Should we scrap the target of a maximum 4-hour wait in emergency departments?

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As waiting times increase, should we scrap the target of a maximum four hour wait in emergency departments? Experts debate the issue in *The BMJ* today.

Consultants Adrian Boyle, from Cambridge University Hospitals Foundation Trust, and Ian Higginson, from Plymouth Hospitals NHS Trust, say that the target should remain as there is no realistic alternative that exists to keep emergency departments running smoothly.

The four hour target for NHS emergency departments in England to see, treat and admit or discharge a patient was introduced in 2004 as a way to combat crowding. Crowding in emergency departments is consistently associated with increased death rates and long hospital stays. Boyle and Higginson comment that the target is a simple, well understood measure that drives flow throughout the whole urgent care system.

"Before the target was introduced, being a sick patient in an emergency department was pretty awful, emergency departments were often full, waiting times were long, and care was poor" stress Boyle and Higginson.

"There is no doubt that the target has reduced waiting times in emergency departments," they say. However, the NHS as a whole has not achieved it since 2015, and this reflects the increasing demand and our full hospitals.

They argue that, on balance, time based targets are probably associated

with reductions in mortality - and say, although the target applies only to emergency departments, "it has stimulated and driven greater understanding of the whole urgent care pathway."

"The NHS is likely to be facing its most challenging winter, with widespread financial and performance problems, staff shortages, and low morale. Eliminating the four hour target would only make this worse," they conclude.

But Peter Campbell, an independent public health consultant and guest lecturer at the University of Heidelberg, disagrees, cautioning that the pressure to achieve targets is not an improvement strategy and leads to perverse incentives and use of resources.

He says that when targets inspire fear they may be met by diverting resources to emergency departments and away from departments with no targets, where patients can wait for hours on understaffed wards. Indeed, he argues that such target-driven behaviour "was a cause of the Mid-Staffordshire scandal."

He highlights how processes have been introduced where departments favour younger patients at the expense of older patients, whose problems may take longer to treat.

"Targets are ultimately the result of negotiation and best guesses. So while a missed target could be due to departmental failure, it could equally be due to poor guesswork. If so, then rewards or penalties for performance cannot be awarded automatically. Why are unrealistic guess makers never held to account?" he asks.

In contrast to Boyle and Higginson, Campbell argues an alternative approach exists that interprets and responds to the data differently, using a two-step approach that he believes has been ignored for too long.

More information: *BMJ* (2017).
www.bmj.com/content/359/bmj.j4857