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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 – 17 December 2015

1.0 INTRODUCTION

1.1 In its commissioning oversight role, NHS England continues to work with clinical commissioning groups (CCGs) and NHS Improvement 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. 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.

Urgent and emergency care

A&E performance

2.2 The most recent data, for October 2015, shows 92.3% of patients attending A&E were either admitted, transferred or discharged within 4 hours. There were 1,923,326 attendances at A&E in October 2015. Attendances over the last twelve months are up 0.6% on the preceding twelve month period.

2.3 There were 479,313 emergency admissions in October 2015, 2.1% more than in October 2014. For the year to October 2015 we had planned for 2.2% growth in emergency admissions. The actual growth rate observed for this period was 1.0%.

Delayed transfers of care

2.4 There were 160,100 total delayed days in October 2015, of which 65.0% were in acute care. This is an increase from October 2014 when there were 142,900 total delayed days, of which 67.6% were in acute care. Appendix B details the actions in place to drive improved early discharge and reduced delayed transfers of care.

Ambulance performance

2.5 Of Category A Red 1 calls resulting in an emergency response, the proportion arriving within 8 minutes was 73.3% in October 2015 compared with 72.2% in October last year. Of Category A Red 2 calls resulting in an emergency response, the proportion arriving within 8 minutes was 68.8% in October 2015 compared with 69.9% in October 2014. Category A Ambulance response in 19 minutes was 93.0% in October 2015 compared with 94.0% in the same period last year.

NHS 111 performance

2.6 The number of calls received by NHS 111 services in October 2015 was 1,083,628. This was an average of almost 35,000 calls per day. 91.4% of the calls answered by NHS 111 services in October 2015 were answered within 60 seconds, which is similar to the proportion for September 2015.

SRG (System Resilience Group) Assurance

2.7 Since April 2015 all SRGs have made significant steps towards implementing the 8 high impact resilience interventions (shown in Appendix C), as well as the 9 interventions to support resilience in ambulance services (shown in Appendix D). The high impact interventions are best practice actions that all systems should have in place for this winter. Progress against these interventions is monitored regularly at a regional level.

2.8 As part of SRG assurance, all systems were required to submit action plans and detailed winter capacity plans which covered:

- acute beds;
- mortuary capacity and mortuary resilience plans;
- community care beds;
- bed-based and home-based intermediate care;
- district nurses and community matrons;
- allied health professionals; and
- mental health.

Christmas and New Year

2.9 Operational issues and pressure will be monitored throughout the system using targeted Sitrep data, which will inform targeted support and escalation. There will be an on-call system in place to ensure senior leaders are made aware of any issues.

2.10 GP practices across the country have been reminded of their obligations around opening hours and we have asked all CCGs to ensure comprehensive arrangements are in place for the very busy bank holiday days for good access to GPs; whether through individual practices, federations, or arrangements with neighbouring practices, or easily accessible and well-publicised out of hours. A detailed assurance process is underway around primary medical care, pharmacy, community care, mental health crisis services, emergency dentistry, NHS 111 and the acute sector.

Emergency Care Improvement Programme (ECIP)

2.11 Acknowledging the pressures experienced in early January 2015, and to get 2016 off to the strongest start possible, ECIP are designing a bespoke support package for January 2016 across all 28 systems engaged in the programme. This support package aims to ensure flow through the system is as smooth as possible when the expected surge in demand arrives. All other systems across the country are also being encouraged to use the support package, with support from NHS England regions.

Referral to Treatment (RTT) Waiting Times

2.12 At the end of October 2015, the Referral to Treatment (RTT) incomplete standard was met with 92.3% of patients waiting less than 18 weeks. The number of RTT patients waiting to start treatment at the end of October 2015 was just over 3.3 million.

2.13 The number of long waiting patients treated (per working day) in the latest three months from August to October 2015 was 24% higher than the same period in 2014. Of those treated in the last three months, 8.8% were long waiters, compared with 7.2% a year earlier. This is a continuing sign that the move to focus on the incomplete standard is having the desired effect and that trusts are focussing on treating longer waiting patients first.

2.14 We recognise that the winter period will have a significant impact on elective care services and have put in place a number of mitigating actions to reduce waiting times (for patients waiting to be referred for treatment and also for those on existing waiting lists).

2.15 We are continuing to work nationally in partnership with NHS Improvement to provide focussed support to those trusts identified as needing it most. All of these identified trusts will be required to produce credible recovery plans as part of existing contract and performance management arrangements.

2.16 The NHS Constitution says that patients have a right to be given choice as to where they are treated. We will ensure that all CCGs implement a choice plan that gives patients the most meaningful information and provides a greater choice of providers, to help them decide where to be treated. Where it is appropriate, we will also proactively work with CCGs to change referral flows to providers where there is capacity.

2.17 We will also exploit opportunities within the new e-referrals system to support commissioners and providers to implement their choice plans and improve the appointment booking process. Independent sector providers will continue to make more appointments available through e-referrals.

2.18 For patients that are already on waiting lists for treatment, we will work closely with NHS Improvement to increase the options that lead to faster treatment. Those trusts struggling to meet the incomplete standard will be supported to make use of the other capacity that has already been identified. CCGs and GP practices will also have access to the most up to date capacity information held by the central project teams meaning that patients can be directed, at the point of referral, to where they will have the shortest waits.

2.19 The Intensive Support Team (IST) will be deployed to priority trusts to help them recover their performance position. We will also continue to explore further options for improvement support through other organisations.

Cancer Waiting Times

2.20 In the most recent reporting period (October 2015), the NHS delivered against all of the eight cancer waiting time measures for which operational standards have been set, with the exception of the 62 day standard.

2.21 Management information shows a gradual improvement in performance against the 62 day cancer standard and a decrease in number of patients waiting over 62 days and beyond from referral by their GP and their first treatment.

2.22 A letter has been issued to the system which includes cancer demand and capacity guidance from the Intensive Support team (IST), and describes how the very few patients who would have waited much longer than the standard must be managed.

2.23 Of the 57 poorest performing trusts required to produce a cancer improvement plan, only 5 trusts remained partially assured at the end of November 2015. All other trusts have fully-assured plans in place to meet the cancer 62 day standard by March 2016. The IST is providing support to 22 of these challenged trusts to improve cancer performance.

2.24 As referred to in previous Board reports, the availability of endoscopy tests is a significant factor in the delivery of the 62 day standard. The endoscopy programme management office has begun to transfer patients from 7 trusts to providers with available endoscopy capacity and is working with a further 56 trusts to support greater uptake of such transfers.

2.25 NHS England is continuing to work with partner organisations to ensure a series of key priority actions for cancer are implemented to support achievement of the 62 day standard. These actions are shown in Appendix E.

Improving Access to Psychological Therapies

2.26 The NHS Mandate commits that at least 15% of people with common mental health disorders should be provided with timely access to treatment. The latest data shows this standard was not met in August 2015, with a rate of 13.5% being achieved; this is due to known seasonal variation. The trend in data shows a steady year-on-year increase for this part of the year, as in previous years rates of 11.0% (2014/15) and 10.5% (2012/13) were achieved for the same month. The rate of recovery remains stable, but falls short of the ambition of 50% and was at 45.7% in August 2015 when providers serving 69 CCGs met the 50% recovery rate standard, of which 25 CCGs achieved over 55%. NHS England is working on reducing the variation in recovery rates with IST support focussed on the lowest-performing IAPT providers to improve their recovery rates. The services that are most challenged have issues in data quality, long waiting times, numbers of treatment sessions offered, leadership and supervision and high levels of deprivation. A number of initiatives are being deployed to address this which include leadership and training events, a 'buddying' scheme for poor performing providers and workshops to spread good practice to all commissioners and providers.

Dementia

2.27 The estimated diagnosis rate for people with dementia as at the end of October 2015 was 66.5%, an increase of 0.3% from September 2015. New prevalence calculations indicate that there were 428,443 patients of all ages on dementia registers within England at the end of October 2015. The October 2015 data is representative of 96.4% of practices, an increase of 0.4% on the September 2015 position. Data capture is expected to improve further in the coming months. NHS England has offered intensive support and recovery planning to all CCGs who require it, in order to reduce the variation in dementia diagnosis rates across the country.

Healthcare associated infections

2.28 We are continuing with our strategy to minimise incidences of methicillin-resistant Staphylococcus aureus (MRSA) blood stream infections and Clostridium difficile (C. diff) infection. NHS England operates a zero-tolerance approach to MRSA, with every reported infection being subject to a post-infection review to determine if the infection should be assigned to the trust that reported it. Through the NHS Standard Contract, commissioners apply contractual sanctions for every incidence of trust-assigned MRSA.

2.29 Similarly, trusts are set annual objectives nationally for C. diff and are asked to review cases with their commissioners to identify any cases associated with lapses in care. All C. diff cases associated with lapses in care count towards a trusts' objective and where that objective is breached, commissioners can impose sanctions

2.30 NHS England is contributing to the cross-government strategy on reducing antimicrobial resistance and is working to incentivise reductions in antibiotic prescribing to support a reduction in C. diff infection rates.

3.0 RECOMMENDATION

3.1 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: **December 2015**

APPENDIX A

Summary of Measures Relating to NHS Standards and Commitments

Indicator	Latest data period	Standard	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	Q2 2015/16	95%	96.8%	↓
IAPT access rate	Aug-15	15%	13.5%	↓
IAPT recovery rate	Aug-15	50%	45.7%	no change
Dementia diagnosis rate	Oct-15	66.6%	66.5%	↑
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	Oct-15	93%	94.7%	↑
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	Oct-15	93%	94.5%	↑
Maximum 31-day wait from diagnosis to first definitive treatment for all cancers	Oct-15	96%	97.7%	↑
Maximum 31-day wait for subsequent treatment where that treatment is surgery	Oct-15	94%	96.1%	↑
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	Oct-15	98%	99.7%	↑
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	Oct-15	94%	97.7%	↑
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	Oct-15	90%	93.4%	↑
Maximum 62-day wait from urgent GP referral to first definitive treatment for cancer	Oct-15	85%	81.7%	↑
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	Oct-15	Not set	89.9%	↑
Patients on incomplete non-emergency pathways (yet to start treatment) waiting no more than 18 weeks from referral	Oct-15	92%	92.3%	↓
Number of patients waiting more than 52 weeks from referral to treatment	Oct-15	0	867	↓
Patients waiting less than 6 weeks from referral for a diagnostic test	Oct-15	99%	98.3%	↑
Patients admitted, transferred or discharged within 4 hours of their arrival at an A&E department	Oct-15	95%	92.3%	↓
Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	Oct-15	75%	73.3%	↑
Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	Oct-15	75%	68.8%	↓
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	Oct-15	95%	93.0%	↓
Mixed sex accommodation breaches	Oct-15	0	449	↓
Operations cancelled for non-clinical reasons on or after the day of admission not rescheduled within 28 days	Q2 2015/16	0%	5.9%	↑

APPENDIX B

Actions in place to drive improved early discharge and reduce delayed transfers of care (DTOC)

Refreshed DTOC guidance: NHS England, DH, ADASS and ECIST colleagues have worked collaboratively to publish refreshed guidance on reporting delays providing clarity on definitions and processes, underpinned by practical resources that areas can use to implement and spread good practice.

Toolkit for Independent Care Sector: NHS England is developing a Toolkit for Independent Care providers (both care homes and care at home) to support patient discharge from acute trusts to the care sector.

ECIP support: Each system will have a length of stay (LoS) review – clinical deep dive looking at every patient with a length of stay > 7 days – to identify where blockages are.

Increased nurse training: Health Education England has increased adult nursing education and training 4.2%; and the number of training places for district nurses by 16.5% for 2015/16.

Community nursing commissioning framework: A Framework for commissioning community nursing has been developed by NHS England to support:

•Moving limited resource from hospital to community-based care;

•Understanding how community nurses can contribute to the effective commissioning of services; and

•Effective discussion about the community nursing workforce including an understanding of workforce planning.

Standards for district nurse education and practice: The new Queen's Nursing Institute (QNI/QNIS) Voluntary Standards for District Nurse Education and Practice place district nursing at the centre of community healthcare.

APPENDIX C

High impact resilience interventions

1 No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.

2. Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS111, ambulance services and out-of-hours GPs should be considered.

3. The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.

4. SRGs should ensure that the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.

5. Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.

6. Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.

7. Daily review of in-patients through morning ward or board rounds, led by a consultant / senior doctor, should take place 7 days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.

8. Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.

APPENDIX D

High impact ambulance interventions

1. **Establishing urgent care clinical hubs** - Clinical hub development should be progressed, with wider multi-disciplinary team and specialist input. The expertise accessible 24/7 through an urgent care clinical hub could include: primary and secondary care expertise, mental health, drug and alcohol services, and social care.

2. **Improving access to community health and social care rapid response, including falls services -** Ambulance services should have (or have plans to put in place) direct access to these services, through simple routes of referral (e.g. a single point of access for professionals/single phone call) as an effective alternative to A&E conveyance and/or hospital admission.

3. **Increasing direct referral to all other components of the Urgent and Emergency Care Network -** Registered healthcare professionals in the employment of ambulance services (e.g. paramedics and nurses) should be empowered and supported to refer patients that they have assessed in person to all other components of the urgent and emergency care network. This includes referral to primary care and hospital-based expertise, combined with conveyance to non-A&E destinations including urgent care centres, assessment units and ambulatory emergency care units.

4. **Enhanced working with community mental health teams -** Ambulance services should work with SRGs, commissioners, community mental health teams and other system partners to improve access to early triage and assessment by mental health professionals following referral from the ambulance service. This should be supported by timely access to crisis care at home and in community-based settings.

5. **Enhanced working with primary care -** In addition to the referral and transport actions outlined under point 3 above, consideration should be given to: paramedic practitioners undertaking acute home visits on behalf of GPs, to avoid unnecessary admission and admission surges; 'call back' schemes whereby in-hours and out-of-hours primary care staff follow-up patients who have been managed at home and not transported by ambulance clinicians (within agreed time-frames); joint planning with GPs and other relevant system partners (e.g. acute trusts) to agree management plans for high-volume service users/frequent callers.

6. **Workforce development -** The development and further training of the ambulance workforce (particularly paramedics) and the employment of a wider range of healthcare professionals (e.g. nurses, midwives and pharmacists) will increase the rates of both "see and treat" and "hear and treat" by enhancing the skills of the ambulance workforce.

7. **Enhanced use of information and communication technologies -** This includes (but is not limited to): sharing and access to electronic patient records to support clinical decision-making; implementation of electronic patient handovers; sharing predicted activity levels with acute trusts on an hourly and daily basis to trigger effective escalation protocols.

8. **Increased use of alternative vehicles to convey patients -** Ambulance services should consider the use of alternative vehicles to transport patients, whenever it is safe and appropriate to do so, thereby freeing up and improving the availability of "front line" ambulance resources.

9. **For patients who do need to be taken to hospital, ambulance services should seek to minimise handover delays**

APPENDIX E

Key priority cancer actions

1. The Trust Board must have a **named Executive Director responsible** for delivering the national cancer waiting time standards.

2. Boards should receive 62 day cancer wait **performance reports** for each individual cancer tumour pathway, not an all pathway average.

3. Every Trust should have a **cancer operational policy** in place and approved by the cancer services team and board. This should include the approach to auditing data quality and accuracy, and the Trust approach to ensure multi-disciplinary team coordinators are effectively trained and supported, and have sufficient dedicated capacity to fulfil their function effectively.

4. Every Trust must maintain and publish a **timed pathway**, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Cancer Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.

5. Each Trust should maintain a valid **cancer specific PTL** and carry out a weekly review for all cancer sites to track patients, review data accuracy and performance and to identify individual patient deviation from the published pathway standards and agree corrective action.

6. A root cause **breach analysis** should be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching). These should be reviewed in the weekly PTL meetings.

7. Alongside the above, a **capacity and demand analysis** for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) should be carried out. There should also be an assessment of sustainable list size at this point.

8. An **Improvement Plan** should then be prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.