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Transformation of urgent and emergency care: models of care and measurement

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Preface

Our urgent and emergency care services play a pivotal role in providing the care that people need, but pressures have risen every year. The number of patients attending our emergency departments (EDs) has risen by 40% over the last 15 years. At the same time the numbers of inpatient beds have fallen, and following a recent increase, the prevention and control measures necessary to tackle the Covid-19 pandemic have required further reduction in available bed capacity.

During the winter of 2019/20, immediately before the onset of the Covid-19 pandemic, the pressure on our acute hospital bed base resulted in unacceptable crowding in our EDs and, in some cases, patients being cared for in inappropriate environments – commonly referred to as corridor care. This is unacceptable for our patients and, collectively, the NHS is committed to ensuring that crowding does not occur in EDs.

Building on The NHS Long Term Plan, we set out here the next steps to transform urgent and emergency care for patients, drawing on the learning from the coronavirus pandemic and building on the findings of the Clinically-led Review of Standards (CRS). Our ambition remains to strengthen the offer for patients, delivering improved access and outcomes, addressing health inequalities and giving a better experience of care. We also want to introduce improved ways of accessing care online and on the phone from NHS 111, at home from a paramedic, and provide booked time slots for care in an emergency department. Through changing the way that the urgent and emergency care system is both perceived and accessed by the patient, we will improve services and reduce the risk to patients by minimising unnecessary healthcare contacts.

In June 2018 the Prime Minister asked for a clinically-led review of the NHS access standards to ensure they measure what matters most to patients and clinically. This report also sets out a new approach to **measuring what is clinically relevant**, offering a holistic view of performance, developed with clinical system leaders.



Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement



Pauline Philip DBE
National Director of Emergency and
Elective Care
NHS England and NHS Improvement

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 (see Chapter 8 for details of how to respond). 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 Report¹ 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

¹ [NHS. Interim Report of the Clinically-led Review of NHS Access](#)

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. See Chapter 8 for more details of the consultation process.

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's² 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.

² <https://www.longtermplan.nhs.uk/>

2. Introduction

The pressure on our urgent and emergency care services has been steadily increasing year-on-year. The number of patients attending our emergency departments (EDs) has increased significantly and, as a result of the increasing complexity and acuity of these presentations, the number of patients requiring admission has also increased. Whilst this has been happening there has also been a reduction in the number of inpatient beds, although we had started to see increases in bed numbers more recently until infection prevention and control measures necessary to tackle the Covid-19 pandemic have required us to reduce available bed capacity.

During the winter of 2019/20, immediately before the onset of the Covid-19 pandemic, the pressure on our acute hospital bed base resulted in unacceptable crowding in our EDs and, in some cases, patients being cared for in inappropriate environments – commonly referred to as corridor care. This is unacceptable for our patients and, collectively, the NHS is committed to ensuring that crowding does not occur in EDs.

This consultation sets out how the proposed changes to measuring urgent and emergency care activity will align to The NHS Long Term Plan programme to transform urgent and emergency care for patients, drawing on the learning from the coronavirus pandemic and building on the findings of the Clinically-led Review of Standards (CRS). The ambition remains to improve the offer for patients, delivering improved access and outcomes with a better experience of care, whether that be online or phone or from NHS 111, at home from a paramedic or when necessary in an emergency department. Through changing the way that the urgent and emergency care system is both perceived and accessed by the patient, we will improve services and reduce the risk.

The proposals will support the NHS with the next phase of the transformation of England's urgent and emergency care services, which will build on the NHS Long Term Plan to ensure the provision of high-quality services, regardless of the impact of the Covid-19 pandemic. In June 2018, the NHS National Medical Director, Professor Stephen Powis, was asked by the Prime Minister to review the NHS access standards to ensure they measure what matters most to patients and clinically. To support this, a Clinical Oversight Group was established along with individual advisory groups for each workstream to help guide the programme. These groups are made up of patient, clinical and healthcare provider representatives and national charities. This engagement, and the expertise that people have contributed throughout, has been an important part of developing the recommendations and proposals set out in this consultation.

The report also sets out an approach to **measuring what is clinically relevant** – the indicators that are critical to understanding, and driving improvements in, performance. The recommended approach is to introduce a system-wide bundle of measures that, taken collectively, will offer a holistic view of performance in urgent and emergency care. This represents the recommendations from the CRS, following field testing in line with proposals set out in the interim report in March 2019. The National Medical Director, supported by the oversight group, recommends this more sophisticated and patient centred set of metrics should replace the simple four-hour measure, enabling systems to focus on addressing what, we have been told, matters to clinicians and patients.

This report follows the patient journey:

- Context – the vision, responding to Covid-19 and principles
- Transforming access to UEC services – developing the NHS 111 model
- 999 ambulance services – optimising performance and reducing wider service pressures
- Urgent Treatment Centres – improving access, capacity and capability
- Improving flow through hospitals – Emergency Departments and Same Day Emergency Care
- Managing hospital occupancy
- Measuring performance in a transformed system
- Moving towards a transformed system.

Context

The ‘Keogh’ Urgent and Emergency Care Review³ was published in 2013, and set out a vision of:

- a) providing highly responsive urgent care services close to home, and
- b) for those with more serious or life-threatening emergency care needs, centres with the very best expertise and facilities to maximise the chances of survival and a good recovery.

There is a golden thread from the objectives of the 2013 review to the current transformation programme for UEC services – the adoption of technology that led to the introduction of NHS 111 Online; the development of NHS 111 as the key point of access to urgent care; the introduction of a consistent model for primary and community based urgent treatment centres; maximising the ability of the ambulance service to treat

³ [Urgent and Emergency Care Review 2013](#)

patients at scene and reduce avoidable conveyance to emergency departments; and developing a networked approach to urgent and emergency care so that no decision need be taken in isolation.

Developments through the Five Year Forward⁴ View and the Long Term Plan have seen the increasing importance of NHS 111 as the access route to Integrated Urgent Care, including locally led Clinical Assessment Services, rapid access to clinical advice for care homes and the ability to book appointments in urgent treatment centres or link to a consultation with a community pharmacist regarding minor illness or urgent medication.

Within hospitals we have introduced a clinically-led streaming model as patients access urgent and emergency care services and are working with acute trusts to eradicate ED exit block and eliminate ambulance handover delays. We have led the development and national roll out of a new model of same day emergency care with the goal of reducing unnecessary overnight admissions, and, working with our partners, have led a programme of work to reduce the length of stay of patients who needed to be admitted and have supported discharge arrangements for patients back into the community.

In 2017 we introduced new standards for ambulance services to ensure that the sickest patients receive the fastest response, and that all patients get the response they need first time and in a clinically appropriate timeframe. Over the past year we have now gone on to develop clinically-led proposals for new standards that encompass the whole urgent and emergency care pathway – from the first call to NHS 111 or 999 through to admission or discharge.

Covid-19: Shifting the urgent and emergency care paradigm

The Covid-19 pandemic of 2020 has had a profound effect upon the delivery of NHS services and the ways in which people access healthcare services. We have seen rapid developments to operational delivery within the NHS in order to ensure patients who are Covid positive receive the treatment they need and at the same time protect those who are most at risk. This allowed us to successfully provide hospital beds for over 100,000 individuals who needed one because of the spread of Covid-19. The social distancing restrictions that were required to control the spread of Covid-19 saw a sharp reduction in attendance at EDs, and a requirement to rapidly increase the availability of capacity within NHS 111 services including online to meet the urgent need for remote access to urgent care services on an unprecedented scale. Subsequently, call volumes have

⁴ [Five Year Forward View](#)

returned to near normal and levels of attendance to ED are also almost back to the pre-Covid situation.

In the wake of Covid-19 it is important that the public can receive urgent care in the right place, at the right time. Not only will this provide a better care experience for patients, but it will also ensure that fewer patients must attend an ED. The impact of ED crowding on mortality and morbidity is already well understood. Supporting our emergency care systems to manage crowding will further reduce the risk of nosocomial transmission of Covid-19. While the measures being consulted on here will not be in place for this winter, the NHS is taking action to reduce transmission risk in ED, and it is important that face-to-face services in all healthcare settings only occur when clinically necessary. The NHS 111 online and telephony services, using NHS Pathways, already provide a well-developed and understood remote triage function that can effectively stream patients to the most appropriate care setting for their needs.

Measuring what is clinically relevant – Findings from the Clinically-Led Review of Standards

The NHS National Medical Director was asked by the Prime Minister in June 2018 to review the core set of NHS access standards, and recommend any required updates and improvements to ensure that NHS standards:

- promote safety and outcomes
- drive improvements in patients' experience
- are clinically meaningful, accurate and practically achievable
- ensure the sickest and most urgent patients are given priority
- ensure patients get the right service in the right place
- are simple and easy to understand for patients and the public
- not worsen inequalities.

The review is being undertaken in three phases:

1. Consider what is already known about how current targets operate and influence behavior;
2. Map the current standards against The NHS Long Term Plan to examine how performance measures can help transform the health service and deliver better care and treatment;
3. Test and evaluate proposals to ensure that they deliver the expected change in behaviour and experience for patients prior to making final recommendations for wider implementation.

This consultation sets out the recommendations from the urgent and emergency care workstream of CRS.

The current access standards in urgent and emergency care are detailed in the Handbook to the NHS Constitution⁵ and are listed below:

- A maximum four-hour wait in A&E from arrival to admission, transfer or discharge;
- All ambulance trusts to:
 - Respond to Category 1 calls in 7 minutes on average, and respond to 90% of Category 1 calls in 15 minutes;
 - Respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes;
 - Respond to 90% of Category 3 calls in 120 minutes;
 - Respond to 90% of Category 4 calls in 180 minutes.

The four-hour standard was the right measure, to drive improvement when it was introduced in 2004 to support improvement in patient flow within acute hospitals. However, since the introduction of the A&E access standard 15 years ago, there have been major improvements embedded in the system, and changes in how urgent and emergency care are delivered mean that, increasingly, this single standard is no longer on its own driving the right improvement. These include

- the introduction of specialist centres for stroke care, for example the reconfiguration of London and Manchester stroke services
- the development of urgent treatment centres
- the introduction of NHS 111
- the creation of trauma centres, heart attack centres and acute stroke units
- increased access and use of tests in emergency departments
- the introduction of new standards for ambulance services
- the increasing use of Same Day Emergency Care (SDEC) to avoid unnecessary overnight admissions to hospital.

There are also well documented issues with the four-hour standard:

- the target does not measure total waiting times
- the target does not take account of patient condition

⁵ [Handbook to the NHS Constitution](#)

- the target does not measure whole system performance
- the target does not consider clinical advances in care, including Same Day Emergency Care
- the target is not well understood by the public
- there is significant variation in the proportion of admitted patients across the country.

The opportunity to review access standards in urgent and emergency care has allowed the CRS to identify proposed standards that overcome the flaws in the current measure and are relevant in the context of the new ways of working signalled in the NHS Long Term Plan. The proposed new standards **seek to drive the next step change in improvements in patient care and experience whilst helping to maintain Covid-secure ways of working.**

Equally important, a new set of access standards must be **supported by NHS staff**, not just those working in emergency departments. We know that staff are feeling the strain of the increased demands on the NHS and we want to introduce standards that reduce the burdens of obstacles and barriers and so support staff to deliver high-quality, patient focused clinical care.

New standards must also **be meaningful to patients** and reflect what matters most to them. Healthwatch reported that 88% of people prioritised delivering the right tests and treatments to people thought to have a life-threatening condition,⁶ and what mattered most to patients was being quickly assessed and kept updated on how long they might have to spend in an ED, with good communication being more important than length of wait. The NHS should be providing the public with a service offer that reflects these wishes, and that they can understand.

Alongside understanding what matters to patients and staff, there is now a wealth of management information routinely collected to help us understand and measure how well we are delivering healthcare. This data can be used to develop much more specific and focused measures of clinical and operational performance that can underpin access standards.

At the start of the Covid-19 pandemic, performance improved against the current four-hour standard (March to June 2020), as bed occupancy decreased alongside reduced attendances, but brought with it a higher acuity case mix. However, this single measure did not provide enough detail on the true changes happening within the urgent and emergency care system, with substantial challenges faced by services despite

⁶ [Healthwatch: What matters to people using A&E](#)

improvement in the headline measure. The CRS proposes a bundle of measures would provide a more accurate and appropriate reflection.

Field-testing of a bundle of measures began in May 2019 with 14 test sites selected with the aim of ensuring they were a diverse group and broadly represented the national picture in terms of geography, performance and size. Further detail on the approach to testing was set out in the progress report published in October 2019⁷.

The learning from this field testing is embedded in the measures we are recommending; further information on these new measures is in Chapter 8.

Next steps for Clinically-led Review of Standards workstreams outside of this report

For mental health care, where new standards are being tested in the context of a programme of service development, investment and expansion, and elective care, more time is needed to reflect not only the length of the pathway but also understand the restoration and recovery work that is underway. Our urgent and emergency care system treats people in mental health crisis and looks after people with mental health problems presenting with other issues. The standards being consulted on in this document will apply to both mental and physical health and will aim to improve care for all patients, regardless of what brings them to the ED. An update for the elective and mental health pathways will be published by March 2021.

The proposed introduction of the Faster Diagnosis Standard for cancer was confirmed in the NHS Standard Contract for 2020/21. The approach and suite of cancer measures will be confirmed as part of the wider restoration and recovery programme to ensure people with suspected cancer come forwards for diagnosis, and that treatment plans are implemented for those with cancer.

Principles of Urgent and Emergency Care service design

The Clinically-led Review of NHS Access Standards (CRS) has considered not only the current models of care but also the transformation underway. The proposals for consultation build upon the four key principles that run through the UEC design model, aligned to our vision for UEC, and developing on core principles first set out in 2013:

1. **People with urgent care needs should get the right advice in the right place, first time**, whether through advice to self-care from NHS 111 online, from a call to NHS 111, from a call to General Practice, or through referral to the most appropriate service after calling NHS 111, whether that be pharmacy, general practice, community services, urgent dental care, mental health

⁷ [Clinically Led Review of Access Standards 2019](#)

services, an urgent treatment centre or an emergency department. Patients should be able to access care as close to home as possible.

2. **We must provide highly responsive, bookable, urgent care services that support reduced avoidable attendance at, or time in an ED, and resultant admissions.** Wherever possible bookable time slots, available to the public through referral from NHS 111, should be offered for all services within the wider urgent and emergency care system. This will ensure that patients spend as little time as possible queuing in order to access care and also that clinicians will already have immediate access to relevant information about patients when they see them. Ambulance services are increasingly able to offer care for patients on the phone or at scene without the need to convey to an ED, and we have committed to developing urgent community response services and rapid access to reablement services. Alongside the increasing availability of Same Day Emergency Care services, these services remain integral parts of reducing avoidable and unnecessary ED attendance and admission. General Practice also has a key role in ensuring patients can access the services they need in a timely manner. The move to the 'Total Triage' model ensures a safe approach and patients need to understand that if they phone their general practice they can speak to a clinician and if required get a face-to-face appointment.
3. **We must ensure that those people with more serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery.** Through capital investment we will improve the capacity and capability of our emergency departments, improving flow through hospitals, eliminating ambulance handover delays and treating all patients who need to be there in a timely and clinically appropriate manner. Crucially, through introducing new 'critical time standards' we aim to improve the quality of care for life-threatening conditions, with the aim of saving more lives and reducing avoidable morbidity.
4. **We must ensure that no patient stays in the emergency department or in hospital longer than is clinically necessary** and that hospital capacity is only used by patients who need it. Ensuring the right capacity is available is reliant both on in-hospital processes that safely reduce the length of time that patients stay in the ED and acute hospital bed, and on 'discharge processes' which support the timely discharge of patients back home where possible or into rehab or residential settings when necessary.

3. Transforming access to UEC services: Changing behaviours and the role of NHS 111

Each year there are 12.5 million ‘unheralded’ attendances of patients self-presenting to A&E services in England. These are attendances where patients self-present at hospital and, in some cases, their needs would be better met by other services. Many of these patients have not chosen to access the health service prior to attending A&E, and often their needs would be better met by alternative services. The development of NHS 111 provides an opportunity to change the way people access urgent and emergency care services, by remotely triaging patients through existing NHS 111 online and telephony towards the service that best meets their needs. This may be an Emergency Department, an Urgent Treatment Centre, primary care, community services or specialty delivered secondary care services.

What this means for patients

- The NHS is providing a safe and convenient way to access urgent care.
- If someone needs medical help, but it’s not a life-threatening emergency, they should use NHS 111 first.
- Depending on their needs NHS 111 will book them an appointment at the most appropriate service, for example at their local A&E or GP practice.
- This will help keep everyone safe and enable social distancing.
- Patients will still be able to walk into any Emergency Department if they need to. That will not change.
- Visiting an Emergency Department before using NHS 111 may mean though they’re offered alternative services that could see them faster if more appropriate.
- In a life-threatening emergency people should continue to call 999.
- With A&E attendances rising fast and social distancing and infection control procedures creating less waiting space in Emergency Departments, we need to act fast to make sure we can keep people safe.
- This includes being able to provide emergency care safely for our most vulnerable patients.

To ensure the NHS 111 offer meets the needs of a transformed UEC system we need to rapidly deliver a number of changes to our current NHS 111 call handling and local Clinical Assessment Service (CAS) provision.

NHS 111 offers a number of different routes to care which, taken together, will augment existing Integrated Urgent Care services (accessed through NHS 111) through increasing capacity, productivity and utility. Developing NHS 111 improves the offer to patients. For example, one site has reported 100% of patients believing it provided the best quality treatment whilst reducing congestion and infection risk, and further that 86% of patients rated the service as excellent or good and 83% of staff made the same assessment. NHS England will make a further £40m available this year to help providers ensure there is sufficient capacity to meet this additional demand. The items being developed include:

- a. **Investment in NHS 111 call handling capacity** to increase the volume of calls that can be managed. This will be achieved through:
 - i. Increasing the number of NHS Pathways trained call handlers;
 - ii. Enhancing the productivity of the service through the deployment of new technologies and working practices.
- b. **Investment in clinical capacity within local Clinical Assessment Services.** Acknowledging that clinical workforce is a clear constraint across all healthcare services it will be important to do this through driving improvement in productivity through the deployment of new processes and technologies such as video consultation. In addition, such employment is ideally suited to portfolio careers and for clinicians with their own health problems or caring responsibilities. These local Clinical Assessment Services will also simplify the process for GPs, ambulance services, community teams and social care to make referrals, via a single point of access, for an urgent response from community health services.
- c. **Improved profiling of all local services on the national Directory of Service** to ensure that NHS 111 services are able to directly bookable time slots in a wide range of urgent healthcare services throughout the week across primary, secondary, community and mental health services.
- d. **Establishing NHS 111 to ED referral processes** to ensure EDs can, as far as possible, plan ahead in the day-to-day running of their services. These heralded patients will benefit from a more bespoke experience.

- e. **Development of processes and IT enablers to appropriately stream low acuity unheralded patients to alternative non-ED settings** such as UTCs, general practice, pharmacy and community services to a greater extent, and with a more standardised approach, than is currently available through existing streaming models.
- f. **Local comms** to further encourage the use of NHS 111 as a remote triage service for the access of urgent care services.

At a national level there are also several initiatives that will be delivered for the benefit of all integrated urgent care systems. These include:

- g. **Continued development of the NHS clinical decision support system ‘NHS Pathways’** to improve its utility and clinical effectiveness for NHS 111 call-handling staff.
- h. **Development of other technologies**, including video consultation services and Natural Language Processing, to improve the effectiveness of provider organisations and the experience for users of NHS 111 services.
- i. **National coordination of comms** to ensure messaging is consistent across the whole of England and, when all systems are prepared, the delivery of a national communications campaign.

The central premise is that the offer to patients must be an improvement on the status quo. NHS 111 already offers a means of accessing a wide range of urgent care services completely remotely. By further expanding this offer to include the full range of urgent primary, secondary, community and mental health services we will be able to move to a new model of access.

Measuring what is clinically relevant

We already collect and publish data on key measures for the performance of NHS 111.

As a fundamental part of the urgent and emergency healthcare system it is important that the performance of local NHS 111 services are properly reflected when considering system wide performance.

For remote access to healthcare services to work effectively, it is essential that there is the right amount of direct clinical input into NHS 111 interactions. This ensures that

patients are directed to the services that are most appropriate for their immediate needs. By ensuring this clinical input is in place we can maintain both public and professional confidence in the NHS 111 system.

With this in mind at a system level, it is important to consider **“percentage of interactions with NHS 111 receiving clinical input”**.

As the remote access offer improves, we also must not overlook the importance of ensuring that increased utilisation and utility of remote access to UEC services is properly reflected when assessing the health of wider urgent and emergency care systems.

Both through service transformation and routine delivery, it is important that an inclusive approach is taken and to note that specific actions may be needed to support any groups of patients who might have unequal access to diagnosis and treatment. Further information is set out in “Implementing phase 3 of the NHS response to the Covid-19 pandemic⁸”, highlighting the requirement to include measures of performance in relation to patients from the 20% most deprived neighbourhoods (nationally and locally, using the Index of Multiple Deprivation), as well as those from Black and Asian communities where data is available.

⁸ [Phase 3 of NHS Response to Covid 19 Pandemic](#)

4. 999 ambulance services: Optimising performance and reducing wider service pressures

Improving ambulance performance and providing a clinically appropriate response for patients are the key drivers for ambulance services; our work with ambulance services builds upon the highly successful Ambulance Response Programme (ARP), which resulted in the adoption of a new operating model in 2017 and the introduction of new ambulance performance standards that ensure the sickest patients get the fastest response and that all patients get the right response first time. Success has been based on extensive and ongoing partnership work with ambulance services, commissioners and stakeholders; not only to develop and implement the standards, but to offer continued support to the sector to drive improvement.

What this means for patients and the public

- Ambulance services are changing to work in different ways.
- This means that patients are treated by skilled paramedics in their own home, given advice over the telephone or taken to a more appropriate setting outside hospital.
- Delivering a safe reduction in ambulance conveyance means that patients are only taken to hospital if that's the right place for them.
- This delivers an improved service for patients through treatment closer to home.
- It also keeps people safe from the risks of transmission of Covid-19.
- A new set of data being developed will enable us to see the whole patient journey, leading to better care.
- Identifying ambulance codes that can safely be reviewed by a clinician before an ambulance is despatched will also offer a more consistent patient response.

Further to this, Lord Carter's report 'Operational productivity and performance in English NHS Ambulance Trusts: Unwarranted variations'⁹, published in 2018, set out recommendations for ambulance to reduce unwarranted variation in areas including

⁹ <https://NHS Ambulance Trusts: Unwarranted variations 2018> /

productivity, workforce, fleet, control centres, use of technology and optimising non-clinical resource. Progress continues at pace, with the vast majority of recommendations delivered; we have agreed a standard specification for ambulance fleet, launched the Model Ambulance portal to routinely provide operational productivity and performance benchmarking data, and introduced 'Disaster Recovery Standards' to improve control centre resilience.

To improve patient experience, and building on the ARP operating model, we have worked with ambulance services and commissioners to gradually increase the proportion of 999 calls that can be managed without dispatch of a paramedic, and have also increased the proportion of calls that can be dealt with by a paramedic without conveyance of the patient to hospital. Through the pandemic, and linked to changes in demand and patient behaviour, we saw a sharp reduction in conveyance to EDs; whilst this trend has been reversed our continued ambition¹⁰ is to maximise the use of these 'Hear and Treat' and 'See and Treat' Pathways for 999 demand, to support a sustained reduction in the number of patients conveyed to Type 1 or 2 EDs. This includes increasing pathways for conveyance to settings such as urgent treatment centres or same day emergency care services.

Measuring what is clinically relevant

Ambulance Quality Indicators, as revised through the ARP, are published on a monthly basis, alongside Clinical Outcomes for patients who present to 999 with cardiac arrest, STEMI heart attack, stroke and sepsis.

When looking at system-wide performance, it is important to reflect two of the key aspects of ambulance performance as measures of the efficiency of pre-hospital response:

- 999 category 2 Response Time – 90th centile. Category 2 calls are emergency calls, excluding those that are immediately life threatening. Some conditions feature in 'Critical Time Standards' (p.32) so this ensures that those patients are appropriately managed from the moment 999 is dialled.
- Conveyance rates to Emergency Departments by 999 ambulances – Reducing avoidable conveyance to Emergency Departments is a key contributor to avoiding nosocomial infection, and alternative pathways of care including treatment at scene, referral to appropriate services or conveyance to an alternative care setting can all reduce conveyance

¹⁰ <https://aace.org.uk/safely-reducing-avoidable-conveyance-programmes/>

5. Urgent Treatment Centres: Improving access, capacity and capability

Urgent Treatment Centres (UTCs) are a fundamental part of the NHS 111 First offer, enabling face-to-face interaction where clinically necessary and enabling booked appointments for those patients with urgent care needs that do not need to be seen in an ED. The national roll out of the UTC model has almost concluded, and we are now looking at how to develop this core element of the UEC offer further.

What this means for patients and the public

- Urgent Treatment Centres (UTCs) are an important part of the changes being made to emergency care. They provide treatment for non-emergency patients, avoiding the need for them to wait in Emergency Departments for treatment when they don't need to be there. This also helps EDs to focus on the patients that need more urgent help.
- The NHS is building the ability of UTCs to make booked appointments for patients, to treat ambulance patients, and make more use of video consultations so more patients can be treated at home.
- Patients will have easier and speedier access to their urgent and emergency care service as patients will be able to book same day appointments at their UTC through NHS 111.
- Patients will benefit from an urgent and emergency care service that works well together.

As well as increasing capacity of booked appointments, we are asking systems to make better use of the capability of UTCs. There is additional scope for ambulance services to convey patients to UTCs rather than ED when this would be clinically appropriate; ambulance crews need to be confident that the UTC is prepared to receive such patients and systems should have pathways in place to support this, with an accurate Directory of Services that reflects a consistent patient offer.

In addition, there is scope to maximise use of video consultation technology, with two main opportunities. First, patients could be referred to clinicians in the UTC for a video consultation following referral from NHS 111; this may avoid a face-to-face appointment. Clinicians within the UTC setting could be available as part the NHS 111 Clinical Assessment Service to support this kind of access. Secondly, where further clinical

advice is required from secondary care during a face-to-face appointment, systems should be establishing referral pathways for access to a rapid video consultation with, for example, acute medicine, frailty services, Same Day Emergency Care and emergency medicine consultants.

Measuring what is clinically relevant

The CRS recommends that all Urgent Treatment Centres should record activity and patient information on the ECDS (Emergency Care Data Set), enabling improved understanding of performance and patient acuity. As part of activity reporting, the number of booked appointments, as opposed to walk in activity, is integral to understanding uptake of this key driver of patient change.

Mean Time in Department for non-admitted patients is an important indicator for patient experience in an Urgent Treatment Centre and could serve as the headline performance measure for these services.

What this means for patients and the public

- Patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided – a much better experience for the patient.
- If emergency departments become too crowded it is harder to provide urgent care to patients who need it, and the risk of catching Covid-19 is higher.
- To help patients flow in and out of hospital better, the NHS is increasing the number of patients who can receive the care they need and be sent home without being admitted to hospital overnight.
- This is better and more convenient for patients, and it also means there will be more hospital beds available for those who really need them. This helps those patients to move out of the ED more quickly and stops it from being too crowded.
- The NHS will also take other steps to make sure EDs don't become too crowded in winter, including redirecting patients with less urgent needs to receive care in other places such as GPs or Urgent Treatment Centres.

6. Improving flow through hospitals: Emergency Departments and Same Day Emergency Care

Over recent years we have seen emergency departments come under increasing pressure. Our staff are delivering expert care to more people than ever before: twenty-two million attendances were completed within four hours in 2018/19, 29% more than when the standard was introduced in 2004/05. But rising numbers have led to increased crowding and congestion, not just during the winter months but throughout the year. The increasing acuity of complex patients and the ability to provide more advanced care in ED has contributed to this challenge.

We know that good patient flow is critical to improving care for patients in ED – this means the flow of patients **into, through and out of the department**. Good patient flow prevents ambulances queuing outside of hospital EDs, prevents overcrowding of departments with resultant risk of corridor care, nosocomial 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.

Delays in ambulances handing over patients to the care of the ED results in the risk of preventable harm for patients in the community by increasing ambulance response times. It is critical that acute trusts always accept handover of patients within 15 minutes of an ambulance arriving at the emergency department (ED) or other urgent admission facility.

Rapid meaningful initial clinical assessment of the needs of all patients, including those who do not arrive by ambulance, is fundamental to our offer to patients, giving assurance that care will be prioritised to those most in need. This may include streaming to a more appropriate care setting, such as a UTC or primary care facility, and trusts should have systems in place to safely stream patients who do not require ED care to an alternative service supported by robust clinical governance arrangements.

In order to be meaningful an assessment should be tailored to a patient's presentation. For some patients this will mean some form of physical examination and the recording of vital signs. For other, less acute, patients this may be a more straightforward assessment based on a brief recording of presenting symptoms, and medical history and risk factors. Whichever approach is appropriate, the assessment will inform the next stage of treatment, be that diagnostic tests or another identified intervention.

Flow out of the emergency department is dependent on two aspects – discharge or admission as soon as possible after the patient is ready to proceed from the ED, and availability of a bed when this is required. Timely discharge and admission are key to the patient experience and clinical outcomes in ED; hospital occupancy is addressed in Chapter 6.

The majority of patients who present to ED can be safely discharged home once they have been assessed and treated and do not require acute inpatient care. Current best practice enables many patients who would hitherto have been routinely admitted to now be managed via Same Day Emergency Care (SDEC) non-admitted pathways, e.g. pulmonary embolus, transient ischaemic attack, some pneumonias. Ensuring that there is sufficient capacity to manage these patients on an SDEC basis will reduce occupancy pressures and benefit all patients irrespective of whether they are admitted or managed via SDEC. In addition to the development of dedicated SDEC services, it is also true that these advances in care mean that, in some cases, it is now preferable to spend slightly longer in an ED if it results in a patient being discharged home – or into the care of another healthcare service – rather than be admitted into hospital at all.

SDEC services treat a wide range of common conditions, including headaches, deep vein thrombosis, pulmonary embolus, pneumonia, cellulitis and diabetes. The types of conditions that can be managed through SDEC will vary depending on the hospital and needs of the local population. Most SDEC services are provided by acute medical units and hospital medical and surgical teams, so close working between them and ED teams is essential to providing safe and effective SDEC.

Increasing adoption of both SDEC and associated acute frailty services has reduced avoidable admissions to hospital. Systems must now build upon this by adopting a consistent, expanded, model of SDEC provision for all providers with a Type 1 Emergency Department.

Patients who require onward admission into hospital will usually require a longer spell in ED than those who can be discharged. This time is required to undertake multiple diagnostics, initiate first-line treatments, arrange specialty assessment and organise an appropriate inpatient bed. While we expect these patients to spend slightly longer in ED, there is also evidence that when admitted patients spend too long in EDs it can compromise their clinical outcomes. We therefore need to ensure there is a steady flow of patients out of ED and into hospital inpatient beds.

Measuring what is clinically relevant

There are key indicators that should form the heart of an acute trust's measure of performance; we propose to include the following in the system wide bundle of measures:

- a. Hospital handover delays – this is a measure of efficiency and flow into Emergency Departments. 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
- b. Time to Initial Assessment – this is a measure of efficiency of streaming and triage of patients. This provides assurance that patients' needs are quickly assessed and in order that they may be treated in the right place and at the right time.
- c. Mean Time in Department for non-admitted patients – this is a measure of efficiency of urgent and emergency care services. While we want to ensure the sickest patients are treated most quickly, 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.
- d. Percentage of patients spending more than 12 hours in A&E – there is no valid reason why any patient should spend more than 12 hours in an A&E department. Any incidence of patients spending this length of time in A&E is suggestive of wider system problems as patients are unable to be transferred to services more appropriate for their needs.

Investment in urgent and emergency care capacity

Many of our emergency departments have not had sufficient capacity to ensure the smooth flow of patients through the peaks of winter. While avoiding ED attendances by providing alternative services is essential in mitigating crowding, it is not enough

on its own. We must also ensure that departments are the right size and configuration to treat the sickest patients who require admission to hospital.

The Government has made a £450m investment across 140 trusts to enable them to prepare ahead of winter this year. This investment is focused on immediate and necessary changes to prevent nosocomial infection, and to improve flow through emergency departments by increasing the capacity and capability of EDs and urgent treatment centres, providing priority admission units and expanding activity in same day emergency care.

7. Managing hospital occupancy

Managing levels of occupancy within acute hospitals, so that hospital capacity is only used by patients who need it, is critical to ensure a bed is available for those patients who need to be admitted in order to receive urgent treatment. Ensuring the right capacity is available is reliant both upon in-hospital processes that safely reduce the length of time that patients stay in an acute hospital, and upon 'discharge processes' which support the timely discharge of people back home where possible or into rehab or residential settings when necessary.

What this means for patients and the public

- To make sure that hospital beds are available for people who need them, the NHS will make sure that patients do not stay in hospital any longer than they need to.
- Hospitals need to make sure that patients have the help they need to go home, like social care or ongoing treatment outside of hospital.
- The NHS will publish new guidelines for hospitals to follow to help ensure that patients can leave hospital when they are ready.

In-hospital reduction in length of stay

Since Covid-19, reducing length of stay and bed occupancy has been, and continues to be, a key element of the strategy to free up acute capacity. This has meant in large part the continuation of longstanding efforts to reduce occupancy levels across all acute hospitals. The predicted levels of Covid-19 pandemic demand and the risk of the NHS being overwhelmed by lack of acute capacity provided significant new energy and focus to these existing challenges, along with the release of the national discharge guidance that set out a series of recommendations for systems to implement.

We know that many individuals who are discharged from acute hospitals require no further formal support from health or social care providers. It is essential that this cohort has a swift and timely discharge from hospital, not least as this will likely have a positive impact through avoiding the need for a package of care further down the line (e.g. due to deconditioning). A forensic focus on in-hospital process delays and subsequent improvement is expected to drive down length of stay in this cohort.

Through Covid-19 we have seen the successful deployment of Clinical Criteria to Reside as part of daily ward rounds, but we know there is variation both in use of the criteria and in the length of stay of this cohort. A priority is for the criteria to be deployed

in every trust, ensuring only those who still benefit from ongoing acute care remain in hospital.

High quality data are critical for local and national understanding; we will work with trusts to improve data quality in the short term, and in the longer term to design a system that supports an end-to-end discharge planning process drawing on data from both acute and community sectors.

Discharge and community response

For those individuals that don't meet the Clinical Criteria to Reside, robust discharge processes are required to ensure that people are able to leave hospital when clinically safe and appropriate to do so, enabling them to receive ongoing care needs or the appropriate end-of-life care they require out of hospital.

For those with ongoing requirements, community capacity is fundamental to our model. Supporting people to go home is the default pathway (in consultation with the patient or family), with alternative pathways for people who cannot go straight home.

The NHS Long Term Plan set out plans for urgent community response services and reablement; these remain integral parts of preventing hospital admission direct from ED. Urgent community response (UCR) services are an integrated service provided by a multi-skilled team providing urgent community response within two hours to deteriorating patients to support their recovery and prevent hospital admission where possible.

Community health services crisis responsiveness should be enhanced in line with the goals set out in The NHS Long Term Plan. Over the coming winter the aim is for urgent community response to be in place 7 days a week, and we continue to work with, and share the learning from, the 7 UCR accelerator sites covering 10% of the population to achieve the national standard by 2022. We are also exploring how NHS 111 can help simplify the process for GPs, ambulance services, community teams and social care to make referrals to these services via a single point of access.

Taken collectively, these initiatives will reduce the demand on acute beds, improve outcomes for patients as well as patient experience, and improve system working across acute, community and social care.

Measuring what is clinically relevant

Average Length of Stay (ALoS) has been used for a number of years as an important operational driver of overall hospital occupancy. We will continue to monitor both ALoS and the number of patients experiencing extended LoS (>14 days) with the intent of understanding both enablers and barriers to maintaining reductions in ALoS.

While not direct measures of hospital occupancy or the effectiveness of local discharge processes, there are important indicators that we will begin to monitor that tell us about the flow of patients through the hospital inpatient system and back into the community:

- a. Mean Time in Department for admitted patients – 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.
- b. Clinically Ready to Proceed – this is a measure of the time taken from the point at which it is agreed a patient is ‘clinically ready to proceed’ from ED, and when they actually leave ED. Capturing this metric aims to avoid patients being kept in ED for too long after they are judged ready to leave. It has been identified by clinicians in acute trusts and the Emergency Medicine GIRFT programme as a useful measure to act as an operational lever to manage patient flow through the department. In order to ensure patients receive timely onward care and to reduce crowding in departments it is vital that there is continuous flow out of Emergency Departments into acute/ general medical and specialty services. This is only achievable if there is sufficient flow out of the hospital to ensure that the right kind of bed is always available to new patients when they need them.
- c. Percentage of patients spending more than 12 hours in A&E – as referenced in the previous chapter, while this measure is focused on the amount of time spent in emergency departments, ensuring that patients do not have these extended stays is the responsibility of the whole hospital and wider UEC system.

8. Measuring performance in a transformed system

Covid-19 has highlighted the need to introduce standards that reflect – and drive improvement in – the flow of patients requiring urgent and emergency care. National polling by Healthwatch in October 2019 and subsequent discussions as part of the review with patients in emergency departments confirmed that time alone does not dictate how people feel about their experience of Accident & Emergency services. Other factors are important, such as communication, attitude of staff, integration with ambulance services, NHS 111 and general practice. It also shows that patients are willing to wait longer if it means critically ill patients are treated more quickly, and that they receive the care they need and clear communications from the outset.

What this means for patients and the public

- a. In 2005, when the four-hour standard was introduced, it provided a good tool to improve care.
- b. The 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 111.
- c. The new measures make transparent that a whole organisation approach is needed, particularly through the ‘ready to proceed’ measure which will ensure that the patient is the right place for the next stage of their care.
- d. They mean that every patient is moved to the next stage of their care as soon as they are ready.
- e. The standards include making sure that the most urgent patients receive the help they need most quickly, including those with a suspected stroke or heart attack, while all patients are seen in an acceptable timeframe.
- f. There are 10 new standards in total – you can see them page 32.
- g. The NHS has tested the new standards for urgent and emergency care, ensuring they reflect your experiences from calling NHS 111 or 999 through to assessment, treatment and the total time you spend receiving urgent and emergency care. More detail on what they mean for you is set out in each chapter.
- h. The NHS is consulting on these standards. Details on how you can respond are given in the ‘Your Views’ section.

This aligns with the findings of the Clinically-led Review of Standards which are reflected in the proposed bundle of UEC measures. These recommendations are the result of the review requested by the Government in June 2018.

The CRS found that a suite of measures used together can support the effective running and management of emergency departments and urgent and emergency care systems. Importantly, this approach supports continuous quality improvement in a way that the current standard is no longer able to. A new system of metrics would support the existing appetite for transformation of the model of urgent and emergency care provided through the NHS and also provide improved information for system leaders about where issues arise, rather than waiting for those challenges to manifest through the four-hour waiting time measure. The bundle presents an opportunity to understand challenges for particular groups such as children and young people, which could be masked within a single measure. As well as providing greater insight on emergency care performance that is relevant to different groups of stakeholders, the bundle of measures is designed in such a way that no measure should be looked at in isolation, but in the context of a system's performance against all the other measures. This is particularly true of the various measures that describe the efficiency of flow through the hospital system.

The measures set out in previous chapters focus on the timeliness of access to various parts of the urgent and emergency care system. In a system-wide bundle these measures will also be supplemented by a new set of Critical Time Standards. These will 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.

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. The recommendation of the CRS is that the existing four-hour standard should not be part of the new bundle of standards. This is because the total time in department is better demonstrated by using the mean time for admitted and non-admitted patients, and there being an additional risk that by including it in the bundle there would be a temptation to continue focusing on this more simplistic view of performance at the expense of the wider bundle of clinical metrics for the benefit of patients.

These recommendations are supported by a wide range of clinical and patient stakeholders including the Academy of Medical Royal Colleges, Royal College of

Emergency Medicine, Royal College of Surgeons and Healthwatch. A full list of participants in the Review can be found in Appendix A.

Proposed New Bundle of Standards by the Clinically-led Review of Standards

Service	Measure
Pre-hospital	Response times for ambulances
	Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances
	Proportion of contacts via NHS 111 that receive clinical input
A&E	Percentage of Ambulance Handovers within 15 minutes
	Time to Initial Assessment – percentage within 15 minutes
	Average (mean) time in Department – non-admitted patients
Hospital	Average (mean) time in Department – admitted patients
	Clinically Ready to Proceed
Whole System	Patients spending more than 12 hours in A&E
	Critical Time Standards

Taken together, it is the view of the CRS that these proposed measures provide far greater assurance that Urgent and Emergency Care systems are functioning efficiently and effectively for service users than the existing four-hour standard can. They also provide improved information for system leaders of where issues arise, enabling them to address problems before they worsen.

Presenting the bundle of measures

There is a mixture of different standards performing different functions, both in terms of which component of the wider system they scrutinise, but also in terms of the way each measure will be utilised by the various audiences that this bundle is designed to address. Similarly, there are multiple approaches we could take to monitoring and reporting performance, which could also provide an appropriate accountability mechanism.

Some measures will be most useful, for example in demonstrating high-level performance of a service or the wider system; others will help set an individual's expectation of their care should they need to access urgent or emergency care. These may be of interest to the general public or regulatory bodies. Other measures, however,

will be far more important clinically and to the operational teams responsible for the delivery of our Urgent and Emergency Care services.

As well as speaking to different audiences, the bundle of measures is also designed in such a way that no measure should be looked at in isolation, but in the context of a system's performance against all the other measures. This is particularly true of the various measures that describe the efficiency of flow through the hospital system.

Potential options for monitoring and reporting performance include:

- A bundle of separate measures each reflecting different parts of the care pathway.
- Aggregation of measures where the composite reflects the extent to which the expectations are met across the range of measures.
- Numerical composite where a score is attributed to each measure and aggregated to a single number using weights.

A holistic assessment of performance can only be made when all measures are viewed together. It would be possible to develop this into a single composite measure that can provide at a glance assurance as to the relative performance of any Emergency Department or Urgent and Emergency Care system. This would offer a simple view for patients of "how their local service and system is performing", informed by the critical performance measures required for managing and assuring services.

A composite scoring system can be scaled up and down to reflect the performance of both individual providers, Integrated Care System (ICS) footprints or an aggregate national view. This could assist in performance monitoring at a national level, but as groups of acute providers begin to work more closely in ICS it will increasingly become the case that performance is managed and reported on at a wider ICS level.

It is proposed that an aggregated approach with all of the measures within the bundle be considered. Each measure would receive an equal weighting and be presented with a binary pass or fail, and be attributed a score of 1 or 0 accordingly. With nine measures currently in the bundle, plus the group of Critical Time Standards, a system could achieve a maximum score of 10.

Data against the metrics would be published monthly, providing transparency to patients, the public and stakeholders on how providers are performing, while also providing clear incentives to poor performing providers to improve over the course of the year to achieve the highest possible year end score.

Feedback on the approach to developing a composite measure is encouraged as part of this CRS consultation. In addition, discussions will be held with key stakeholders and experts during the consultation to develop this further, including how to present the composite score clearly.

Setting thresholds for the new measures

This consultation covers the proposed measures themselves, but depending on the outcome of the consultation, further work is needed to assess the appropriate thresholds for each measure before they could be implemented.

Prior to the Covid-19 outbreak, the phasing in of expected improvements in performance was discussed with stakeholders, given the extremely challenging situation faced by UEC systems.

The Covid-19 outbreak has had a significant impact on current performance and ways of operating. Whilst we firmly acknowledge that a return to historic performance levels is not acceptable, we need to take these changes into account in setting targets against the UEC CRS measures this year. As part of this consultation, in order to determine where these thresholds should be set, we will engage further with relevant stakeholders, including the Royal Colleges and patient groups. Both the setting of thresholds and the implementation of new measures are subject to cross-Government agreement.

Critical Time Standards

The Critical Time Standards (CTS) are being developed on these principles:

- The highest priority patients will get high-quality care with specific time-to-treatments, with proven clinical benefit.
- A focus on evidence-based clinical interventions that should be commenced within one hour of a patient's arrival in an acute hospital (by any route, not just via ED).
- Clinical audits show that there is the potential to save many more lives by focusing all hospitals on treating killer conditions within the first hour of treatment.

We have developed, and are testing, evidence-based measures to support early intervention in stroke, STEMI heart attack, acute physiological deterioration (RAPID) and major trauma. National performance in these pathways has improved dramatically in recent years, with an additional 600 patients surviving major trauma in 2016/17 compared with the previous year, and a 19% increase in survival since the

inception of major trauma centres in 2012/13. There also has been a reduction by more than half in the 30-day mortality rate for hospitalised stroke, which has fallen from 27% in 1998 to 17% in 2010 and 13.6% in 2015/16.

Whilst some of the data needed to drive improvement in care in these is routinely collected, further work is underway to enable routine capture of all key data items. We are introducing the ability to capture NEWS2 scores through ECDS and are working with clinical audit teams to enable accurate and timely return of key data that will support local teams to challenge and improve their performance.

We continue to work with clinical leaders to finalise the CTS standards, including the appropriate thresholds, and will make more information available in due course. In parallel, we are developing proposals for future developments in CTS, including a focus on paediatric care and how we can develop the RAPID standard to capture key interventions required in respect of other presenting conditions such as asthma.

A new offer to the public

From the outset it has been the overriding priority for all those involved in CRS to arrive at a set of standards which measure what matters most to the public, as well as support staff to provide the best quality care.

The experiences during the Covid-19 pandemic have sharpened this focus, but in the main the clinical need to be able to provide safe care has reinforced what we had already learnt from the testing and insight from patients and the public that we undertook, and were able to draw upon over the last two years.

We know from work by Healthwatch that quick triage when arriving at A&E is important to patients, providing reassurance and helping to understand what will happen next. It is also important to patients that the most urgent cases are treated as a priority, and that people will not be in A&E longer than necessary.

For many people though, their time in A&E is only part of their journey. The proposals set out in this report therefore extend our commitment beyond the Emergency Department, to be clear that the same commitment to quickly assess and prioritise patients will be undertaken whatever route people choose to access urgent and emergency care, and place equal focus on the wider hospital and health system beyond the emergency department, to ensure that every patient's journey is as swift and smooth as possible. Based on all of this, the new offer to patients who need Urgent and

Emergency Care services, and the wider public, that we are proposing is described below.

Right care, right place, right time: the full NHS offer to patients

1. In an emergency, 999 ambulance services will get the right vehicle to you quickly.
2. Wherever possible, ambulance staff will give or help arrange the care you need in your own home, avoiding an unnecessary trip to hospital.
3. If they need to take you to an Emergency Department, the handover between clinicians should take no longer than 15 minutes.
4. When it's not an emergency, the NHS 111 phone and online service will support you to get the right care in the right place, putting you in touch with doctors, nurses and other healthcare professionals where appropriate.
5. If you need it, the NHS 111 service will also be able to book you an appointment at a convenient time with a GP, pharmacist or local urgent care service – and if it's more serious, they can arrange an ambulance response or give you a timed slot to go to an Emergency Department.
6. You will be assessed within 15 minutes of arriving in a hospital Emergency Department
7. If you are critically ill you will be treated as a priority and get the right tests and treatments fast.
8. For all patients, staff will work to ensure you don't spend longer in A&E than necessary.
9. The NHS will work to eliminate long waits of 12 hours or more as measured from the time of your arrival rather than the point at which a decision is made to admit you.
10. Where possible and the right thing clinically, you will get any tests, treatment and prescriptions you need to allow you to go home the same day.
11. Where your clinicians think you need to stay in hospital after your initial care, you will be moved to an appropriate bed within one hour.

Your Views

These proposals have the support of leading clinical groups, including the Royal College of Emergency Medicine, patient groups including Healthwatch, and hospital leaders. We are now launching a consultation to capture views from the public and wider stakeholders and other interested organisations on the approach recommended by the CRS across urgent and emergency care as well as the refinement of the measures.

The NHS Constitution for England aims to safeguard the enduring principles and values of the NHS, and to empower the public, patients and staff to help improve the care it provides by setting out their existing legal rights and the pledges that the NHS has made towards them in one place. A Government pledge on the maximum four-hour wait in A&E from arrival to admission, transfer or discharge is set out in the Handbook to the NHS Constitution for England. The Handbook may require updating to reflect the outcome of this consultation and any recommendations for change accepted by the Government.

We are seeking your view on the proposed standards for urgent and emergency care set out in this document. Responses are welcome to all or some of the questions.

Engagement 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.

Measure
Response times for ambulances
Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances
Proportion of contacts via NHS 111 that receive clinical input
Percentage of Ambulance Handovers within 15 minutes
Time to Initial Assessment – percentage within 15 minutes
Average (mean) time in Department – non-admitted patients
Average (mean) time in Department – admitted patients
Clinically Ready to Proceed
Percentage of patients spending more than 12 hours in A&E
Critical Time Standards

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?

How to respond

Responses can be submitted through the consultation form on the NHS England website, [UEC CRS consultation](#) or by email to England.reviewofstandards@nhs.net.

The consultation period will run from Tuesday 15 December 2020 to Friday 12 February 2021.

9. Moving towards a transformed healthcare system

This document describes the longer-term direction of travel for urgent and emergency care, and measurement proposals which are expected to enable improvement in care. These measures reflect what, both patients and clinicians involved in the clinical review of standards have told us, matters to them. Tactically, all systems will already be preparing for winter and the additional pressures we can expect Covid-19 to present.

The following actions should all form part of systems “Preparations for winter”:

- a. Increase NHS 111 capacity.
- b. Ensure availability of alternative secondary care dispositions to users of NHS 111 services.
- c. Implement an ED referral and booking system for users of NHS 111 services.
- d. Develop and deliver a local communication strategy.
- e. Ensure capacity identified within ambulance services to meet additional demand.
- f. Subject to piloting, implement recommendations for additional clinical validation of lower acuity 999 calls.
- g. Finalise designation of UTCs and increase capability and capacity of UTC services to offer booked appointments.
- h. Ensure acute trusts have systems in place to respond to crowding in emergency departments, eliminating ambulance handover delays and corridor care.
- i. Ensure streaming arrangements in place for patients who do not require ED care.
- j. Ensure consistent provision of Same Day Emergency Care.
- k. Introduce a new bundle of system-wide performance measures.
- l. Deliver on capital investment where available.
- m. Ensure robust discharge processes are in place within acute trusts and community services.
- n. Implement the Community Urgent Response time of 2 hours, to include

referrals from the Ambulance Service, 111 and Same Day Emergency Care (SDEC)

Beyond winter, we expect to see continued development of the model of care set out in the preceding sections. These models of care are not quick fixes for winter, or in response to the new pressures of Covid-19, but represent the refinement of the vision for transformed urgent and emergency care services. The NHS has made huge progress over recent years, but there is still more to achieve, and healthcare systems should regard the principles in this strategy as the blueprint for further progress.

To support delivery of this strategy, including measurement which supports and stimulates improvement, NHS England and Improvement's regional teams will work with local systems to agree improvement support packages. These packages may include clinical support from regional emergency medical and acute medical experts, additional analytical support to ensure trusts can more easily collect and share patient data, or the provision of dedicated resource at a provider level.

10. Conclusion

Through delivery of the goals of the UEC transformation programme set out above, and the underpinning operational and transformational plans, national, regional and local healthcare organisations will work together to change the way we access urgent and emergency healthcare services, resulting in **both an improved experience for patients and reduced risk of coronavirus infection.**

We will enable **greater efficiency and clinical effectiveness** through treating patients at the **most appropriate care setting** for them, increasingly making use of telephone and online resources to treat people at home without attending a face-to-face service.

We will support patients to **leave hospital as soon as they are able** and no later, with **clinically and socially appropriate support packages** in place. The proposed changes to clinical standards offer the opportunity to **measure what is clinically important and use this to drive tangible improvements in care.**

Appendix A: Oversight and Advisory Group Membership

Urgent and Emergency Care Advisory Group
Academy of Medical Royal Colleges
Royal College of Emergency Medicine
Royal College of Paediatrics and Child Health
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
Royal College of General Practitioners
Society of Acute Medicine
NHS Clinical Commissioners
NICE UK
Healthwatch England
Patient's Association

Clinical Oversight Group
Academy of Medical Royal Colleges
Royal College of Surgeons
Royal College of Physicians
Royal College of Nursing
Royal College of General Practitioners
Royal College of Emergency Medicine
Royal College of Psychiatrists
NHS Providers
NHS England and NHS Improvement
NHS Clinical Commissioners
NICE UK
Healthwatch England
Patients Association
Cancer Research UK
Breast Cancer Care
Macmillan Cancer Support
Mind

NHS England and NHS Improvement
 Skipton House
 80 London Road
 London
 SE1 6LH

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