

BMA Response - Transformation of urgent and emergency care: models of care and measurement

About the BMA

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

This response sets out the BMA's views on the [recommendations of the Clinically-led Review of NHS access standards \(CRS\)](#)ⁱ around the transformation of urgent and emergency care (UEC) and the measurement of performance of services that patients receive.

Overview

- 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 BMA recognises that NHS England and NHS Improvement (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 call on NHSEI to publish the full findings of the pilots it has 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).
- Changing targets will not affect the fundamental underlying issues in the NHS and in emergency care, which are about a lack of resources and staff and rising demand.



Despite its imperfections, the four-hour standard has proven instrumental in reducing waiting times in EDs. While we welcome the attempt to improve how the performance of the whole UEC system is measured, those changes should only be made if there is clear clinical evidence of their potential benefits.

Since its introduction in 2004 as a result of the Department of Health's strategy [Reforming Emergency Care](#)ⁱⁱ, the BMA has had doubts about the ability of the four-hour waiting target to improve performance in UEC services overall, and voiced concerns about its impact on the quality and safety of care that patients receive as a result of perverse incentives created by this new target.

Many observed that the increased focus on this performance target, rather than the development of a strategy to improve emergency care overall, could have unintended consequences on patient care. Studies and analyses led by the British Medical Journal (BMJ) and others at the time, demonstrated for instance that to meet the target, many patients could be rushed out of departments in the last 20 minutes of [the 4-hour period](#)ⁱⁱⁱ, with a negative effect on receiving teams, and effectively transforming EDs in "[queue processing machines](#)"^{iv}.

A number of surveys^v carried out by the BMA itself prior to and following the introduction of the target revealed that clinicians felt that most departments directed their efforts towards achieving the target at the expense of clinical quality and staff well-being. Strong top-down pressures to achieve the target have also been attributed to an increase in organisational bullying and fear, resulting in unsafe patient care.

The BMA continues to receive similar reports from clinicians more than 15 years on, who are concerned about the perverse incentives linked to the four-hour target. Examples cited include situations where patients may be discharged without an appropriate community support plan in place or admitted to hospital to meet the deadline, when a slightly longer wait and access to care in EDs could have helped to avoid admission.

Clinicians are also concerned that the four-hour standard only provides a limited insight into the actual performance of UEC services. In its current form, the target fails, for instance, to measure mean waiting time in EDs or to differentiate between the severity of condition that a patient may present with when they attend Accident and Emergency (A&E) services. In addition, the target does not account for the different case mixes between hospitals or consider the overall pathway patients have to go through.

However, while we are aware of these shortcomings associated with the four hour standard, clinicians also report that it has often acted as an operational tool to drive improvements and facilitate patient flow across services in the past. The BMA is concerned that without such a standard the impetus on organisations to improve patient flow could diminish and could worsen ED crowding.

A number of [studies](#)^{vi} have also revealed that the introduction of the four-hour waiting target has had a meaningful impact on patient outcomes, such as the reduction in A&E waiting times, but also a large reduction in the mortality rate of A&E patients, especially for those with severe and potentially time-sensitive conditions such as sepsis and stroke.

In addition, the current access standard provides a reliable long-term measure of A&E departments' performance that proves instrumental in holding the government to account for

resourcing the NHS.

With the NHS in the midst of a severe crisis and recording the worst performance against the standard, the proposal to replace the waiting time target have also raised concerns among the profession that the move could be motivated by political expediency rather than patient safety.

Therefore, while we believe changes need to be made to measuring the performance of the whole UEC system, these changes should only be made if there is clear evidence demonstrating that a new approach to measuring performance in UEC will lead to improvements in patient care, instead of being politically driven.

The efforts to develop alternatives to the four-hour standard are welcome but undermined by the absence of sufficient evidence demonstrating their potential benefits to patient care.

As part of the CRS process, NHSEI launched a number of pilots across the country in 2019 to test its new approach to measuring performance by replacing the four-hour standard with a bundle of new metrics. This included measuring mean waiting times, time to initial assessment in EDs and time to emergency treatment for critically ill and injured patients.

The evidence from the test field sites, which was presented in the [CRS progress and update report](#)^{vii} in October 2019, was mixed. While it showed that the absence of an incentive to admit patients prior to the four-hour cut-off point could contribute to reduced admissions to hospitals, there was less clarity about the outcomes for the increased number of patients who would overall have to wait longer. The fact that this progress report only presented very early findings from a number of pilots launched only a few months before, made it impossible to comprehensively assess the potential winners and losers of any new approach and therefore measure their potential benefits.

The BMA is concerned that no updated findings from the pilots have been made publicly available since the publication of the early progress report in 2019. The lack of clear evidence of improvements from the pilots makes it impossible to validate the potential benefits of these new metrics or uncover unintended consequences on the performance of the system. We therefore call on NHSEI to publish the full findings of the pilots. We believe that the publication of these findings could contribute to assuaging fears about the potential political motivations behind the proposals.

Regardless of the potential benefits and risks of the new approach, the change in standards can only have a limited impact on the quality and timeliness of the services patients receive and is no replacement for adequate NHS funding.

Prior to the pandemic NHS services were already struggling to cope with significant resourcing challenges. The NHS has experienced a decade of under-spending which has made it difficult for it to provide a robust response to the challenges posed by the pandemic and beyond, including the growing backlog and the non-COVID winter pressures.

This ever-increasing pressure on the NHS and the impact of the pandemic on A&E capacity, are having a detrimental impact on patients' experience of care in environments which are increasingly becoming less safe.

While the BMA supports efforts to reduce pressure in A&E and reduce patients' waiting time, we believe that a new approach to measuring performance will not be enough and should be complemented by an increase in funding and staffing numbers to support services across the NHS and, particularly, along the UEC pathway.

While approximately [£450 million](#)^{viii} of capital spending has been earmarked until the end of the financial year for ED reconfiguration as well as £24 million in revenue funding for NHS 111 until April 2021, no clear indication have been given with regards to the funding committed to these services beyond that date, let alone for other parts of the system. It will be impossible to successfully transform UEC services unless the Government and NHSEI commit to providing additional resources for the NHS and in particular for those services that play a role in reducing pressure in EDs.

This includes increasing bed numbers significantly outside of EDs, something the BMA has consistently called for the government to do to address the ever-increasing pressures on the NHS. Increasing bed numbers would help to address the issue of 'exit-block' in EDs, which is caused largely by hospitals being run at excessive occupancy levels¹.

In order to reduce pressure on A&E, NHS capacity must continue to be expanded in and outside EDs, including the development of alternative pathways to traditional UEC settings. Recruiting sufficient numbers of clinicians and other healthcare workers to run these services will be crucial too. To ensure this is the case, a major funding injection is needed, to enable them to cope with the ongoing impact of COVID-19 and build up the resilience for the future.

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.

The new data collection and reporting requirements that will be associated with the introduction of the different new metrics will fall on clinical staff who are already facing unprecedented levels of pressure. We are therefore concerned that the timing of the proposed changes might not be appropriate and would recommend that the option of a significant transition period be explored.

We believe that the transition period could also allow for more work to be done around the definition of some of the new metrics, such as the time to initial assessment and the clinically ready to proceed metric before they can be rolled out. In order to ensure that accountability is guaranteed and well defined, it is important that clinical teams working collaboratively throughout the UEC pathway have a good understanding of the consequences of these new metrics on the functioning of the different parts of the system.

A longer transition period during which the new set of metrics are implemented, should also allow trust to keep publishing data on their performance against the four-hour target. The data emerging from this transition period would give an opportunity to evaluate the potential risks and benefits of the new metrics. In particular the measurement of performance against the historic target will help to understand if the new standards are effectively driving improvements and positive outcomes for patients.

We call 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

¹ Bed occupancy in the NHS: <https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/bed-occupancy-in-the-nhs>

We understand that the CRS recommend the use of the new metrics as standards against which performance of services will be measured. We are also aware that the thresholds to meet those standards are intended to be realistic and will evolve to ensure that services are given enough time to adapt to the new standards and meet them. However, NHSEI have not indicated how these thresholds will be set at and we would welcome more clarity on this.

It is also not clear 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. As indicated above, 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 BMA has previously indicated its opposition to crude performance management through targets. Regardless of the standards against which performance is measured, standards should always be contextualised, and support should be made available to support improvement where required.

We would also welcome more clarity on how the results of trust performance against the new standards would be presented. The consultation document suggests the development of a single composite measure aggregated from each individual metric. 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.

In addition, a simple pass or fail system to measure performance of each individual part of the system might lead to perverse incentives where providers might take radical decisions regarding the allocation of resources after failing against one metric. Other options that could help to reinforce providers' aspirations to progress against each individual metric over time should be explored.

NHSEI should work with local NHS 111 providers on the development of quality and performance standards to measure the outcomes of NHS 111 calls that receive clinical validation.

When it launched its NHS 111 First national campaign on December 1st NHSEI argued that it would help to better direct patients to the right place of care and at the right time. To ensure this happens NHSEI have proposed to increase the proportion of calls to NHS 111 which will receive clinical validation.

While we have previously expressed concerns around the ability of NHS 111 providers to recruit enough clinicians to support the service, we welcome the proposal from the CRS to measure the percentage of interactions with NHS 111 receiving clinical input.

We are, however, surprised that while the CRS also suggests that ambulances' conveyance rates should be measured with the aim to reduce avoidable trips to emergency departments by 999

ambulances, no recommendation is made in the review regarding measuring the outcome of an increasing proportion of NHS 111 calls receiving clinical input.

We are aware that NHSEI have worked with ambulance services, commissioners, and other stakeholders as part of the Ambulance Response Programme (ARP) in 2017, to develop new ambulance performance standards that ensure that all patients get the right response first time.

The Ambulance Quality indicators and other performance standards developed through the ARP have helped to ensure patients are treated by skilled paramedics in their own home, given advice over the telephone or taken to a more appropriate setting outside hospital.

We think NHSEI should work with local NHS 111 providers to explore whether similar quality indicators and standards for this service could be developed to ensure that patients receive the right care in the right place and at the right time.

NHS111 and NHSEI should however ensure that these standards do not create perverse incentives that could affect patient care.

To reduce the number of patients driven to EDs by 999 ambulance services, the proportion of category 3 and 4 calls that receive clinical validation should be increased.

One of the new standards recommended by the CRS will measure conveyance rates to EDs by 999 ambulances dealing with category 1 and 2 calls. NHSEI's intention with this is to ensure those patients who could benefit from alternative pathways of care including treatment at scene or referral to other appropriate services, do not end up in EDs.

We believe that there is a non-negligible risk that this metric could have unintended consequences or incentives that would lead 999 ambulance services to make decisions based on their performance against a conveyance rate target rather than the safety of the patient. Because of the increased focus on conveyance rates into EDs, patients with the most serious and urgent issues (category 1 and 2 calls) might risk being re-directed to alternative pathways even if their condition would have required a visit to A&E.

The BMA instead recommends increasing clinical input into category 3 and 4 calls, to ensure that those patients will not be driven to EDs by 999 ambulance services, when it is more appropriate for them to use alternative pathways,

Finally, we call NHSEI to provide more clarity on the reporting of the performances of co-located UTCs and Same Day Emergency Care (SDEC) units to ensure that patients will not be transferred to those centres simply to avoid being part of the performance measurement in EDs.

Conclusion

The BMA agrees that there are imperfections in the current approach of measuring performance of UEC services, and it recognises the attempts made by NHSEI to develop metrics that will help to get a better understanding of the performance of the whole UEC system. However, the BMA will only be able to fully support the implementation of a new approach to measuring performance if and when there is clear and clinical evidence that it has potential benefits to improve patient care in UEC services.

The BMA would also like to call for a careful consideration of the timetable to implement these proposals given the level of pressure facing NHS services and the considerable transformation that the replacement of the four-hour historic target represents.

ⁱ NHS England and NHS Improvement, Transformation of urgent and emergency care: models of care and measurement (December 2020): <https://www.england.nhs.uk/publication/transformation-of-urgent-and-emergency-care-models-of-care-and-measurement/>

ⁱⁱ House of Commons, Public Accounts Committee, 16th Report of Session 2004-2005: Department of Health: improving emergency care in England: <https://publications.parliament.uk/pa/cm200405/cmselect/cmpubacc/445/445.pdf>

ⁱⁱⁱ Locker T E, Mason S M. Analysis of the distribution of time that patients spend in emergency departments. BMJ (2005): <https://www.bmj.com/content/330/7501/1188>

^{iv} Hughes G. The four hour target; problems ahead (editorial). Emerg Med J 2006;23:232: <https://emj.bmj.com/content/23/1/2>

^v British Medical Association BMA Survey of accident and emergency waiting times. 2003 and 2005.

^{vi} Gruber J, Hoe T, Stoye G. Saving lives by tying hands: the unexpected effects of constraining health care providers, IFS Working Paper No. 24445 (March 2018): <https://ifs.org.uk/publications/12887>

^{vii} CRS progress and update report (NHSEI, October 2019): <https://www.england.nhs.uk/wp-content/uploads/2019/10/crs-progress-report-v5-311019.pdf>

^{viii} HM Government, *New measures to improve patient care ahead of winter*, (September 2020): <https://www.gov.uk/government/news/new-measures-to-improve-patient-care-ahead-of-winter>