

Time and Quality Targets – the English Experience

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England 2000

Ambulance offload
delay
Trolleys in corridors
No beds available
Ambulance diverts
Violence against staff
Staff recruitment
problems

Patient complaints
Litigation
Poor clinical
performance
Adverse events rising
Specialist withdrawal

My department

120,000 new pts/yr

40 adult beds

10 paed's beds

8 bed CDU

17% admission rate

98% leave in 4 hours

Expanding role

Increasing budget



Why did we get a four hour standard?

How did we achieve it?

What made it work?

Was it real?

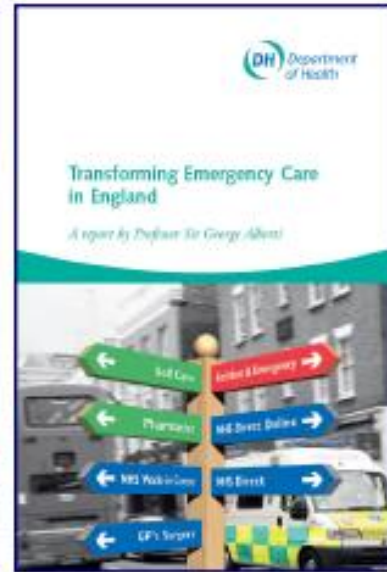
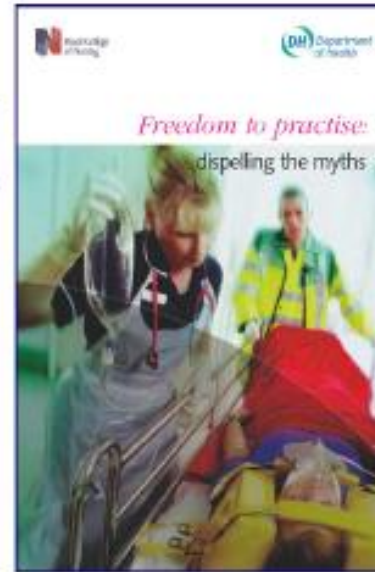
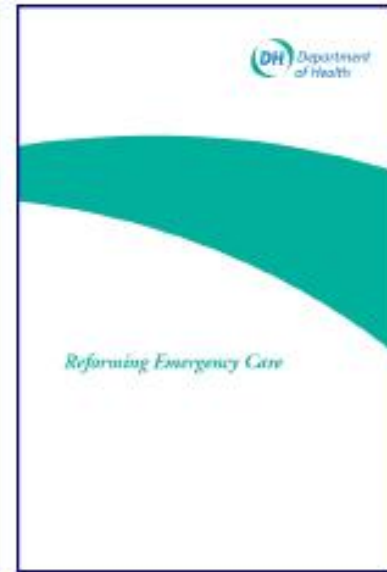
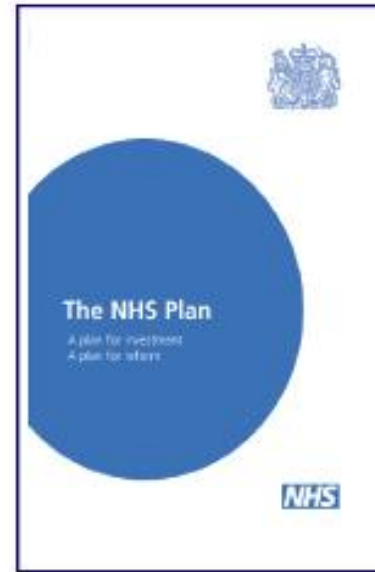
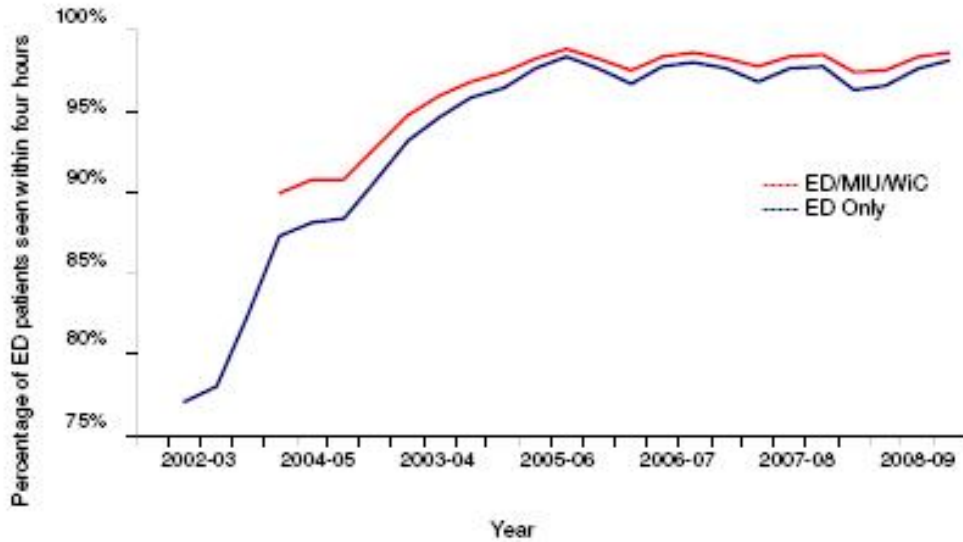
What is happening now?

Does this apply to Australian EDs?

Why it happened?



United Kingdom – Four Hour Target Performance



Modernising Emergency Care

The UK Perspective: The Story So Far.

Guide implementation guide
Wait for assessment

Welcome

Against a high level of demand, emergency care has achieved significant improvements and patient experience has progressed considerably towards meeting patient expectations.

Time to first assessment has been demonstrated to be one of the key determinants of patient experience in emergency departments and assessment units. 'Wait for Assessment' is now the highest remaining breach cause nationally. These delays can, in most instances, be resolved by changes focused within the Emergency Department.

Recent checklists have provided guidance on reducing breaches of the 4-hour operational standard due to waits for a bed and waits for a specialist. This document provides guidance on reducing breaches caused by 'Wait for Assessment'.

Where first assessment could or should be undertaken by a relevant specialty, this document should be read in conjunction with the Wait for Specialist Checklist.

Any feedback or requests for further advice should be addressed to: emergency@nhs.uk

Click [here](#) to enter the guide



Reforming Emergency Care

2001

1. Patients have to wait too long for care and treatment
2. Staff capacity in A&E departments is too stretched
3. Capacity in Hospitals is not sufficient
4. Delays in Discharge patients from hospital
5. Patients with emergency needs compete with those who have elective needs
6. Diagnostic and other services are not available at evenings and weekends
7. Patients are expected to wait in a single queue in many A&E departments
8. Demarcation of Working Practices
9. Patients end up going to the wrong service
10. The whole system is fragmented
11. Standards of care vary in different parts of the system

Analysis

Manufacturing Industry Techniques

- Reducing variation
- Process not diagnostic groups

Healthcare Commission benchmark data

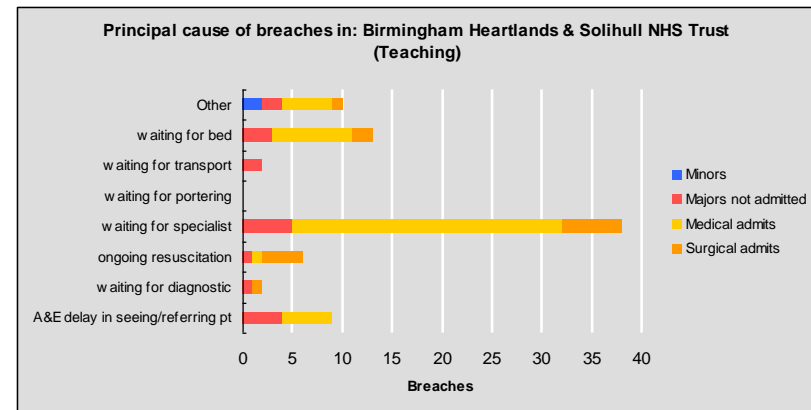
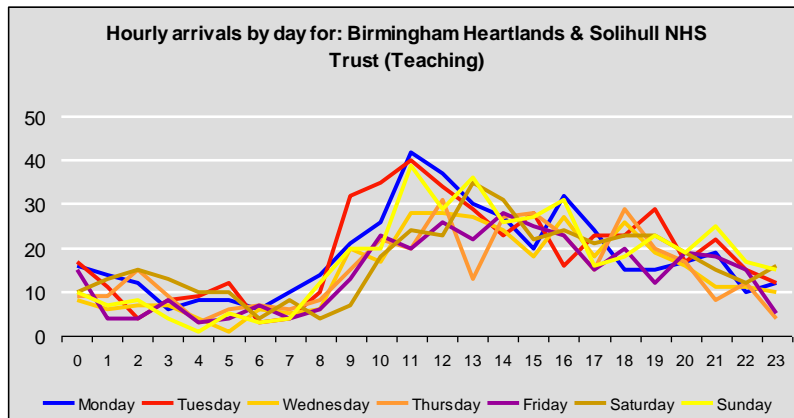
National Survey

Dept of Health Toolkit

DATA

Data is great, live data is even better
Understanding

arrival patterns
when long waits occur
why they occur



Before the ED

Improved access to primary care

Prevention e.g. assaults, alcohol

Chronic Disease management

Alternative sources of care

Ambulance service

- 999 call handling
- Alternative destinations
- Ability to treat and discharge



In the ED

Senior involvement early

See and Treat

Diagnostics and access to results

Social care and frequent attenders

Staffing levels, surge capacity

Live data and progress chasing

Primary care in the ED

In the ED -See and Treat

Senior Staff

Separate Staff

Separate Area

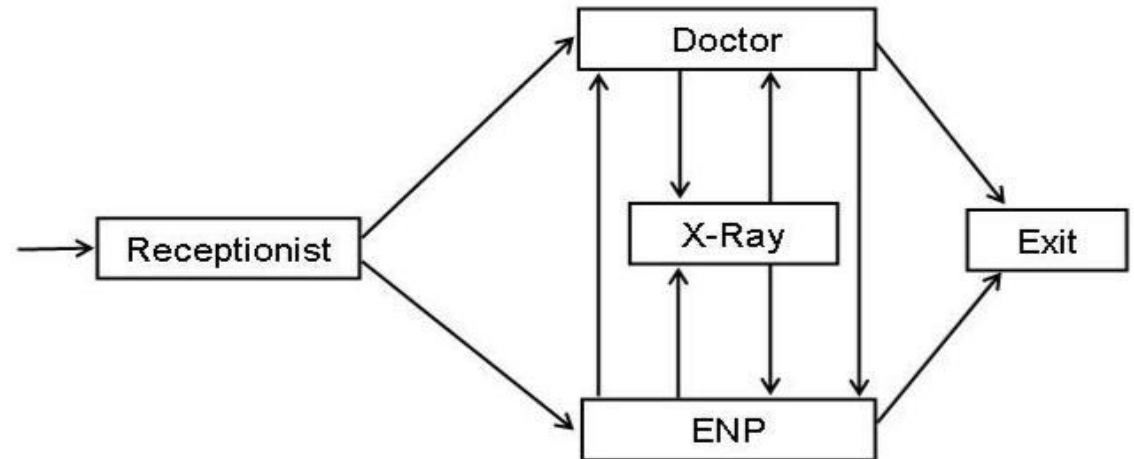
Separate Flow

No triage

Nurse Practitioner

National Programme

?? TWO hour target



"See & Treat" Patient Flow

The triage controversy

Abandon triage

Now or later



Only when wait is excessive but.....

In the ED – Rapid Assessment Team

Senior team receive patient

Rapid assessment

Early decision

- Admit
- Discharge
- Think

In the ED – after referral

ED staff send them to the ward

Use of Assessment Units

Waits for specialist initiative

Mental Health issues



Beyond the ED

Bed availability

- Bed occupancy
- Predictive analysis
- Reducing length of stay
- Planning electives



Outflow

Discharge planning

- Simple discharges
- Complex discharges

Discharges before midday

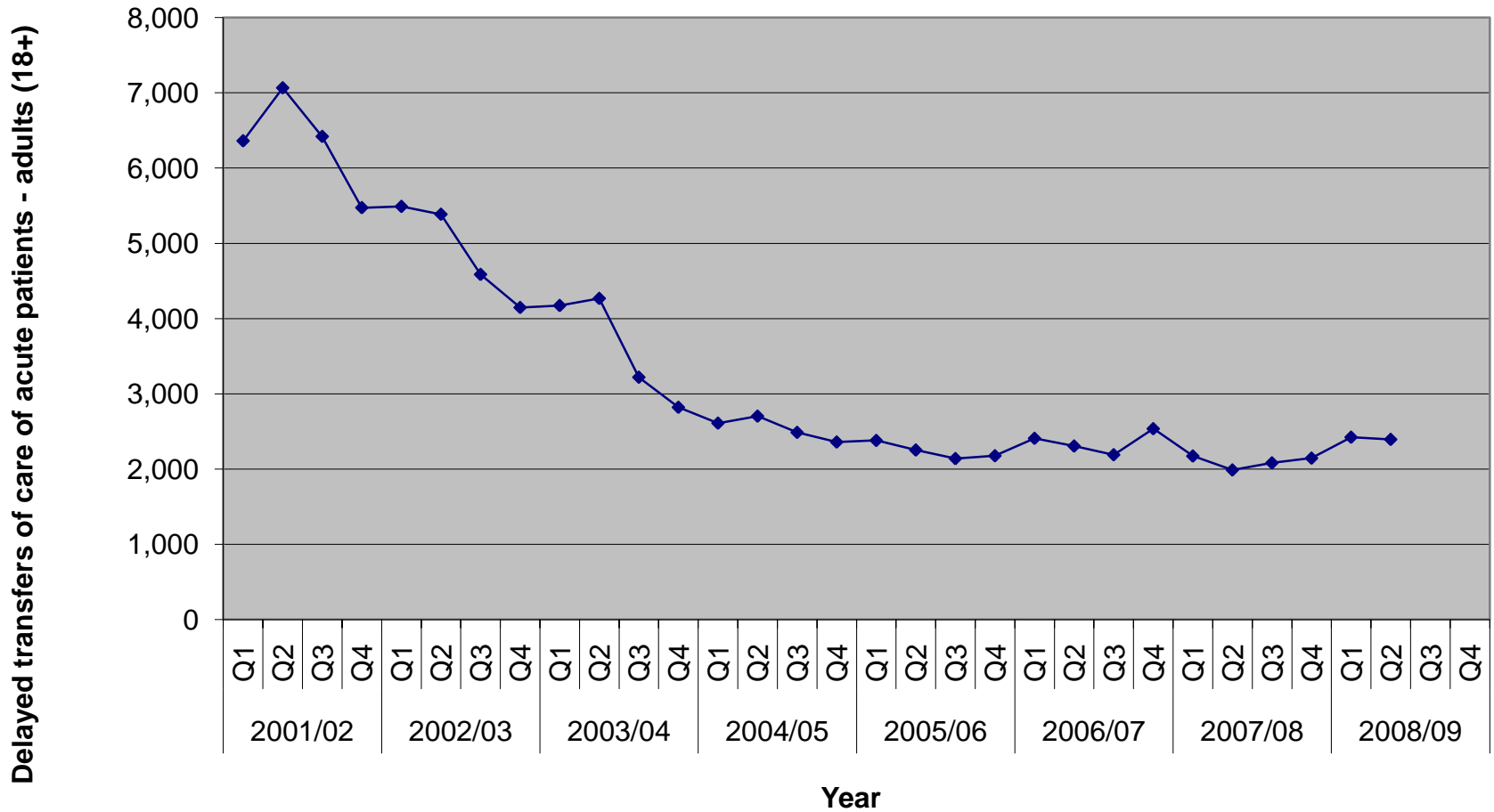
Discharge Lounges

Weekend Discharges



"Don't look at me! You're meant to be discharged!"

Delayed Discharges, England, 2001/02 to Q2 2008/09



BMA 2005

According to the BMA^[2] the main reasons for not reaching this target are:

Not enough inpatient beds

Delayed discharges

Delay in accessing specialist opinion

Not enough nurses

Not enough middle grade doctors

Department too small

Delay in accessing [diagnostic services]

Make the diagnosis before you decide the treatment.

www.warwick.ac.uk/go/edwaits

General issues

Predictable Events

Executive and senior clinician involvement

Whole system working

Tackling issues directly

Capacity management

How did we do it?

High Profile Target
Clinicians and evidence
Royal College Involvement
Checklists and Toolkits
Incentives



Emergency Services Collaborative

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Wednesday, 23 January, 2002, 20:42 GMT

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The case that sparked a storm



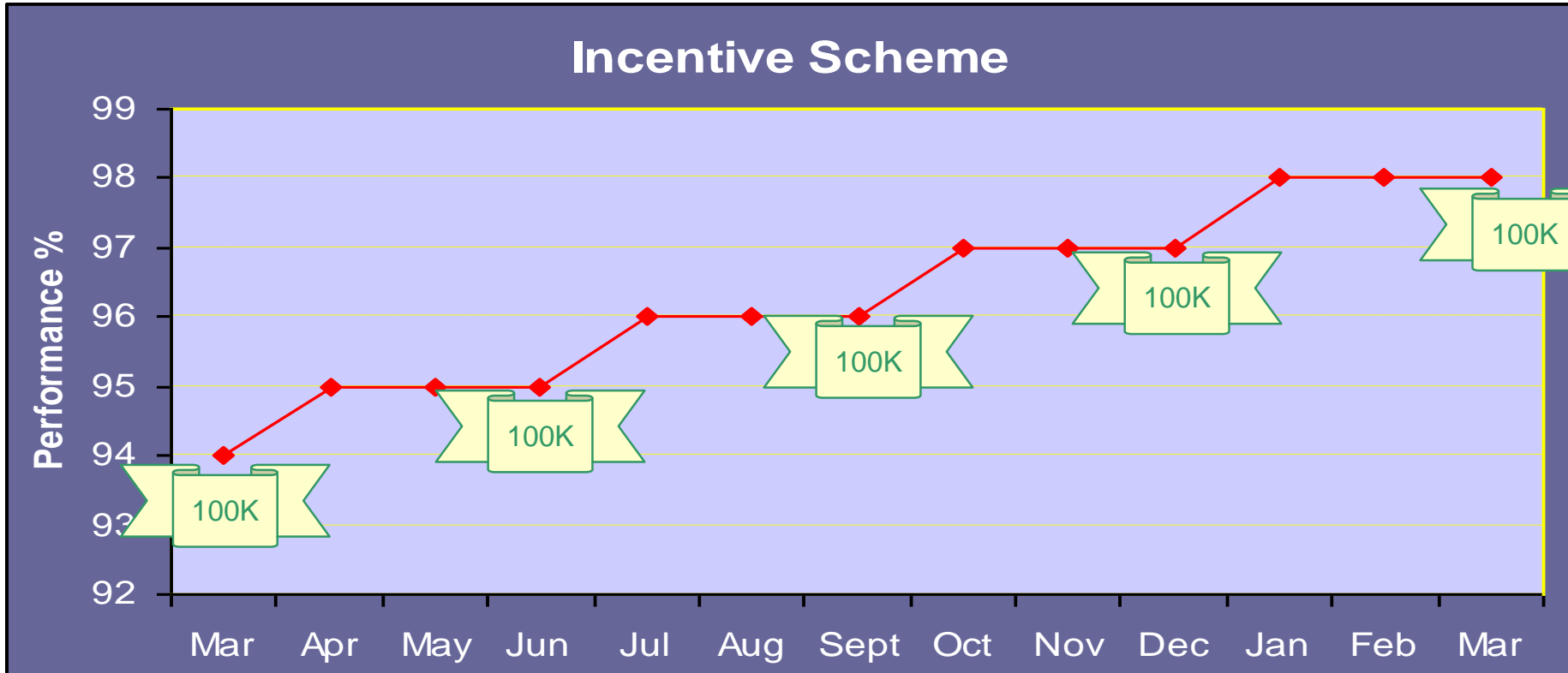
Rose Addis's family claims she was left unwashed

A fall at home has landed in 94-year-old Rose Addis at the centre of a political row over the state of the NHS.

Her family claim she was left abandoned, unwashed and bloody for nearly three days in Accident and Emergency at a London hospital.

COMMONWEALTH GAMES**BBC SPORT****BBC Weather****SERVICES**Daily E-mail
News Ticker
Mobiles/PDAs

Financial Incentives



.....and perverse incentives

New roles

- Emergency Nurse Practitioners
- Nurse Consultants
- Emergency Care Practitioners
- Emergency Department Practitioners
- Consultant Physiotherapists
- ED Technicians



- 48% of patients treated in my ED didn't see a doctor

The continuing saga of “inappropriate attenders”

Right Place First Time

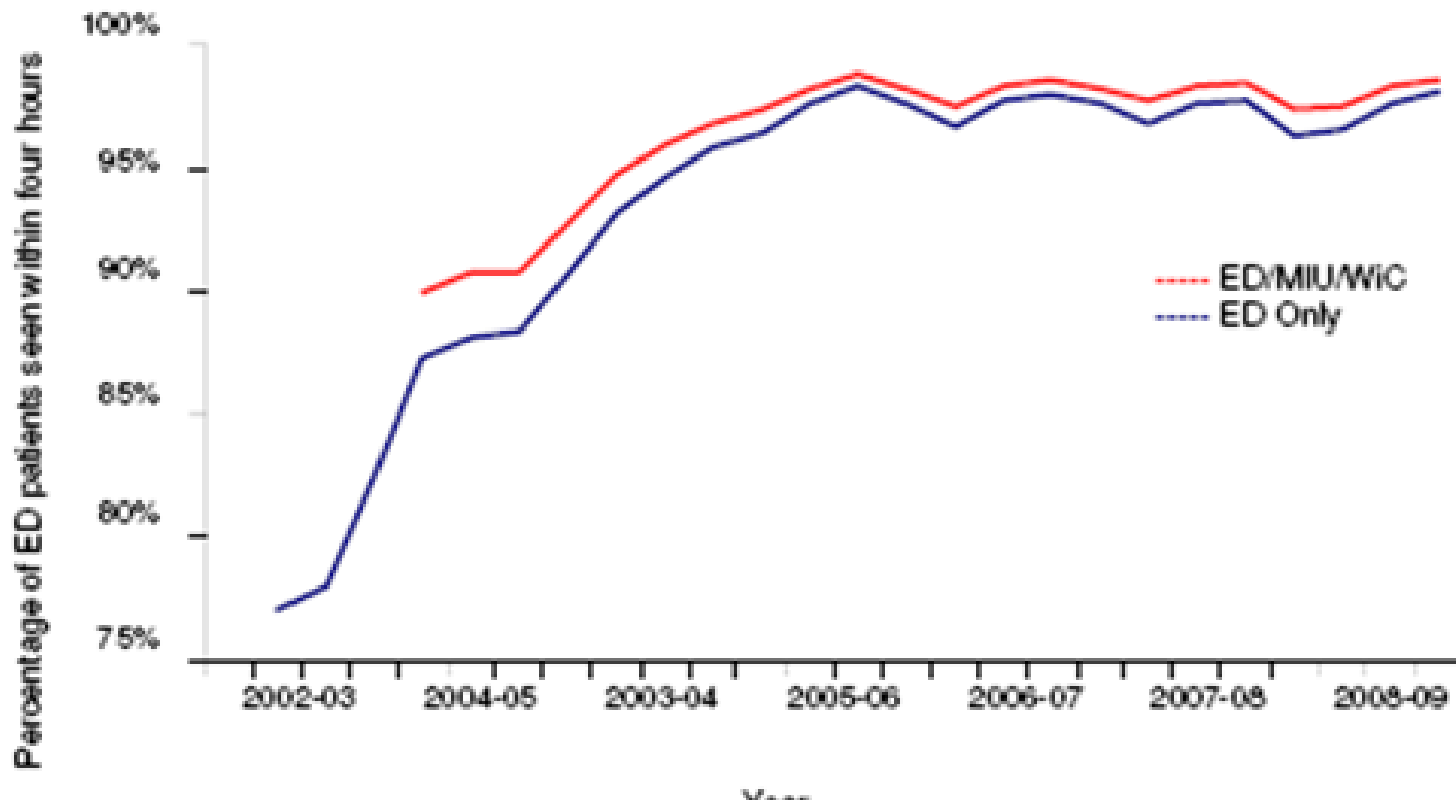
Or

Make the ED the Right Place



- 999 advice (hear & treat)
- Ambulance discharge (see and treat)
- Correct destination (see and refer)
- Other open access services

United Kingdom – Four Hour Target Performance



Is it really 98%

Gaming

Rules

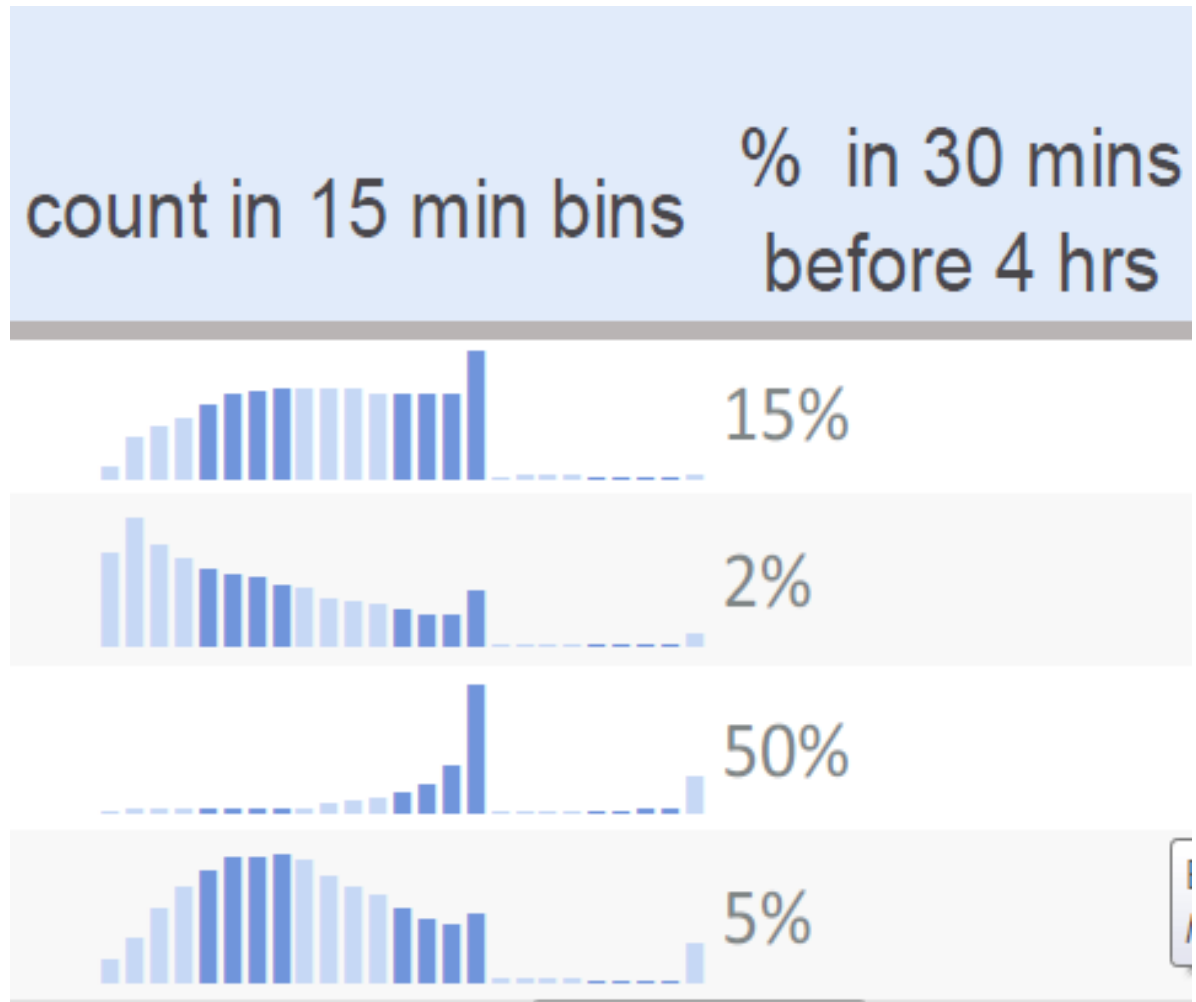
- Type 3 EDs
- Excluded patients
- Clinical Decision Units
- Assessment Units

Adverse effects

- ? Increased attendances
- ? Staff stress
- ? Time before quality

- ? Excessive Focus on the target

Does it
discourage
modern
emergency
medicine?



PMDU

“The A&E story represented powerful evidence of how thoughtful reform combined with effective management of performance could radically improve results quite rapidly”

“Many staff celebrated their success...but a few cynics in the NHS who hated government targets did their best to shoot the service they purported to defend in the foot”

Sir Michael Barber

Instruction to Change, 2007

Harvard Review

“ No evidence for any of the dysfunctional effects that have been hypothesized in connection with this target”

The target “produced efficient enhancing improvements in treatment ethnologies”

Stephen Kelman

Kennedy School of Government 2006

Changing culture

Silos, Tribes & Specialists

Worker inspired, worker led

Measured in ED – Cause and Effect

My CEOs approach...

But we can all do something

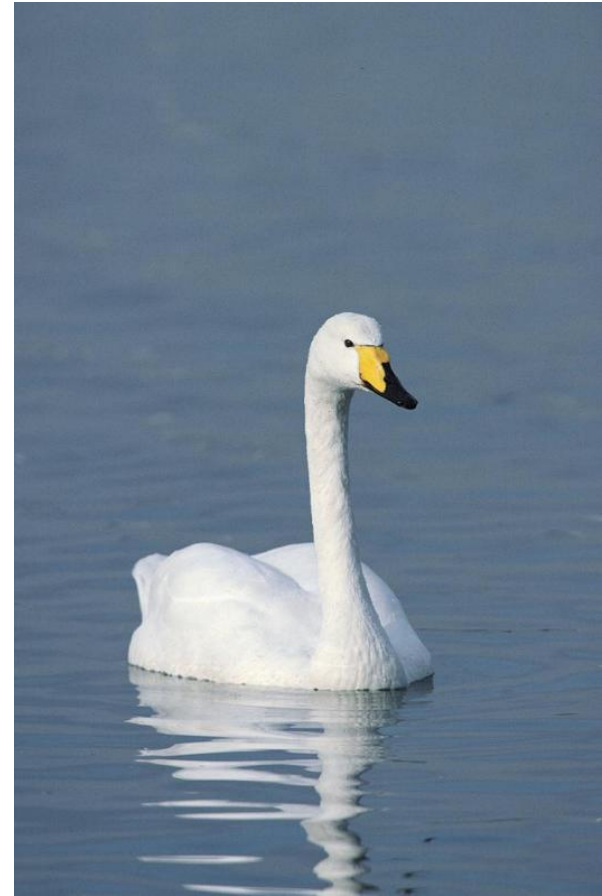
The continuing problems 2009

Availability of beds

Surge capacity

Time to stop and think

Time at expense of.....





And then....

Warwick
Medical School



WARWICK



- Representing nurses and nursing
- Promoting excellence in practice
- Shaping health policies

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RCN welcomes reduction in four-hour target

Published: 21 June 2010

The Royal College of Nursing welcomes the move to reduce the four-hour accident and emergency waiting time target in England. The target rate has been reduced to 95 per cent in the revised NHS Operating Framework for the NHS in England 2010/11, published today.

The RCN has been explicitly calling for greater flexibility around the target for a long time and is pleased the government has listened but RCN Chief Executive & General Secretary Dr Peter Carter says it is essential to get the balance right:

"The four-hour A&E target has undoubtedly helped to improve patient care by reducing waiting times for treatment. However, nurses have been telling us that they were put under tremendous pressure – in some cases to the detriment of patient care – to meet the 98 per cent target. We are therefore pleased that the government has listened to our explicit calls to make patient care safer by increasing flexibility around the treatment of A&E patients.

4 hour standard reduced to 95%
immediately

Replaced from April 2011

New quality indicators, publically available

More freedom for local NHS

Outcomes based assessment by
government

Replacing with clinical indicators

Outcomes
Experience
Safety
Timeliness



Do you need to have a 4 hour target and address quality and safety?



Thank you



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