

This response is co-signed by the Association of Paediatric Emergency Medicine (APEM).

## **Introduction**

The Royal College of Paediatrics and Child Health (RCPCH) welcomes this opportunity to respond to the proposals outlined in this consultation by NHS England and Improvement. Our response builds on the expertise and experience of RCPCH members delivering urgent and emergency care to children and young people, reflecting our role in specialist training for paediatric emergency medicine and setting service standards through our leadership of the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings.

RCPCH is a member of the NHS England Urgent and Emergency Clinical Advisory Group (as described in Appendix A of the consultation paper<sup>1</sup>). To support our role on this group we brought together an advisory group with membership drawn from paediatric emergency medicine, emergency medicine, and emergency care nursing to consider the proposals arising from the NHS England Clinical Review of Standards and ensure children and young people 'get the right care fast, while reducing both unnecessary admissions to hospital and very long waits.'<sup>2</sup>

We hope our feedback is helpful and we would be happy to expand on this response further if that is necessary.

### ***Urgent and emergency care for children and young people***

Our response is made through the lens of children and young people, a group whose needs are often overlooked despite the fact they make up 25% of attendances for urgent and emergency care. The aim to provide the best high-quality care possible should include minimising the time that children and young people spend in emergency settings.

We are aware that definitions of children and young people in urgent and emergency care settings vary across local practice and policies. While the upper age limit for some emergency departments is 16, others see and treat those up to 18 years of age, with more adopting this practice over the last year during the COVID-19 pandemic. Defining children and young people up to age 18 is aligned with the UN Convention on the Rights of the Child and consistent with a common safeguarding message.

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<sup>1</sup> NHS England 2020. Transformation of urgent and emergency care: models of care and measurement Available at: <https://www.england.nhs.uk/publication/transformation-of-urgent-and-emergency-care-models-of-care-and-measurement/> [accessed 11 February 2021]

<sup>2</sup> NHS England. Clinically-led review of NHS access standards. Available at: <https://www.england.nhs.uk/clinically-led-review-nhs-access-standards/> [accessed 5 February 2021]

## Key themes in our response

We have commented on the individual measures and answer the specific questions posed by the consultation paper below. Ahead of this detailed feedback we highlight the some cross-cutting themes which we consider are important:

***Reflecting the experience of children and young people*** - Data collected under these proposals must be available in a disaggregated form so that the measures for children and young people can be seen separately from adult data. This is especially vital for waiting time data as children are generally 'brought to' emergency and urgent care settings, rather than choosing to attend. Similarly, what may be viewed as a reasonable waiting time or clinical approach for an adult may not be considered appropriate for a child, regardless of the acuity of their condition.

Not being able to see the children's waiting times distinctly from adult waiting times may give skewed information; this is especially true for the non-admitted children as their durations of stay may be submerged within the larger adult dataset. We have repeatedly encouraged this approach through the Advisory Group, and we welcome NHS England's commitment in these proposals to producing disaggregated data. We acknowledge that there will need to be decision about the age ranges which define a young person (up to 16 or 18) and would be very happy to assist in this discussion.

While we acknowledge a general paucity of validated paediatric outcome measures some do exist, or proxies can be found.<sup>3,4</sup> The majority of the proposed new measures are process based, and while clinical relevance may be assumed, it is not definite and cannot infer quality of care that is delivered. It was, therefore, a missed opportunity in the piloting phase not to report specific metrics for children and young people across the 14 sites. Future pilots must secure robust data for children and young people to allow judgements on the appropriateness and the validity of the measures relating to their care.

***Capturing all pathways of care*** - In addition to emergency departments and urgent care centres, urgent and emergency care for children and young people is delivered through Short Stay Paediatric Assessment Units (SSPAU), sometimes called observation and assessment units. While the most common route for admission to an SSPAU is via the emergency department, referrals may also be received from primary care and other healthcare professionals, either directly to the unit or through the emergency department for initial triage and assessment before confirming the child's care as being most suitably managed within the SSPAU. Routes and rates of referral will vary depending on the unit. These proposed measures should reflect and accommodate these alternative pathways. At present, we are aware that when accounting for long waits patients in SSPAU may 'get lost' in the admitted population when they are waiting long periods of time in nothing more than a waiting room or on a trolley.

***Improving patient flow*** - The need to review and revise national standards is an important one and we strongly support the overarching commitment to ensure that overcrowding does not occur in emergency departments. This need is particularly acute given current measures to maintain social distancing and reduce risk of SARS-CoV2 infection. More generally, this is important for children and young people as the emergency department may represent an unfamiliar and disturbing environment,

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<sup>3</sup> Bele S, Chugh A, Mohamed B, Teela L, Haverman L and Santana MJ. 2020. Patient-Reported Outcome Measures in Routine Pediatric Clinical Care: A Systematic Review. *Front. Pediatr.* 8:364 <https://www.frontiersin.org/articles/10.3389/fped.2020.00364/full>

<sup>4</sup> Alongside our response we have shared the outputs of an exercise to detail time related standards in NICE guidance and recommendations relating to the paediatric patient population.

particularly to very young children with limited understanding of events around them or those with specific learning needs.

***Driving improvements in care*** - We note that the ambition with these proposed measures is “to strengthen the offer for patients, delivering improved access and outcomes, addressing health inequalities and giving a better experience of care.” Improvements may arise from these proposals that benefit the delivery of care and management of children and young people, but this will be dependent on and subject to further work to define and clarify the measures themselves and performance thresholds. As measures of access to care, these proposals will not on their own achieve the ambitions outlined by the review as they dwell primarily on process measures. Embedding quality markers within the details of these proposals will provide the opportunity to contribute to improvements in delivery of urgent and emergency care.

***Defining the measures*** - From the proposals presented it is evident that many details are yet to be developed. We look forward to seeing further definition of the measures and the thresholds for acceptable performance along with the processes of encouraging improvement as well as the monitoring system and surrounding governance that should accompany these measures so that they can be seen to be effective and useful from the outset.

***Reporting data*** - Data to demonstrate performance against all measures should be easy to collect, analyse and report. As far as possible, this process should be automated and resources should not be diverted away from delivery of care. In reporting performance against the proposed measures, it will also be important to show ranges for total duration of time in the Emergency Department, so that departments are required to declare the minimum and maximum time children and young people spent in the department.

## **Feedback on proposed bundle of measures**

### ***1. Response times for ambulances (Cat 2)***

***Comment:*** It would be considered unacceptable for a child to have a prolonged wait to receive urgent care but appreciate it is extremely challenging at the point of contact to determine relative acuity. Protracted ambulance response times may just be a sign of an overloaded or over-cautious system and it might be worth considering response times for a suite of specific conditions in which there is demonstrable evidence of poorer outcome with prolonged delay in definitive assessment.

### ***2. Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances***

***Comments:*** It is not clear from the consultation paper which category of 999 calls would be captured within this measure.

While this measure has face validity, the determination of an agreed definition of avoidable conveyance could be challenging and will require input from across the entire urgent and emergency care pathway.

As part of this determination, it will be important to consider whether avoidable conveyance is defined nationally or locally, based on services available. The latter

obviously diminishes the utility of a national standard but the former would require considerable resource adjustment as mandatory conveyancing decisions (e.g. < 2 years automatically being brought to hospitals) are not currently nationally sanctioned.

It also highlights the need to disaggregate data collection and measures for children and young people, as described above.

### **3. *Proportion of contacts via NHS 111 that receive clinical input***

**Comments:** This measure needs more information on the definition of clinical input (i.e. specialty, experience). Is the aim that few require clinical input as a result of well-defined and efficient NHS 111 algorithms or that high quality is delivered because access to clinical input is readily available?

For either approach there needs to be a measure to judge whether clinical input is adding true value or compensating for poor systems.

We understand that recent informal work to increase access to paediatric clinical expertise via NHS 111 has been successful. We would encourage further work to establish the full value that this approach can offer as part of a package of integrated urgent and emergency care measures.

### **4. *Percentage of Ambulance Handovers within 15 minutes***

**Comments:** This is a relevant measure but it must be clear that the handover is to a clinically relevant member of staff (i.e. someone able to undertake an assessment – see (5) below). The importance of disaggregation is relevant here. It is unacceptable to keep children waiting in ambulances.

### **5. *Time to Initial Assessment – percentage within 15 minutes***

**Comments:** We support this measure. The Intercollegiate Standards for Children and Young People in Emergency Care Settings state “All children attending emergency care settings are visually assessed by a doctor or nurse immediately upon arrival with clinical assessment undertaken within 15 minutes to determine priority category, supplemented by a pain score and a full record of vital signs”.

It is important that time to assessment is a full assessment as described above (i.e. including priority categorisation, pain scoring and a full record of vital signs) and not just a visual inspection. It may be challenging for many emergency departments to achieve this standard at present, but it will hopefully be a catalyst for improved staffing and process changes and hence the quality of emergency care offered to children and young people.

Our experience with this measure has demonstrated that performance against a 15-minute target ebbs and flows over a 24-hour period. Reporting averages over a 24-hour period will not accurately, or appropriately capture, performance in an emergency department.

This measure must be disaggregated and thought given to the timescale for assessment. In peak evening periods, this time may be unacceptably long, but a daily average will hide this important safety issue. Therefore, it is important to present both the percentage achievement of the time to initial assessment on a daily basis and the

minimum and maximum time to assessment on a rolling daily, weekly and monthly basis. We believe it would also be appropriate to report the median time to initial assessment on a rolling daily, weekly and monthly basis.

**6. Average (mean) time in Department - non-admitted patients**

**Comments:** We support the separation of the two different groups (admitted and non-admitted) and highlight any standards based on this may need to be considered separately from adults.

It should also reflect any care delivered in a SSPAU. While the most common route for admission to an SSPAU is via the emergency department, referrals may also be received from primary care and other healthcare professionals, either directly to the unit or through the emergency department for initial triage and assessment before confirming the child's care as being most suitably managed within the SSPAU. Routes and rates of referral will vary depending on the unit and these proposed measures should reflect and accommodate these alternative pathways.

We do not believe that mean is the correct measure unless the data is normally distributed - instead a median should be used (with 95% confidence intervals or - if that is not possible - a minimum and maximum length of time and IQR (interquartile range) on a rolling daily, weekly and monthly basis).

**7. Average (mean) time in Department - admitted patients**

**Comments:** The measure should avoid classifying a child who comes through an emergency department straight to an assessment unit as an 'admission'. We recommend that care delivered in a SSPAU should not be regarded as an admission.

We do not believe that mean is the correct measure unless the data is normally distributed - instead a median should be used (with 95% confidence intervals or - if that is not possible - a minimum and maximum length of time and IQR on a rolling daily, weekly and monthly basis).

**8. Clinically ready to proceed**

**Comments:** We understand the rationale for introducing this new measure, but clearer definition and detail are needed to avoid any misinterpretation or error. What is the definition of proceed? Is it when the emergency department judges a patient is ready, or when inpatient/specialty team(s) judge(s) patient is ready? There is considerable variation in this across clinical groups and without tight definitions the measure will be meaningless.

This measure will also need integrated electronic systems in all reporting sites to enable it to be collected in a valid way and in real time.

**9. Percentage of patients spending more than 12 hours in A&E**

**Comments:** This is a relevant measure but 12 hours seems an unnecessarily prolonged time and we would suggest reporting 6-8 hours, and we would refer to the above

suggestion regarding minimum and maximum length of time on a rolling daily, weekly and monthly basis.

## **10. Critical Time Standards**

**Comments:** The stated aim of the critical time standards is to provide highest priority patients with high-quality care with specific time-to-treatments with proven clinical benefit.

We welcome the consultation paper's acknowledgement that specific paediatric critical time standards are needed. Through our work with the NHS England Clinical Advisory Group, we have submitted a proposed standard for neonatal fever. A vital signs composite is going to be developed as part of the national standardised PEWS programme (System-wide Paediatric Observations Tracking, SPOT).

### **Are there any additional measures that should be included within the bundle?**

We note that earlier versions of the basket of measures included specific reference to Same Day Emergency Care pathways (SDEC). While there are currently few SDEC pathways developed for children and young people, this may change in time. Reporting the proportion of patients presenting with a condition suitable for SDEC (from a defined list) that are managed along that pathway would be a useful measure of the operation of an integrated system of urgent and emergency care.

It may also be useful to report the proportion of children attending emergency departments versus those directly attending a paediatric assessment or short stay unit, with admission rates to hospital from both. This will enable a review of the scale of change of paediatric emergency care services over time.

As noted above, developing paediatric critical time standards will be an important part of the bundle of measures and offer the potential to improve the quality of care in emergency settings. We are keen to continue to provide support in this important area, using agreed guidelines and standards to drive access to clinical care, such as time to antibiotics in sepsis, the percentage prescribing of Movicol in constipated children, the use of asthma plans in discharged patients.

### **To what extent do you agree with the recommendation to replace the current measure with the proposed new bundle of measures?**

We strongly believe that the whole bundle of measures should be equally applied across the range of services providing acute and emergency care to include urgent treatment centres, emergency departments, medical and surgical assessment units, specialty assessment units (such as SSPAUs), and SDECs.

Further discussion, engagement and consultation will be essential to ensure that the final measures and associated thresholds of performance are designed and understood so that they meet the ambitions for this work.

As part of these discussions, we would strongly urge that the resourcing and operational demands associated with reporting these new measures are well understood. All opportunities should be taken to provide support to implement IT systems that can

collect and report data with minimal additional human input once established. The measures should be easy to adopt and apply in all urgent and emergency care settings.

**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?**

We agree provided the start and end points are clearly defined and consistent across the entire system (to reduce opportunities for “clock stops”). There is also value in including the range of performance for a particular measure (as described in comments on individual measures, above).

**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?**

Given the College’s role in paediatric emergency medicine and subject to the comments provided in this response, this bundle of measures (and the associated definitions) seems reasonable if data is collected and reported in a disaggregated manner. As we have already outlined above, this is especially vital for waiting time data as children are generally ‘brought to’ emergency and urgent care settings, rather than choosing to attend.

We note that these proposals have been informed by research into the views of patients and the public aged 18 and over, but that no specific engagement activity has been undertaken with children and young people. Through our RCPCH &Us programme of activity, we have gathered the views and experiences of children and young people on urgent and emergency care. This informed the development of the Intercollegiate Standards for Children and Young People in Emergency Care Settings, and we would encourage NHS England to reflect in a similar fashion as these proposals are developed further.

From our engagement work we know that children and young people are concerned about waiting times for urgent and emergency care, but also about information sharing between different parts of the pathway, a child-friendly environment in emergency departments, access to paediatric expertise, and the quality of initial assessments. Alongside this some children and young people with long term conditions report varying experiences in different settings across the urgent and emergency care pathway.

Guided by the United Nations Convention on the Rights of the Child (UNCRC) which was ratified into UK law in 1991/92, we need to support children and young people to have their voices heard in decisions that affect them (Article 12) and work with them to help shape services so they have the best healthcare possible (Article 24). We would encourage further consideration and action to be taken with regards to patients who are under 18 with due regard to the UNCRC.

We can see these proposals, through such measures as the critical time standards and well-defined initial assessments, offer an opportunity to encourage wider quality improvement that could lead to more consistent high-quality care for children and young people. Measures of quality should be included within the definitions of these reviewed and revised 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?**

These proposals represent a major change in approach to measuring performance in urgent and emergency care. Alongside communicating with patients and visitors, in our view it is important that those working in the services are advised about these changes, so they understand the measures, the policy intention and the responsibilities and opportunities that they offer.

Any advice for patients and visitors about the new measures will need to respect and be tailored to different communication preferences across different groups within the population. Some communications channels that would be expected to provide information about these changes include NHS online and social media channels, information leaflets across urgent and emergency health settings, and others in the community (such as primary care, pharmacy, dentistry), as well as through third sector organisations and local authorities.

**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?**

Before these measures can be implemented, further details will need to be provided to address key issues and barriers, including the following:

- Nationally accepted definitions, for consistency across different providers of urgent and emergency care settings, sharing understanding as to how measures can play a role in functional improvement
- Readily collectable data with consistent data fields
- Support to implement IT systems that can collect and report data with minimal additional human input once established.
- Governance of the measures, including expectations on reporting frequency, publication and accountability mechanisms
- Clarity as to how averages are to be assessed so comparisons can be made across systems to identify good practice

**Do you support the idea of a composite measurement approach to presenting the effectiveness of urgent and emergency care across a system? How frequently should this composite be updated and published?**

No. The proposal for a composite score appears to be an attempt to create an easily explainable metric to replace the public discourse around the current four-hour target at the expense of logic. The measures in the proposed bundle are not all of a similar scale or level of impact. To create an arbitrary summary measure from these disparate measures risks public misunderstanding and gaming of values which are easier to achieve. Further, it appears to defeat the purpose of moving away from a solitary measure upon which so much resource emphasis is placed.

A single score does not tell much unless there is weighting to different measures. Instead, the focus should therefore be similar to major trauma dashboards with scrutiny of individual measures to identify improvement projects. Any composite or summary reporting should be initially be published on a monthly basis.

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