Clinically-led Review of NHS Access Standards

Interim Report from the NHS National Medical Director

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PREFACE FROM THE NHS NATIONAL MEDICAL DIRECTOR

Last summer I was asked to undertake a clinical review of standards across the NHS, with the aim of determining whether patients would be well served by updating and supplementing some of the older targets currently in use.

In this interim report, I set out my recommendations for doing so. As a result, patients should see four main benefits, which I know staff will welcome:

- First, the NHS will be rolling out **short waits for a far wider range of important clinical services**. Patients will now benefit from newly established standards covering areas such as mental health and community health services that previously have been neglected. Millions of people each year will gain.

- Second, greater emphasis will be given to **standards that help improve clinical quality and outcomes** - such as earlier diagnosis of cancer and faster assessment and treatment for major emergencies such as heart attacks, stroke and sepsis. To be clear: we are *not* proposing that new standards should require non-urgent patients to wait longer than they do now. But we do believe there should be focused effort on further improving and speeding up care for the most urgent conditions.

- Third, we want to lock-in **short waits for A&E and planned surgery**. To help incentivise that we need to track the *whole wait* experienced by *every* patient. The current A&E and elective care targets do not do that. For example, they do not distinguish between the hospital where 10% of its patients wait five hours to complete their A&E treatment versus the hospital where 10% of its patients wait eleven hours.

- Fourth, the new standards will **help, rather than penalise, hospitals who modernise their care**. For example, if a GP is able to discuss a patient's diagnosis directly with a hospital specialist, so that the patient doesn't have to travel to a hospital outpatient appointment, that actually makes the hospital's waiting time statistics look worse given the way the statistics are currently calculated. And the A&E department that is able to treat a patient so they can go home in five hours is reported as having a worse performance than an

equivalent department that admits the patient overnight for 24 hours. That is one reason why hospitals report they currently admit around one in five of their emergency patients from A&E in the 10 minutes immediately before the four-hour target. By contrast, modern medicine means we want to redesign outpatient services to avoid many unnecessary visits, just as we want to look after many more patients with ‘Same Day Emergency Care’. Our management targets need to support, not penalise, these developments.

I am recommending that many of these new approaches should now carefully be field tested during 2019/20, which will therefore be a transition year between the old targets and updated standards.

We will use this time to work with frontline clinicians, NHS managers and patient groups to ensure that the new proposals work as intended and that we learn from – and if necessary adjust – the approach in the light of experience.

That is how every other aspect of medicine works, and the same principle should apply here.

Professor Stephen Powis

NHS National Medical Director

March 2019

1 INTRODUCTION

The NHS Long Term Plan set out an ambitious but practical roadmap for the future of the health service that builds on the undoubted success of the last 70 years and ensures it will continue to deliver high quality care for all over the coming decade. The Government has now confirmed the long-term funding settlement – providing the NHS with the sustainable financial basis on which to deliver the Plan.

The history of the National Health Service is one of evolution and innovation, with each generation using the latest technology and treatments to meet the changing needs of patients and the public.

During the last 20 years a system of standards and targets has developed to provide public assurance on quality, and help to drive improvements in care and outcomes, from record cancer survival rates to the dramatic fall in patients waiting over a year for operations, down from more than 570,000 to fewer than 5,000, a fall of 99.6%.

The NHS Long Term Plan seeks to go even further in tackling cancer by increasing the number of patients diagnosed early, when the condition is easier to treat, from half to three quarters.

As well as seeking to save tens of thousands more lives each year, the Plan also commits to a step change in mental health provision, addressing needs that, until recently, have gone unrecognised and unmet.

And, while the NHS has always strived to deliver convenient treatment close to home, the Plan set a new service model for the 21st century that will boost out of hospital treatment, dissolve the divide between GPs and community services, usher in a new era of more personalised care which is digital by default, and place a renewed focus on prevention.

Technological advances coupled with workforce changes that will increasingly see specialist help available in the community are already transforming the way that care is delivered. This will only accelerate over the next 10 years.

That is why the time is right, as the Prime Minister has requested, to look again at targets underpinning the delivery of care to ensure they prioritise what is most important to patients and their families, support the goals of the NHS Long Term Plan, and are fit for the future.

It is well documented that the current performance measures can have unintended consequences, pushing hard-pressed staff to focus on targets rather than patient need – “hitting the target but missing the point”.

We also know from research by Healthwatch and others that these measures all too often fail to capture what patients value most. We have therefore been reviewing these targets, working with clinical colleagues and patient groups, as part of a Clinical Oversight Group (membership is set out in the Annex).

Our terms of reference were:

> To review the core set of NHS access standards, in the context of the model of service described in the NHS Long Term Plan, informed by the latest clinical and operational evidence; and to recommend any required updates and improvements to ensure that NHS standards:
>
> - 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; and
> - do not worsen inequalities.

Following the Prime Minister's request in June 2018, we began by reviewing what is already known about how current targets operate and influence behaviour. This was then mapped against the NHS Long Term Plan to examine how performance measures can help transform the health service and deliver better care and treatment.

Through the proposals in this interim report, we aim to lock in the achievements of the past, while refining standards to meet the challenges of the present; and to free up nurses, doctors, physiotherapists and others to focus on what matters – the quality of care and the outcomes it delivers.

The interim findings contained in this report include proposed new standards for mental healthcare, which would be a significant stride towards parity of esteem with physical conditions. Changes to access standards for cancer allow a renewed focus on diagnosis – the most crucial determinant of cancer survival – rather than interim steps along the patient pathway.

The proposals would also reinforce patient choice for those requiring elective care and ensure no return to the widespread long waits of the past; while updating how we measure timeliness of emergency care to ensure rapid assessment and urgent help for those who need it most.

This is all part of delivering the clear commitments set out in the NHS Long Term Plan to improve urgent and emergency care performance and reduce provider waiting lists over the next five years, as well as delivering the new ambitions set out, all within the final long-term funding settlement.

In each case we believe that the new proposals will measure what matters to patients and what is most clinically important, be clear and straightforward to understand, and be an improvement on what we have today. These proposals will now be rigorously field tested to gather further evidence on clinical, operational, workforce and financial implications.

Alongside field testing, we will also undertake extensive engagement across the wider health service, ahead of presenting the evidence and making final recommendations to Government, and full implementation beginning spring 2020.

Our new set of standards will support the delivery of the ambitions in the NHS Long Terms Plan, including the performance improvements promised, within the agreed long-term funding settlement.

2 MENTAL HEALTH

2.1 Current access standards

The current access standards in mental health are detailed in the Handbook to the NHS Constitution [1] and are listed below:

- 75% of people referred to the Improving Access to Psychology Therapies (IAPT) programme should begin treatment within six weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- More than 53% of people experiencing a first episode of psychosis currently will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within two weeks of referral. This is due to rise to 60% by the end of 2020/21.

In addition, the NHS has committed that by 2020/21, 95% of children and young people referred for assessment or treatment for an eating disorder should receive NICE-approved treatment with a designated healthcare professional within one week for urgent cases and four weeks for every other case.

2.2 New service models

The NHS Long Term Plan [2] outlines a programme of service expansion and improvement for mental health, which builds on foundations set out in the Five Year Forward View for Mental Health [3] finally to deliver parity of esteem between mental and physical illness.

The NHS already has begun to turn the tide in mental health for a range of conditions and at every stage of life.

Thousands of women benefited from specialist perinatal mental health care last year and improvements to our children and young people's services mean more children and young people can access treatment, including timely, evidence-based care for eating disorders and more acute care beds opening for children and young people in under-served parts of the country.

A world-leading programme of talking therapies for adults with common mental illnesses saw in excess of one million referrals in 2017-2018, with more than half of people recovering [4], while GPs are now better equipped to spot and treat mental illness in the over-65s.

As we continue to expand these services and accelerate the integration of physical and mental healthcare, the NHS must put in place a set of standards that not only supports high quality patient care but addresses the need to join up our targets across settings and conditions.

Families who have experienced a mental health crisis know the importance of being able to depend on a fast response; while parents whose children require specialist

care rightly want to know that support will not just be timely and appropriate, but close to home and joined up with every part of their lives, including their school or college.

2.2.1 Urgent and emergency mental health care

In the next ten years the NHS will provide a single point of access, ensuring that anyone experiencing mental health crisis can access 24/7 age-appropriate mental health community support via NHS 111.

For adults and older adults, the NHS Long Term Plan outlined a commitment to ensure that a 24/7 community-based mental health crisis response is available across England by 2020/21, with intensive home treatment available as an alternative to an acute inpatient admission. We will ensure that no acute hospital is without a mental health liaison service in A&E departments and inpatient wards. By 2020/21, at least 50% of these services will meet the 'core 24' service standard as a minimum, working towards 70% by 2023/24, and 100% coverage thereafter.

For children and young people, we will ensure that by 2023/24 all children and young people experiencing a mental health crisis will be able to access crisis care 24 hours a day, seven days a week, with a single point of access through NHS 111. Every area will have age appropriate, urgent and emergency assessment, intensive home treatment and liaison functions in place.

Figure 1: 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%	79%	100%	100%

Source: NHS England Mental Health Programme Team

Where people are accessing urgent and emergency mental health services in the community, they will receive a timely initial assessment of their needs. Where they have emergency needs they will receive expert care and nobody with urgent mental health needs will be expected to wait longer than 24 hours.

A&E is often not the best place for people in need of urgent mental health care, however in some cases it will be unavoidable. Those coming to A&E will receive a response from a 24/7 liaison psychiatry team (or equivalent children's and young people's service) within the first hour of their referral, and will receive the appropriate, timely support to meet their needs and an evidence-based package of care.

These standards will support our ambition for the NHS to be able to meet as many needs as possible in the community, and that when people do attend A&E, it is equipped to be responsive to their needs.

Alongside this we also will increase alternative forms of provision for those in crisis. Sanctuaries, safe havens, and crisis cafés provide a more suitable alternative to A&E for many people experiencing mental health crisis, usually for people whose needs are escalating to crisis point, or who are experiencing a crisis but do not necessarily have medical needs that require A&E admission.

2.2.2 Non-urgent, community mental health care

The NHS Long Term Plan [2] commits to offering more comprehensive mental health support for children and young people. The NHS will work with schools, colleges, parents and local councils to understand whether more upstream preventative support, including better information sharing and the use of digital interventions, improves outcomes and helps moderate the need for specialist child and adolescent mental health services.

Building on the success of existing waiting time standards, work is already underway to test what it would take to introduce a four-week waiting time for children and young people who need help from specialist mental health services. These 12 waiting time pilots will run over the next three years alongside the introduction of new Mental Health Support Teams.

The NHS Long Term Plan also extended the commitment for more comprehensive mental health support to the design and roll out of a new integrated model of adult community mental health care. Adults with severe mental illness (SMI) receiving care from community mental health services includes, but is not limited to, those who have a diagnosis of psychosis, bipolar disorder, personality disorder, eating disorders, severe anxiety or severe depression, and those with co-morbid substance misuse. This cohort represents approximately 10% of mental health needs and 90% of spend: there is therefore not only a clinical, but a resource imperative, to have a dedicated focus on these patients and their families.

We will introduce new and integrated models of primary and community mental health care across England for adults who have an SMI so they are supported to have greater choice and control over the care they receive, and so they can live well in their

community. This includes developing new services for people who have the most complex needs.

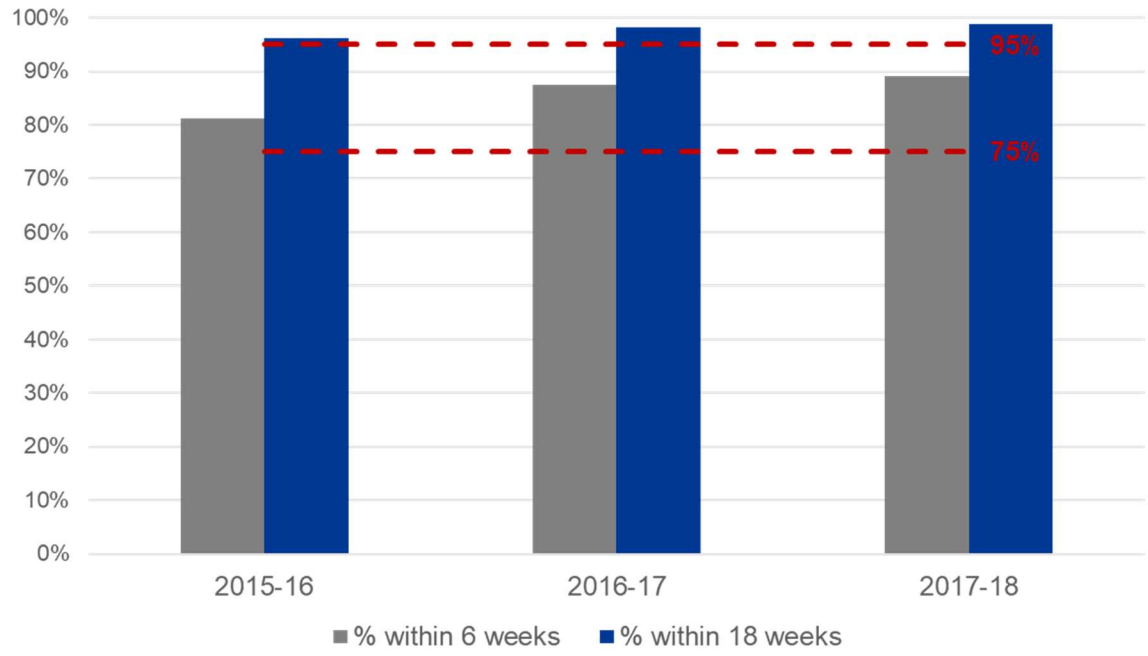
Alongside work to explore the effectiveness of different approaches to integrated delivery with primary care, we will test four-week waiting times for adult and older adult community mental health teams with selected local areas to build our understanding of how best to introduce ambitious but achievable improvements to access, quality of care and outcomes. In doing so, we also will consider the interfaces with specialist community mental health services, particularly where there is an existing evidence base for rapid direct access, such as adult eating disorder services, or early intervention in psychosis services, for which there is already a national access and waiting time standard in place.

2.3 Considering the current standards

In addition to national ambitions to increase access and improve quality of mental health services, *The Five Year Forward View for Mental Health* [3] introduced the first waiting time standards for mental health: these standards are now being met and exceeded or are on track for delivery, in line with our stated commitments, by 2020/21.

People being given NHS talking therapies through the IAPT programme are getting it in good time: 89% of people are seen within six weeks while more than 99% within 18 weeks, against targets of 75% and 95% respectively [4].

Figure 2: Proportion of patients meeting IAPT waiting time standards since they were first introduced in 2015/16, by year



Source: NHS Digital Improving Access to Psychological Therapies dataset annual publications. Notes: Six-week standard is 75% and 18-week standard is 95%.

The majority of people – 77% – experiencing a first episode of psychosis are seen within two weeks of being referred, far above the standard of 50% [5].

For children and young people referred for an eating disorder, the latest data show that 80.7% of young people started treatment for an urgent case within one week and 86.8% of young people started treatment for a routine case within four weeks.

We propose building on this progress by retaining existing standards and implementing others which target the most important areas of clinical need, support proposed targets for other areas of NHS care, and ultimately sustain our momentum towards delivering parity of esteem for mental and physical ill health.

2.4 Proposed standards

This Review recommends the testing of the following standards, including considering 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 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.	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 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.

	Measure	Clinical rationale	Implications for patient care
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.

2.5 Value of the proposed standards

Measure what's most important clinically, and to patients: the guarantee of a timely response for mental health crises means people with the most acute need will have assurance that their mental health emergency will be responded to with the same speed and tailored care as life-threatening physical conditions.

For less urgent needs, these proposals will provide assurance to families and the public that they and their children will not face long waits to access support in the community. Early intervention in treating mental illness in children will stop problems escalating and give reassurance to parents about their child's care.

Clear and straightforward to understand: access to community care will be aligned for adults, children and young people, with urgent care provided in A&E on the same basis as for physical health.

An improvement on what we have now: it is well recognised that mental health has lagged behind physical health, in funding, the ease of access, and the level of attention on the need to improve the quality of, and access to, services. By introducing new standards, more proportionate focus will be placed on mental health services, to underpin the NHS Long Term Plan commitments to improve quality and access.

2.6 Testing these propositions

Pilots to test the four-week commitment for children and young people's mental health are already underway. 12 pilot sites have been identified from amongst those receiving development funding to support new models of integrated care for children and young people, linked with schools and colleges. Pilot sites have been asked to set out what it would take to reach a four-week waiting time, track progress, and demonstrate improvement over the next three years.

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

The urgent and emergency mental health standards will be tested through the wider urgent and emergency care field testing as described in chapter four. Proposals for community crisis response services will be tested in a similar fashion, with a focus on ensuring that those individuals who need to be seen rapidly are able to access the help they need.

3 CANCER

3.1 Current access standards

The current access standards in cancer are detailed in the Handbook to the NHS Constitution [1] and are listed below:

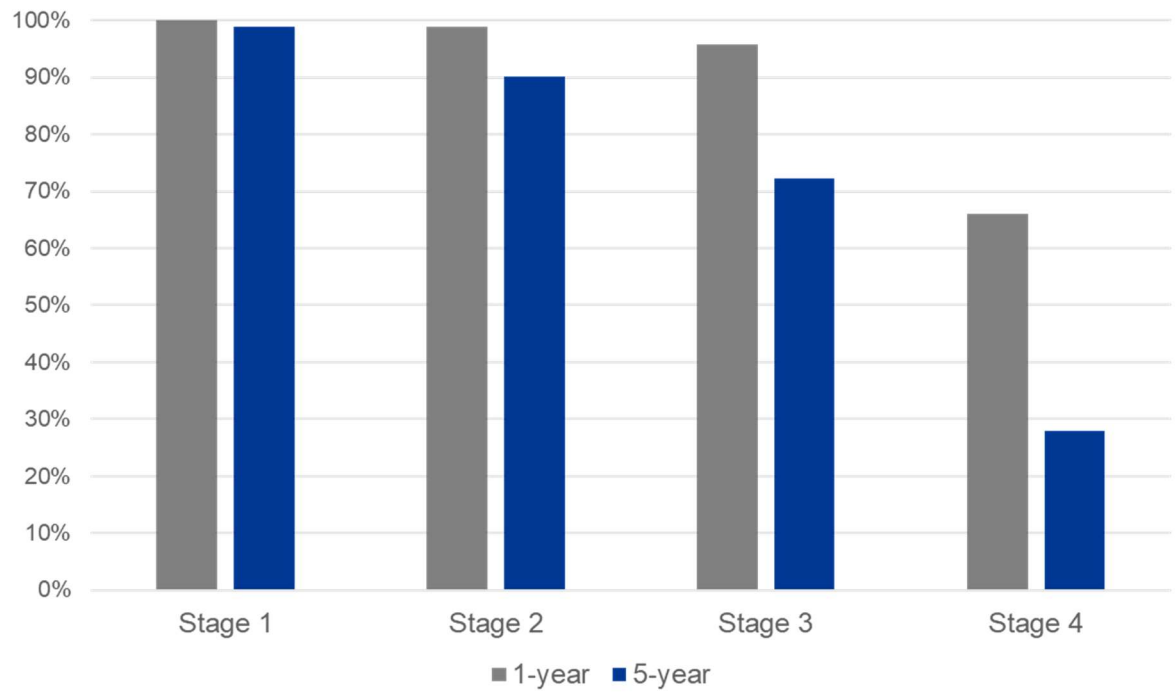
- The right to be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected;
- A maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms, even if cancer is not initially suspected;
- A maximum one-month (31-day) wait from diagnosis to first definitive treatment for all cancers;
- A maximum 31-day wait for subsequent treatment where the treatment is surgery;
- A maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy;
- A maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen;
- A maximum two-month (62-day) wait from urgent referral for suspected cancer to first treatment for all cancers;
- A maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer;
- A maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers).

3.2 New service models

Survival rates for cancer in England are higher now than they have ever been, with thousands more people alive thanks to better care. More than 52% of people diagnosed with cancer in 2011 survived five years or more, up from 42% for those diagnosed in 2000 [6]. But there is more to do. Despite the improvements, our outcomes for some cancers still lag other European countries [7].

In 2015, the independent cancer taskforce, chaired by Sir Harpal Kumar, showed that earlier diagnosis is central to bringing survival rates in England into line with other comparable countries, and will be a key enabler to improving the care and efficiency provided by cancer services. Five-year breast cancer survival improves from around 28% to 99% when the disease is diagnosed at stage one rather than stage four [8].

Figure 3: Age-standardised one-year and five-year net-survival for women diagnosed with breast cancer between 2012 and 2016



Source: Public Health England – National Cancer Registration and Analysis Service, Office for National Statistics

Recognising that our current standards measure the time to be seen by a doctor, rather than time to being provided a diagnosis of cancer, the independent cancer taskforce recommended [9] the introduction of a new faster diagnosis standard (FDS) to ensure that people receive a life changing confirmation of whether or not they have cancer within 28 days. Given that this was considered a significant improvement on the current standards, the taskforce suggested that the two-week waiting time standards would be superseded.

The NHS Long Term Plan [2] sets out plans to improve early cancer diagnosis, and a new ambition that, by 2028, the proportion of cancers diagnosed at stages one and two will rise from around half to three-quarters of cancer patients. This will be achieved through raising greater awareness of symptoms of cancer, accelerating access to diagnosis and treatment, maximising the number of cancers that we identify through screening, and harnessing new innovations in technology. A radical overhaul of the way diagnostic services are delivered will ensure that people can get their diagnosis more quickly, including the roll-out of new Rapid Diagnostic Centres (RDCs) across the country to upgrade and bring together the latest diagnostic equipment and expertise.

The introduction of RDCs represents a significant and complex transformation of current diagnostic practices, which, once developed and embedded, will result in faster and earlier diagnosis, leading to higher cancer survival rates.

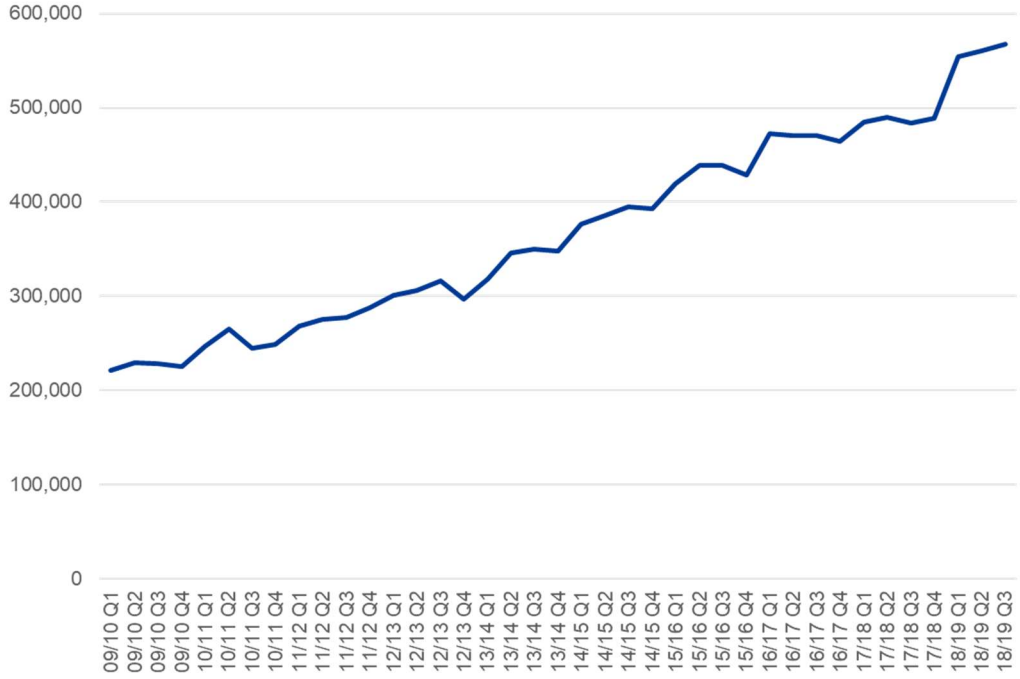
3.3 Considering the current standards

Access standards have been a key element of the NHS's approach to improving the timeliness of treatment for people with cancer since they were introduced in the NHS Cancer Plan in 2000 [10], with the nine standards currently in place having been set in 2009, and remaining unchanged since. They measure the time taken to see a specialist following referral from a GP, and the time taken to receive treatment following a decision to do so. Different reporting rates were set for different procedures, based on historic reasons that are largely no longer applicable, adding unnecessary complexity.

A total pathway standard was introduced to ensure that any treatment was received within 62 days of an urgent referral, to cover gaps in the pathway not otherwise covered, crucially including diagnostics.

It is undoubtedly welcome that the number of people being referred for urgent cancer tests has doubled since 2010, with just under two million people getting a two-week urgent referral for suspected cancer in 2017/18, and more people than ever before being treated for cancer within the 62-day standard [11]. This in part reflects improvements in referral practice by GPs, which will be vital if we are to deliver on the ambition in the NHS Long Term Plan to diagnose 75% of cancers at stages one and two.

Figure 4: Total number of people referred by urgent GP referral onto the two-week-wait cancer pathway, by quarter



Source: NHS England analysis of Cancer Waiting Times data

3.4 Proposed standards

This Review recommends testing the following standards:

	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. 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.	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 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.

3.5 Value of the proposed standards

Measure what's most important clinically, and to patients: for cancer, what matters most to patients is survival, quality of life and patient experience. We will continue to measure and publish long-term success using survival at one year, five years and 10 years, stage at diagnosis and the annual cancer patient experience survey, and will bring in the new quality of life metric currently in development.

However, the time lag on these indicators does not provide assurance to patients today. We will therefore ensure that patients receive a diagnosis quickly for most urgent cases, limiting the period of uncertainty. We will then ensure those who require, and choose treatment, receive this quickly. Both of these will provide the best chances of survival.

As well as being important to patients, we know that retaining and improving focus on time to treatment, with a new drive to speed up diagnosis, is what will drive improvements in survival rates.

Clear and straightforward to understand: people will have the expectation of diagnosis within one month and treatment to start within two months. In each of the three proposed standards, a clear threshold will be set which is ambitious yet deliverable and clinically relevant. The proposals reduce the number of standards from 10 to three, to avoid confusing people using services and simplifying how services are managed.

An improvement on what we have now: the faster diagnosis standard for urgent referrals measures and provides certainty on the time to receive an actual diagnosis, rather than just to be seen by a consultant. The 62-day wait for first treatment from urgent referral, and 31-day wait from decision about treatment to treatment are already in place, but by having a single headline measure for these standards, and ensuring the clinical guidance governing inclusion within the standards reflects modern clinical practice, we add more clarity for patients, and greater focus on what really matters.

3.6 Testing these propositions

The aim of the package of proposals for cancer access standards is to provide simplified measures of performance for patients and those working in the NHS.

The approach to testing these proposals is still in development. We will be working with partners and key stakeholders to develop the detail further of what we will test and how we test it. We will ensure that the cancer community is engaged before and during the testing phase before final recommendations on changes are made.

To get the maximum benefit from these proposed standards, testing will need to explore:

- the detail of the clinical guidance governing what should be included in the measurement of these standards to ensure it reflects the latest clinical practice (for example, prostate cancer, which is often slow-growing, and can be subject to over-treatment);
- whether these are sufficient, without the need for other standards;
- what threshold should be applied as the standards are combined (any threshold will be set at a level that provides access that is at least as timely as current performance); and
- whether incomplete pathways should be reported, in line with the current reporting for all other referral to treatment pathways.

Based on the findings of testing, we would propose to roll out the new suite of standards from April 2020.

4 URGENT AND EMERGENCY CARE

4.1 Current access standards

The current access standards in urgent and emergency care are detailed in the Handbook to the NHS Constitution [1] and are listed below:

- A maximum four hour wait in A&E from arrival to admission, transfer or discharge;
- All ambulance trusts to:
    - Respond to Category 1 calls in 7 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.

4.2 New service models

The four-hour standard was introduced in A&E departments in 2004. It was in recognition of the crowding within A&E departments at the time and to support improvement in flow within acute hospitals. The introduction of the standard, coupled with high levels of investment in health services, has helped increasing numbers of people to be seen, treated and either discharged, admitted or transferred within four hours. Today, the standard still supports improved performance, with 21 million A&E attendances completed within four hours in 2017/18 [12], 23% more than when the standard was introduced in 2004/05 [13].

Since the introduction of the A&E access standard 15 years ago there also have been major changes in the practice of medicine and in the way urgent and emergency care services are delivered. These include:

- the introduction of specialist centres for stroke care, including the 2010 reconfiguration of London stroke services;
- the development of urgent treatment centres;
- the introduction of NHS 111;
- the creation of trauma centres, heart attack centres and acute stroke units;
- increased access and use of tests in A&E departments;
- the introduction of new standards for ambulance services; and
- the increasing use of Same Day Emergency Care (SDEC) to avoid unnecessary overnight admissions to hospital.

The NHS Long Term Plan [2] sets out how these services will be further improved, including the provision of direct booking of GP appointments from NHS 111 and the accelerated roll out of Same Day Emergency Care. The Plan also sets out our intention to ensure an increased focus is placed on the management of acute life-

threatening conditions such as heart attacks and strokes. This is additionally important if we are to improve outcomes and reduce deaths from cardiovascular and respiratory disease, a core ambition of the NHS Long Term Plan.

Given that models of care have changed and will change further, it is important that our headline access standards both reflect these changes and encourage behaviours that support the new models of care.

4.3 Consideration of the current standards

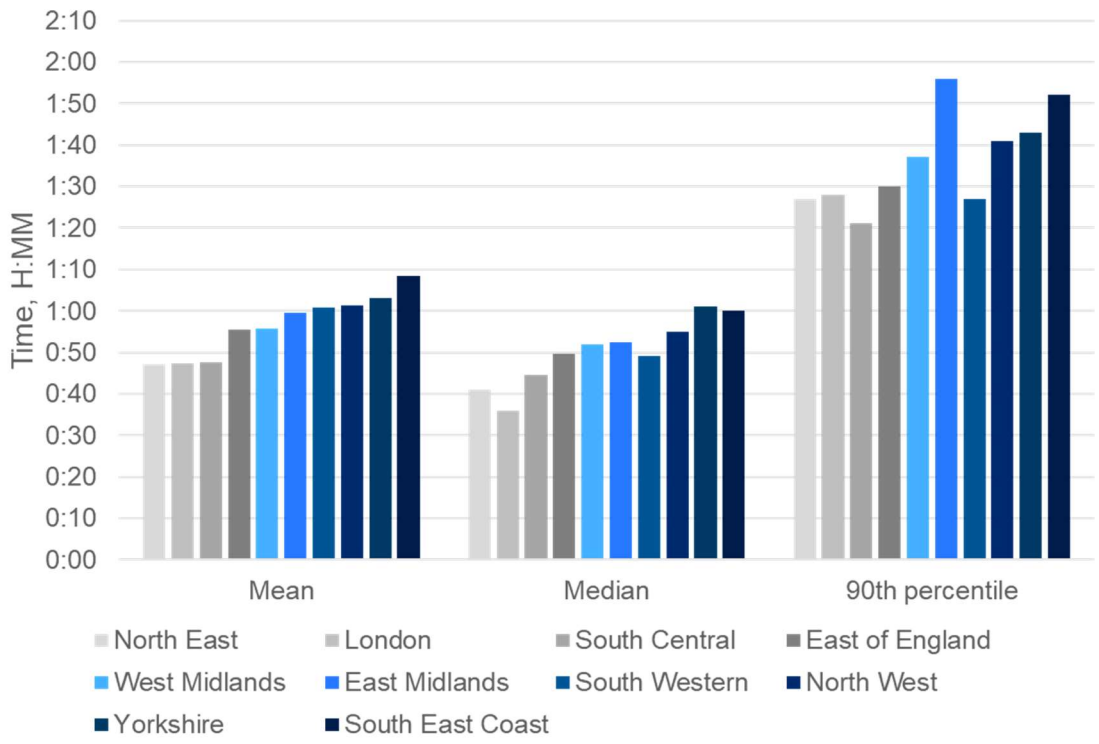
The current headline four-hour access standard is used to measure and report performance against one aspect of the urgent and emergency care system. It has proved useful in focusing on flow in the best hospitals, and permits comparison of individual healthcare organisations and health systems. However, given the changing nature of urgent and emergency care services, the current single standard only offers a limited insight into patient care. There are a number of well-documented issues, which suggest that alternatives are worth exploring. Five of these issues are described below.

First, the standard does not measure total waiting times. The standard only reports performance during the first four hours and is therefore blind to the additional length of time patients spend in departments beyond this point. Because it does not measure total time, departments with the same headline performance may be performing very differently in reality. Indeed, there is a high degree of variation in the proportion of patients waiting more than 12 hours in A&E, with some departments having more than 8% of patients waiting more than 12 hours.

Second, the standard does not differentiate between severity of condition. It provides no insight or assurance into how departments are managing the most life-threatening illnesses. It also focuses on completion of treatment whereas, for life-threatening conditions, it is the timely commencement of treatment that is crucial.

National performance against life-threating conditions such as stroke and trauma has improved dramatically in recent years with an additional 600 patients surviving major trauma in the year 2016/17 compared with the previous year and a 19% increase in survival since the inception of major trauma centres in 2012/13. There also has been a reduction by more than half in the 30-day mortality rate for hospitalised stroke, which has fallen from 30% in 1998 to 17% in 2010 and 13.6% in 2015/16. Evidence from Healthwatch [(14)] shows that 79% of people think prioritising the most urgent patients is ‘very important’. Yet the current national standard does not support this prioritisation.

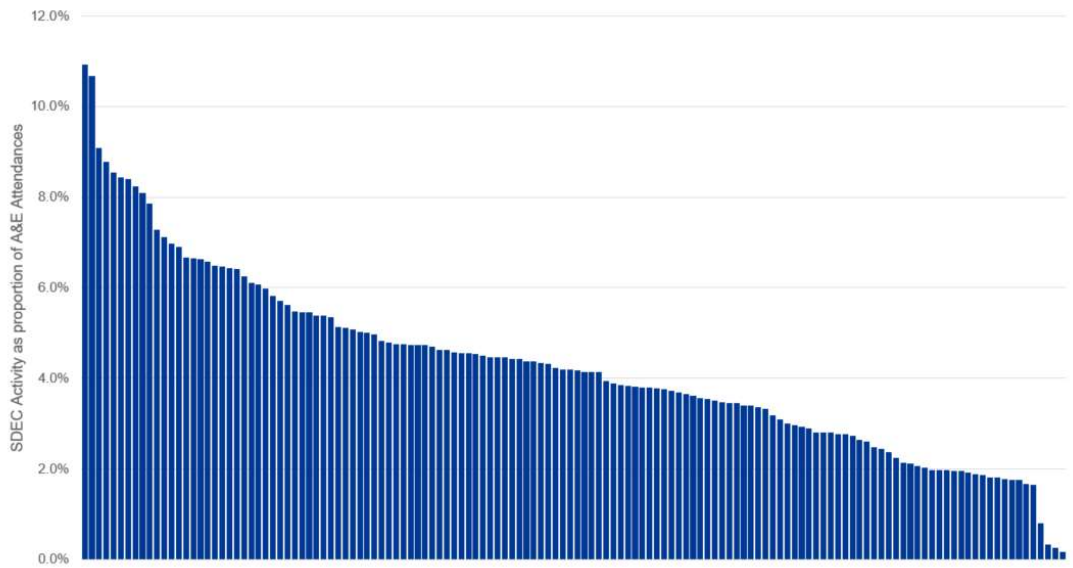
Figure 5: Variation in mean, median and 90th percentile time from arrival at hospital to thrombolysis across Ambulance Trusts for Stroke patients, September 2018



Source: NHS England Ambulance Quality Indicators Data 2018 - 2019

Third, the current standard measures a single point in often very complex patient pathways, that for some patients can begin with a call to our ambulance services, require a stay in a hospital bed, followed by reablement and/or social care services. This can lead to a false perception that delivery against the standard is the sole responsibility of those working within our emergency departments, whereas the reality is that it requires the combined effort of many across the health and social care system. With the move to Same Day Emergency Care, a four-hour "admission" cut-off is, for an increasing number of patients, clinically meaningless. Maintaining a singular focus on the four-hour target could penalise the very departments who are making the most progress towards Same Day Emergency Care.

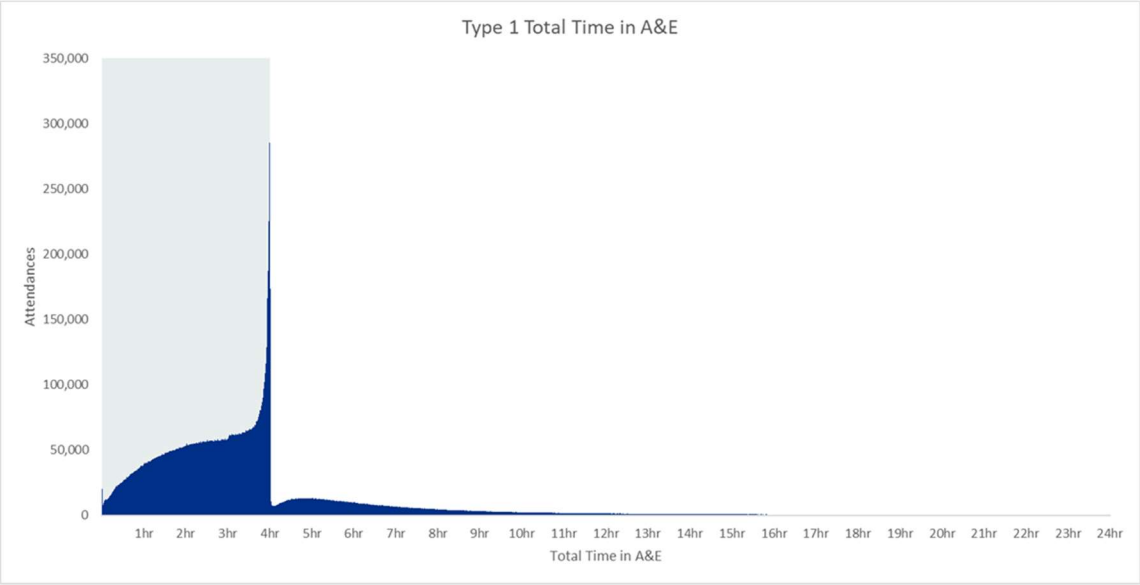
Figure 6: Proportions of eligible patients who receive Same Day Emergency Care by provider between January and December 2018.



Source: NHS England analysis of Secondary Uses Service (SUS) data

Fourth, 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. Figure 7 below shows that the total time that people spend in A&E departments follows a reasonably normal distribution for the first three and a half hours, before a large spike as the clock approaches four hours. 18% of all admissions via A&E departments occur between 3 hours 50 minutes and four hours.

Figure 7: Total time that people spend in Type 1 A&E departments by minute, between January and December 2018.



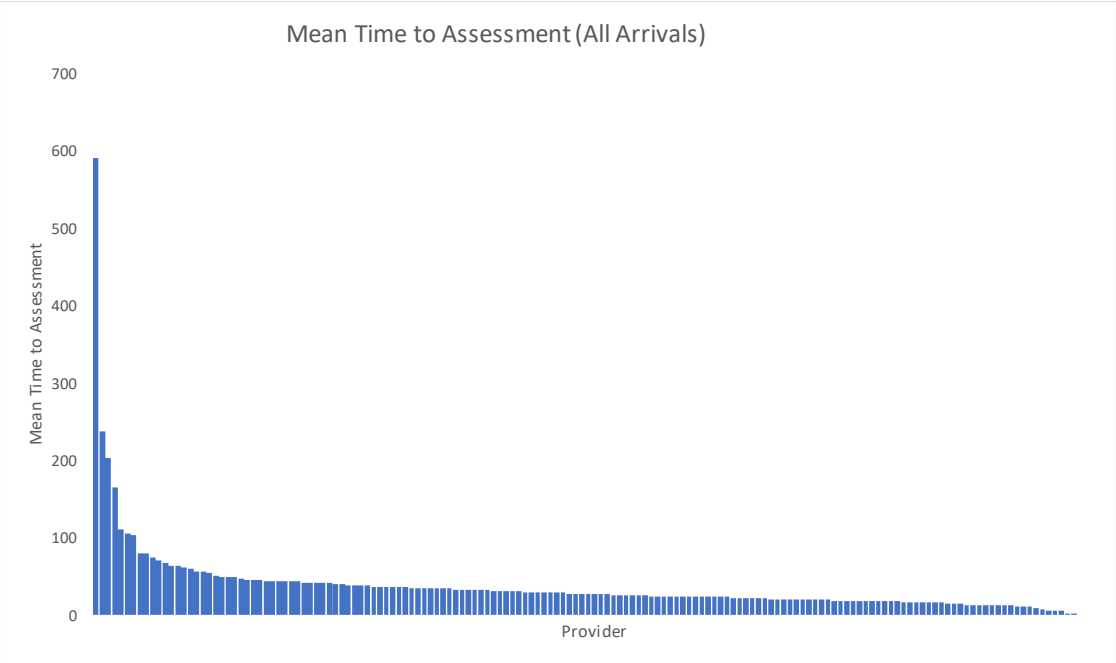
Source: NHS England analysis of Secondary Uses Service (SUS) data.

Further evidence shows that the current target only directly improves the total waiting time for a minority of patients (10%), who are close to the four-hour breach time. For the remaining 90%, there is no incentive to reduce waiting times because they are already within four hours, or their wait is so long that even large reductions, i.e. from 16 hours to five, is not reflected in the target. This has led to criticism that the NHS is encouraged to 'treat the target rather than the patient'.

Fifth, although described as simple, the standard is actually not well understood by the public. There is a misconception that four hours is the time for a patient first to be seen, rather than for their treatment to be completed or to be admitted, transferred or discharged. While this assumption is incorrect, it is understandable, as crucially it is time to be seen that people deem most important, along with the knowledge that if they need urgent care quickly, they will receive it.

The same Healthwatch polling mentioned above [14] shows that people's perceptions of long waits are not related to whether their total time was within four hours. Rather, the way people feel about their wait in A&E is affected by how they were triaged, whether or not they were told how long they might have to wait, whether they were kept updated if things changed, the support they received and whether they were satisfied with the treatment they received. Data published recently from Healthwatch indicate that 75% of people think that assessing and treating patients quickly is 'very important' compared to 38% for treating/admitting all patients in a certain time. Yet the current standard focusses on the latter, and does not provide information on the variation in the time that people will have to wait before they are first seen, which clearly affects their experience.

Figure 8: Variation in reported average time to assessment across all A&E Departments for all arrivals between January and December 2018



Source: NHS England analysis of Secondary Uses Service (SUS) data

4.4 Proposed standards

It is right that we use this Review to build on and enhance the successes of the current standard, whilst also addressing the problems with the current target set out above. This Review recommends the testing of the following four access standards and one supporting indicator, to understand their impact on clinical care, patient experience and the management of services, when compared to the current approach of a single standard:

	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 (described in chapter 3).
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.

	Measure	Clinical rationale	Implications for Patient 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 111 and 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.

4.5 Value of the proposed standards

Measure what's most important clinically, and to patients: the public are most concerned with time to be seen, and want to know that the sickest patients are prioritised. By measuring time to assessment, the standards will assure patients that they will be seen quickly; and much quicker than the four hours they often believe they will have to wait to be seen. Then, the standards will measure whether those with the most life-threatening conditions are beginning their treatment quickly.

The life-threatening conditions selected for measurement of commencement of treatment are those for which there is strong clinical benefit, and where patients will most want reassurance.

Additionally, although patients themselves do not identify total time in department as a priority, there is strong clinical evidence that spending a long time in A&E has negative consequences, particularly when this leads to overcrowding. So measuring total time in department for all patients is clinically important.

Clear and straightforward to understand: people often misinterpret the current four-hour standard as the time taken to be seen. So, by actually measuring this – rather than assessing performance on the basis of time for care to be completed as we currently do – it will be clearer to patients, while assuring them that actual time to be seen is less than four hours.

For total time, an average, measured using a mean, is a common concept that allows for clearer comparison between different sites.

An improvement on what we have now: above we describe five of the limitations of the current standard. We believe that these proposals offer improvements against all five, although these hypotheses will be tested:

"The standard does not measure total waiting time" – the use of a mean for total time means that everyone's time counts, not just the one in 10 directly affected by the current standard. Therefore, services are incentivised to improve waiting times between zero and four hours. But more crucially, the use of a mean results in very long waits having a larger impact on performance assessment, rather than being counted in the same way as waits between four and five hours.

"The standard does not differentiate between severity of condition" – This is addressed by measuring the time to treatment for the sickest patients and guaranteeing the right package of care, administered quickly, for urgent conditions.

"The current standard measures a single point in an often very complex pathway" – The proposed standard will offer a more sophisticated measure of both A&E performance and patients' experience of care, and it will assess the most important part of the pathway, which is when treatment begins.

"Hospitals' processes, rather than clinical judgement, are resulting in admissions or discharge in the period before breach" – By moving to a mean, the threshold effect is removed, allowing clinicians to admit when appropriate, rather than at an arbitrary point in time.

"The standard is not well understood by the public" – as explained above, measuring time to assessment is consistent with what people understand the current standard as being. A mean for total time is a common concept that allows for clearer comparison.

4.6 Testing these propositions

This set of core access standards for urgent and emergency care services will be field tested to ensure that they drive better outcomes and are a more effective tool for improving patients' and families' experience of care. As well as testing the proposals above, testing also will consider whether there are any additional or different measures that could be recommended for management purposes, to ensure that the principles set out in the terms of reference for this Review are met, and particularly that the interests of all patients, including the most ill and those requiring admission, are best served.

NHS England and NHS Improvement are identifying a number of sites that we will work with over the coming six months to field test the above measures. These sites will provide geographical spread across the country, and include a range of urban, rural, and mixed communities. The sites chosen also offer variation in terms of current performance so that we can understand how systems in different circumstances respond to the changes that are being tested.

Those sites not included in the field testing will continue to operate against the current national standard.

The testing approach will be conducted in four- to six-week cycles, with review, feedback, and evaluation at the end of each cycle. The testing period will run from April 2019. Data and learning from the field testing period will be considered, alongside expert advice from stakeholders to inform further recommendations and any wider roll out from autumn 2019.

Throughout the trial period, the safety of patients will be paramount. Test sites will be closely monitored to ensure that the quality of care to patients is maintained, and there will be mechanisms through which a decision to discontinue the trial in a particular site will be made should patient care be comprised or risk being compromised.

The time to emergency treatment standard will necessarily need to evolve over this period and beyond, to ensure that the right situations and clinically appropriate treatments are identified.

More generally, as service models for urgent community care continue to evolve, this set of standards will be kept under review. In particular, they will need to be considered in light of the development of community and intermediate care services over the next five years. It is expected that the extra investment into primary and community services will improve the responsiveness of community health crisis, to deliver services within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate. In addition, over the next five years, all parts of the country should be delivering reablement care within two days of referral to those patients who need it.

These improvements will help to prevent unnecessary admissions to hospitals and residential care, improving timely crisis care in the community. We will develop our approach to testing the community health crisis and community reablement response times in the NHS Long Term Plan implementation framework to be published in the spring.

5 ELECTIVE CARE

5.1 Current access standards

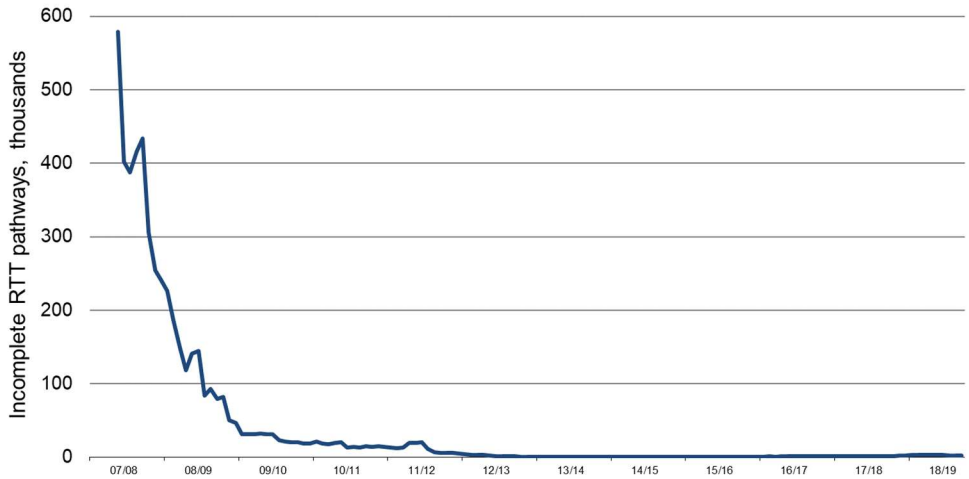
The current access standards in elective care are detailed in the Handbook to the NHS Constitution [1] and are listed below:

- Patients have the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions;
- Patients waiting for a diagnostic test should have been waiting fewer than six weeks from referral;
- All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons should be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.

5.2 New service models

It can be easy to forget that people used to have extremely long waits for their routine operation. In August 2007 well over half a million people had been waiting over a year for treatment: 14% of all people on the waiting list. Today, the number of people waiting this long has fallen by 99.6%, accounting for just 0.1% of all people waiting [15]. This shows how successful the NHS has been at treating more people. These efforts were supported by a national target set at 18 weeks.

Figure 9: Total number of people on incomplete pathways waiting more than 52 weeks from referral to treatment, by year



Source: NHS England analysis of Referral to treatment waiting time statistics for consultant-led elective care

The NHS Long Term Plan [2] set out how outpatient services would be redesigned fundamentally over the next five years. Whilst primary care referral growth for new outpatients over the past two years has been flat, hospital outpatient visits have nearly doubled over the past decade from 54 to 94 million, at a cost of around £8 billion a year.

The NHS Long Term Plan sets out to transform the outpatient model with better support to GPs from secondary care clinicians to avoid the need for a hospital referral, single visit consultation and diagnostic visits to replace multiple visits, and alternatives to traditional appointments including digital appointments, where appropriate.

Through these changes, it is expected that over the next five years patients will be able to avoid up to a third of face-to-face hospital-based outpatient visits, removing the need for up to 30 million outpatient visits a year. This will in turn change the nature of what patients are waiting for when they are on elective waiting lists, and so the standards we use to measure performance need to be updated to reflect this. Otherwise the current waiting list targets will penalise those clinicians and hospitals who actually make progress on redesigning outpatient services since up to four-fifths of referral to treatment time clock stops are in outpatients, which may in future not occur.

Similarly, transformation in the way we deliver diagnostic tests and whole pathways will impact the nature of the waiting lists in our hospitals as more diagnostic work is delivered in Rapid Diagnostics Centres. These will upgrade and bring together the latest diagnostic equipment and expertise so that patients, including those with suspected cancer, can get faster diagnosis and so begin their treatment more quickly.

The NHS Long Term Plan has committed the NHS to a zero-tolerance approach to people waiting over a year for planned care and introduced a 52-week maximum wait with fines on commissioners and providers for any breaches. It also strengthens the right of patients to select an alternative provider where their current one cannot provide them with the elective care they need within six months. This choice of alternative provider at 26 weeks is being rolled out from 1 April 2019, as indicated in the NHS Operational Planning and Contracting Guidance [16].

5.3 Considering the current standards

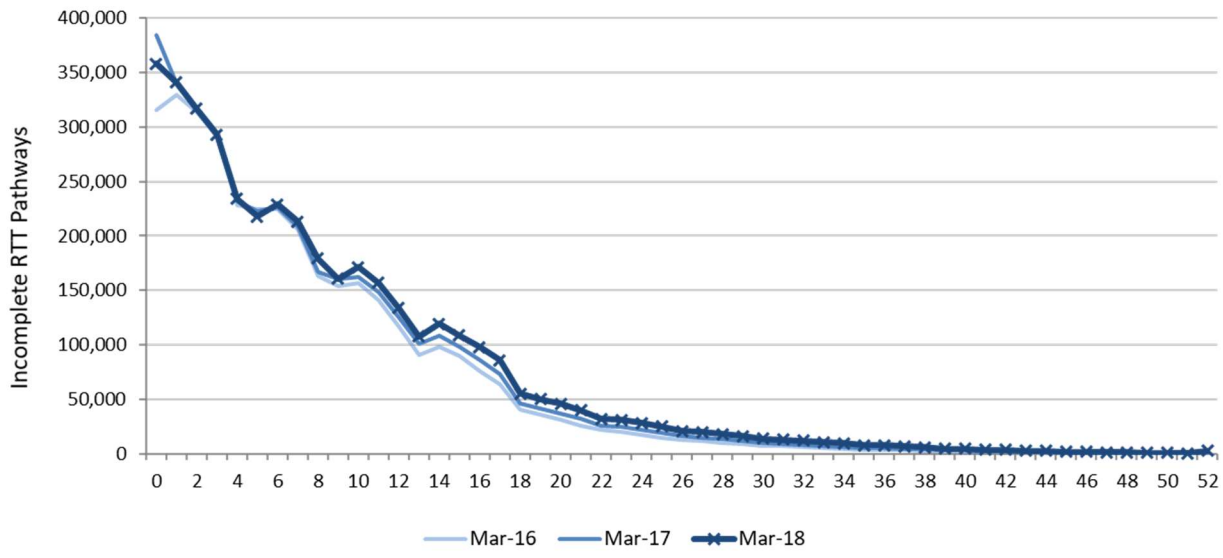
The current standards for elective care, introduced in 2009, have supported significant improvements in the timeliness of treatment and experience for patients, at a time of large additional investment in expanding the capacity of planned care across the NHS in England.

A single standard approach has been useful in keeping focus on the current list and taking action to expedite treatment, although there are some issues.

By simply counting whether someone has waited more or less than 18 weeks, no account is given to how long beyond 18 weeks someone has waited, meaning that there is a long tail of waits. Performance is therefore rated the same whether treatment is provided to someone at 19 weeks or if it is provided to someone at 49

weeks. In the current system, long waits are only flagged when people have been waiting for more than 52 weeks.

Figure 10: Total number of incomplete pathways in England at the end of March each year, by number of weeks waited



Source: NHS England Referral to treatment waiting time statistics for consultant-led elective care, 2017/18 Annual Report

For patients who have waited longer than 18 weeks the current model places the emphasis on the patient to potentially find an alternative provider. This ability to exercise choice is important, however more could be done to help the patient exercise that right with more emphasis placed on the providers and commissioners of treatment to help find and offer suitable alternatives that will deliver faster treatment.

The current target can also be misleading to patients, who may believe that the majority of people will have to wait as long as 18 weeks for their treatment. In fact, the majority will wait fewer than eight weeks, and even accounting for the long-waiters, the average (mean) wait is fewer than 10 weeks. [15]

Given the transformation to services outlined in this chapter, there is the opportunity to consider changes to elective access standards and, informed by detailed field testing, to update and improve them.

5.4 Proposed standards

This Review recommends the following headline access standards, alongside the two supporting measures:

	Measure	Clinical rationale	Implications for patient care
Access standards			
1.	Maximum wait of six weeks from referral to test, for diagnostic tests[1].	Ensure that patients are accessing diagnostic tests quickly, so that a diagnosis can be reached and treatment can begin in a timely manner.	Need for more consistent achievement in all places. Achieve opportunity for faster overall pathway to diagnosis and decision and create a clear plan for treatment earlier.
2.	Defined number of maximum weeks wait for incomplete pathways[2], 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 measures			
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.

[1] Current standards have set the threshold for this at 99%. The Review does not propose any changes to this at this stage.

[2] Current standards have set the maximum wait at 18 weeks, and the threshold at 92% of patients who are on incomplete pathways. Field testing will consider whether these values are appropriate.

	Measure	Clinical rationale	Implications for patient care
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.

5.5 Value of the proposed standards

What matters most clinically, and to patients: people rightly want assurance that they will get their treatment in good time, and that the NHS's progress in reducing excessively long waits will not just be sustained, but improved.

Using an average waiting time, rather than communicating to patients with reference to an upper most length of time that they could wait, may better reflect how long they are actually going to wait. Furthermore, the new 26-week offer of an alternative provider of treatment places a requirement on the NHS to find alternative arrangements for patients, rather than the patients themselves having to do so.

Clear and straightforward to understand: we are keeping the most important and clear aspects of current standards while testing the use of a more representative measure of likely wait times, and enhancing patients' opportunity to get faster care.

An improvement on what we have now: These proposals shift the responsibility from the patient to the NHS to make alternative arrangements for people who have been waiting a long time. Also, commissioners now will have the same incentives as providers to secure treatment for the patients they are responsible for and who have waited over 52 weeks.

5.6 Testing these propositions

NHS England and NHS Improvement will field test variants of the two alternative approaches to the proposed elective access standards for incomplete pathways in a number of pilot sites. These sites will provide geographical spread across the country, and include a range of urban, rural, and mixed communities. The sites that are chosen will also offer variation in terms of current performance so that we can understand how systems in different circumstances respond to proposed changes.

The testing approach is likely to involve a group of sites testing the use of average waiting times. Testing will seek to evaluate:

- Changes to recording – sites will evaluate whether new data are required;
- Changes to reporting – the impact of changes on the reporting of patients at specialty level, and at organisational level;
- Changes to operational process – how the management of patients might need to change, including booking and scheduling, and managing urgent patients;
- Outcomes and experience for patients – understanding whether and how the length of pathways, of diagnostic and treatment stages changes; how changes compare between different specialties; and the impact of changes at provider and/or system level.

Data and learning from the field testing, alongside advice and input from experts and stakeholders, will inform further recommendations on any changes to access standards for elective care.

6 NEXT STEPS

6.1 Field testing and implementation

Now that we have defined the proposals for the new suite of access standards, we will field test these at a selection of sites across England, before wider implementation. The approach and timeframe for this testing varies across the four service areas according to the nature of care and the changes that are being proposed. The previous four chapters set out the approach to each. We will work with our partners and key stakeholders in developing our detailed testing approach. Prior to testing, detailed guidance will be provided to test sites to ensure clarity and consistency in what they are testing and measuring, and to support robust evaluation.

The previous chapters set out a clear timeframe for testing the proposed standards for each clinical area, and where appropriate rolling out from Autumn 2019, with final recommendations to be published in spring 2020.

Before any final changes are implemented to access standards which are set out in legislation (elective care and cancer care) and which are detailed as rights or pledges in the NHS Constitution Handbook (elective care, cancer care, and urgent and emergency care), a public consultation will be conducted. We will also publish detailed guidance to the system on how any new standards should be measured, to ensure clarity and transparency in their implementation and monitoring.

6.2 Evaluation strategy

Through field testing we will evaluate whether the new suite of standards address the issues identified within each service area, but also whether they meet the following principles:

- 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; and
- do not worsen inequalities.

In order to evaluate this, we will look to address the following questions within each service area:

Topic	Question(s)
Patient safety	• How have the standards strengthened patient safety?
Waiting times	• What happened to waiting times when the new standards were implemented in practice? • What were the mean and distribution of waiting times?
Process	• What set up process did sites go through to implement the new standards? • What changes to data collection, operational, and clinical workflows had to be made to implement the standards? • What resources were involved in implementing the new standards? • What operational barriers or opportunities were encountered? • To what extent did data on the new standards enable effective operational management and clinical decision-making? • What decision making and behaviours did the new standards drive?
Clinical outcomes	• What was the impact of the new standards on relevant clinical outcomes?
Patients' and public experience	• How clear and acceptable were the new standards to patients, the public, and patient advocate organisations? • How satisfied were patients with their experience of care?
Staff experience	• How clear were the new standards to staff? • How motivating were the new standards for staff? • How manageable did staff find it to meet the new standards?
Variation	• How did waiting times, patient and public experience, and clinical outcomes vary according to site factors (e.g. geography) or patient characteristics (e.g. condition)?

Our evaluation findings will inform the decisions on whether and how to rollout the standards more widely.

During the testing phase and alongside evaluation, we will continue to engage with partners and key stakeholders nationally, and through our test sites to gain expert advice and input locally. This will include the clinical community, and patients and the public through working with Healthwatch.

As set out in the introduction to this report, the information we gather through field testing, and extensive engagement during the field testing period, will inform final recommendations from this Review, and ahead of full implementation beginning spring 2020.

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ANNEX - Clinical Oversight Group membership

Chaired by Stephen Powis, National Medical Director

Organisation / Role
Academy of Medical Royal Colleges
Royal College of Surgeons
Royal College of Physicians
Royal College of Nursing
Healthwatch
NICE UK
Newcastle-upon-Tyne Hospitals NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Kettering General Hospital NHS Foundation Trust
NHS Clinical Commissioners
From NHS England and NHS improvement:
Executive Medical Director
Chief Nursing Officer
Medical Director for Clinical Effectiveness
Medical Director for Acute Care
National Director of Urgent and Emergency and Elective Care
National Mental Health Director
National Cancer Director
National Clinical Director for Mental Health
National Clinical Director for Urgent and Emergency Care
National Clinical Director for Musculoskeletal Conditions
Associate National Clinical Director for Elective Care