and service users, and the need for these standards to support the delivery of timely care for those with mental health conditions. Therefore, there must be read across between the two workstreams in the review as we are sure NHS England intend there to be.

Trust leaders have highlighted how difficult it can be to evidence the pressures facing emergency departments in terms of the number, complexity, and acuity of mental health patients presenting. We know, for example, that a large proportion of current 12-hour breaches in emergency departments are mental health patients waiting for a bed in a more appropriate service.

Further progress is needed to ensure that mental health is treated in the same way as physical health, and we agree with the direction of travel for NHS 111 to be used as an access point for people experiencing crises. At the moment there are a limited number of sites which have implemented NHS 111 as points of access for urgent mental health care, and so it should not be underestimated how much work is needed to effectively integrate the nascent mental health 24/7 crisis lines to NHS 111 – a crucial element of the urgent and emergency care pathway. It will be important to fully evaluate this work and take the appropriate learnings from the implementation of the 24/7 crisis lines so far and other approaches, such as mental health urgent access centres, taken by local areas during the pandemic to meet the needs of people in crisis.

To address issues in the more immediate term, mental health liaison needs to be supported and feature as part of early assessment in every emergency department. There also needs to be an appropriate number of dedicated spaces in or near all emergency departments where people in mental crisis can be assessed. Furthermore, it is important that robust training and support is provided to help clinical teams across the urgent and emergency care pathway understand psychosis, and to care for people who have self-harmed or have attempted suicide.

There must be comprehensive engagement with the whole mental health sector to develop the mental health urgent and emergency care standards, and to determine what type of data will be needed to underpin the measures.

Frequency of reporting

While we do not support burdensome, and disproportionate bureaucracy, we agree that it is important that NHS activity and performance data is transparently reported to ensure the NHS remains accountable to the public, regulators and the government. Previously, NHS data has been used to calibrate the need for additional investment in the NHS and this function should not be lost as a result of having multiple measures.

The data should also be harnessed to drive improvements in patient experience, especially in the context of integrated care systems. We know patient experience is often enhanced by better data sharing across the pathway and with primary care.

We recommend reporting across all measures continues to take place on a monthly basis, in line with other activity and performance reporting structures.

Communications strategy

It is vital that a robust, joined-up communications strategy helps inform the public about the bundled measures. The new measures should be clear across a range of media, from social media to printed materials in GP surgeries.

The public should be able to access clear information on the different access points to the NHS, from across emergency care pathways, to the role of pharmacists. Moreover, it is important that the headline measures are not reduced to a single measure – such as the 12-hour measure – and that any communications strategy encompasses the totality of the changes. Key messages should also be visible in primary care settings.

The changes need to make sense to the public. NHS England and NHS Improvement should acknowledge that some of the measures are deliberately more public facing, and others are deliberately intended to be internally facing. Indeed, an outcome of this consultation should be to identify which measures must be clearly communicated to the public regularly and how.

In terms of access to data on trusts' performance against the standards, data must be clearly visible and accessible to patients and the public on hospitals' and NHS England and NHS Improvement websites.

Barriers to implementation

Although the sector supports the vision of transforming the urgent and emergency care pathway, there are some overarching considerations regarding implementation, which include:

- the priorities of COVID-19 recovery for the service and where urgent and emergency care sits within those priorities;
- workforce challenges, particularly viewed through the COVID-19 lens;
- digital and technical capacity and capability across the provider sector;
- data sharing and information governance, particularly between providers and across systems;
- the incomplete picture of:
    - how the measures will be used in any performance management and oversight framework;
    - what the thresholds will be to drive real tangible improvements in patient care;
    - how the measures align with system working.

We have already addressed several of these issues above and will now briefly summarise our feedback and questions regarding IT and digital capability, which were also covered in our 2020 briefing, Setting good standards for NHS patient care.

The implementation of the new measures raises significant data and IT challenges with varying degrees of change required to implement different measures. To fully move to the new basket of measures, trusts will need to submit data to the emergency care data set (ECDS) and a number of condition specific data sets. The ECDS has been in development for a number of years, and the ambition is that trusts should be in a position to submit data in a timely and accurate way.

However, providers tell us there is huge variation in trusts' ability to submit the full range of data required by the new standards. Digital capability is an issue for a significant proportion of acute trusts, and in the case of the new standards, is largely linked to the implementation of electronic patient records (EPRs) systems. Without significant financial investment and support from national bodies, it is unclear how trusts who do not currently have the EPRs or the IT systems they need will be able implement (and be held account) for delivering the new standards.

In addition, the proposed standards introduce new time points at which trusts need to capture data, such as. time to initial assessment. There must be clear and concise definitions around the new measures to ensure trusts are consistently measuring the same things.

Trusts have told us that the additional clinical and operational data requirements are extensive and time consuming. Therefore, the value in dedicating additional clinical, coding, and administrative time to implementing changes needs to be clearly understood and communicated to frontline staff.

Additional investment to drive up the standard of care provided across the pathway

Implementing the bundle in its totality would demand significant investment and resources which appear to be lacking in any detail from the consultation. Some of the proposals may create additional cost pressures for trusts, and the overall future financial picture for the NHS is currently unclear: how will funding be prioritised to meet the objectives of the long term plan, the government's manifesto commitments, and the immediate COVID-19 recovery?

It's vital that emergency care services receive adequate funding to support the delivery of the proposed new bundle of measures. Recent non-recurrent funding allocations to acute hospitals have focused on tackling the elective backlog. For example, in November 2020, an additional £3bn was announced for the NHS to spend in 2021/22 to address immediate, COVID-19 related operational pressures. While £1bn of this has been allocated to paying for operations, scans and diagnostics, it is unclear what additional funds will be spent on emergency care in future.

As we set out above, we have also been calling for an expansion in hospital, community and mental health beds to address the inherent mismatch between demand and capacity. Expansion in the bed base is needed to bring our bed to population ratios in line with other European countries as set out by the OECD.

While the NHS estate has shown great resilience and adaptability to enable major service reconfigurations, it is unclear how long the current COVID-19 pressures will continue for. If emergency departments and acute wards still face capacity constraints over the medium-term, this will impact on their ability to meet some of the proposed composite measures. For example, adequate infection prevention and control measures, and the need to safely place patients in the right beds, will limit providers' ability to make the efficiency gains that were factored into the long term plan's funding assumptions.

There will also be a need for additional funding to support trusts to deliver the necessary digital transformation: both in terms of ensuring providers have the necessary IT enablers, and so that providers' data infrastructure is transformed to enable interoperability and the sharing of EPRs. This will require additional revenue and capital investment, and it is important that targeted financial support is provided to trusts who struggle to access additional funding for long-term digital solutions.

The effectiveness of the new bundle of measures will in part depend on the relevant financial support available to other parts of the health and care system, including funding to support discharge to assess, as this reduces bed occupancy and delayed discharges. As we also highlighted in our 2021 budget submission, emergency funding for now and in 2021/22 is required to support discharge to assess. This needs to be coupled with a longer-term funding settlement for social care to properly support the transformation across urgent and emergency care.

NHS England and NHS Improvement should also continue to work with providers to understand how good operational performance, service quality and patient outcomes can be rewarded, and particularly in the urgent and emergency care context. This should include consideration of both financial and non-financial incentives at ICS and provider-level.

Our five tests

In March 2020 we set out five conditions that needed to be met for the provider sector to support changes to access standards:

1) There is a strong, clear, and widely supported, clinical case for change.
2) New standards are meaningful to patients and the public.
3) Trust leaders are fully involved in the design, consideration, and implementation of any changes.
4) Implementation planning is realistic and honest about what resource and time is needed to make any change, taking full account of the current operationally challenged context.
5) It is demonstrably clear that the changes are not an attempt to abandon the inherent performance in the current standards and that there is a credible, fully funded, agreed plan to recover those inherent performance levels.

When reviewing our five tests, we agree that numbers one, two and three have, on the whole, been satisfied. We are, however, concerned the sector has not been able to feed into the consultation process in the way it should have, given the current operational challenges.

In relation to test four, as set out in our response, the provider sector has genuine concerns around the timing, resource and support available to implement the changes. Trusts leaders ask that NHS England and NHS Improvement is realistic and honest about the resource and time that will be needed to implement this systemic policy change, taking full account of current operational pressures. The sector needs more information relating to the plans and investment for our fourth test to be met.

Moreover, until there is more detail available relating to the thresholds that will accompany the new bundle, as well as a decision on a composite measure, it is also unclear if our fifth test can be met.

Summary

In summary, we are encouraged by the work we have been involved in as part of the clinical review of standards oversight group. We believe that all stakeholders genuinely want to see real improvements in patient care and that the new bundle is not an attempt to abandon the inherent performance in the current standards. We look forward to receiving more information relating to the thresholds and composite measure, and will continue to work alongside our members and NHS England and NHS Improvement as part of the review.