Paper PB.23.07.15/09

BOARD PAPER - NHS ENGLAND

Title: NHS Performance Report
From: Dame Barbara Hakin, National Director: Commissioning Operations
Purpose of Paper: • To inform the Board of current NHS performance and give assurance on the actions being taken by NHS England and tripartite partners to maintain or improve standards. •
The Board is invited to: • Note the contents of this report and receive assurance on NHS England's actions to support NHS performance.

NHS Performance Report
NHS England Board – 23 July 2015

1.0 INTRODUCTION

1.1 In its commissioning oversight role, NHS England continues to work with Clinical Commissioning Groups (CCGs), NHS Trust Development Authority (TDA) and Monitor to improve the delivery of services and their associated access and performance standards. This note updates the Board on the current position on planning and contracting which is key to the underpinning of delivery. It also highlights areas of specific concern about performance and describes our mitigating actions.

2.0 PLANNING AND CONTRACTING

2.1 At its meeting in May 2015, the Board received a report setting out how NHS England had carried out a detailed assurance exercise of every CCG operational plan for 2015/16.

2.2 NHS England has continued to work with CCGs to finalise their plans. This is to ensure that they not only contain adequate levels of activity but also that there is sufficient local capacity to deliver that activity. Finalised operational plans were submitted on 27 May 2015. In total, the plans expect to deliver 6.8m spells of elective care (in-patient and day case), amounting to 2.7% more than in 2014/15. For non-elective care a total of 5.6m additional spells have been commissioned which amounts to growth of 2.3% from 2014/15 levels.

2.3 A review by regional teams has indicated that the vast majority of signed contracts reflected the levels of activity commissioners required. In some areas where capacity constraints exist, commissioners and providers are working together to secure good alternative local provision from the full range of available providers. Further information on the mitigating actions being taken is given in section 4 of this paper.

3.0 BETTER CARE FUND

3.1 A key element of CCG planning for 2015/16 has been the development of plans with local authorities to implement the Better Care Fund (BCF). The first quarterly (Q) performance reports on implementation (covering Q4 2014/15) have now been received.

3.2 Performance on key BCF performance metrics for Q4 (non-elective admissions and delayed transfers of care) show positive movement in some areas but it is too early to judge the impact of BCF at this stage. Many interventions/schemes will have only been implemented from 1 April 2015 and there will be a lead-in period until a scheme is anticipated to fully deliver the benefits envisaged. Performance payments (which are based on non-elective admissions) for Q4 reflect the fact that some areas have performed well, with 59 out of the 150 BCF plan areas receiving some payment (equivalent to c.£20m out of a total available of c.£56m).

3.3 Implementation issues and consequent support needs identified through the quarterly reporting process are being followed up through regional teams.

4.0 DELIVERING THE NHS CONSTITUTION STANDARDS

Referral to Treatment (RTT) Waiting Times

4.1 The NHS Constitution includes the commitment that patients have the right to start their consultant-led treatment for non-urgent conditions within 18 weeks of referral. Thus far we have measured our achievement through three standards, ensuring that 90% of admitted patients and 95% of non-admitted patients are treated within 18 weeks, and that 92% of those still waiting to start treatment have been waiting less than 18 weeks. We also monitor the

total number of patients on the waiting list, especially those who have been waiting a long time.

4.2 Chief Executive, Simon Stevens, wrote to NHS organisations on 4 June 2015 to inform them that we had accepted Sir Bruce Keogh's recommendations on improvements to the RTT waiting time standards, including a move to focus solely on the incomplete pathway standard. This means that there is a simplified, clearer focus on one RTT standard, which covers all patients on the waiting list and encourages hospitals to prioritise the treatment of those who have waited the longest. For patients waiting to start treatment (incomplete pathways) at the end of April 2015, 93.3% were waiting up to 18 weeks. The number of RTT patients waiting to start treatment at the end of April 2015 was just over 3 million.

4.3 The Department of Health (DH) has started the process to amend legislation so that the admitted and non-admitted standards can formally be removed from Standing Rules Regulations. This should be completed by 1 October 2015.

4.4 The NHS Standard Contract will then be amended, probably as part of the planning process for 2016/17. In the interim, NHS England with the TDA and Monitor has written to trusts and CCGs providing operational detail on the changes. This includes confirmation that commissioners will not levy contractual sanctions on provider organisations with respect to the admitted and non-admitted standards for any period of 2015/16.

4.5 As described in the planning and contracting section, we are confident in the volume of activity CCGs and NHS England have commissioned and, with a small number of exceptions, that providers have identified the capacity to deliver this. We have agreed a specific programme of work to identify additional capacity, especially that available in the independent sector, to meet the current small number of current gaps. This programme will create a comprehensive database of available capacity which can also be used as we go through the year should any contracted providers struggle to deliver the volumes required.

Cancer Waiting Times

4.6 In the most recent reporting period (Q4 2014/15), the NHS delivered all but one of the nine cancer waiting time standards, with the 62 day – urgent referral to first treatment standard being missed with performance of 82.0% against a standard of 85%. In large part this is due to the increasing number of urgent referrals for suspected cancer, currently growing at over 10% per annum (approximately 1.6m million urgent GP referrals were seen in 2014/15) and the number of patients treated for cancer has increased by approximately 5% a year since 2011/12.

4.7 The increase in referrals is partly due to successful campaigns, such as the DH *Be Clear on Cancer* initiative, to raise public awareness of cancer symptoms. As a result of the 2014 National Breast Cancer In Women over 70 campaign, over 16,400 cancer referrals were made between February and April 2014, an increase of 67% in the number of referrals made in the same period in 2012. It is anticipated that new National Institute for Health and Care Excellence (NICE) guidelines on cancer referrals and the forthcoming cancer strategy will focus more on early cancer diagnosis and further increase referrals for cancer services.

4.8 It is therefore essential that we work with all parts of the system to increase capacity and efficiency to deliver these standards. NHS England, TDA and Monitor have agreed a full operational delivery plan with a broad range of actions. These actions include measures such as additional scrutiny of capacity plans, improved waiting list management processes, and implementing clinical best practice. An enhanced package of support will be available to struggling patches.

4.9 One key factor in the increase in waiting times has been the delay in undertaking certain diagnostic tests, especially endoscopy. This is borne out by increased waiting for endoscopy services and that waiting times have deteriorated faster for those cancers requiring an

endoscopic diagnosis (urological and bowel cancers) than for those that do not (breast and skin). We are currently mapping all the available endoscopy capacity across England including what is available from the independent sector, in order to support the reduction of a backlog over the next 4-6 months.

Ambulance Services

4.10 The most recent data shows that there has been an improvement in ambulance response times, with two of the three NHS Constitution standards achieved in April 2015. Ambulance performance during 2014/15 was affected primarily by increased activity, workforce capacity and productivity. A number of actions are being taken to address these issues.

4.11 All trusts have plans in place to address workforce supply issues, including the recruitment of staff from abroad where necessary and management plans to support the retention of staff. Health Education England is seeking to ensure that paramedic training provides for an additional 1,900 full time equivalents growth in available workforce over the next five years.

4.12 High ambulance utilisation rates mean that vehicles are less likely to be optimally positioned to be able to respond quickly to calls. Two pilot schemes are in place which, along with other initiatives across the country, will identify and disseminate clinical best practice.

Urgent Care, A&E and Winter Planning

4.13 So far this year, almost 94% (93.9%) of patients attending A&E were either admitted, transferred or discharged during within 4 hours, slightly below the standard of 95%.

4.14 An Urgent and Emergency Care vanguard programme has been established to rapidly test and roll out the implementation of the Urgent and Emergency Care Review. As part of this programme, NHS England, Monitor and TDA will work with the chosen sites to develop new approaches, helping them identify opportunities and to tackle barriers to make it easier for change, and improvements in performance, to be secured more quickly.

4.15 System Resilience Group (SRG) assurance for this year will focus on the eight high impact interventions, winter readiness, mental health, and supporting the implementation of Urgent and Emergency Care Networks. SRGs will conduct a self-assessment to provide a comprehensive overview of current service provision, which will identify gaps in service and priorities for improvement against nationally agreed criteria. Based on this, high risk systems will be subject to increased scrutiny and intervention. We are working with Monitor, TDA and the DH to build an expanded urgent care support team, which will be deployed flexibly at the behest of regional tripartite panels. This team will also include skills in social care to assist with work to decrease delayed discharges.

Improving Access to Psychological Therapies (IAPT)

4.16 Against the 15% and 50% ambitions for IAPT access and recovery, rates of 17.2% and 45.2% respectively were achieved. March saw the highest access and referral rates (24.2%) being achieved in 2014/15. The last three months of data give an estimated performance of 15.6% for the Q4 2015-16 IAPT annualised access rate, suggesting that the Mandate commitments will be met for Q4. This will be confirmed in July with the final quarterly data release. The progress made in 2014/15 was underpinned by a number of key interventions:

i. Timely publication of data combined with routine monthly communication to CCGs on current performance gap against Q4 plan enabled early identification of CCGs failing to deliver against planned ambition.

ii. Intensive support through senior level intervention calls to a group of CCGs identified as being at highest risk of delivery, supported by Regional Directors and Directors of Commissioning Operations.

iii. Continued Intensive Support Team (IST) support to a number of high risk organisations in the key areas causing underperformance. For IAPT, this included a particular focus on resolving data quality and reporting and issues, along with activities to ensure referrals and referral routes are maximised to support access.

iv. Linking high risk CCGs with high performing CCGs for peer support.

Other Standards

4.17 A separate report on Learning Disabilities is also being presented to the Board on 23 July 2015.

5.0 RECOMMENDATION

5.1 The Board is asked to note the contents of this report and receive assurance on NHS England's actions to support NHS performance.

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Date: **July 2015**

APPENDIX A

Summary of Measures Relating to NHS Standards and Commitments

Indicator	Latest data period	Latest Performance	Change in performance from previous data period
Patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care	2014-15 Q4	97.2%	↓
IAPT access rate	Mar-15	17.2%	↑
IAPT recovery rate	Mar-15	45.2%	↓
Dementia diagnosis rate	Mar-15	61.6%	↑
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	2014-15 Q4	94.7%	no change
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	2014-15 Q4	94.7%	↓
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	2014-15 Q4	97.4%	↓
Maximum 31-day wait for subsequent treatment where that treatment is surgery	2014-15 Q4	94.9%	↓
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	2014-15 Q4	99.5%	↓
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	2014-15 Q4	97.7%	↓
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	2014-15 Q4	91.4%	↓
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	2014-15 Q4	82.0%	↓
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	2014-15 Q4	88.5%	↓
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	Apr-15	93.3%	↑
Admitted patients starting treatment within a maximum of 18 weeks from referral	Apr-15	87.5%	↑
Non-admitted patients starting treatment within a maximum of 18 weeks from referral	Apr-15	95.2%	↑
Number of patients waiting more than 52 weeks from referral to treatment	Apr-15	411	↑
Patients waiting less than 6 weeks from referral for a diagnostic test	Apr-15	98.0%	↓
Patients admitted, transferred or discharged within 4 hours of their arrival at an A&E department	2015-16 Q1 to 21.6.15	94.0%	↑
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	Apr-15	75.6%	↑
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	Apr-15	72.4%	↑
Category A calls resulting in an ambulance arriving at	Apr-15	95.0%	↑

the scene within 19 minutes			
Mixed sex accommodation breaches	May-15	362	↓
Operations cancelled for non-clinical reasons on or after the day of admission not rescheduled within 28 days	2014-15 Q4	8.7%	↓