Clinically-led Review of NHS Access Standards

Progress Report from Professor Stephen Powis, NHS National Medical Director

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EXECUTIVE SUMMARY

The NHS National Medical Director was asked in June 2018 to review access standards to ensure that they measure what matters most to patients, and clinically.

The interim report was published in March 2019, setting out proposals to test new access standards in mental health services, cancer care, elective care and urgent and emergency care, to see whether they can be used safely and improve patient experience and outcomes.

Since then, the NHS nationally has been working to identify and support local teams to test how the different proposals work in the real world. More than 70 organisations or local health groups have answered that call, and this report sets out what they have done so far and the early learning from that work.

A Clinical Oversight Group is helping guide the programme, as are individual advisory groups for each workstream made up of patient groups, national charities, and clinical representatives. This engagement, and the expertise that people have contributed throughout, has been an important part of this process, and will continue alongside further testing and evaluation.

In testing the proposed **urgent and emergency care** standards, we are working with 14 hospitals across England to find out whether using a broader set of measures than the current four-hour threshold can better ensure those who need it get the right care fast, while reducing both unnecessary admissions to hospital and very long waits.

Initial results have been promising. The number of patients spending over 12 hours in A&E has fallen faster in trial sites than a control group, and there are signs that more people are getting the help they need to return home on the same day. Further testing over the traditionally busier winter period will help medics and other experts determine whether this continues.

We are encouraged too by research conducted on behalf of Healthwatch England, which found that the public place the highest priority on A&E teams providing early initial assessment on arrival for everyone, allowing staff to prioritise those patients with the greatest need, and ensuring that patients with critical conditions get the right standard of care quickly. Further, they found that the current measure was not well recognised, and that more people would find an average waiting time understandable and useful.

The proposed **mental health** standards – covering both urgent and emergency care in hospitals and the community – are being trialled in more than 30 parts of the country. They represent a significant expansion of access standards in mental health – both over the last few years and in the future, as part of the NHS Long Term Plan – and are designed to give more people who need mental health support an expectation of timely access.

Early signs suggest that they can be implemented safely and can support improvements in how care is delivered.

From late August, 11 hospital trusts began to test the use of a faster diagnosis standard for people with suspected **cancer**. This standard means that people can expect to be told whether or not they have cancer within 28 days of an urgent referral from their GP or a cancer screening programme, instead of the current standard of seeing a specialist, with no measurement of when someone should be told the result.

Initial testing has focused on establishing that it is possible safely to shift to the new standard, and no issues have been recorded. Promisingly, sites are also reporting some early improvements, against a continuing backdrop of significant increases in the number of people who are being referred for urgent cancer checks.

In **elective care**, 12 hospital trusts are testing whether the use of an average (mean) wait between being referred by a GP and starting treatment for routine conditions can better achieve the goal of reducing long waits for care than the current threshold standard.

Initial modelling and analysis work with expert groups supported this hypothesis, and the initial feedback from trusts has assured us that it is possible to implement the measure effectively. Again, we are encouraged by public polling, conducted for Healthwatch England, which suggests that moving to an average measure would be more meaningful for patients when exercising choice over where to receive treatment.

As there have been positive initial results in each of the four service areas, testing will continue across all of them. The data that this provides will continue to be monitored and analysed, alongside learning from independent research on patient experience (led by Healthwatch England) and on how staff view the current and proposed standards (led by SQW).

All of this will help inform refined proposals, which will be subject to public consultation that we would expect to launch in early 2020. The results of that consultation, combined with further analysis and evaluation and continued input nationally from clinician and patient groups, will inform a final report and set of recommendations by the end of March 2020. If recommendations require changes to the NHS Constitution, they will be subject to further consultation.

The approach to implementation of the proposals for each pathway will therefore be considered individually, to ensure that sufficient time and consideration is given to each, and to their interplay with the ongoing review of access to general practice.

INTRODUCTION

The NHS National Medical Director was asked by the Prime Minister in June 2018 to review the core set of NHS access standards, in the context of the model of service described in the NHS Long Term Plan, to ensure that they measure what matters most clinically and to patients, and to recommend any required updates and improvements to ensure that NHS standards:

- 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, and;
- do not worsen inequalities.

The review has been undertaken in three phases:

1. **Considering what is already known about how current targets operate and influence behaviour** – during the earlier stages of engagement on the NHS Long Term Plan, the review assessed the available academic and operational evidence on the effectiveness of the current standards as a driver for improvement in quality, safety and outcomes for patients.

2. **Mapping the current standards against the NHS Long Term Plan** – as the planned improvements in care took shape, the review assessed the extent to which the current standards would help to achieve this transformation and deliver better care and treatment.

3. **Testing and evaluating proposals** – where proposals for new and updated standards were made, the review committed to ensuring that they deliver the expected change in behaviour and experience for patients through real-world testing prior to making any final recommendations for wider implementation.

To support this review, a Clinical Oversight Group was established to provide advice and insight as we developed the recommendations and approach to testing, and as we begin to learn from test sites. The group includes members from the Academy of Medical Royal Colleges, the Royal Colleges of Surgeons, Physicians, Nursing, Psychiatrists and Emergency Medicine; as well as patient representative bodies including Healthwatch, the Patients Association and cancer and mental health charities. In addition to this overarching group, specific advisory groups have been advising on individual service areas. Membership of these groups can be found in the Annex.

In March 2019, the NHS National Medical Director published an interim report[i] which set out findings from the first two phases and proposals for testing new access

standards across four major pathways of NHS care. This included creating new standards for mental health care to support the ambitions for expanded access to mental health services and good patient experience set out in the NHS Long Term Plan[ii].

Changes to access standards for cancer were proposed with the ambition of creating a renewed focus on earlier diagnosis – the most crucial determinant of cancer survival – rather than interim steps along the patient pathway.

Proposed refinements to waiting time standards for those requiring routine care were made to support wider ambitions to reinforce patient choice, ensure a reduction in long waits, and be future-proof, recognising that the current measure would be invalidated by proposed changes to how outpatient services are delivered.

Similarly, expanded and refined measures for emergency care were proposed with the aim of supporting A&E staff to provide modern and effective care, deliver the right care quickly for those who need it the most, and ensure that every minute counts for every patient, reducing longer waits.

As set out in the interim report, any new standards will support the delivery of the ambitions in the NHS Long Term Plan, including improving urgent and emergency care and reducing provider waiting lists over the next five years. This will all be delivered within the agreed long-term funding settlement.

These proposals, and the commitment to test them carefully in 2019/20, were warmly welcomed by a range of stakeholders, representing frontline NHS staff, local system leaders, patients and families.

The proposed new standards are now being field tested across England by hospital trusts, supported by their commissioners, clinicians, patient groups and NHS England and NHS Improvement teams.

What happens in these field test sites is being monitored and evaluated by NHS England and NHS Improvement, working with our two independent partners: Healthwatch, who are providing insight on patient experience in test sites and on public views; and SQW, who are providing insight on staff experience and changes in behaviour.

Through the quantitative and qualitative evaluation, we are capturing data from hospital systems, from staff and from patients, so that we can test whether the proposals meet the three tests we set ourselves in the interim report:

- to improve on what we have now;
- to measure what's most important clinically, and to patients;
- to be clear and straightforward to understand.

Early signs are promising: new behaviours, processes, and understanding are being developed by clinical teams as they work to implement the proposed new standards.

This progress report is intended to do three things. Firstly, to recap on the proposed new standards in each of the four areas, the rationale for those proposals, and update on what we are finding through testing. Secondly, to set out the planned next steps in terms of continuing with testing. And thirdly, to outline our timetable for making final recommendations and implementing any agreed new standards.

URGENT AND EMERGENCY CARE

Recommendations

The interim report recommended 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; • acute physiological deterioration; asthma. Theses are known as Critical Time Standards
3	Time in A&E (all A&E departments and mental health equivalents).	Measure the overall waiting time experience for <u>all</u> patients. Strengthen rules on reporting prolonged trolley waits for admission, including reporting to the CQC.	Measures the time all patients are in A&E. Reduces risk of patient harm through long waits for admission or inappropriate admission. Reduces very long waits for those who need care.

4	Use 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. Reduces overnight admissions and improves 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.

Rationale

The four-hour standard was introduced in A&E departments in 2004 to support improvement in flow within acute hospitals.

It has focused resources – particularly staffing – into emergency care; the number of emergency medicine doctors has grown by almost 50% since 2009, within which the number of consultants has almost doubled. There have also been significant increases in nurses working in A&E. This is positive progress, which any proposed new standards should help maintain.

However, since the introduction of the 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, from the introduction of specialised centres for major trauma and stroke, to new mechanisms for entering the system through NHS111.

The NHS Long Term Plan sets out how these services will be improved further, including 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 sepsis, heart attacks and strokes.

The current headline four-hour access standard is used to measure and report performance against one aspect of the urgent and emergency care system. As set out in detail in the interim report, there are well-documented issues, which suggest that a more sensitive method of measuring the timeliness of care is needed:

- **The target does not measure total waiting times**: the target only covers performance during the first four hours, meaning total waits for patients who take longer to see, treat and admit or discharge are not measured.

- **The target does not take account of patient condition:** the target applies equally to all patients, regardless of condition. It focuses on time to complete treatment, when we know what particularly matters to patients and clinically for serious conditions is the time it takes to start the right treatment. Healthwatch have reported that 88% of people prioritised delivering the right tests and treatments to people thought to have a life-threatening condition[iii].

- **The target does not measure whole system performance:** it measures a single point in time in an often-complex patient pathway, leading to a false perception that delivery is the sole responsibility of emergency department staff, when it really requires the combined effort of many across the organisation and the health and social care system.

- **The target does not consider clinical advances in Same Day Emergency Care:** patients with conditions such as asthma attacks increasingly can be treated and safely able to go home the same day rather than admitted, but that may take longer than four hours. The target is therefore redundant for growing numbers of patients, and penalises hospitals and staff for providing the best quality care.

- **The target is not well understood by the public:** Healthwatch polling shows that people do not understand the four-hour standard. Only 21% of people said they thought they knew what the national target for A&E was, while 79% said they thought they didn't know. When asked about what would be most meaningful to them, 70% of people felt an average was easy to understand, higher than any other option.[iv]

The proposed set of access standards for urgent and emergency care set out in the interim report seeks to overcome the identified weaknesses in the current standard in the following ways:

- By removing the four-hour cliff edge, the new standards ensure that clinical decision-making will take place at a clinically appropriate time. This also means that there can be additional time if needed to observe or treat a patient so that they can be discharged home rather than being admitted unnecessarily;
- By measuring every minute waited by every patient, the new standards place additional focus on those who need to be admitted, and so supporting flow through the hospital;
- By looking at data systematically for those who have been in A&E departments for 12 hours or more from the point of arrival, rather than from a decision to admit as has been measured in the current regime, the new standards shine a light on patients who are waiting a long time to be treated or admitted;

- The new Critical Time Standards ensure that when someone is critically ill, they receive the immediate care they need to save their life;
- The set of new standards is more sensitive in measuring what is meaningful to patients and reflects what they value from their urgent and emergency care services.

A key focus of the proposed new standards is improving the quality of care for life-threatening conditions, with the aim of saving more lives.

Critical Time Standards for stroke, ST-Elevation Myocardial Infarction (STEMI), asthma, trauma, and acute physiological deterioration (including sepsis) were proposed in the interim report.

National performance in these pathways has improved dramatically in recent years, with an additional 600 patients surviving major trauma in 2016/17 compared with the previous year, and a 19% increase in survival since the inception of major trauma centres in 2012/13.[v] There also has been a reduction by more than half in the 30-day mortality rate for hospitalised stroke, which has fallen from 27% in 1998[vi] to 17% in 2010[vii] and 13.6% in 2015/16[viii]. Through the new set of standards, focus will be on ensuring that every patient receives the critical first steps in their treatment quickly.

Engagement

NHS England and NHS Improvement has benefited from a high level of interest and engagement in these proposals from a range of stakeholders, particularly staff groups.

As part of the Urgent and Emergency Care Clinical Advisory Group, input has been sought from: the Royal Colleges of Emergency Medicine, Physicians, General Practice, Paediatrics and Child Health, Nursing and Surgeons; the Society of Acute Medicine; Healthwatch England; the Patients Association; NHS Clinical Commissioners; and NHS Providers.

Further specialist input has been sought as part of developing the Critical Time Standards from clinical experts. As we seek to implement these standards we will continue to work with experts and charities such as the Sepsis Trust, British Lung Foundation, Asthma UK, the Stroke Association and British Heart Foundation.

Locally, field testing sites have been engaging with their staff, patients and local stakeholders prior to and during the testing period, and as part of evaluation we will be capturing their views to help inform final recommendations.

Field testing these proposals

The following 14 hospital trusts have been field testing the proposals set out in the interim report. The group was carefully selected to ensure that there was a mix of rural and urban communities included, that there was geographical spread across the country, that strong and poorer performing organisations were included so that they reflected typical performance across the rest of the NHS, and that trusts had the necessary IT infrastructure in place to enable robust recording and reporting during the test period.

Hospital Trust	Region
Cambridge University Hospitals	East
Chelsea and Westminster Hospital	London
Frimley Health	South East
Imperial College Healthcare	London
Kettering General Hospital	Midlands
Luton and Dunstable University Hospital	East
Mid Yorkshire Hospitals	North East and Yorkshire
North Tees and Hartlepool	North East and Yorkshire
Nottingham University Hospitals	Midlands
Plymouth Hospitals	South West
Poole Hospital	South West
Portsmouth Hospitals	South East
Rotherham	North East and Yorkshire
West Suffolk.	East

Testing began with a first six-week period on 22 May 2019, and focussed on testing standard three, the total time in department, from arrival to discharge or admission. The primary objective for this period of testing was to ascertain that this standard could be implemented safely and provide clinicians with a useful measure of activity and patient experience.

The measure was introduced successfully across all sites, with no reported safety concerns linked to the testing.

The Urgent and Emergency Care Clinical Advisory Group for this workstream, and the trusts involved, therefore supported continuing testing. This has subsequently included:

- measuring time to initial assessment;
- assessing the feasibility of the Critical Time Standards; and
- continuing to monitor total time in department and long waits from arrival, aiming for continual improvement.

In order to understand the impact of field testing, we have compared changes in key measures in the group of field testing trusts with a control group of non-field testing trusts. We have chosen a group of 19 trusts, where data submissions are timely and

historical data is of adequate quality. We have analysed the key characteristics and trends of this group to ensure they are broadly representative of all non-field test trusts and therefore provide a robust comparator. We looked at trends in performance and conversion, along with the age structure of those attending emergency departments.

As described in the Mental Health section, neighbouring mental health trusts are also testing standards for urgent community mental health services that can prevent avoidable A&E attendances. When people do need to attend A&E, the selected trusts are measuring how long people who arrive at A&E experiencing a mental health crisis wait for a psychiatric assessment and, where required, a transfer to appropriate mental health care.

We are working with trusts on how best to capture consistent data on Same Day Emergency Care. We will subsequently review and test what an appropriate measure should be.

Regarding the supporting indicator, we are developing new call answering standards for 999 and 111, as rapid response to patients' calls is important in ensuring they are assessed promptly and can access the most appropriate service. Through introducing these standards, we hope to reduce variation and improve and maintain performance.

As part of testing the proposed new measures, data against an additional set of supporting measures are being captured. This is to understand the affect that the new standards might have on the flow through the organisation and are set out in the table below.

Timestamp	Definition	Rationale
Time to treatment decision	A&E Clinical Quality Indicator	Ensuring patients are seen by a decision-making clinician as quickly as possible, regardless of their condition
Time to specialty referral	Time at which patient is referred to any specialty team	Required in order to understand whether patients are seen by specialty teams in an appropriate timeframe
Time to specialty assessment	Time at which patient is assessed by specialty team	Required in order to understand whether patients are seen by specialty teams in an appropriate timeframe

Ready for ward	The time at which an admitted patient's emergency department care is complete and they can be transferred to an inpatient unit	Ensuring that patients who require admitting are moved to an appropriate inpatient bed as quickly as possible to support good flow through the UEC system

These measures will help us to understand whether patients follow the most appropriate pathway for their condition: admitting patients as quickly as possible where necessary while maximising the opportunity for doctors to make clinically based, rather than process-driven, judgements about who can safely go home. We must also understand the impact that the proposed standards have on crowding within the emergency department and are monitoring this through the field testing.

What we have learnt so far

Initial data from the field testing sites have identified three areas in which we are beginning to see differences when compared to our control group, and to the period of time before field testing began.

Firstly, **the number of patients spending over 12 hours in A&E from the point of arrival has fallen faster at the test sites than hospitals using the old standards**, suggesting that the use of the new package of standards may be effective in bringing down long waits. We are also for the first time measuring a true reflection of how long patients are in the department, with the 'clock' starting the moment the patient arrives at the department, rather than at the point at which a decision is taken to admit. This is important to fully understand how departments are performing.

Weekly average number of 12 hour total time waits (from arrival), Type 1 A&E Department

	Baseline (six weeks prior to field testing)	Field testing (22nd May to 1st October)	Difference from baseline	Percentage change from baseline
Field testing trusts	662	545	-117	-17.7%
Control group of non-field testing trusts	1268	1201	-68	-5.3%

Secondly, **the proportion of patients admitted to hospital from A&E – known as the 'conversion rate' - appears to be falling faster in field testing sites than in the control group**. This measure is important as we know that patients do not want to be admitted to hospital unless it is absolutely necessary, that time spent on wards can put people at risk of physical deterioration, and that every bed occupied by someone who could instead be at home is a bed which cannot be used for a patient who genuinely needs it.

Conversion rate, Type 1 A&E Department

	Baseline (six weeks prior to field testing)	Field testing (22nd May to 1st October)	Difference from baseline	Percentage change from baseline
Field testing trusts	32.2%	30.7%	-1.5pp	-4.7%
Control group of non-field testing trusts	31.0%	30.6%	-0.4pp	-1.2%

Thirdly, we have seen that **achieving the reduction in the conversion rate has been accompanied – as would be expected – by a small increase in the mean time in department for non-admitted patients, and so a slight increase of six minutes in the overall mean**. In other words, a slightly longer time in A&E, on average, means that more patients are able to go home rather than go into a hospital bed. It is notable that the main movement in the time spent in department is seen particularly around the four hour mark, which **implies that the new standards have removed the incentive to admit rather than discharge patients to meet the previous four-hour standard**.

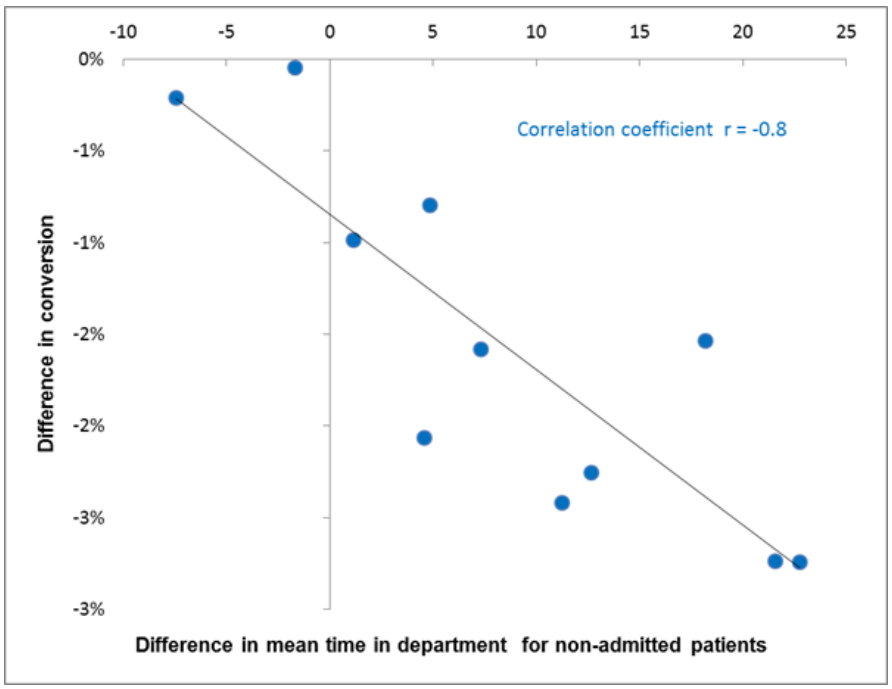
If, as these initial returns suggest, removing the influence of the four-hour 'cliff edge' has the effect that more people are able to go home from A&E having completed treatment, this would reduce the total amount of unnecessary time that people spend in hospital. An admission to hospital can often result in a stay of one or more days, so avoiding this by spending an additional one or two hours in A&E is clearly a benefit for individual patient experience and outcomes. We will test this further as we gather more detailed data for the final report.

In response to the emerging relationship between the conversion rate and the mean time for non-admitted patients, NHS England and NHS Improvement also has been exploring the value of monitoring the average time in department for admitted and non-admitted patients separately, instead of having one aggregate mean covering both groups. This is because patients may be prepared to accept a slightly longer wait if they are able to go home, but it is still clinically appropriate for hospitals to do what they can to reduce the time that patients spend in A&E before being admitted.

Mean time in department (minutes), Type 1 A&E Department

	Baseline (six weeks prior to field testing)	Field testing (22nd May to 1st October)	Difference from baseline	Percentage change from baseline
Field testing trusts	222	228	6	2.7%
Admitted*	315	312	-3	-1.0%
Non-admitted*	181	190	9	5.1%
Control group of non-field testing trusts	219	219	-1	-0.3%
Admitted*	310	308	-3	-0.9%
Non-admitted*	179	180	1	0.5%

The chart below shows the difference in mean time in department for non admitted patients and the difference in conversion rate, six weeks prior to field testing vs during the field testing period to 1 October 2019, type one. **As intended, by spending slightly longer in A&E the proportion of patients who are admitted to hospital seems to have fallen.**



Note: excludes three Trusts with limited availability of disposition data

We have also been capturing data on time to initial assessment from all sites involved. We know that there are different models in place to initially assess patients on arrival at emergency departments, for example, triage, streaming or a combination of both. We will be working to better understand these different approaches and ensure that there is a consistent framework in use, which can

support timely assessment for all patients, and that will form part of this review's final recommendations.

The Critical Time Standards for stroke, heart attack, acute physiological deterioration asthma and major trauma were initially tested in three test sites each to understand feasibility and how they can best be measured. From 1 October, the standards for stroke and heart attack are being tested in all reporting field test trusts, and we intend to test accelerated capture of the RAPID (Responding to Acute Physiological Deterioration) standards in all 14 trusts before the end of 2019. We expect that all test sites also will be testing the standards for asthma and major trauma by the end of 2019. The variability of current performance – as seen in both clinical audits and our early returns – provides a strong prima facie argument for this approach.

In summary, testing to date has further demonstrated that one measure alone is not sensitive enough to understand the effectiveness of care in urgent and emergency care services, and that a wider package of measures can be implemented safely and effectively. And while no firm conclusions can yet be drawn from the data returned, meaning that continued testing is needed, early returns combined with the feedback received from clinical and operational staff in test sites, suggests that there may be benefits for patients.

MENTAL HEALTH

Recommendations

The interim report recommended 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.
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 signposting 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.

These new standards would be in addition to those already in place or planned for improving access to psychological therapies (IAPT) services, early intervention in psychosis services and eating disorder services for children and young people.

Rationale

Over the last five years, the NHS has prioritised a major investment in the quality and range of mental health services, with the ambition that people experiencing a wide range of conditions are able to access appropriate care where and when they need it. The NHS Long Term Plan builds on the foundations set out in the Five Year Forward View for Mental Health[ix] and sets out the most ambitious transformation of mental health services England has ever known.

The proposed new access standards for urgent and more routine community care represent a significant expansion of access standards in mental health, ensuring that more mental health pathways, both urgent and routine, are captured by expectations of timely access. They seek to set expectations and then measure delivery of timely services to people who need them, in light of the expansions in services that are set out in the NHS Long Term Plan, and support the spread of the best models of care for those who need them.

Engagement

NHS England and NHS Improvement's mental health programme benefits from a high level of engagement from expert stakeholders, encompassing both clinical and professional groups like the Royal College of Psychiatrists, and patient groups and voluntary sector organisations such as Mind.

These proposals, and the commitment to test them carefully, have been well supported by those stakeholders, who continue to work with us nationally in overseeing the testing process.

Locally, those organisations taking part in field testing have been encouraged to engage with their relevant stakeholders, particularly staff, to ensure that the testing process is well understood.

Field testing these proposals

Different approaches and timescales have been employed in testing standards in each of the three areas of mental health services that have been considered in this review, as outlined below.

Urgent mental health services

The neighboring mental health trusts to those testing UEC standards are testing the approach to urgent community mental health services that can prevent avoidable A&E attendances by providing crisis care in more suitable environments where possible.

These trusts are as follows and began testing on 1 October 2019:

Hospital Trust	Region
East London Foundation Trust	London
Tees, Esk and Wear Valley NHS FT	North West
Central and North West London NHS FT	London
West London Mental Health NHS FT	London
Surrey and Borders Partnership NHS FT	South East
West London Mental Health NHS FT	London
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust	North East and Yorkshire
Cambridge & Peterborough NHS FT	East
South West Yorkshire mental health Trust	North East and Yorkshire
Northamptonshire Healthcare FT	Midlands
Livewell South-West	South West
Nottinghamshire Healthcare NHS FT	Midlands

For those people experiencing mental health crises who do attend A&E, we will be seeking to understand waiting times for people with mental health needs throughout the A&E pathway from time of arrival to departure from hospital. This includes testing the standard that many psychiatric liaison teams work to, of responding within an hour from referral.

Community Children and Young People's services

12 of the 25 2018/19 Mental Health Support Team trailblazer areas[x] are piloting a four-week waiting time for access to specialist NHS children and young people's mental health services. These are:

Area	Region
Bromley	London
Camden	London
Haringey	London
Tower Hamlets	London
North Staffs and Stoke on Trent	Midlands
South Warwickshire	Midlands
Doncaster and Rotherham	North East and Yorkshire
Northumberland	North West
Buckinghamshire	South East
Oxfordshire	South East
Gloucestershire	South West
Manchester	North West

The pilots are testing not only what it takes to achieve and maintain a four-week waiting time, but also how best to define and measure this access to specialist children and young people's mental health services. They are testing its impact on outcomes for children as well as any impact on other services.

Community adult mental health services

The following areas have been selected to test a four week waiting time access standard. These areas have been selected at system level, to reflect the need for community mental health services to work together with primary care through the new primary care networks. Not all parts of each system will be involved in the testing.

STP/ICS	Region
Cambridgeshire and Peterborough STP	East of England
Hertfordshire and West Essex STP	East of England
North East London STP	London
North West London STP	London
Herefordshire and Worcestershire STP	Midlands
Lincolnshire STP	Midlands
Humber Coast and Vale Health and Care Partnership	North East & Yorkshire
South Yorkshire and Bassetlaw ICS	North East & Yorkshire

Cheshire & Merseyside STP	North West
Frimley Health and Care ICS	South East
Surrey Heartlands Health and Care Partnership	South East
Somerset STP	South West

All sites are in the initial stages of mobilisation of new models of delivering care. Most will begin on a small geographical footprint and scale up as we move into 2020/21. A key part of this mobilisation is sites establishing data collection systems that will allow them to record and report waiting times on a routine basis – many services do not currently have an accurate or complete baseline.

The testing of waiting times is to be incorporated into the wider testing of new models of integrated primary and community mental health care, to ensure that all individuals can access care in a clinically appropriate timeframe. Sites have been asked to test a maximum of four weeks from initial contact in primary or secondary care to receiving appropriate care in NHS-funded services. This represents a significant change in practice as new models are moving away from systems based on primary care referring to secondary care mental health services, towards genuinely integrated working between primary care, secondary care mental health and the voluntary sector.

Waiting time points will therefore not be based on referral and response to referral. The definition of 'appropriate care' and time points will be tested within the new models and will require sites to engage extensively with patients, families, carers and professionals as to what is acceptable and achievable within a four-week timeframe.

Sites 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 two-week waiting time standard in place. Testing of waiting times for generic care will ensure there are no perverse incentives to 'game' the existing EIP standard or unintended consequences in introducing or perpetuating artificially long waits for specialist community services.

The national implementation support offer to all sites testing new models includes specific support around waiting times testing and data collection. Testing, support and evaluation will continue throughout 2020/21 and will inform any subsequent decisions regarding the introduction of standards, their nature and any appropriate timescales.

What we have learnt so far

Due to the complexity of developing and implementing new standards from scratch – and the requisite data collections – it is not possible at this stage to provide sufficient analysis of progress.

Due to the fact that they were already working to the model of care supported by the standard proposed, those involved in the children and young people's community services field testing have reported good progress.

Many have focused on improving the ease of entry into services, introducing a 'single point of access', 'triage' and 'navigation hubs' to make sure that service users access the right care, support and treatment more swiftly. Some are building the voluntary and independent sector into these via secondments or co-location, to ensure that the NHS isn't always seen as the only option to meet the needs of children, young people and their families.

From initial testing, the following issues have been identified by test sites:

- Recruitment of new staff and supporting them to manage cohorts of children and young people who have complex needs including those that may need input from non-NHS services triage;
- Delivering and sustaining reduced waiting times for children and young people's mental health services requires services to think not just about how to expand but how to deliver differently;
- Improving measuring and monitoring consistently and including the use of SNOMED CT. This has real potential to improve how we understand the service delivery and the breadth and nature of the needs that services cater for.

CANCER

Recommendations

The interim report recommended the testing of the following standards, including considering any thresholds that might accompany the 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.

Rationale

The NHS Long Term Plan set out ambitions for improving cancer services and therefore outcomes for patients, including that by 2028, the proportion of cancers diagnosed at stages one and two will rise from around half now to three-quarters of cancer patients. This is because all the evidence shows that for many types of cancer, finding it early saves lives. Five-year breast cancer survival improves from around 28% to 99% when the disease is diagnosed at stage one rather than stage four[xi].

The NHS Long Term Plan builds on the work set out in the Independent Cancer Taskforce strategy[xii], published in 2015. Recognising that our current standards measure the time to be seen by a doctor, rather than time to being provided a diagnosis of cancer, this strategy recommended a Faster Diagnosis Standard, to ensure people receive a life-changing confirmation or ruling out of cancer within 28 days of urgent referral from their GP or screening programme. This represents a significant improvement on the current two-week wait to first appointment target, and a more patient-centred performance standard (9). Given that this was considered an improvement on the current standards, the taskforce suggested that the two-week waiting time standards would be superseded, which was endorsed by this review.

Overall, there are currently nine standards covering a range of types of treatment and referral routes. They are complex and difficult to understand even for those working in organisations that are trying to meet them, never mind for patients who are on the receiving end of care. The interim report also recommended replacing the three separate standards related to treatment within 62 days for urgent referrals, consultant upgrades and screening with one standard, and replacing the four standards related to first and subsequent treatments within 31 days for all patients with another single treatment standard.

Engagement

In advance of field-testing the proposals, NHS England and Improvement undertook a period of online engagement for stakeholders. Online public engagement closed at the end of June 2019, with responses received from 46 organisations, including trusts, cancer alliances, and charities across different specialisms.

Responses included overall support for the core recommendations of the interim report, including the simplification and modernisation of standards, although support for the immediate removal of the two-week wait standard was more mixed.

As with the mental health programme, the cancer programme continues to benefit from a well-established stakeholder reference group which is helping to oversee this testing process, including professional groups like the Royal College of Radiologists, and the wide range of cancer charities.

Field testing these proposals

The following hospital trusts have been field testing the proposals set out in the interim report. The group was carefully selected to ensure that there was a mix of rural and urban communities included, that there was geographical spread across the country, that strong and poorer performing organisations were included, and that

trusts had the necessary IT infrastructure in place to enable robust recording and reporting during the test period:

Hospital trust	Region
Mid Essex Hospital Services	East of England
Epsom and St Helier University Hospitals	London
Kingston Hospital	London
Chesterfield Royal Hospital	North East and Yorkshire
Northampton General Hospital	Midlands
Doncaster and Bassetlaw Teaching Hospitals	North East and Yorkshire
East Lancashire Hospitals	North West
Warrington and Halton Hospitals	North West
Hampshire Hospitals	South East
The Royal Bournemouth and Christchurch Hospitals	South West
Torbay and South Devon	South West

Testing began in August 2019 and is expected to run until the end of March 2020. There will be two phases of testing, with the first phase running from August-November 2019. Following this initial phase, we will make an assessment of progress in each trust and agree those to continue into phase two as 'frontrunner' trusts.

What we have learnt so far

Qualitative and quantitative analysis is underway, making use of existing data sources, both publicly available and internal, to minimise the burden on trusts of participating in testing.

Initial testing is focused primarily on demonstrating that there is no detriment to patients or overall operational performance in moving to the Faster Diagnosis Standard as has been recommended by the Independent Cancer Taskforce. We are also seeking to demonstrate that shifting focus in this way, as well as the increased pathway flexibility that comes with the change, allows trusts to make faster progress towards delivering the Faster Diagnosis Standard.

To date no significant issues have been raised by either clinical or patient groups, and we have begun to see promising improvements in some areas, against a continuing backdrop of significant year on year increases in the number of people being referred for an urgent cancer check.

We are also seeking to use the testing period as an opportunity to emphasise further the importance of data quality, to implementation of the Faster Diagnosis Standard. All trusts have been collecting data on the new standard from 1 April 2019. Data completeness currently stands at 67% nationally, an improvement from 54% following the mandating of this dataset nationally in April 2019.

Testing will continue during 2019, with qualitative and quantitative evaluation taking place in line with the review's evaluation approach (see Next Steps).

ELECTIVE CARE

Recommendations

The interim report recommended the following headline access standards, alongside 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. 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 keeping 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 report 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.

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.

Rationale

Access standards in this area of planned, also known as elective, care are important to ensure that people are treated in a timely way. The current standard sets a maximum waiting time of 18 weeks from referral to treatment, and a percentage threshold of 92% of patients. However, the way we design care and treat people has changed over the last decade and will continue to do so, as more tests, consultations and check-ups will be provided closer to home or through secure phone and internet services.

While a single standard approach has been useful in keeping focus on the current list and taking action to expedite treatment, there are some issues and possible improvements that could be introduced.

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 of a service, an organisation and the NHS, is therefore rated the same whether someone gets the treatment they need at 19 weeks or 49 weeks. In the current system, long waits are only flagged when people have been waiting for more than 52 weeks.

The current target also can be misleading to patients. Recent public survey work by Healthwatch England found that fewer than one in five people was able to accurately identify the current standard. The same poll found that one in three people believed, incorrectly, that the standard time for treatment was between six months and 12 months[xiii]. In fact, the majority will wait fewer than 8-9 weeks, and even accounting for those who have had to wait the longest, the average (mean) wait is fewer than 10 weeks[xiv].

Finally, most 'clock stops' in the current standard are for outpatient appointments and as these services are redesigned in line with the NHS Long Term Plan, even if nothing else changed, the current measure would become invalid.

This review recommended that alternatives to the current single standard be tested, not just to understand better how well services are performing but also to ensure that the standards are easily understood and relevant for people receiving treatment and their families. The Healthwatch polling identified that 72% of people found an average easy to understand and helpful in comparing performance across organisations (higher than the other options), and it is testing this kind of measure that has therefore been prioritised.

Engagement

NHS England and NHS Improvement have sought and received input throughout the development of the proposals and testing process from an Elective Advisory Group established for this purpose, which will continue throughout the testing and as final recommendations are developed.

This has included relevant professional organisations, including the Academy of Medical Royal Colleges as well as individual Royal Colleges of Surgeons, Physicians and General Practice.

The patient perspective has been provided by Healthwatch England and the Patients Association, as well as organisations representing specific groups, including Versus Arthritis, National Voices through the Arthritis and Musculoskeletal Alliance and the MS Society.

Locally, field testing sites have been engaging with their staff, patients and local stakeholders prior to and during the testing period, and as part of evaluation we will be capturing their views to help inform final recommendations.

Field testing these proposals

The focus of testing the proposed elective standard is on assessing the benefits and risks of an alternative headline measurement approach, using a mean waiting time standard, comparing it to experience of using the current approach.

The approach has incorporated central analytical work and behavioural assessment, undertaken in parallel to the early stages of field testing. The three elements are:

- **Behavioural Assessment and Evaluation –** workshops were conducted with staff in hospitals and in commissioning organisations at field test sites and with experts to test understanding of the impact of both headline measurement approaches, to determine which is most likely to drive the right operational and clinical behaviours to reduce waiting times. The work also helped to inform sites on how to set up live field testing.

- **Analytical Modelling** – workshops were conducted to forecast how waiting list size, mix and distribution are likely to change as a result of outpatient reform, and the way diagnostic services will be provided in future. An assumptions-based model was developed to forecast the impact of these reforms, and also to explore the relationships between means and the shape of waiting lists.

- **Live Field Testing** - The 12 field sites, set out in the table below, were selected using set of criteria that reflect the diversity of the provider sites in the NHS, including geography and performance. From 1st August, this single cohort of field testing sites have been testing use of the mean waiting time headline measure only to complement the current knowledge of operationalising a maximum waiting time with a percentage threshold.

Hospital trust	Region
Barts Health	London
Calderdale and Huddersfield	North East and Yorkshire
East Lancashire Hospitals	North West
Great Ormond Street Hospital for Children	London
Harrogate and District	North East and Yorkshire
Milton Keynes University Hospital	East of England
Northampton General Hospital	Midlands
Surrey and Sussex Healthcare	South East
Taunton and Somerset	South West
The Walton Centre	North West
University Hospitals Bristol	South West
University Hospitals Coventry and Warwickshire	Midlands

There is good engagement across the 12 test sites, who are working towards individually set mean levels of performance. As we progress to the next phase of testing in November, an additional stretch measure of performance will be identified for test sites.

Supported by the Elective Intensive Support Team, there has been a series of site visits designed to collect critical qualitative information that will reflect the impact of these measures within providers, and contribute to the overall evaluation. The independent sector also continues to be engaged across the programme.

Working with test sites, NHS England and NHS Improvement has developed an evaluation framework that incorporates qualitative and quantitative analysis from the workshops, advisory groups and field site visits. This is in line with the review's overall evaluation approach (see Next Steps).

Healthwatch has supported the programme by developing a national survey questionnaire. Further work on patient & public understanding will be delivered by Healthwatch England in the coming months and this will help understand the experiences of patients and their perspectives on the new approach.

What we have learnt so far

Work with experts as part of the behavioural assessment and analytical modelling workshops yielded some provisional hypotheses that a movement to a mean average waiting time measure would support the ambition to minimise the perverse incentives that the current target can create, including incentives to focus on longest waiters and work to reduce length of all pathways of care regardless of current length of wait. The workshops also identified some possible impacts to be avoided and the evaluation has been adapted to check for these and mitigate them.

The public polling conducted for Healthwatch suggests that moving to an average measure would be more meaningful for patients when exercising choice over where to receive treatment. Test site feedback is similar, whilst at the same time suggesting further benefit in seeking to identify the expected waiting time for an individual patient.

Due to the nature of elective care –the longer lead times for treatment as compared with emergency care – testing was not expected to have provided enough data at this stage to have a conclusive picture of what impact the proposed new standard is having. However, initial feedback from field testing trusts suggests that implementing the measure is practically achievable without changing provider processes and has been implemented effectively.

NEXT STEPS

The previous chapters have set out the latest progress in testing the proposals set out in the interim report for new access standards in the four pathways of care. This chapter outlines the planned next steps in terms of continuing and completing the testing and evaluation, consulting on proposals, and making and implementing final recommendations.

Evaluation

Testing will continue in the field test sites. The field test sites and NHS England and NHS Improvement agreed a Memorandum of Understanding (MoU) setting out the arrangements the Trust and the national team have committed to ensuring are in place prior to and during the field test. This includes additional data requirements that will support the evaluation.

As set out in the interim report, the evaluation will consider quantitative and qualitative information to assess whether the proposed new standards have had a positive effect in the following areas:

- patient safety;
- waiting times;
- process change;
- improved clinical outcomes;
- patient and public experience;
- staff experience; and
- reducing variation in outcomes, experience & performance.

Tailored approaches to evaluation are being developed for each pathway of care with both quantitative and qualitative evidence, such as that relating to patient and public experience as well as staff experiences and behaviour change.

Patient and public understanding & experience

A range of approaches are being used to capture both the patient experience, and public understanding of the proposals. The work is being led by Healthwatch England, with input through the Advisory Groups from a number of other patient groups and charities.

National survey work has been undertaken to inform the approach and capture public understanding and expectations. Healthwatch England in collaboration with the local Healthwatch network are undertaking semi-structured interviews, with people accessing care through an A&E department at various times of the day and week.

Staff experience

An independent evaluation company, SQW, has been appointed to provide qualitative evidence to understand staff experience. They will be working with a sample of staff to include, clinicians, administrators, ward managers, and

commissioners. The staff groups will be reflective of the pathway and proposals being tested and will come from different sizes and locations of organisations.

The evidence captured through the semi-structured interviews will then be used to identify common themes and reveal any emerging relationships in the data. A survey will also be developed to allow a wider group of staff across field test sites to give their views.

Wider consultation

NHS England & NHS Improvement have further committed to capturing the public's views through an engagement / consultation that will be informed by evidence from the field testing, and the additional work being undertaken nationally and locally.

This is likely to take place in early 2020, so that the responses can inform final recommendations from the review, which will be set out in a final report by the end of March 2020.

If recommendations made by the NHS and accepted by Government require changes to the NHS Constitution, these changes would be subject to further consultation.

Implementation

The approach to implementation of the proposals for each pathway will be considered individually, to ensure that sufficient time and consideration is given to each, recognising their particular circumstances.

For urgent and emergency care, where the field testing has been running longer and will be able to conclude sooner, the intention is to support the NHS to implement any changes from 1 April 2020. For elective care and cancer, implementation is likely to be during mid 2020/21. In mental health, where completely new standards are being proposed, implementation will be to a longer timeframe, as testing is likely to continue in 2020/21 to ensure that the introduction of standards in these areas is sustainable. All timelines are subject to change and government agreement.

In parallel, NHS England is reviewing access to general practice services. The aim of the review is to improve access both in hours and at evenings and weekends, and to reduce unwarranted variation in experience. As part of this, the review will also be considering how other services impact on access to general practice and vice versa and will take account of what we are learning from testing new access standards in the four pathways of care that have been described in this report. Final recommendations from both reviews will be developed alongside each other reflecting the interdependencies and impact of access across the spectrum of care for patients.

In all cases, guidance and support will be made available to help NHS organisations make and communicate the changes in their local areas. This will be informed by what we learn during field testing and co-produced with those who will be implementing the changes on the ground.

ANNEX A - Oversight and Advisory Group Membership

Clinical Oversight Group
Academy of Medical Royal Colleges
Royal College of Surgeons
Royal College of Physicians
Royal College of Nursing
Royal College of General Practitioners
Royal College of Emergency Medicine
Royal College of Psychiatrists
NHS Providers
NHS England and NHS Improvement
NHS Clinical Commissioners
NICE UK
HealthWatch England
Patients Association
Cancer Research UK
Breast Cancer Care
Macmillan Cancer Support
Mind

Urgent and Emergency Care Advisory Group
Academy of Medical Royal Colleges
Royal College of Emergency Medicine
Royal College of Paediatrics and Child Health
Royal College of Nursing
Royal College of Physicians
Royal College of Surgeons
Royal College of General Practitioners
Society of Acute Medicine
NHS Clinical Commissioners
NICE UK
Healthwatch England
Patient's Association

Mental Health Independent Advisory and Oversight Group
Royal College of Psychiatrists
Royal College of Nursing
Faculty of Public Health
Mind
Rethink
British Psychological Society
Young Minds
National Survivor User Network
NHS Confederation
Dundee University
Race Equality Foundation

Cancer Clinical Advisory Group
Macmillan
South East London Cancer Alliance
NHS England and NHS Improvement
Chemotherapy Clinical Reference Group
Exeter University
Northern Cancer Alliance
Royal College of General Practitioners
Transforming Cancer Services – London

Elective Advisory Group
Academy of Medical Royal Colleges
Royal College of Surgeons
Royal College of Physicians
Royal College of General Practitioners
NHS England and NHS Improvement
NICE UK
Healthwatch
Patients Association
National Voices
Versus Arthritis
MS Society

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