NHS England and NHS Improvement Board meetings held in common

Paper Title: Clinical Review of Standards: Progress Update

Agenda item: 7 (Public session)

Report by: Professor Stephen Powis, National Medical Director

Paper type: For noting

Summary/recommendation:
The Boards are asked to note the progress to date and the latest learning from the Clinically-led Review of NHS Access Standards.

This paper sets out the learning so far and the intended approach to concluding the review for each of the four pathways of care: mental health, cancer, urgent and emergency care and elective care.

Background

1. The Clinically-led Review of NHS Access Standards is seeking to ensure that the national access standards in four key pathways of care measure and incentivise improvements on a) clinical outcomes, b) patient experience and c)efficient NHS care.

2. A set of proposals for testing were outlined in an interim report in March 2019, that built upon the review's findings from the first two phases: phase one considered what is already known about how the current targets operate and influence behaviour; and phase two looked at how standards map across to the ambition within the NHS Long Term Plan and the opportunities to help support the delivery of better care and treatment through continued transformation.

3. The approach to testing the proposals for mental health, cancer, elective and urgent & emergency care was set out in a progress report in October 2019. This report also set out the early learning from the testing alongside a commitment to continue testing.

4. The continued testing has yielded further learning and is informing the proposed way forward for each workstream, including refining the proposals, the development of a public engagement exercise, informing the review's final recommendations and an operational model to support implementation.

Update

Mental Health proposals:

5. Testing is continuing across more than 30 parts of the country. The proposed new access standards for urgent and emergency mental health care, and community care , are being tested as part of a significant expansion in access to high quality mental health services as part of delivering the NHS Long Term Plan.

6. Good progress has been made in testing the proposed access arrangements for children and young people's community services. Many sites have adopted the Thrive framework with arrangements being put in place to share learning across all providers. Emerging issues across all sites include recruitment of new staff, the need to redesign services, and measuring and monitoring consistently.

7. Testing of adult and older adult community services mental health access standards is in the initial stages. Sites involved in testing have begun to identify definitions for 'appropriate care' and time points in the pathway. There are challenges in being able to capture information through existing datasets.

8. Testing will continue and the review will issue final recommendations in respect of mental health pathways by April 2021, as planned.

Cancer proposals:

9. The Cancer Taskforce, and an engagement period prior to testing both identified support for the simplification and modernisation of standards. Initial testing during phase one focused on demonstrating that there is no detriment either to patients or overall operational performance in moving to the Faster Diagnosis Standard, with phase two focussing more specifically on the impact of interventions to improve 28-day performance. Testing is also seeking to explore whether focusing on the Faster Diagnosis Standard leads to increased pathway flexibility.

10. To date no significant issues have been raised by either clinical or patient groups involved in the test sites, 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 receiving an urgent cancer referral.

11. When considering the impact of the new standards, where the emphasis is on time to diagnosis rather than time to first appointment, there were concerns that an unintended effect might have been a longer time to first appointment. Pleasingly there is no significant change in patients waiting up to 7 and up to 14 days for their first outpatients appointment for both the test trusts and the control group relative to the baseline.

12. Given these findings, and that the Faster Diagnosis Standard was first proposed in 2015 by the independent Cancer Taskforce, the consultation on

the NHS Standard Contract published in December has proposed that the FDS becomes a contractual standard from April 2020. The threshold at which this standard is initially set is being consulted upon, and responses received, alongside further findings from testing, will inform the decision as to its initial level.

13. This review will make its final recommendations in respect of cancer in the spring of 2020.

Urgent and Emergency Care proposals:

14. Testing has continued during winter across 14 NHS organisations to understand how a broader set of measures can ensure those who need care get the right care fast, while reducing both unnecessary admissions and long waits.

15. Testing has shown that increased levels of admission just before four-hours has reduced in the test sites, and the numbers of patients spending over 12 hours in the A&E department has grown more slowly at test sites compared to non-test sites.

16. The 'conversion rate' for those people attending an A&E department who are then admitted to hospital is falling faster in the test sites. By enabling patients to go home they can expect to spend slightly longer in A&E. The ability to treat people and discharge home rather than admitting them to a ward is one of the things patient say is important to them. This will also help ensure beds are available for those patients who do need admission.

17. To provide assurance that care for those who are critically ill is provided in a timely manner, all test sites are now testing Critical Time Standards for conditions including stroke, heart attack and acute physiological deterioration. The variability of current performance – as seen in both national clinical audits and early data through field testing – provides a strong argument for this approach, and is in line with what surveys show patients want and expect. NHS England and Improvement are working closely with six trusts where there is evidence that with targeted quality improvement, they could improve their performance against key stroke and STEMI standards. This will help inform final recommendations and implementation.

18. Patient feedback from test sites, and national polling, suggest that major factors in determining how people feel about their experience of A&E services include communication, staff and integrated working with ambulance services, NHS 111 and general practice.

19. Testing to date has demonstrated that one measure alone is not sensitive enough to understand the effectiveness of care in urgent and emergency care services. It is increasingly clear that recognition of the different stages in the pathway is required to address the complexity of urgent and emergency care services. Building on the five measures initially proposed, the review is therefore testing a wider basket of measures identified by field test participants that span the urgent and emergency care pathway, reflect the stages of the

pathway as they are experienced by patients, and support operational and clinically appropriate processes.

20. Further work is also being undertaken to consider the approach to implementation of any new standards that may be recommended through this review's final report. It is likely that a phased implementation period will be necessary, with services and systems moving across when able to demonstrate their readiness in terms of appropriate capacity , and new operating models are in place. The review will make final recommendations in respect of new access standards in urgent and emergency care in the spring of 2020, including a recommended approach to implementation.

Elective Care proposals:

21. 12 NHS Trusts are testing an average (mean) wait from referral to treatment for routine conditions to understand if it can better achieve the goal of reducing long waits for care than the current threshold-based standard. Initial modelling and analysis supported this hypothesis and the trusts involved have found it is operationally possible to implement the measure effectively.

22. The first phase of testing from August to November has shown that using a headline mean wait as a measure avoids perverse incentives after the current 18 weeks target has passed, and instead reinforces good waiting list practice to treat patients in the order that they are on the list, after first treating according to clinical need and urgency. However, it is too early to draw conclusions on the likely impact on reducing long waits, or the size and distribution of the waiting list.

23. Testing is therefore continuing in a second phase, in which test sites have been set a stretch target to achieve in their mean wait, and an expected set of best practices that they will be supported to follow.

24. The public polling conducted for Healthwatch suggests that moving to an average measure could be more meaningful for patients when exercising choice over where to receive treatment. Test site feedback is similar, while at the same time suggesting patients also need more personal information about the implications for them individually.

25. Patient groups, clinical representatives and test sites have also identified the need to consider additional measures that will support both operational management and patients' experience of waiting. Initial suggestions have included, providing individual patients with an expected length of wait for their treatment, specialty group level average waiting times being published and monitored, and maintaining focus on a maximum wait. Further work is needed to understand these proposals in more detail and to what extent they would support patient experience, which we will be taking forward with patient groups and National Voices.

26. Work is continuing to understand the likely impact of transformation programmes across the elective pathway, including but not limited to the

reform of outpatients, the introduction of managed choice at 26 weeks, the evolving role of technology in enabling care, and changing approaches to delivering diagnostic activity. On the latter, the Richards Review of diagnostic services is likely to make recommendations which will be relevant to this review.

27. There is therefore a need to continue testing different approaches to access standards in elective care over a longer period to fully understand the implications across an appropriate range of patient pathways. Testing will continue during 2020/21 with the review issuing final recommendations by April 2021.

Next steps

28. For cancer and urgent and emergency care, the review will report final recommendations in the spring of 2020. For mental health and elective care, where a longer period of testing is required, the review will report final recommendations by April 2021.

29. For each pathway, implementation will be planned and supported by the learning gathered during testing from test sites, both in terms of what it has taken to introduced new measures, and what good practice can be identified that will support improving performance. In all cases, changes to data systems will need to be supported through working with NHS Digital and system suppliers.

30. Where the introduction of new standards requires resulting changes to legislation and the NHS Constitution, NHS England and Improvement will work with the Department of Health and Social Care to progress the necessary public engagement and consultation.

Summary and key points

31. The Boards are asked to note the progress update and learning set out in this paper, building on previous updates to the board and the latest progress report which was published in October 2019.