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BOARD PAPER - NHS ENGLAND

Title: NHS Performance Report.
Lead Director: 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 – 24 September 2015

1.0 INTRODUCTION

1.1 In its commissioning oversight role, NHS England continues to work with clinical commissioning groups (CCGs), the NHS Trust Development Authority (TDA) and Monitor to improve the delivery of services and their associated access and performance standards. This report updates the Board on current NHS performance and the actions we have taken with our partners to ensure delivery of key standards and measures, including progress against the NHS Outcomes Framework. It also highlights specific areas of concern and describes our mitigating actions.

2.0 DELIVERING THE NHS CONSTITUTION STANDARDS AND OTHER COMMITMENTS

2.1 The latest performance data for measures relating to NHS standards and commitments are shown in Appendix A of this report.

Referral to Treatment (RTT) Waiting Times

2.2 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. Earlier this year, Sir Bruce Keogh reviewed the current waiting time measures and recommended that we now use the incomplete pathway standard as our single measure of RTT performance, which identifies the patients waiting to start treatment. The standard is that 92% of those still waiting to start treatment have been waiting less than 18 weeks. This gives a simplified, clearer focus on one RTT standard, which covers all patients on the waiting list, and focusses on those who have waited the longest.

2.3 To reflect these changes to the NHS Standard Contract, a contract variation was published at the end of August 2015 which will become effective from 01.10.15. Until the contract variation becomes effective, NHS England has directed that commissioners will not levy sanctions on provider organisations for breach of the former admitted and non-admitted standards for any period in 2015/16. We have also consulted on a proposal to increase the remaining RTT sanction for incomplete pathways from £150 to £300. The increased sanction for breach of the incomplete standard will come into effect from 01.10.15. The current level of sanctions relating to the incomplete standard will remain in place until then.

2.4 At the end of July 2015, the incomplete standard was met with 92.9% of patients waiting less than 18 weeks. The number of RTT patients waiting to start treatment at the end of July 2015 was just under 3.3 million.

2.5 For the three months to June 2015, elective activity grew by 4.1% when compared to the same three months in 2014. This elective growth of 4.1% comprises a growth of 5.7% in day cases against a plan of 3% growth, and a 2.4% reduction in ordinary admissions against a plan of 3.1% growth. So, within the elective growth, the day case rate continues to increase.

2.6 Although the cumulative position is 1% above plan it is still relatively early in the year. We will keep under review the volumes of activity and what this means for growth against plan. To help ensure that all available capacity across the country is fully utilised, we are putting in place a project team to identify spare capacity, including in the independent sector, to help the NHS deliver the contracted volumes of activity for 2015/16.

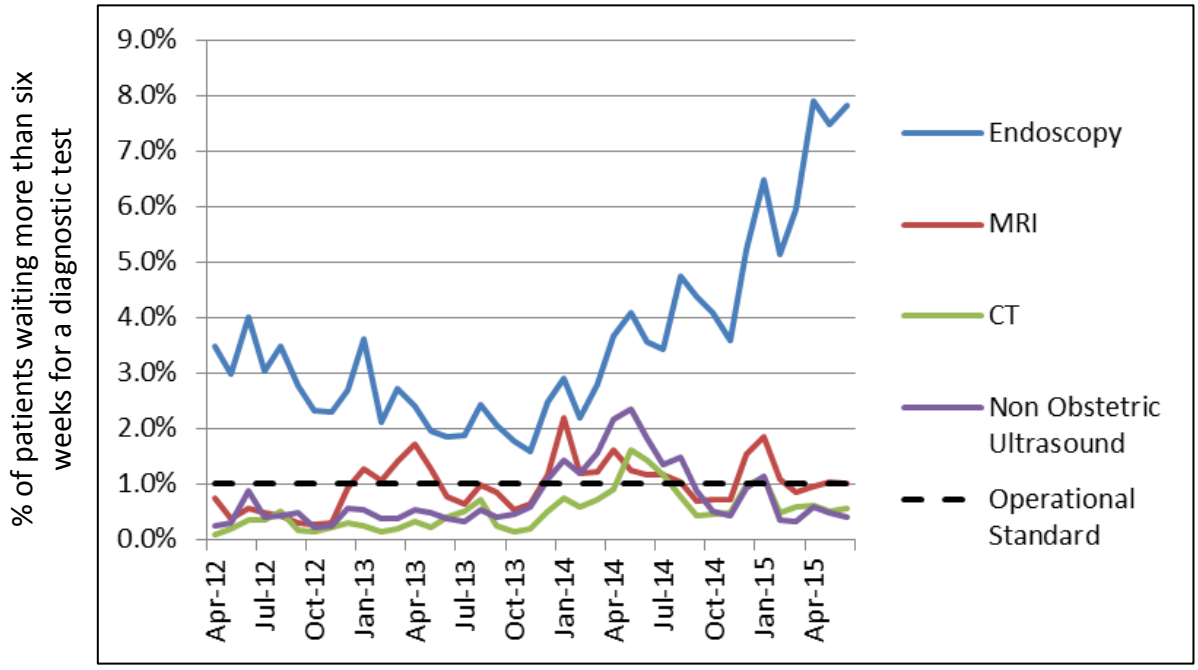
Cancer Waiting Times

2.7 In the most recent reporting period (Q1 2015/16), the NHS delivered all but one of the nine cancer waiting time standards; the '62 day – Urgent Referral to First Treatment' standard was missed with performance of 81.7% 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, demonstrating the success of the various campaigns to raise awareness. The number of patients treated for cancer has increased by approximately 5% a year since 2011/12.

2.8 A significant factor in delivering the standard is the availability of diagnostic tests where trusts may need to secure additional highly technological equipment or recruit specialist staff. Endoscopy is a particular problem. Activity undertaken has risen by an average of 6.1% over the past three years but despite this, demand has increased at a faster rate.

Figure A: Waiting times for diagnostic tests



2.9 The three arms-length bodies (ALBs) wrote to the NHS in July 2015 on the actions needed to improve and sustain performance on cancer waits. A joint national delivery group for improving 62 day performance is overseeing these actions, and will work closely with the Cancer Waiting Times Taskforce and Intensive Support Team.

2.10 The action plan covers the following areas:

i. **Eight key priorities** have been defined for local systems to implement which offer practical actions to help providers and also support CCGs with effective commissioning of cancer services. All acute trusts have been asked to complete a self-assessment of compliance and a plan to achieve full compliance by the end of August 2015.
ii. The worst performing trusts will be expected to produce an **Improvement Plan** by the end of August for review and sign off by their regional tripartite.
iii. All trusts and foundation trusts will be expected to produce **weekly performance information** for the 62 day standard.
iv. Each local health system will be required to prepare a cancer **capacity plan** setting out how it will deal with the projected increase in cancer demand. The approach to this is currently in development.

2.11 Given the significant impact that endoscopy is having, we have set up a specific team to map all the available endoscopy capacity both in NHS and independent sector across England and to facilitate the transfer of patients to maximise the use of this capacity. The aim is to reduce the numbers of patients waiting more than six weeks for an endoscopy by the end of March 2016.

Ambulance Services

2.12 The most recent data shows that there has been a slight deterioration in ambulance response times during July 2015, when compared to performance in the previous month.

2.13 Addressing demand, supply (capacity) and productivity is central to improving ambulance performance. High ambulance utilisation rates mean that vehicles are less likely to be optimally positioned to respond quickly to calls. Working with our partner organisations, we have agreed two 'dispatch on disposition' trial schemes. These pilots give 999 call handlers an additional 120 seconds to assess calls, other than those which are in the most urgent Red 1 category, before responding. This gives additional time to assess a call in order to determine the best response and should reduce the inappropriate dispatch of some vehicles which can then be available for the most urgent calls. The evaluation of these trials has been encouraging in relation to operational performance, clinical outcomes and patient safety. Accordingly this scheme is to be trialled in further sites.

2.14 We have also developed a set of high impact interventions for ambulance services. Implemented together with the high impact interventions for general operational resilience, they will reduce A&E conveyance and hospital admission, improve the availability of ambulance resources, and increase operational efficiency and performance. They have been developed from the good practice contained in *Safer, Faster, Better - Best Practice Guidance on Delivering Urgent and Emergency Care* which will be published by NHS England shortly. We expect every ambulance trust to address these, in partnership with local System Resilience Groups (SRGs). Progress on these interventions will be addressed through wider SRG assurance.

2.15 We continue to work closely with partners in Monitor and TDA to ensure a whole system approach is taken to supporting improvements in ambulance services.

Urgent Care, A&E and Winter Planning

2.16 The most recent data, for July, shows 95.0% (94.996% to 3 decimal places) of patients attending A&E were either admitted, transferred or discharged within 4 hours, just on the standard of 95%. However, 2014/15 saw a particularly challenging winter for the NHS. We have analysed the reasons for the additional pressures, looked at what worked well and used this as a basis for our preparations for 2015/16. Our actions are part of, and the precursor to, the medium term implementation of the recommendations of the Urgent and Emergency Care Review.

Dementia

2.17 The importance of maintaining the good practice that led to the substantial successes last year continues to be emphasised through a monthly letter to CCGs from the National Clinical lead. Actions in 2015/16 will be prioritised around achieving and maintaining the national ambition, improving post-diagnostic support through financial incentives, and developing measures of the quality and impact of these services. This will be supported by the publication of a fully costed five year transformation plan by the end of March 2016 to support year on year improvements in post-diagnostic support.

Mental Health

Improving Access to Psychological Therapies (IAPT)

2.18 The NHS Mandate committed that by Q4 2014/15, IAPT services should be providing timely access to treatment for at least 15% of people with common mental health disorders. This was met and exceeded in Q4 2014/15 when a rate of 15.6% was achieved. This has been followed by lower rates with performance in subsequent months at 14.8% and 13.6% for April and May respectively. NHS England will continue to track performance against CCG plans and take corrective action where required. The rate of recovery continues to fall short of the ambition of 50%, remaining static for most of the year in 2014/15, and is now at 45.5% in May

2015. High performing CCGs show that the recovery ambition is achievable as in May 2015, 70 CCGs reached or surpassed the ambition.

2.19 The reasons for recovery rates not improving in a number of IAPT services vary and include lack of leadership and adoption of best practice which are further compounded by workforce issues in some services. This aspect will receive focussed attention over the next year through a number of leadership and training events aimed at providers in addition to the re-launch of the IAPT "Enhanced Recovery High Impact Changes" in Q2 of 2015/16. Work is also planned to collect more detailed data on recovery and understanding improvement rates at individual provider level.

2.20 National waiting times standards to improve access to mental health services begin in 2015/16 with the introduction of waiting time standards for IAPT (75% of patients seen within 6 weeks and 95% within 18 weeks). Whilst these standards are being met, there is evidence of some long waits to first treatment and post-first treatment. To address this, £10m of non-recurrent funding has been made available to CCGs to support the sustainable delivery of the IAPT waiting time standard by April 2016.

Early Intervention in Psychosis (EIP)

2.21 The introduction of national waiting time standards and Early Intervention Psychosis (EIP) (more than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral) will commence in April 2016. There is still significant work to do to ensure delivery of the standard. A new dataset has been developed to take into account the required reporting arrangements.

Children and Adolescent Mental Health Service (CAMHS)

2.22 The Government has allocated £1.25bn extra funding over a five year period to transform children's mental health services and to develop specialist community teams to tackle eating disorders in young people.

2.23 The funding is contingent on CCGs developing and implementing transformational plans in collaboration with partner organisations and Children and Young People (CYP). Guidance describing the content and assurance process for CAMHS transformation plans was published on 03 August and funding will be allocated to CCGs following regional assurance of plans.

Transforming Care

2.24 The Transforming Care programme aims to improve services for people with learning disabilities and/or autism, and drive system-wide change to secure appropriate care and treatment with a particular focus on reduced use of inpatient services.

2.25 There was a total inpatient cohort of 2,605 as of 30 June 2015. However, this increase in inpatient count is in part due to commissioners carrying out on-going validation work to ensure that all existing patients are included in this count. Nationally there have been 365 admissions/transfers of patients from their current setting between 01 April 2015 and 30 June 2015, which is broadly the same as admission/transfer rates at the same time last year, although significant validation work has been done over the last twelve months, which may indicate that there was a degree of under reporting in previous years.

2.26 Discharge/transfer rates continue to progress, with 400 transfers across inpatient care/discharges from inpatient care to community settings recorded between 01 April 2015 to 30 June 2015. For the 01 April 2014 cohort, discharge rates continue to be actively monitored.

2.27 We are continuing to deliver care and treatment reviews (CTRs) for people in inpatient facilities; however, more is expected to be achieved to avoid hospital admissions as the new pre-CTR process is fully implemented.

2.28 The target of a 10% reduction of the all inpatient cohort from 01 April 2015 has been agreed for 2015/16, and planning is underway to support the delivery of this.

3.0 NHS OUTCOMES FRAMEWORK

Background

3.1 The NHS Outcomes Framework:

i. Provides a national overview of how well the NHS is performing.
ii. Is the primary accountability mechanism, in conjunction with the Mandate, between the Secretary of State for Health and NHS England.
iii. Drives up quality throughout the NHS by encouraging a change in culture and behaviour focused on improving health outcomes.

3.2 The 68 national Indicators in the NHS Outcomes Framework are grouped around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve.

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm

Latest Performance

3.3 The latest quarterly release of data and breakdowns for a number of indicators in the NHS Outcomes Framework were published on 19 August 2015. However, some data takes a long time to collate and quality assure, so some of the data points are from earlier than May – August 2015.

3.4 Data released in August updated seven formal indicators. **Overall, the results of the data are mixed.** Four indicators have improved since the previous data point and three indicators have deteriorated. The **most notable change** has been the increase in C.difficile incidents for the first time since 2007/8. 2014/15 has seen an increase of 6.0% compared to the previous year. The results should be read with caution as they reflect the change from the last data point for the respective indicator.

3.5 For the following indicators, the results have been positive (compared to the last data point):

Indicator 2.2 – Employment of People with Long-term Conditions

3.5.1 The indicator, which measures the gap between the employment rate of people with long-term conditions and the employment rate of the general population, has improved slightly from 13.2%in Q4 of 2014 to 13.1% in Q1 of 2015. This is the first improvement since Q2 of 2014. Overall the trend remains mixed; falling from 15.2% in 2006 to 11.2% in 2010 before increasing to 13.2% in Q2 of 2014. Work on long-term conditions in NHS England has focused on establishing wellbeing and independence as key outcomes of person-centred care. This has included, for example, promoting personalised care and support planning which supports people to reach their personal goals, including retaining or gaining employment, as well as achieving more conventional clinical goals.

Indicator 2.5.i – Employment of People with Mental Illness

3.5.2 The indicator, which measures the gap between the employment rate of people with mental illness and the employment rate of the general population, has shown a steadily decreasing favourable trend between 2006 and 2015. The gap has further decreased from 36.0% in Q4 of 2014 to 34.6% in Q1 of 2015.

Indicator 4.2 – Hospital Responsiveness to In-patients' Personal Needs

3.5.3 The national scores for this indicator rose slightly between 2013/14 and 2014/15 from 68.7% to 68.9%. This continues a trend which has seen the overall score rise slowly each year since 2009/10.

Indicator 5.2 i – Incidence of Healthcare Associated Infection (HCAI) – MRSA

3.5.4 The number of MRSA (methicillin-resistant Staphylococcus aureus) incidences has continued to fall. 801 cases were reported during 2014/15 which represents a reduction of 7.1% compared with the 862 cases reported in 2013/14. Cases of MRSA have decreased greatly since the time series began; the 2014/15 count is now 72.7% lower than in 2008/09.

3.6 For the following indicators the trend has worsened (since the last data point):

Indicator 4b – Patient Experience of Hospital Care

3.6.1 This indicator captures the experience of patients who have received medical treatment in hospital. The overall rate has declined slightly from 76.9% in 2013/14 to 76.6% in 2014/15. This decrease is not statistically significant and overall the 2014/15 figure is higher than all other years dating back to 2003/04, with the exception of 2013/14. Over the time series (2003/4-2014/15) the overall patient experience score has stayed relatively stable, at between 75.3% and 76.9%.

Indicator 4.6 – Bereaved Carers' Views on the Quality of Care in the Last Three Months of Life

3.6.2 This indicator measures the quality of end-of-life care as reported by carers or relatives of the deceased. The percentage of positive experiences reported fell again slightly from 75.9% in 2013 to 75.1% in 2014, which is the lowest score since the first data point was recorded in 2010/11. However, these figures are survey estimates and the differences are small, therefore these figures should be interpreted with caution. Further statistical investigation would be necessary to determine if this is a true decline in opinion or if the changes are due to natural variation in the data.

Indicator 5.2 ii – Incidence of Healthcare Associated Infection (HCAI) – C.difficile

3.6.3i This indicator has had the most notable change in its trend. Between April 2014 and March 2015 a total of 14,165 cases were reported across the NHS. This represents a 6.0% increase compared to the number of cases reported in 2013/14 when 13,361 cases were reported. This is the first annual increase since the enhanced mandatory surveillance of C. difficile infections was initiated in 2007. However, the 2014/15 data is not yet at 2012/13 levels and even with the recent increase there remains a 74.5% overall reduction in the number C. difficile infections between 2007/08 and 2014/15. This should be read alongside the continued fall in MRSA.

3.6.3ii The observed increase is currently under investigation by Public Health England who are working closely with the NHS and the wider health service to look for any underlying causes.

4.0 RECOMMENDATION

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

Author: **Dame Barbara Hakin, National Director: Commissioning Operations**
Date: **September 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	Q1 2015/16	97.0%	↓
IAPT access rate	May-15	13.6%	↓
IAPT recovery rate	May-15	45.5%	↑
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	Q1 2015/16	93.6%	↓
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	Q1 2015/16	93.4%	↓
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	Q1 2015/16	97.4%	**No Change**
Maximum 31-day wait for subsequent treatment where that treatment is surgery	Q1 2015/16	95.0%	↑
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	Q1 2015/16	99.6%	↑
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	Q1 2015/16	97.5%	↓
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	Q1 2015/16	93.1%	↑
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	Q1 2015/16	81.7%	↓
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	Q1 2015/16	88.8%	↑
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	Jul-15	92.9%	↓
Number of patients waiting more than 52 weeks from referral to treatment	Jul-15	785	↑
Patients waiting less than 6 weeks from referral for a diagnostic test	Jul-15	98.1%	↑
Patients admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Jul-15	95.0%	↑
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	Jul-15	74.5%	↓
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	Jul-15	70.6%	↓
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	Jul-15	93.8%	↓
Mixed sex accommodation breaches	Jul-15	340	**No Change**
Operations cancelled for non-clinical reasons on or after the day of admission not rescheduled within 28 days	Q1 2015/16	7.3%	↑

↑	**improvement**
↓	**deterioration**