From the Rt Hon Andrew Lansley CBE MP
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21 JUN 2010

Thank you for coming to see me on 20 May and for your advice on the future of the four hour waiting time standard in A&E.

Having taken into consideration your advice and that of Professor Matthew Cooke, I have decided that the four hour standard should be abolished from April 2011. The four hour standard is a process target. It provides an incentive to move patients through A&E quickly, but does nothing to ensure that patients are receiving the highest quality care. It is time to take a more balanced approach to measuring the quality of care provided by A&E departments and make sure that the needs of each individual patient is at the heart of the urgent and emergency care system.

I have therefore asked Matthew to work with clinical partners to put together a dashboard of quality indicators. Taken together these will give a broader picture of the success of each A&E department within the wider urgent and emergency care system. First and foremost there needs to be a focus on clinical outcomes and the experience of the patient – these are what really matters to patients. My intention is that information on these indicators will be made public for each hospital so that patients can see for themselves the quality of care provided. I would like to invite the College of Emergency Medicine, among other clinical partners, to work with Matthew on developing the dashboard.

However, I agree that timeliness of care is an important element of quality of care. There is clinical evidence that timeliness affects both outcomes and mortality. It would therefore be unacceptable for the timeliness of care to deteriorate. Moreover, I would expect to see the NHS continue to take action to reduce unnecessary delays. In particular, once a patient is ready to leave the A&E for the ward there should be no delay. For such reasons the abolition of the four hour standard will come into force from April 2011, allowing sufficient time for a balanced dashboard to be in place.

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Nevertheless, there is a distinction to be made between unnecessary waiting and active treatment. As you so clearly set out, modern practice involves more investigations such as CT scans, and more early treatments. As a result there are more patients who could benefit from a longer period of active treatment in A&E than the current 98% threshold allows for. I have therefore decided to reduce the threshold to 95% with immediate effect.

Timeliness will always remain an important element of any balanced approach to quality, but there needs to be a change of emphasis. Most importantly, timeliness must not be the only measure of care quality. You will therefore want to include this in some form when you are working on the development of the dashboard with Matthew.

I have copied this letter to NHS Chief Executives, Professor Matthew Cooke, Dr Peter Carter, General Secretary, Royal College of Nursing, and Professor Steve Field, Chair of Council, Royal College of General Practitioners.

With my thanks again for your advice.

Yours,

ANDREW LANSLEY CBE