Transformation of Urgent and Emergency Care: proposed standards

What matters to people in Cambridgeshire and Peterborough

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Summary

NHS England asked us to assist in getting local people's views on proposed new standards to measure the performance of urgent and emergency care services. The new standards will replace the current 'treatment within four hours' standard.

In 2019 we had taken part in a pilot consultation exercise, collecting patient views about what was important to them when using the Emergency Department at Addenbrookes hospital.[1] These subsequent workshops identified many of the same concerns raised in that exercise.

What we did

We hosted two workshops in February 2021 inviting members of the public to join us via Zoom for a conversation about their understanding of the proposed new set of standards for monitoring urgent and emergency care services. The workshops were widely advertised through Healthwatch Cambridgeshire and Peterborough's networks.

Sixteen people took part, eight people in each of the online workshops. Our participants were a wide mix of ages, ranging from people in their 20s to some in their 80s. The two groups included men and women, and people who identified as non-white British. The participants lived in various parts of our Clinical Commissioning Group area and were users or potential users of all the A&E departments in our area.

The workshops lasted roughly 90 minutes. Participants were asked how important each of the 10 proposed new standards were to them, personally. We also asked them if they felt there were other measures that should be included in the bundle of standards, and how they felt the new measures should be communicated to patients and visitors. As well as considering the questions, the participants shared their rich experiences of using local urgent and emergency care.

[1] Tracking patient experience in new A & E target trial at Addenbrooke's | Healthwatch Cambridgeshire

Key themes from the workshops

- The importance of being able to speak to the right person at the right point when accessing urgent and emergency care.
- Good, regular communication.
- Managing the patients' expectations
- Looking at the proposed standards
    - One measure alone isn't enough
    - Keep it simple
    - Three or four measures only
    - Some of the standards felt more important for internal management than for the public.
- The patient experience of using the system was very important too.
- Improve clinical access to patient records for clinicians from different organisations through a secure shared system, and give patients access to their own online records.

Our participants suggested that the new bundle should include four standards:

- Time to initial assessment.
- Clinically ready to proceed.
- A measure similar to the existing four-hour wait standard.
- A measure of patient experience.

Setting the scene

We started the workshops by asking the participants if they were familiar with the existing four-hour standard.

All the participants in the first group were familiar with it. Participants in the second group had a wider range of understanding. Five members were confident that they knew what the standard meant, with four members saying they didn't know about it.

What does the four-hour standard mean to you?

Participants explained their understanding as:

> 'Waiting in the department could take up to four hours before the start of treatment.'
>
> 'Treatment could start at some point within four hours.'
>
> 'Current standard is a useless measure that disguises system failures.'
>
> 'Treated or discharged within four hours.'

One of the participants described herself as being a "victim" of the current standard having been admitted to a ward where she overheard staff say that she was only there to avoid breaching the four-hour standard.

We went on to ask the participants whether they felt that a single measure – as now, or a 'bundle' of measures – as proposed, would help them to better understand how well urgent and emergency care services were doing.

Only one person preferred a single measure, eight people said they preferred a bundle and the remaining seven people either didn't respond or said that they didn't know.

All the participants agreed that accessing and using emergency services is complicated and fragmented, and that one single measure couldn't adequately reflect the complexity of the system. However, they all felt that any new measures needed to remain simple if they are to have any real meaning to the general public. They agreed that a small bundle of three or four key measures would be better, but the bundle needed to be relevant to the patient and public and also reflect patient experience.

The participants felt that the urgent and emergency care system has become increasingly complicated, and it was often hard for patients to know how to use services appropriately. While they welcomed direction and triage in the system, they stressed that it needed to be clinically appropriate and timely.

Before you get to hospital

How important is it to you to know about ambulance response times?

All our participants told us that it was useful to have an indication at the time of calling an ambulance about how long they would likely have to wait in order to manage their expectations.

We heard about both good and not so good personal experiences of using the ambulance service and response times. One participant told us that the anticipated response time to their call was shortened as the circumstances became more critical and welcomed that they were kept appraised of the change.

We heard about the difficulties some participants had experienced particularly relating to disabilities and transferring patients in wheelchairs. They stressed the importance of the response being the right response as well as the timeliness of response. And the importance of staff having the appropriate training and information to deal with the emergency in relation to disabled people and people with mental health problems.

Some of the participants acknowledged that they trusted the system and expected the system to be able to identify and prioritise those with the most severe needs and that measures of response time would reflect this.

However, some participants felt that as a standard or measure, response time could simplify what could be a complicated process and potentially become meaningless.

How important is it to you to know about reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances?

The participants felt that it was important to measure the rate of avoidable trips. They expressed hope that knowing about these rates would mean less abuse of the service. They also raised concerns about the pressure on ambulance staff when there may not be adequate appropriate support in the community for some patients.

> "People don't want to go to hospital if they don't have to be there."

Participants felt that this would be one of a number of standards that could indicate when something was going wrong in the system. They felt that whilst a very important measure, it was more relevant to service management than to the general public. They asked who and how would performance be managed. And if the standard indicated 'poor', how would 'poor' be defined?

How important is it to you to know about the proportion of contacts via NHS111 that receive clinical input?

Our participants felt that this also was an important standard, but some of them felt this was of greater relevance for the people running the service than for the general public.

A broader conversation followed about participants' experiences of using NHS111 and how they felt about the service being used as a gateway to emergency services. Most of the participants had used the service, all had heard of it.

> "When the service is good it is excellent but otherwise it can be dreadful."

One of the participants told us of her positive experiences of being called back by clinical staff in the NHS 111 service when her complex health problems were recognised.

Concerns centred around:

- the reliance on scripts by call handlers
- the lack of flexibility
- the seemingly low level of clinical training
- and the difficulty in being able to talk to a clinician with sufficient knowledge of particular disabilities

The last point was exacerbated by limited, if any, access to patient records.

One of the participants, who cared for their paraplegic husband, described their experiences as 'horrific'. She said that the system seemed unable to cope with serious neurological conditions, and that they would continue to directly access their local A&E if they felt it necessary, rather than via NHS 111.

The participants all felt that the scripts used by the service needed to be:

- more tailored to a wider range of conditions
- rely less on a flowchart of questions that could lead a conversation down an inappropriate path
- and staff should be able (and trained) to go 'off script' when necessary.

They cited their understanding of 999 call handling and felt that would help maintain a holistic view of the patient and the call.

The participants proposed that there should be recognised 'magic words' which would alert call handlers to the patient having a very specific condition or set of conditions which required intervention from a clinician with more specialist knowledge. Ideally this might mean from an on-call specialist at a tertiary care centre, such as Stoke Mandeville Spinal Injuries Unit.

The participants believed there should also be similar flexibility at the Emergency Department, where patients with emergencies connected to their long-term conditions could bypass assessment and wait in the department and quickly move instead, to the part of the hospital most able to provide the most appropriate care.

In the A&E department

How important is it to you to know about the percentage of ambulance handovers which take place within 15 minutes?

Participants were divided in terms of whether they felt it was important to them to know about this standard. All the participants wanted to be told how long they might be waiting in the ambulance at the Emergency Department. Only those in the first workshop wanted to know about this standard.

They believed that if the percentage of handovers that exceeded 15 minutes was high, this would affect behaviour, putting some people off using an ambulance. They may prefer to use a different service, wait, or make their own way to the Emergency Department.

They were concerned about the wider implications within the emergency care system of ambulances stacking up at A&E departments unable to hand over patients and felt that this standard was very important,

> "If the standard is to be 15 minutes, then the wait should be no longer than 15 minutes."

Participants in the second workshop felt it was more important as an internal measure of performance than to them personally. These participants believed that if all patients, regardless of how they arrived at the department, were then queuing for assessment, then it isn't necessary to separate one from the other.

How important is it to you to know about the time taken to initial assessment - percentage within 15 minutes

All our participants agreed that this was a standard they would want to know about. All felt that setting this at 15 minutes was an ambitious target and wondered how speedy initial assessment would make much difference to the overall wait in the department.

They acknowledged that their reaction was coloured by their perception of long waits in A&E having become the more usual experience. They wondered how this would be changed by the adjustments made within the system currently in response to the Covid 19 pandemic, such as wider triaging, elsewhere in the health system. One of the participants said he had been impressed recently at seeing the degree of assessment undertaken by paramedics in advance of a trip to A&E.

The participants felt that for this standard to be meaningful, assessment needed to deal with the potential barrier posed by the reliance on questions relating to pain, which in the case of patients with spinal injuries was inappropriate.

Participants raised the issue of limited physical space in local A&E departments, when A&E assessments were delayed, and that space was under pressure even in 'normal' times, without the additional pressure now with the demand for social distancing. This also impacts on the patients' experience of using the service.

How important is it to you to know about the average (mean) time in the A&E department for patients who are not admitted?

Participants wondered if this standard would tell them anything valuable. They told us that relying on an average is "dispiriting" or "an average may actually be a reflection of nobody's real experience."

> "There must be a better standard than this?"
>
> "An average doesn't really tell me anything".

However, the participants acknowledged that this was a simple, easy to understand standard and that made it attractive. They commented that how this was calculated was very important, that it must be calculated over a range of days and times across the year, to attempt a more accurate measure.

Hospital admission

How important is it to you to know about the average (mean) time in the A&E department – for patients who are admitted?

The participants had similar reservations about reliance on an average for this standard too. They stressed the value of the right clinician being available at the right time, particularly with reference to patients with long term conditions experiencing a clinical emergency, to prevent lengthy waits.

They felt, however, that this was an important standard as a management measure. They were aware of the constraints that could delay admission, such as bed availability.

How important is it to you to know about the proportion of patients who are admitted within one hour of it being safe to do so (Clinically Ready to Proceed)?

Participants expressed a degree of scepticism about this standard and some felt that like the current four-hour to treat standard, could encourage action being taken to avoid *"busting the standard"* which may not be the most clinically appropriate steps.

They felt that patients would rather wait in the Emergency Department and get appropriate treatment in the right place then be moved around the hospital even if that meant a longer wait.

Whole system

How important is it to you to know about the percentage of patients spending more than 12 hours in A&E?

Our participants felt that such a long wait was never acceptable and therefore would want to know about this standard.

How important is it to you to know about the Critical Time Standards for some conditions?

Participants understood that these standards were clinically driven and as such felt that made them the most important of the standards.

Is there anything else that you think should be included in the bundle?

Participants felt that the standards should include a measure of patient experience which would let them give feedback about their treatment and experience. They believed it was important to remember patient wellbeing whilst in the system. And stressed that this was enhanced by good communication to keep patients informed about delays, incidents and likely length of wait. The participants firmly believed that communicating well with patients - about both the specifics of their own wait and more generally about the situation in the department - improved the overall patient experience.

Our participants told us that information and communication should take many forms, beyond the usual NHS leaflets, the television and frequently broken refreshment machine in the Emergency Department. They told us that the waiting room felt like a vacuum and was not an environment that promoted wellbeing.

They proposed:

- someone tasked with monitoring patients' experience in A&E, circulating the room to update patients, and see if there was anything that would make patients' wait less onerous? Described as *"a professional floater"*.
- A mini survey or feedback form, or even just one question about being kept informed, a question that highlighted the importance our participants felt about communication.
- A push button 'rate your experience' machine.

They also stressed that they wanted assurances that measures were taken within the system to act on the information and intelligence provided by the standards.

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?

The participants suggested:

- A local media campaign – although only some of the participants advocated for this whilst others felt that people only wanted this sort of information when they were within the A&E system.
- Promoting through GP surgeries – the point was made that a lot of regular visitors to GP surgeries were also users of A&E services.
- Involving the people using the service - service users should be included designing how people are informed about new measures. This is about the importance of people feeling that they are a part of something not that 'something [is] being done to them'.
- Keeping wider health and care staff informed - the participants who worked in other parts of the wider health and care system told us that they had 'added value' if they were able to inform the people they helped to care for, about changes in services.
- We live in a multimedia era – use all the methods available, including social media.
- Incorporate new standards into NHS apps to provide an opportunity to see up to date performance measures when considering accessing urgent and emergency services.
- Learn from the Covid 19 dashboard of key measures[2].

Additional points our participants wanted to raise

- An emphasis on equality with the people with the greatest clinical need to be seen first.
- It is damaging to wait without information.
- Improving internal communication allowing staff access to the full patient record.
- Use technology to enable patients to access their own records digitally.
- Encourage clinicians to look at the whole patient especially with multiple conditions, not just taking the single and immediately presenting condition.
- Note the time lost within the system due to poor and inadequate communication.
- Specialist services should be accessible on an emergency basis to assist with triage even if only via the phone.

[2] https://coronavirus.data.gov.uk/

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