NHSProviders

Briefing

March 2020

SETTING GOOD STANDARDS

for NHS patient care

Key points

- NHS access standards – measuring patient waiting times in a defined number of areas of NHS service delivery – were first introduced in 1999. As the successful amendment of the ambulance standards, and the introduction of new mental health standards, has shown, it is right to review these standards on a regular basis to ensure they reflect current clinical practice, meet the public's expectations of access to services and support patient safety.
- The current access standards have become central to the operation of much frontline service delivery. The standards fulfil a wide range of different purposes – clinically, operationally and in terms of planning, performance measurement, regulation and oversight, governance and accountability. This means that they are used in different ways by different groups of people. For example, members of the public are likely to want to use the standards to understand what quality of care they are entitled to if they need to use a local ambulance, mental health trust or hospital service. However, they are also likely to be interested in the overall performance of the NHS nationally against its key performance standards, given the centrality of the NHS in our national life and the fact that taxpayers fund it.
- The NHS' principal purpose is to provide outstanding patient care, so it is right that any review of standards should initially be clinically led. But before any standards are changed, it is vital that the needs of the different audiences who use the standards – clinicians, trust leaders, operational managers, politicians, regulators and the national bodies, and the public – should be fully considered. This may require difficult trade-offs – for example, frontline clinicians might prefer a basket of standards reflecting the complexity of care provided in a particular area, whereas those overseeing NHS performance might prefer a single, simple measure which allows easy comparison with historic and international benchmarks.
- The central role that the current standards now play in how the NHS operates, plans, oversees performance, and is governed and held to account means that the implementation of any changes to the current standards needs to be carefully thought through and fully planned. Changing the standards is a significant undertaking, particularly given the current operational pressure the NHS is experiencing. It is vital that all those involved in the use of standards are properly consulted on what will be needed, including the resource and time required, to ensure the success of any change. Obvious examples of potential challenges in implementation include:

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- The operational change requirements – the IT system, workforce planning, process flow, and changes in performance measurement – needed to adopt new standards in 132 different type 1 accident and emergency departments, for example. In assessing these requirements, it will be important to appropriately recognise variation across trusts, for example in their IT infrastructure.
- The changes required for trust boards, and for the national bodies and regulators, to adapt many of the measures they currently use to manage performance and regulation and oversight respectively.
- How NHS leaders responsible for performance at a national level can monitor NHS performance and be held to account for it, if the standards change in such a way that a comparison can no longer easily be made with historical data, or across UK/international benchmarks. How the robustness of national system performance data can be maintained over the period of transition if trusts move to implement new measures.
- How any changes to individual institutional level standards relate to the emerging new sustainability and transformation partnership (STP) or integrated care system (ICS), system-level performance measurement approach currently being developed.

- Current NHS performance against the standards is the lowest it has been since the standards were first introduced. This is likely to engender suspicion that any attempt to change the standards is being made because recovery of performance to the required standard is either impossible or very difficult to achieve, or will be too costly. It is therefore particularly important that any change should command widespread support across the NHS, politicians and the general public who fund and use the service.
- Debate on changing the standards has focused on the higher profile accident and emergency four-hour and elective surgery 18-week standards. While there are common features involved in changing any individual standard, the reality is that each individual potential change needs to be examined on its own merits and will have its own set of relevant factors. It is important that any debate on potential changes does not default to a generic 'lowest common denominator' conversation about change in general or pretend that talking about changing the four-hour A&E standard is an adequate proxy debate for any other change.
- Trusts support the proposals to develop new standards covering a broader range of mental health services. This is an important step towards parity of esteem in providing more information about the demand for, and access to, mental health services and a potential means to support more effective models of care. Trusts are also positive about the ambitions set out in the new cancer standards which would result in people receiving a diagnosis and starting treatment more quickly. If the NHS is resourced to meet these new standards, they will prompt a genuine improvement for patients.

- NHS Providers believes trust leaders will support any change to the standards, as they did with the ambulance standards and the introduction of mental health standards, if five key conditions are met:
    1. There is a strong, clear, and widely supported, clinical case for change.
    2. New standards are meaningful to patients and the public.
    3. Trust leaders are fully involved in the design, consideration and implementation of any changes.
    4. Implementation planning is realistic and honest about what resource and time is needed to make any change, taking full account of the current operationally challenged context.
    5. It is demonstrably clear that the changes are not an attempt to abandon the inherent performance in the current standards and that there is a credible, fully funded, agreed, plan to recover those inherent performance levels.

1 Introduction

The clinically-led review of access standards is expected to make a number of recommendations to amend existing waiting-time targets within the NHS within the next few weeks. It is therefore a timely moment to reflect on the history and purpose of those original targets, on the broader benefits and limitations of access targets within health and care, and on the multiple functions the constitutional targets have come to serve within the NHS as it operates today.

This briefing examines the range of functions that the existing standards currently fulfil and what will be required to amend them effectively and sustainably. We hope that this briefing will also support conversations to build a broad consensus about the purpose, role and future of access standards in the NHS among those who use the current standards in their different ways – NHS leaders, frontline staff, the public, politicians and wider stakeholders.

A short history of access standards

The purpose of NHS waiting time standards is to set out the maximum amount of time people can expect to wait before they are able to access certain forms of NHS care. The NHS constitution is enshrined in law and sets out the principles and values we can all expect from the service.[1] They also support the delivery of high-quality care in terms of patient experience and safety. The constitution should be renewed every ten years. The NHS constitution handbook provides more information about the rights and pledges staff and the public can expect from the NHS (including the current access standards) and can legally be amended by the secretary of state without public consultation.[2] Together, these documents provide a 'compact' between the health service and the public.

The bulk of the current access standards were introduced in the early 2000s under the Labour government in response to a very challenging performance position in which patients were waiting an exceptionally long time to access treatment.[3] The decision was made to focus on a small number of areas that were deemed particularly important to the public and the access standards were used as a means of driving and measuring improvements in operational performance in those areas. Following significant financial investment in the NHS over the period, measuring performance against the waiting-time targets was also used to effectively demonstrate the return on the extra investment to government and taxpayers.

The constitutional standards currently cover a range of NHS access points, including urgent and emergency care services (both ambulances and A&E), diagnostic testing, planned and routine operations and cancer screening and treatment.

1 Department for Health and Social Care, *The NHS Constitution*, July 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf

2 Department for Health and Social Care, *The NHS Constitution Handbook*, October 2018. https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

3 The Kings Fund, *NHS waiting times: our position*, August 2019. https://www.kingsfund.org.uk/projects/positions/nhs-waiting-times

As such, the constitutional targets are acute focused and do not include mental health or community pathways. Perhaps the most well known of the standards, often cited in political and media discourse, is the target to admit, discharge or transfer at least 95% of people within four hours of arriving in A&E. In relation to non-urgent, consultant-led care, the target is that 92% of people should receive treatment within 18 weeks. In terms of targets for cancer services, the standard is that patients should expect to begin treatment within 62 days of being referred for a suspected cancer.

There have been some small alterations to some of the standards over the years with the NHS leading the way with the introduction of mental health standards, the first in the world of their kind. In the last few years, the ambulance standards have been overhauled and there are plans underway to pilot two new community response standards which currently sit outside the clinical review of standards.[4]

The clinically-led review of NHS access standards

In 2018, Professor Stephen Powis, the NHS national medical director, was asked to carry out a clinical review of access standards across the NHS in England. The then prime minister commissioned the review to ensure that NHS performance measures reflected and encouraged latest medical practice and supported the delivery of the long term plan. In March 2019, an interim report was published which set out initial proposals to update several of the existing standards set out in the NHS constitution handbook.[5] The review also proposes to expand the number of mental health standards so they include a broader range of services.

Rightly, the review is clinically led and sets out that any changes to the existing standards must:

- promote safety and outcomes
- drive improvements in patients' 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
- not worsen inequalities.

4 NHS England, *Ambulance Response Programme*, 2017. https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp

5 NHS England, *Interim Report from the NHS National Medical Director*, March 2019. https://www.england.nhs.uk/wp-content/uploads/2019/03/CRS-Interim-Report.pdf

The proposed standards are being tested by providers across England. In January 2020, the national clinical director confirmed that testing for mental health and elective care would roll into 2020/21 and final recommendations for cancer and A&E are due this spring.[6]

As the review progresses at pace, the potential impact these changes may have on the NHS, and on the provider sector is becoming clearer (see section 5).

The proposed changes are significant and will require changes to the NHS constitution handbook which NHS England has promised would involve public consultation. This report is intended to examine some of the arguments involved, and act as a springboard towards the consensus needed in redefining such an intrinsic element of how the NHS operates.

Examples of successfully introducing new standards

In 2015, following a sustained campaign to move towards parity of access between mental and physical health care and in consultation with the sector, the first set of mental health access and waiting time standards were introduced.[7] The standards were focused in three areas:

- **Psychological therapies** – 75% of adults referred to the improving access to psychological therapies (IAPT) programme should begin treatment within six weeks of referral and 95% of adults referred to the IAPT programme should be treated within 18 weeks of referral.
- **Psychosis** – at least 50% of people experiencing a first episode of psychosis should start treatment within a National Institute of Care Excellence (NICE)-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral.
- **Liaison psychiatry** – Care Quality Commission (CQC) inspections of acute services should include a specific focus on liaison mental health services and mental health care, as well as the quality of treatment and care for physical conditions. By 2020, all acute trusts should have in place liaison mental health services for all ages appropriate to the size, acuity and specialty of the hospital.

In 2016, in line with initial ambitions to introduce access and waiting time standards across all mental health services, the government introduced waiting-time standards to improve access to **eating disorders services for children and young people**.[8]

6 NHS England, *NHS England and NHS Improvement board meetings held in common*, January 2020. https://www.england.nhs.uk/wp-content/uploads/2020/01/board-meeting-item-7-clincial-review-of-standards.pdf

7 NHS England, *Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16*, February 2015. https://www.england.nhs.uk/wp-content/uploads/2015/02/mh-access-wait-time-guid.pdf

8 NHS England, *Guidance for reporting against access and waiting time standards: Children and Young People with an Eating Disorder and Early Intervention in Psychosis*, February 2016. https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/02/tech-cyped-eip.pdf

By 2020/21, 95% of children and young people with an eating disorder should receive treatment within one week for urgent cases and within four weeks for routine cases.

After the largest academic study into ambulances in the world, and extensive piloting with the sector, the ambulance quality standards were updated in 2017. The ambulance response programme made changes that prioritised the sickest patients, ensuring they receive the fastest response, drove clinically and operationally efficient behaviours and put an end to unacceptably long waits by ensuring resources are distributed more equitably across all patients.[9]

The changes were piloted with two ambulance services in England and the University of Sheffield carried out a large-scale study in which over 14 million 999 calls handled with the new 999 script were reviewed over an 18-month period. The roll out of the new operational model was then staggered across different ambulance services with them now all working within the new framework.

The new standards, in the NHS handbook instruct the ambulance service to:

- respond to Category 1 calls in seven minutes on average, and respond to 90% of Category 1 calls in 15 minutes
- respond to Category 2 calls in 18 minutes on average, and respond to 90% of Category 2 calls in 40 minutes
- respond to 90% of Category 3 calls in 120 minutes
- respond to 90% of Category 4 calls in 180 minutes.

9 NHS England, *Ambulance Response Programme*, 2017. https://www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp

How do we use access standards?

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Existing access standards currently fulfil a number of different functions. In the areas where they exist, they play a key role in the provision of effective, quality care, and in regulation, performance management and oversight, as well as in planning, prioritisation and resource allocation. The standards also enable tax payers to hold both the government and NHS leaders to account for the performance of a publicly-funded service.

It is important that when we think about access standards, we take full account of each of these different purposes which we explore in more detail below.

Service level clinical – for clinicians and patients
Informed by clinical practice, the standards act as an expression of the responsiveness of the care and patient experience the NHS should be providing. Most of the standards have traditionally been widely regarded as a good proxy for the quality and safety of care (as far as possible within the constraints of a single measure). There is a danger, however, as we have found with the previous ambulance standards, that standards become outdated, particularly as clinical practice develops over time.

Service level operational – for clinicians and service managers
The delivery of consistently excellent frontline care requires the highly complex marshalling of a number of different elements – such as making best use of skills of a wide range of different staff, using physical and technological infrastructure/resources to best effect and structuring patient journey and flow in the best way possible.

Most trusts now use the standards as the key organising principle of service provision. The relevant standard for the service is embedded right at the heart of how providers operate, including in IT systems, how rotas are planned, how staff are deployed, how physical space (e.g. an emergency department) is used and laid out and providing frontline staff and trust leaders with daily, weekly and monthly performance management information that is critical for planning and providing services.

Trust level planning, performance measurement and governance – for trust senior leaders and boards
Having these clear metrics helps inform oversight and assurance mechanisms, which give trust boards evidence and insight into the quality and responsiveness of the care they provide. They act as a crucial suite of measures, to guide longer term and annual planning, prioritisation, staffing decisions and resource allocation. Traditionally, they have provided the foundation for how the acute and ambulance sectors have structured service delivery.

Trust, system and regional level oversight, support and regulation – for the arm's-length bodies

Access standards are a means of measuring NHS system-level performance in a near real time, which assists the arm's-length bodies in:

- supporting decisions on resource allocation and the identification of trusts needing support e.g. in identifying which trusts require additional support in their winter planning
- identifying trusts that need support in making quality of care and patient experience improvements
- providing an important element of the regulatory and system oversight framework.

National system level oversight and accountability – for the public, politicians and the media

The standards are a well established part of the 'compact' between the public who fund the service and the NHS. As a constituent part of the accountability framework between the public and the NHS, the public and politicians, and the government and the NHS, the standards provide:

- transparency of performance, enabling frequent and robust public, media and political scrutiny
- an accessible, understandable measure providing the public with the means to see what taxes are paying for
- a means of enabling the NHS to demonstrate over time that it is providing a return on extra investment (and often a means to evidence increases in demand and the need for additional investment)
- an instrument for the public and stakeholders to monitor the quality of care in their local services and to scrutinise the spending and promised improvements in the NHS – particularly where political promises have been made
- data which tracks NHS performance over time, enabling both local and national trend analysis, international benchmarking and benchmarking across the four nations in the UK which use broadly similar performance metrics.

Overall, the mechanism of having clear and easy to understand measures allows the public a clear and demonstrable means to hold politicians to account on manifesto commitments and policy changes. Importantly, the standards also act as a means for politicians and parliament to hold the NHS to account for the delivery of a key public service that accounts for 14.5% of all public spending.[10]

10 Department for Health and Social Care, *Department of Health and Social Care Annual Report and Accounts 2018-19*, July 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832765/dhsc-annual-report-and-accounts-2018-to-2019.pdf, and
HM Treasury, *Spending Round 2019*, September 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/829177/Spending_Round_2019_web.pdf

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The pros and cons of access standards

Over the past twenty years, waiting-time standards have become a central pillar in how the health service is organised, managed, overseen and held to account. In the words of The Health Foundation: "NHS waiting-time performance has dominated public and political debate since the late 1990s".[11] The move to monitoring and measuring NHS activity in this way has been mostly positive for the service and patients. There are of course pros and cons to any set of standards and how it operates in practice.

For years, the standards have played an important role as effective, understandable, proxies for the level of care the NHS should be providing. They correctly measured some key things patients consider important including how long people can expect to wait before being seen in A&E or for a routine operation. There were huge improvements in waiting times during the 2000s and the public and politicians saw a clear, tangible, measurable return on the extra financial investment made over the decade.

The link between performance against the standards, perceptions of overall NHS success, and NHS funding has also continued more recently. The continued decline in NHS performance against the standards, despite the NHS treating record numbers of patients, has been a key plank of the argument made by those calling for additional NHS funding.

Over the past decade, the access standards have been largely supported by clinicians. The royal colleges, for example, have consistently argued that standards have helped bring appropriate focus to their area (e.g. helping facilitate whole hospital mobilisation at times of extreme pressure in emergency departments or reducing the number of people waiting over a year for an operation).

Operationally, access standards have also given NHS leaders clarity on where to focus resources and prioritise, bringing a unifying purpose across a complex range of resources, activities and processes. These organising principles have worked effectively in terms of managing staff, infrastructure and resources for the last twenty years.

Lastly, as a key component of regulatory and oversight mechanisms, having clear performance metrics has helped contribute to the positive shift in quality improvement across the sector.[12] As a result, the access standards have been an important element in driving significant and important performance improvement – it is motivational for staff and trust leaders to see and be able to demonstrate service improvements.

11 The Health Foundation, *NHS performance and waiting times*, November 2019. https://www.health.org.uk/news-and-comment/blogs/nhs-performance-and-waiting-times?gclid=EAIaIQobChMI1_LzkavJ5wIV04jVCh1cMQKjEAAYASAAEgJ2kfD_BwE

12 NHS Providers, *Providers Deliver: better care for patients and service users*, October 2019. https://nhsproviders.org/news-blogs/news/providers-are-delivering-and-heres-how

Clinical perspective

However, from a clinical perspective, there is a strong argument that some of the standards no longer reflect modern clinical practice. A key example is in the case of urgent and emergency care. We know that in emergency care, the way care is provided has changed with significant growth in same-day emergency care.[13] NHS111, urgent treatment centres and A&E front door GP triaging have removed lower acuity patients from A&E departments, which would have typically been counted within the four-hour standard. Trusts have been left with more complex presentations which take longer to assess and performance against the four-hour target will inevitably be worse. This is the case even though the treatment provided to those patients attending may be just as good as it has been in the past, potentially even better.

The current standards may mean that the right data that accurately reflects all trust activity on a particular pathway is not collected. It is important to ensure activity is captured correctly so trusts can be paid fairly for what they are doing and their performance is judged fairly and accurately.

There is a danger with all standards that the focus on particular targets may distort clinical priorities. For example, mental health trusts increasingly tell us that sector investment has simply followed the standards, and that we are in danger, for example, of prioritising improving access to psychological therapies at the expense of provision for those with more severe and enduring mental health conditions.[14]

As with all standards or targets, there is a danger of creating waiting-list cliff edges, where trusts manage and provide care to meet the standard as opposed to what is best for the patient. For example, we know there is a spike in emergency admissions just before the four-hour mark in A&E to enable clinicians more time to make the decisions they need which also 'stops the four-hour clock' for the patient concerned. In reality, some patients may not need to be admitted, instead requiring a more straightforward intervention which can be given on the day.

Many also suggest that waiting-time standards reduce something that is inherently complex to potentially unhelpful simplicity – for example:

- there have been occasions when performance at 0.1% above standard is seen as good and 0.1% below standard as bad when the difference between the two are essentially the same in terms of performance
- when performance against standard has been regarded as the sole responsibility of a trust when it is often a function of local or national system conditions.

13 NHS England, *Clinically-led Review of NHS Access Standards Progress Report* from Professor Stephen Powis, NHS National Medical Director, October 2019. https://www.england.nhs.uk/wp-content/uploads/2019/10/crs-progress-report-v5-311019.pdf

14 NHS Providers, *Mental health services: addressing the care deficit*, March 2019. https://nhsproviders.org/mental-health-services-addressing-the-care-deficit

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Under the umbrella of the NHS long term plan, the NHS is adopting a much more integrated approach to the provision of care. However, the current measures do not reflect local system performance, out-of-hospital care or the full breadth of mental health provision. There is a danger of being locked into an outdated, acute hospital-centric view of what services the NHS should be providing. We also want standards which drive the right incentives and behaviours for an integrated approach.

Operational perspective

From an operational management perspective, the current standards are at risk of offering a very narrow definition of NHS performance – so the way trust leaders and managers organise services are tightly focused on a small basket of acute hospital dominated measures.

There is a danger that this focus has driven a culture focused on delivering narrowly defined targets as the key task for the NHS frontline, opposed to a much broader set of objectives, such as delivering excellent care, driving patient-centred improvement and empowering and engaging staff.

There is also concern that the standards drive particular types of top-down performance management behaviour. The interim people plan explicitly points to the need to move away from this top down, target-driven culture to a culture based on improvement, learning, support and staff empowerment.[15]

Public/political perspective

The standards offer a narrow definition of NHS success and fail to take into account the broader context (see section 5), which is not necessarily helpful in providing the full picture to the public or politicians.

The standards were positive in driving and showing return on investment at a time when investment in public services was increasing and in the absence of the critical workforce pressures seen today. But there is a danger that during the longest and deepest financial squeeze in NHS history and workforce shortages, that any standards drive an excessively negative view of NHS performance. Despite the fact that the NHS is treating more patients than ever before, and staff are working harder than ever, the prevailing NHS narrative is often one of the NHS failing to meet constitutional standards. This risks having a negative and demotivating impact on NHS staff and eroding public faith in the health and care model.

15 NHS England, *Interim People Plan*, June 2019. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

Performance against the current standards

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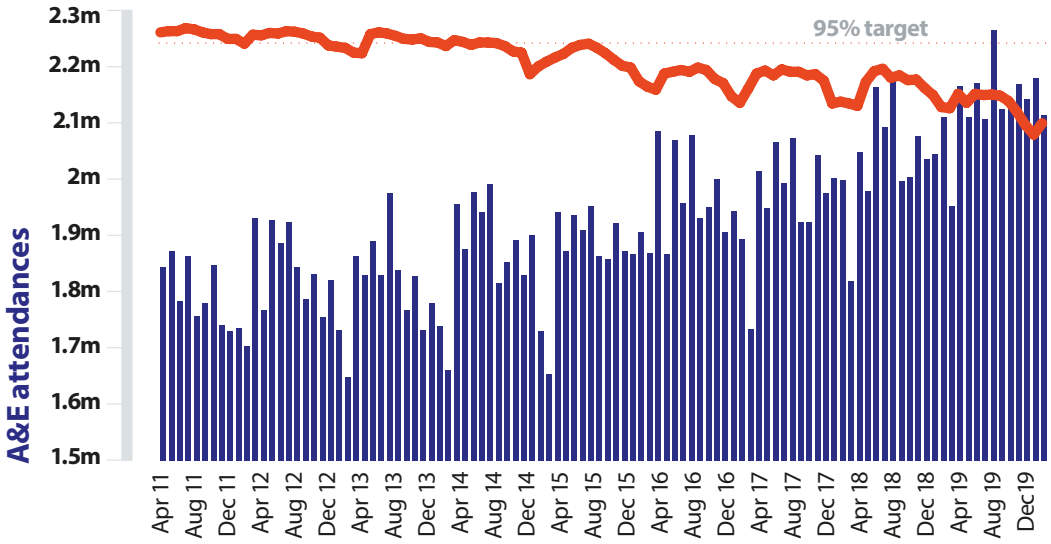
Parts of the NHS in England are experiencing the worst performance against waiting times targets since the targets were set.[16] Performance has steadily deteriorated over the past six years. This includes the highest proportion of people waiting more than four hours in A&E departments since 2004, and the highest proportion of people waiting over 18 weeks for planned hospital care since 2008. People are also waiting longer for diagnostic tests and to access cancer services than they were several years ago.[17]

Figure 1

A&E performance against the four-hour standard



16 The Health Foundation, *NHS performance and waiting times*, November 2019. https://www.health.org.uk/news-and-comment/blogs/nhs-performance-and-waiting-times?gclid=EAIaIQobChMI1_LzkavJ5wIV04jVCh1cMQKjEAAYASAAEgJ2kfD_BwE

17 The Nuffield Trust, *NHS waiting times: Missed targets, missed pledges?*, December 2019. https://www.nuffieldtrust.org.uk/news-item/nhs-waiting-times-missed-targets-missed-pledges

Figure 2

Percentage of patients waiting less than 18 weeks for elective treatment

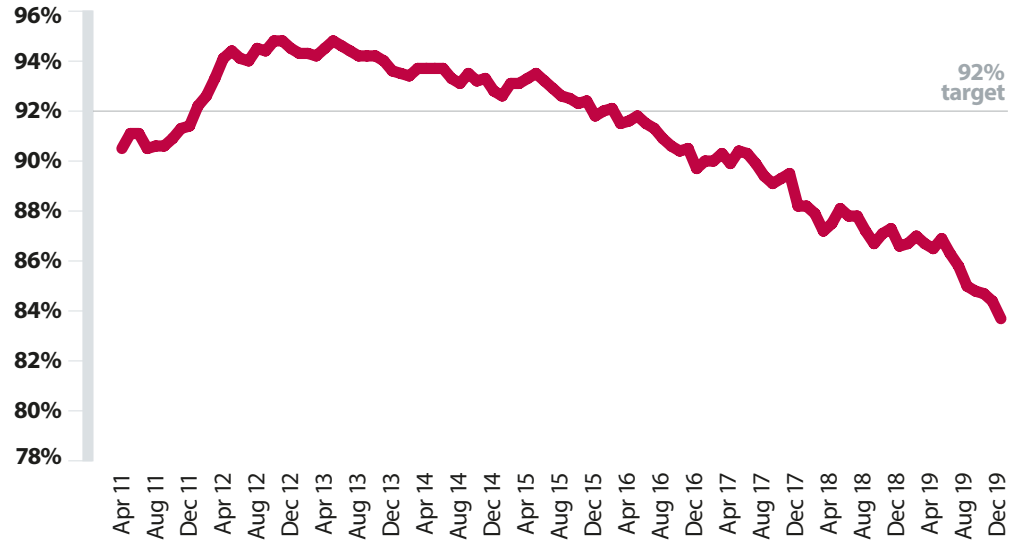
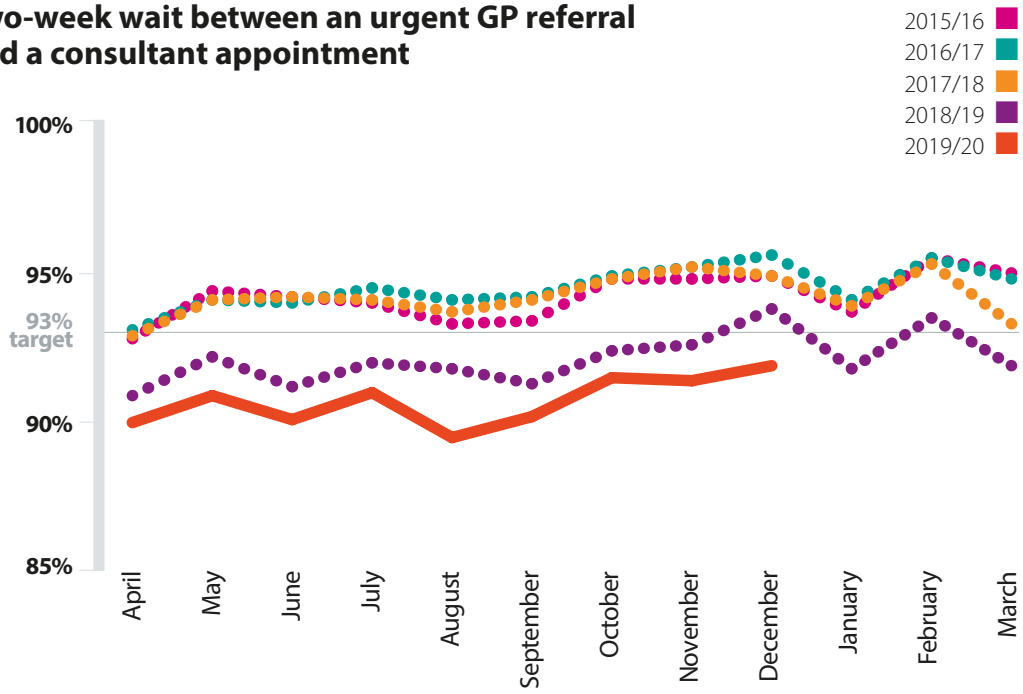


Figure 3

Two-week wait between an urgent GP referral and a consultant appointment



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These challenges are not unique to England, and performance against the standards has slipped across the UK. People are waiting longer for treatment as a direct result of the fundamental mismatch between capacity and demand. A growing and ageing population has fuelled rapid increases in demand for care compounded by a decade of much lower than average funding growth in the NHS and workforce shortages.[18]

This has four consequences which are important when reflecting on the changing context in which we need to review the use of access standards:

1. Some standards have effectively lost their relevance and become inoperative as a means of managing performance and motivating staff. If it's impossible to achieve the standard, they become redundant for these purposes.
2. The inability to achieve the standards condemns the NHS to the ongoing narrative of failure, irrespective of how hard or effectively NHS staff are working. We must be cognisant that this may undermine public confidence in services.
3. This makes a debate about changing access standards more tricky and complex because there will obviously be a perception that the standards are being changed because they can no longer be met, however strong the case for clinical change. This reinforces the need for a broad and wide consensus across all the relevant audiences on how and why any changes are being made and how the range of purposes they have filled to date will be met.
4. This also means that, to carry credibility, any changes need to be clear and explicit about the inherent performance levels being aimed for in relation to the existing standards. This is clear in the proposed changes to the cancer standard – an explicit improvement is being sought compared to the current standard. This is less clear in the proposed direction of travel on the A&E and elective surgery targets. Linked to this, if the new standards are proposing to improve (e.g. cancer) or recover lost performance (e.g. A&E and elective surgery), then any change must be accompanied by a clear, fully-funded and planned, credible, performance improvement plan and trajectory. This is particularly important at a point where some believe that there is already insufficient workforce and money to deliver the priorities in a long term plan that lacks a detailed performance trajectory. Changing any standard will not, by itself, improve performance.

18 The Health Foundation, *NHS performance and waiting times*, November 2019. https://www.health.org.uk/news-and-comment/blogs/nhs-performance-and-waiting-times?gclid=EAIaIQobChMI1_LzkavJ5wIV04jVCh1cMQKjEAAYASAAEgJ2kfD_BwE

Feedback on the proposed standards

4

Debate on changing the standards to date has focused on the higher profile accident and emergency four-hour and elective surgery 18-week standards. While there are common features involved in changing any individual standard, the reality is that each proposed change needs to be examined on its own merits and will have its own set of relevant factors. It is important that the debate does not default to a generic 'lowest common denominator' conversation about change in general or use proposals to amend the four-hour A&E standard as a proxy for the package of proposals within the clinical review of access standards as a whole.

We set out detailed feedback which we have received on each of the proposed new standards below from clinical and operational perspectives. Each standard under review has its own specific clinical and operational issues. However, there are some overarching considerations around the implementation of any changes which run across each clinical area:

- workforce challenges
- digital and technical capacity and capability
- information and data governance
- infrastructure and facilities constraints
- whether full opportunity has been taken to embrace the move to system working, or whether the proposed new measures are too organisationally focused.

Mental health proposals

Providers support the move to extend the breadth of the mental health standards. This is an important step towards parity of esteem in providing more information and data about the demand for mental health services. Hopefully, it will also help shift the current perverse incentives linked to the current mental health investment standard which does not always enable funding for mental health to reach the frontline as intended. Understandably, progress in this area is slower and it is important that all partners are brought into examine the proposals and comprehensively test new standards.

However, it has been noted that there are a number of barriers that may inhibit progress and successful implementation. There is a need to invest in building up mental health community provision and providers would welcome greater alignment between the review of clinical standards and NHS England and NHS Improvement's helpful programme to look at the model of provision for community services more generally.

Both acute trusts and mental health trusts flagged concern the introduction of psychological assessment centres in emergency departments may drive patients to acute hospitals and not community services, placing even more pressure on this pathway.

It is also clear that many mental health trusts do not necessarily have the digital capability required to implement the breadth of the proposals. Due to the nature of the referral-based approach, and timescales in the proposed standards, there is work to do locally between primary and secondary care providers around information sharing and data governance to build the capability. In the long run, this may be a positive development and further support local collaboration. However, building IT capacity across the sector will take time and have resource implications for trusts.

Urgent and emergency care

The proposals set out in the review mark a move away from one single measure – the four-hour A&E waiting time target – to a wider basket of urgent and emergency care measures. These include time to initial clinical assessment, time to treat the most critically ill and measuring the average wait in A&E.

Updates from the pilots show positive developments in consistently reducing the number of emergency admissions and the longest waits. It is also clear from research by Healthwatch that waiting time alone does not dictate how people feel about their experience of A&E and that the public may relate to a mean wait.[19] However, it is still unclear if trusts and the public will be issued with guidance on 'what a good average wait' looks like.

The current A&E target acts as an operational tool to assist trust with moving patients through the hospital and into other services. Feedback from our members suggests that this is harder under the new standards as operationally you cannot ascribe a mean wait to an individual patient – which prevents frontline staff from having a clear operational lever at their disposal to maximise patient flow.

There are also data and IT challenges. To fully move to the new basket of measures trusts need to submit data to the emergency care data set (ECDS) and a number of condition specific data sets (relating to the standard for those who are critical ill such as stroke, heart attacks etc.). The ECDS has been in development for a number of years and the ambition is that trusts should be in a position to submit data in a timely and accurate way.

However, providers tell us there is huge variation in trusts' ability to submit the full range of data required by the new standards. Digital capability is an issue for a significant proportion of acute trusts, and in the case of the new standards, is largely linked to the implementation of electronic patient records systems (EPRs). Without significant financial investment and support from national bodies, it is unclear how trusts who do not currently have the EPRs or the IT systems they need, will be able implement (and be held account) for delivering the new standards.

19 Healthwatch, *What matters to people using A&E*, February 2019. https://www.healthwatch.co.uk/report/2020-02-20/what-matters-people-using-ae

In addition, the proposed standards introduce new time points at which trusts need to capture data e.g. time to assessment. There must be clear and concise definitions around new measures to ensure trusts are consistently measuring the same things.

Trusts have told us that the additional clinical and operation data requirements are extensive and time consuming. Therefore, the value in dedicating additional clinical, coding and administrative time to implementing changes needs to be clearly understood and communicated to frontline staff.

Some trusts have queried whether the new basket of measures are too organisationally focused and whether they will act as a 'barometer' of system capacity in the same way as the four-hour target.

Trust leaders say that as with other areas of care, recovering the level of performance inherent in the current A&E standard is simply unachievable without an expansion in capacity and the right sizing of emergency departments, as well as expanding community and mental health support. Trusts welcome the recognition of this in the 2020/21 planning guidance, but we need more information about how improvements in performance will be operationalised and funded.[20]

Elective care

The proposed standards include the current six-week diagnosis standard, a move to an average wait target or fixed-week target and the supporting measures, 26-week patient choice offer, and the elimination of people waiting longer than a year. These two supporting measures set out in the 2020/21 planning guidance.

As a result of the longer periods of time involved in the elective care pathway, testing will continue into 2020/21 and therefore we will need to wait longer before we have any early indications of the benefits or possible drawbacks.

We know that elective care is currently a key concern for providers who are doing all they can to manage longer waiting lists than ever before. Trusts allocate beds and staff to help reduce the waiting list but with extreme pressure on emergency and cancer care, capacity is often the most challenging factor. We have consistently called for a growth in the number of beds in acute hospitals to help relieve these pressures. Trusts tell us that changing the standards in elective care must be supplemented by an expansion in capacity.

Capacity constraints are also being compounded by workforce challenges. In this area of clinical practice, shortages in the consultant workforce are being exacerbated by the ongoing NHS pension and tax issues.

20 NHS England and NHS Improvement, N*HS Operational Planning and Contracting Guidance 2020/21*, January 2020. https://www.england.nhs.uk/wp-content/uploads/2020/01/2020-21-NHS-Operational-Planning-Contracting-Guidance.pdf

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Cancer care

Trusts are positive about the ambition behind the new cancer standards and agree the new proposals will act in the interest of patients by driving faster diagnosis and treatment. In some respects, cancer services are better placed to move to the new standards as they already measure distinct points on the patient pathway. On the whole, this means trusts have the appropriate IT capability and implementing the changes will require less support.

However, trusts have expressed serious concerns around the deliverability of the new standards given specific workforce challenges in diagnostics and oncology, the need to update and invest in scanners and equipment across the country and the required roll-out of rapid cancer diagnostic centres. Trusts have also told us that they are struggling to resource the necessary administrative support to implement the faster diagnosis 28-day standard despite welcoming it as a positive move for patient care.

5 Conclusion

It is entirely right that the access standards are regularly reviewed and we fully support the clinical focus of the review and the principles on which it is based. It is timely to look at what standards are fit for purpose to support the NHS in delivering the vision set out in the long term plan.

However, we must remain mindful of the need to build a broad and wide consensus about what would constitute an appropriate set of access standards for the NHS. It is vital that we have a robust and rigorous process to do that in a way that is inclusive. We feel strongly that all those who have a stake in the standards need to be part of the debate: patients, the public, politicians, clinicians, leaders and managers.

Different standards and targets will always create different pros and cons. However, as we have established in this briefing, it is also crucial that we think carefully about all the purposes that standards fulfil within the NHS while recognising the primary importance of clinical considerations. It is only right that the start of process has had a strong clinical focus but we will soon need to broaden out the process of engagement and debate to take account of the other functions which these standards fulfil and to ensure there are no unintended consequences for any stakeholders involved. This is particularly important within the broader context of the shift to measuring a wider basket of outcome-focused metrics to track the progress and implementation of the vision set out in the NHS long term plan.

NHS Providers believes trust leaders will support any change to the standards, as they did with changes to the ambulance standards and the introduction of mental health standards, if the following five key conditions are met:

1. **There is a strong, clear, and widely supported, clinical case for change**.
   The changes must be evidence-based, in the interest of patients, reflect modern clinical practice; and align with the relevant clinical professional code. This will require broad support and consensus from across the clinical community including frontline staff, trust leaders and royal colleges.
2. **They are meaningful to patients and the public**.
   Access standards must resonate with the patients and their families, and the wider public. These standards are key in providing information about what they public should expect from particular NHS services, and offer a means to benchmark the performance of different providers.
3. **Trust leaders are fully involved in the design, consideration and implementation of any changes**.
   There should be an effort to facilitate a genuine and full debate with the hope of building a consensus across the provider sector. This must include thorough testing, wide sharing of results and the chance to fully consider what the proposed changes will look like through each of the purposes the standards fulfil as set out in this briefing.

4 **Implementation planning is realistic and honest about what resource and time is needed to make any change, taking full account of the current operationally challenged context**.
There needs to be proper due diligence on what resource and time any changes will actually take to deliver. Any changes must be presented a part of well thought through and fully co-created implementation plan that takes full account of current operational, financial and workforce pressures. Trusts will also need adequate support in making the changes including the right IT, right staff, right resources and training where required. Frontline staff with also require clear instructions from national bodies setting out the expectations and timelines.

5 **It is demonstrably clear that the changes are not an attempt to abandon the inherent performance in the current standards and that there is a credible, fully-funded, agreed, plan to recover those inherent performance levels**.
The case for change and accompanying plan must be clear that the new standards are ambitious and fit the long-term vision of the NHS. The plan must demonstrate how the sector can recover the inherent performance levels which have slipped over the past decade.

It is not for NHS Providers to specify what other groups of key stakeholders would require but we would assume that the public will want the ability to see a top-level summary of the NHS' performance nationally, to understand the relative performance of their local trust and to review performance over time. The public will also need the reassurance that the NHS is not abandoning the performance levels implicit in the current standards set out in the NHS constitution. There must be adequate time for a full public consultation on any changes to the handbook because of the wide-reaching impact of the proposals. Finally, the public, parliament and the media will all want a clear, simple to understand, and rigorous performance framework that enables them to hold the NHS properly to account.

Given the fundamental and multiple functions the current standards play within the NHS – it is vital we build a broad consensus and collectively get this right.

Your feedback on this briefing is very welcome. For any comments or questions please contact
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For more information:
www.nhsproviders.org/setting-good-standards

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