



Royal College of
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11 February 2021

NHSE England and Improvement: Transformation of urgent and emergency care: models of care and measurement

Introduction

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to this consultation on the transformation of urgent and emergency care: models of care and measurement.
2. The RCGP is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has over 54,000 members who are committed to improving patient care, developing their own skills, and promoting general practice as a discipline. The RCGP is an independent professional body with expertise in patient-centred generalist clinical care.
3. It is essential that primary care pathways and implications are considered as these new standards are produced and implemented. The College believes that a collaborative approach to reform will lead to stronger outcomes across the system and supports the Royal College of Emergency Medicine (RCEM) in its calls for reform of the current standards.

A whole system approach to urgent and emergency care

4. The RCGP believes strongly that the healthcare system as a whole cannot be effective if any single part of it is not functioning well, and that problems or pressures in one part of the system will have repercussions across other areas of care. For that reason, we welcome this report's emphasis on taking a whole system approach to urgent and emergency care transformation.
5. Over the last decade, there has been a sustained decline in emergency department (ED) access as measured against the four-hour wait target.ⁱ While the reasons for this decline are complex and multi-faceted, increasing patient need is likely to be a key determining factor. As this report acknowledges, there is a significant proportion of care currently delivered in ED which could more appropriately be delivered in primary care. In other words, healthcare provision in ED and general practice (both in hours and out of hours) are inextricably linked, with patient behaviour shaped by ease of access to different services as well as the appropriateness of those services. Strengthening general practice is likely to reduce the burden felt by EDs, minor injuries and other urgent and emergency care services.
6. It is therefore disappointing that this review of urgent care standards does not fully engage with the role of primary care in delivering urgent care to patients with low-acuity conditions. While there is recognition that some patients may be more effectively managed in primary care, that management is not fully addressed, nor is consideration given to the possibility that new standards implemented in secondary care could have knock-on implications for primary care.

7. Equally, patient flows from primary care to ED settings are not addressed. At present, GPs often struggle to access urgent specialist advice for patients, and must resort to directing patients to ED, which can then assess and admit patients on an urgent basis. Such onwards direction is stressful and disruptive for patients, and places additional burdens on secondary services, even though (if supported with access to appropriate advice and guidance from specialists), GPs would be able to manage such cases in the community.
8. The RCGP would therefore support further work to better understand and integrate the role of general practice within urgent and emergency care pathways, and to ensure that GPs are able to access urgent specialist advice, so that they can provide high-quality urgent care outside a hospital setting.

A “bundle of measures”

9. With that caveat, the College is broadly supportive of the move towards a bundle of measures instead of a single access standard. It is our view that this approach will better capture the complex, multi-faceted nature of urgent and emergency care. The current four-hour standard only captures a small part of the patient journey, while any potential composite measure could conceal specific areas of weaker performance. A single metric is also more susceptible to uncontextualized and potentially misleading comparisons between services, which may undermine morale. In contrast, a bundle of measures can drive quality improvement across the whole pathway, encouraging all clinicians to work together rather than focusing on performance within the narrow window of a single measure.
10. The bundle of metrics is also an approach which can more easily be adapted if found not to be meeting needs, either by adjusting the current metrics, or adding in additional metrics. As the metrics are implemented on a larger scale, it may become apparent that there are key gaps or perverse incentives built into the chosen metrics, for example in terms of their interaction with primary care activity, so this flexibility is beneficial.

Performance thresholds

11. The move to a new system allows for a refreshed emphasis on the offer to patients, rather than on meeting a specific target. The RCGP believes that setting thresholds for performance may be counter-productive, incentivising ‘gaming’ in order to meet those thresholds, and thereby making the measures less useful as indicators of performance. For example, under the current system, there is a clear spike in admissions shortly before four hours, indicating that the need to meet a performance threshold may be driving clinical decision-making. Equally, it’s entirely possible to envisage a situation whereby new performance thresholds incentivise a shift in workload out of ED and into other

settings, such as general practice, without adequate support being provided to enable this shift, undermining patient care.

12. Rather than a blunt national threshold, quality improvement should take into account a provider specific initial benchmark reading. This would better account for both local factors outside the control of EDs, and the exceptional pressures currently facing all healthcare services. Furthermore, as the benchmarks would be based on current ways of working, there would be significantly less risk of perversely incentivising changes to operating models which could undermine patient care and overwhelm other parts of the urgent and emergency care system.

Phased implementation

13. Finally, it is important that the new metrics are implemented in a phased way. This will provide scope for clinicians, including those referring into acute settings from primary services, to be supported to understand and accurately report metrics. A gradual implementation will also allow further scope for 'beta' testing, to ensure that the selected metrics are adequately capturing urgent and emergency care activity, and to provide additional support to services as they move to the new suite of metrics.

ⁱ The King's Fund, *What's going on with A&E waiting times?* (March 2020).