Clinically-led review of NHS access standards

Professor Stephen Powis, NHS National Medical Director, has published his interim report setting out proposals to update several of the existing performance standards set out in the NHS constitution handbook. The review was commissioned by the Prime Minister to ensure that NHS performance measures reflect and encourage the latest medical practice and support the delivery of the long term plan. This briefing provides a summary of the proposals. For further information, please contact: Claire.helm@nhsproviders.org.

Overview

The review proposes a number of changes to existing standards for mental health, cancer, physical urgent and emergency services and elective care. As set out in the NHS Long term plan, the review also introduces new standards for urgent and emergency mental health services

The interim report states that the new standards will:

- introduce short waits for a far wider range of important clinical services
- provide standards that help improve clinical quality and outcomes
- lock-in short waits for A&E and planned surgery
- help, rather than penalise, trusts who modernise their care.

The proposed new standards will be piloted and evaluated during 2019/20 which will form a transition year between the old targets and updated standards.

Mental health

There are currently several access standards that apply to a limited number of mental health services covering access to talking therapies, starting treatment for psychosis and eating disorder treatment for children and young people.

The Long term plan outlines how the NHS will continue on the current trajectory of substantially expanding mental health services to deliver parity of esteem with physical health services. The plans include continuing to expand access to talking therapies, perinatal mental health services and access to crisis care. In the next ten years the NHS 111 is the single point of access for anyone experiencing mental health crisis can access 24/7 age-appropriate mental health community support.

The Long term plan also sets out a range of other goals for crisis, community service, and new care models. A few of the changes for urgent and emergency mental health service and the projected trajectory for coverage are included in the review and set out below.

Projected trajectory for transformation in urgent and emergency mental health services

	Current	19/20	20/21	21/22	22/23	23/24	27/28
Expected % of adult liaison services at core 24	30%	40%	50%	59%	64%	70%	100%
Expected % of adult community mental health crisis services that are 24/7	45%	70%	100%	100%	100%	100%	100%
Expected % of urgent & emergency community and liaison children and young people's services at core 24	24%	30%	35%	47%	70%	100%	100%

Proposed mental health standards

The review recommends that the following standards be tested. In addition consideration will be given to any thresholds that might accompany the standards:

	Measure	Clinical rationale	Implications for patient care
1	Expert assessment within hours for emergency referrals; and within 24 hours for urgent referrals in community mental health crisis services.	While for many people with urgent mental health needs, A&E is appropriate, consensus among clinicians, patients and commissioners is that many urgent mental health needs could be met more effectively in the community. Appropriate response times will need to be explored as part of testing. Many local areas have already set a	Rapid assessment of needs to determine urgency, and clear communication of expected next steps to the patient or referrer. Many needs will be met on the telephone or by facilitating access to non urgent support. When people are assessed as having urgent or emergency needs, they will need timely face-to-face assessment from a

		local target of four hours, for example. However, the severity and need of individual patients will need to be taken into account – some patients will need a quicker response.	specialist mental health professional.
2	Access within one hour of referral to liaison psychiatry services and children and young people's equivalent in A&E departments.	Patients of all ages presenting in A&E in crisis require quick assessment to determine risk. If they are not seen quickly, the A&E environment can exacerbate symptoms and they may leave without treatment, potentially with risk of serious harm or suicide. Managing patients who have not been assessed adds pressure and anxiety to staff.	Someone experiencing a mental health crisis would receive a response from the liaison mental health service within one hour.
3	Four-week waiting times for children and young people who need specialist mental health services.	Waits for treatment for children and young people's mental health services vary significantly from referral to treatment. Long waits can impact both clinically and on the individual waiting for treatment.	Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS funded services and/or appropriate sign posting or interface with other services, including outside the provider and specialist community services.
4	Four-week waiting times for adult and older adult community mental health teams.	Clear waiting times are to be incorporated into the design of new integrated primary and community mental health services, to ensure that all individuals are seen within a clinically appropriate time.	Maximum of four weeks from referral to an assessment and start of treatment or plan in NHS funded services and/or appropriate sign posting or interface with other services including outside the provider and specialist community services.

Testing the mental health standards

Pilots to test the four-week commitment for children and young people's mental health are already underway. NHS England has asked pilot sites to set out what it would take for them to reach a four-week waiting time, track progress, and improve over the next three years.

In 2019/20, selected Integrated Care System (ICS) and Sustainability and Transformation Partnership (STP) areas will receive additional funding, working with primary care networks and other local partners, to deliver improved and more integrated community mental health care for adults and older people with moderate to severe mental health needs. As part of this, local areas will test the four-week waiting time standard.

The review states that the urgent and emergency mental health standards will be brought together with the wider changes in urgent and emergency care and tested together.

Cancer

There are currently nine specific cancer standards that have been in place in their current form since 2009. They measure the time taken to see a specialist following an urgent referral from a GP, the time to receive treatment from diagnosis and other standards depending on the occurrence.

One pillar of the NHS Long term plan is to improve early detection of cancer and to bring cancer survival rates in line with other comparative countries. The proposals set out in the review offer a faster diagnosis standard, bring together existing urgent referral routes into one standard and guarantee treatment is started quickly.

Under the new standards people will have the expectation of diagnosis within one month and treatment to start within two months.

Proposed cancer standards

The review recommends that following standards be tested:

	Measure	Clinical rationale	Implications for patient care
1	Faster Diagnosis Standard: Maximum 28- day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening.	Urgent cases include: • those referred by their GP with urgent cancer symptoms; • those referred by their GP with breast symptoms; • those referred by cancer screening services.	More explicit focus on measuring and incentivising early diagnosis, which is linked to improved survival rates. Improves on current two-week waiting time, as measures time to receive

		It is important that people are diagnosed quickly after referral so they can start treatment as soon as possible. Patients will need to have their first appointment with a consultant well before the 28- day point to ensure communication of diagnosis within that timeframe.	diagnosis, rather than time to be first seen by a consultant. Brings together existing urgent referral routes into one simple standard.
2	Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening.	Includes urgent cases as above. Having a single headline measure, and ensuring the clinical guidance governing inclusion within it reflects modern clinical practice, adds clarity and greater focus on what really matters.	Brings together three existing urgent referral routes into one simplified standard.
3	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	All cancer patients need to begin treatment quickly after the decision to treat is taken.	Maintains guarantee of swift start to treatment for all cancer patients. Brings together four existing treatment standards into one simplified standard.

Testing the cancer standards

The review is yet to determine how the new standards will be tested and evaluated. The interim report commits to engagement with key stakeholders, including the cancer community in agreeing the approach.

Based on the findings, the new standards are expected to be rolled out from April 2020.

Urgent and Emergency Care

The clinical review of ambulance standards in 2017 set out a range of new response time targets for the ambulance service. In addition to these there is one other urgent and emergency care standard - a maximum four hour wait in A&E from arrival to admission, transfer or discharge.

The four hour waiting time target has been in place since 2004. The review sets out a range of changes to urgent and emergency care services in the past 15 years which means that the standard is out of date. These include the introduction of NHS 111, specialist stroke services, trauma centres, heart attack centres and acute stroke units, and increased use of same day emergency care treatment.

The review sets out a list of shortcomings of the existing standard, all of which the review states are addressed by the proposed standards:

1. The standard does not measure total waiting times
2. The standard does not differentiate between severity of condition
3. The standard measures a single point in often very complex patient pathways
4. There is strong evidence that hospital processes, rather than clinical judgement, are resulting in admissions or discharge in the immediate period before a patient breaches the standard.
5. The standard is actually not well understood by the public who believe they will receive treatment within four hours.

The proposed changes in urgent and emergency care sit alongside other elements of the Long term plan including the improvements in community and reablement services which are aimed at reducing readmission to hospital.

Proposed urgent and emergency care standards

The review recommends that following standards be tested:

	Measure	Clinical rationale	Implications for patient care
Access standards			
1	Time to initial clinical assessment in Emergency Departments and Urgent Treatment Centres (type 1 and 3 A&E departments).	Focus on patient safety prioritisation and streaming to the most appropriate service, including liaison psychiatry and community mental health crisis services. This needs to be easily understandable for patients, and is regarded by the public as important.	This will identify life-threatening conditions faster. It ensures timely clinical assessment to identify anybody who is in need of immediate treatment, and allows patients to be directed to the service and practitioner best able to meet their needs at an early stage in the patient's journey.
2	Time to emergency treatment for critically ill and injured patients.	Highest priority patients get high-quality care with specific time-to-treatments, with proven clinical benefit.	Complete a package of treatment in the first hour after arrival for life threatening conditions such

			as: • stroke; • heart attack (MI-STEMI); • major trauma; • critically ill patients (including sepsis); • acute severe asthma; • mental health presentation
3	Time in A&E (all A&E departments and mental health equivalents).	Measure the mean waiting time for all patients. Strengthen rules on reporting prolonged trolley waits for admission, including reporting to the CQC.	Measures the time all patients are in A&E. Reduce risk of patient harm through long waits for admission or inappropriate admission. Reduce very long waits for those who need care.
4	Utilisation of Same Day Emergency Care.	Incentivise avoidance of overnight admission and improve hospital flow.	Identifies a group of patients with urgent healthcare needs who would benefit from rapid assessment and review by a senior clinician. The aim is to complete all diagnostic tests, treatment and care that are required in a single day, in order to avoid an unnecessary overnight hospital stay. Reduction in overnight admissions and improved patient experience.

Supporting indicator

5	Call response standards for 111and 999.	Assure a rapid response, and match patients (including mental health patients) to the service that best meets their needs.	Ensures that a patient's call is answered and assessed promptly when seeking help by telephone. Encourages patients to access out of hospital services, and to make use of telephone triage.

Testing of the urgent and emergency care standards

NHS England and NHS Improvement are identifying a number of sites to work with over the coming six months to field test the above measures. The sites will provide a spread in terms of geography, a range of urban, rural, and mixed communities and sites with varying current performance against the existing standard.

The testing cycles will run in four to six week cycles from April 2019, with plans to roll out the final recommendations to all trusts this autumn. Trusts that are not a test site will continue to measure the existing standard.

Elective care

There are currently three standards set out in the NHS constitution relating to elective care which cover how quickly a patient can expect to begin consultant led care, a diagnostic standard and a standard for those who have their operations cancelled at late notice.

It is evident that the introduction of the 18 week target had a significant impact in reducing the number of people waiting over a year for a routine operation.

The Long term plan states that the NHS will have a zero tolerance approach to people waiting over 52 weeks for a routine operation. The review argues that the extensive redesign of outpatients and diagnostics services over the next five years means that it is only right that changes to access standards to elective care are also considered.

The proposals put forward in the review see a continuation of a diagnostic standard but also says it will test two different approaches for measuring the waiting list. First, the tests will consider if the current thresholds are appropriate with the possibility of these being changed. Secondly, the testing will consider the impact of changing the measure to an average wait target.

Proposed elective standards

The review recommends that following standards be tested:

	Measure	Clinical rationale	Implications for patient care
Access standards			
1	Maximum wait of six weeks from referral to test, for diagnostic tests.	Ensure that patients are accessing diagnostic tests quickly, so that a diagnosis can be reached and treatment can begin in a	Need for more consistent achievement in all places. Achieve opportunity for faster overall pathway to diagnosis and decision and

		timely manner.	create a clear plan for treatment earlier.
2	Defined number of maximum weeks wait for incomplete pathways, with a percentage threshold. OR Average wait target for incomplete pathways.	Will test both approaches to consider the impact on prioritisation of care and reduction of long waits. Every week counts for all patients in achieving an average, hence keeps focus on patients at all stages of their pathway.	Measure from the point of referral until treatment. Clock stops and starts will reflect new arrangements for outpatients.

Supporting standards

3	26-week patient choice offer.	Ensures that patients who have not accessed treatment within recommended timeframe, are able to choose whether to access faster treatment elsewhere in a managed way.	Faster care for many patients by re-directing to providers who can treat them more quickly.
4	52-week treatment guarantee.	This is too long for any patient to wait and incentivising action to eliminate 52-week waits will focus on finding solutions to services that are unable to meet demand.	All patients must be treated within 52 weeks, with fines imposed on commissioners and providers who are jointly accountable if not.

Testing of the elective care standards

In line with the other changes, NHS England and NHS Improvement will field test variants of the two alternative approaches to the proposed elective access standards across a range of pilot sites with appropriate spread and mix. The review states that the testing approach is likely to involve a group of sites testing the use of average waiting times. Testing will seek to evaluate the changes to recording, changes to reporting, changes to operational process and the outcomes and experience for patients.

Next steps

- The proposals for each distinct service area will be tested across pilot sites.
- During the testing phase, NHS England and NHS Improvement say they will engage with partners and key stakeholders. This will include the clinical community, and patients and the public through working with Healthwatch.
- NHS England and NHS Improvement will evaluate the testing for each proposal by applying the following principles to guarantee the changes:
  - promote safety and outcomes
  - drive improvement in patient experience
  - are clinically meaningful, accurate and practically achievable
  - ensure the sickest and most urgent patients are given priority
  - ensure patients get the right service in the right place
  - are simple and easy to understand for patients and the public
  - do not worsen inequalities
- The public will be consulted on any changes to the NHS constitution handbook
- The timeframe broadly sets six months for testing with rolling out in the autumn. The final recommendations are expected in spring 2020.

NHS Providers view

Responding to the announcement of plans to trial new NHS clinical standards, including new standards for mental health and cancer care, the deputy chief executive of NHS Providers, Saffron Cordery, said:

"The key NHS targets have played a valuable role in improving access to care. They have become a widely recognised indicator of NHS performance. But clinical practice moves on so it is right to consider whether they remain relevant and reflect best practice.

"In order to win public confidence, it will be vital to ensure this process is clinically led and that any changes have been carefully tested and evaluated. Any roll out will need to be incremental and must have the full backing of the clinical community and leadership of NHS trusts. This is particularly important in view of the fact that performance against the current standards has slipped. We must guard against any sense of 'moving the goalposts' to bring the standards back within reach.

Ultimately, the decision to change the constitutional standards will lie with politicians. But it must be informed by clear and compelling evidence on best clinical practice – and driven by what is in the best interests of patients and service users."