Glossary of some key performance targets, monitored by CCGs and NHS England/ Improvement

A&E 4 Hour Target

The operational standard for A&E waiting times is that 95% of patients should be admitted, transferred or discharged hours of their arrival at an A&E department.

Trolley-waits of over 12 hours

The waiting time for an emergency admission via A&E is measured from the time when the decision is made to admit, or when treatment in A&E is completed (whichever is later) to the time when the patient is admitted.

** Note this time is not calculated from the time of arrival at the department, it is from the time a decision is made to admit a patient. By definition therefore any 12 hour breach, excludes time spent in A&E waiting to be seen, assessed and before a decision to admit had been made.

A&E Department Type

1. Emergency departments are a Consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

2. Consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients

3. Other type of A&E/minor injury activity with designated accommodation for the reception of accident and emergency patients.

   The department may be doctor led or nurse led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP Practice or Out-Patient Clinic) is excluded even though it may treat a number of patients with minor illness or injury. Excludes NHS walk-in centres

4. NHS walk in centres

Cancelled Operation on the Day

A last-minute cancellation is one that occurs on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation.

For example, you are to be admitted to hospital on a Monday for an operation scheduled for the following day (Tuesday). If the hospital cancels your operation for non-clinical reasons on the Monday then this would count as a last-minute cancellation. This includes patients who have not actually arrived in hospital and have been telephoned at home prior to their arrival.

It excludes cancellations which are initiated by the patient, i.e. patient not turning up.

The elective cancelled operations standard is a pledge in the Handbook to the NHS Constitution which states “all patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another

binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.

Cancer Targets

**Note there are 9 operational targets relating to cancer treatment times, 8 of which has an expected operational standard – this standard is below 100% as there is an acceptance that there will be understandable clinical exceptions that would be expected to fall outside this operational target. It is also useful to note that this target is 'of the patients seen' the performance is, patients not seen are not counted in this measure – there are separate targets for this.

In additional nationally performance is formally assessed on a quarterly basis, although each month performance is nationally reported as well by CCG and by NHS provider. The monthly figures are therefore earlier indicators of performance, but it is the quarterly figure that is used to judge an organisations performance actually in year.

This is to avoid issues in regard of low patient volumes in a month, if a Trust only see's five patients in a month if it fails to treat one patient in the month, the operating performance is 80%, remembering that some clinical exceptions are expected and accounted for in the quarterly performance figures.

- A **maximum two-week wait** to see a specialist for all patients referred with suspected cancer symptoms, standard is that **93%** should be seen within the standard;
- A **maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms**, even if cancer is not initially suspected, standard is that **93%** should be seen within the standard;
- A **maximum one month (31-day) wait from the date a decision to treat (DTT)** is made to the first definitive treatment for all cancers, standard is that **96%** should be seen within the standard;
- A **maximum 31-day wait for subsequent treatment where the treatment is surgery**, standard is that **94%** should be seen within the standard;
- A **maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy**, standard is that **94%** should be seen within the standard;
- A **maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen**, standard is that **98%** should be seen within the standard; ;
- A **maximum two month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers**, standard is that **85%** should be seen within the standard;
- A **maximum 62-day wait from referral from an NHS cancer screening service** to the first definitive treatment for cancer, standard is that **90%** should be seen within the standard; ;
- A **maximum 62-day wait for the first definitive treatment following a consultant's decision to upgrade** the priority of the patient (all cancers), **no operational standard in place**;

Issues with low numbers an example:

Using the earlier example, 80% performance against an 85% target could be as simple as 4

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Met	4	4	5	4	4	4	5	4	4	4	5	4	51
Total	5	5	5	5	5	5	5	5	5	5	5	5	60
Actual %	80%	80%	100%	80%	80%	80%	100%	80%	80%	80%	100%	80%	85%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Q1	Q2	Q3	Q4
13	12	13	13
15	15	15	15
87%	80%	87%	87%

from 5 patients, the fact that the target is 85% signifies that it is not expected that 100% would ever be expected to be delivered, but the fact that 1 from 5 failed to meet the standard, means mathematically the organisation trips against the standard numerically.

Taking this example further (see below) over 12 months if 5 patients were treated each month, then this gives a total of 60 patients in total, if 85% is the standard – in the year we might then expect 15% of 60 patients to have not met the target, or 9 patients.

If 1 patient failed each month this would give 9 months from 12 not meeting the standard, but over the full year 51 from 60 patients will have met the standard, which equates to 85% so over the year the standard was met.

It also means the organisation met the target in 3 quarters of the year, this is important as often some targets are officially measured for performance on a quarterly basis, such as many of the cancer targets, but performance is reported on a monthly basis.

So for this example, only 25% of monthly data met the target, 75% of quarterly data met the target but 100% of yearly data met the target. Context in this example is clearly very important in judging overall performance.

Cancer Waits over 104 days

The Going Further on Cancer Waiting Times operational standards have been designed to take in to account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons.

For these reasons, some patients may have a recorded waiting time in excess of 62 days, which is both accurately reported and is clinically directed in the best interests of the patient concerned.

It is also recognised that a small proportion of patients will have a recorded waiting time of more than 104 days for this reason i.e. 6 weeks beyond a breach of the 62 day standard.

The exact approaches to managing patients with a long waiting time, both proactively and retrospectively, require clarification so that avoidable non-clinical factors can be identified and separated from clinically appropriate management, and patient choice.

Equally, providers should have effective processes in place to review such patient pathways and escalation approaches for delays which may have direct clinical significance and/or have resulted in a harm event for the delayed patient concerned.

This ‘backstop’ standard aims to ensure that the cancer operational standards, performance management and reporting arrangements act as a tool to improving access times for all cancer patients.

NHS Provider Boards should receive routine reports on cancer waiting times performance. These reports must show performance against each of the cancer operational standards and the actions being taken to improve and sustain cancer performance.

These reports should be presented in a way which allows the Trust Board to see the number and proportion of patients with a long waiting time.

Where required , the Trust Board should see outcomes of the root cause analysis (RCA) in relation to the cancer pathway/s concerned, and may request further forms of exception reporting as required by local circumstances.

Clinical Commissioning Groups (CCGs or equivalent) may request further exception reporting and ensure that themes identified within the RCAs are embedded in the Trust’s Cancer Improvement Plan.

Diagnostic Waiting Times

The monthly diagnostics collection is used to measure performance against the diagnostic operational standard (less than 1% of patients should wait 6 weeks or more for a diagnostic test).

The monthly diagnostics collection collects data on waiting times and activity for 15 key diagnostic tests and procedures, by provider organisation level, from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers. Data is also reported by Commissioning organisation, i.e. Clinical Commissioning Groups, but in addition, NHS England also nationally commissions some specialised services.

The 15 key diagnostic tests reported within the overall summary measure generally reported in performance reports are:

- Magnetic Resonance Imaging
- Computed Tomography
- Non-obstetric Ultrasound
- Barium Enema
- DEXA Scan
- Audiology - Audiology Assessments
- Cardiology - Echocardiography
- Cardiology - Electrophysiology
- Neurophysiology - Peripheral Neurophysiology
- Respiratory Physiology - Sleep Studies
- Urodynamics - Pressures & Flows
- Colonoscopy
- Flexi Sigmoidoscopy
- Cystoscopy
- Gastroscopy

These waiting times are reported separately to Referral to Treatment Times (RTT) to ensure access to diagnostic tests are managed for all patient pathways, not just GP referrals.

However, the RTT waiting time includes any diagnostic wait. The RTT waiting time is time from referral by a GP to the start of treatment, or discharge back to a GP.

The diagnostic waiting time is exactly that a current aged waiting list profile of current waiters for a diagnostic test, it is not the actual time it took for patients to receive their diagnostic test.

Referral to Treatment (RTT) Waiting Times

92% of patients on an RTT Pathway must have waited less than 18 weeks, from the point of referral by a GP.

A patient's waiting time starts from the point the hospital or service receives a referral letter, or when a patient books their first appointment through the NHS e-Referral Service.

During this time period, the patient may:

- undergo tests, scans or other procedures to help ensure that their treatment is tailored appropriately to their condition
- have medication or therapy to manage their symptoms until they start treatment
- be referred to another consultant or department
- the waiting time ends if a clinician decides no treatment is necessary, you decide you don't want to be treated, or when your treatment begins.

This could include:

- being admitted to hospital for an operation or treatment
- starting treatment that doesn't require the patient to stay in hospital, such as taking medication
- beginning fitting for a medical device, such as leg braces
- agreeing to the patients' condition being monitored for a time to see whether they need further treatment
- Receiving advice from hospital staff to manage their condition.

The 92% standard is the current operating standard used to monitor performance of CCGs and Trusts, and is again of the current patients on an existing RTT pathways, 92% of them have been waiting less than 18 weeks.

The target of actual experienced waiting times by patients ceased to be operationally monitored several years ago.

Constitutional Standard 18 weeks RTT

The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible.

This patient right exists separately to the operational management standard of 92% of current waiter having waited less than 18 weeks.

The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day your appointment is booked through the NHS e-Referral Service, or when the hospital or service receives your referral letter.

However, the patient's right to an 18-week waiting time does not apply if:

- They choose to wait longer
- delaying the start of their treatment is in their best clinical interests – for example, where stopping smoking or losing weight is likely to improve the outcome of the treatment
- it is clinically appropriate for their condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage
- the patient fails to attend appointments that the patient had chosen from a set of reasonable options
- the treatment is no longer necessary

Management of Long Waits over 18 weeks

The NHS Long Term Plan has committed the NHS to a zero-tolerance approach to people waiting over a year for planned care and introduced a 52-week maximum wait with fines on commissioners and providers for any breaches.

Operationally this means that there should be no over 52 week waits reported by any CCG or any Trust, from April 2019 onwards.

It also strengthens the right of patients to select an alternative provider where their current one cannot provide them with the elective care they need within six months. This choice of alternative provider at 26 weeks has to be in place across all systems by 1 April 2020.

Delayed Transfers of Care (DTOC)

A delayed transfer of care (DTOC) from NHS-funded acute or non-acute care occurs when an adult (18+ years) patient is ready to go home and is still occupying a bed.

A patient is ready to go home when all of the following three conditions are met:

- a clinical decision has been made that the patient is ready for transfer home
- a multidisciplinary team (MDT) decision has been made that the patient is ready for transfer home
- the patient is considered to be safe to discharge/transfer home.

The monthly return captures delays for patients awaiting lower levels of care, either a discharge home or a transfer to a non-acute bed for intermediate or interim care, irrespective of whether these beds are within the same or a different care provider.

Patients may spend longer in NHS-funded care than is necessary because of delays caused by internal systems within the reporting trust. Although good practice means these delays should be addressed as part of normal internal business improvement practices, internal delays do NOT equate to a delayed transfer of care (DTOC) and must NOT be reported in the monthly return.

Delays caused by external systems, which are outside of the control of the care provider, DO equate to a DTOC and must be reported in the monthly return.

Operationally Trusts are monitored against a target of reducing DTOCs to being less than **3.5%** of total occupied beds. So if a Trust has 100 beds, of which 80 are occupied, and of which 5 of these are reported as DTOCs, this equates to 6.3% DTOCs (5 from 80 beds), note it is not 5 from 100 i.e. total available beds.

Dementia Diagnosis (CCGs)

The NHS publish data about people with dementia for each GP practice. So that the NHS (GPs and commissioners) can make informed choices about how to plan their services around their patients' needs.

These publications include a dementia diagnosis rate indicator, as not everyone with dementia has or is expected to have a formal diagnosis. This statistic compares the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over.

The expectation is that each CCG achieves a **66.7% identification rate** on GP practice lists compared to their estimated prevalence of dementia (calculated nationally). This data is published every month.

Early Intervention in Psychosis

The Early Intervention in Psychosis Waiting Times data contains information on the number of people with first episode of psychosis who have accessed or are waiting for treatment.

From 1st April 2016 at least 50% of people experiencing a first episode of psychosis will commence treatment with a NICE-approved care package, with a specialist early intervention in psychosis (EIP) service within a maximum of two weeks from referral to start of treatment. The standard will be extended to reach at least 60% of people experiencing first episode psychosis, by 2020/21.

Improving Access to Psychological Therapies (IAPT)

This programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. IAPT is widely-recognised as the most ambitious programme of talking therapies in the world and in the past year alone more than one million people accessed IAPT services for help to overcome their depression and anxiety, and better manage their mental health.

Plans set out in the NHS Long Term Plan build on the ambitions of the Five Year Forward View for Mental Health, and will see the number of people with anxiety disorders or depression who can access talking therapies through IAPT increase by an additional 380,000 per year to reach 1.9 million by 2023/24.

For the duration of the Five Year Forward View , prevalence estimates are based on the Adult Psychiatric Morbidity Survey (APMS; 2000).

For the 2023/24 long term plan LTP ambition, the NHS are adopting updated prevalence estimates (APMS; 2014) which include over 75s for the first time, take account of population growth since 2000 and reflect updated CCG boundaries.

This updated prevalence estimate was used to calculate the overall activity ambition set out in the Long Term Plan but are being used to set STP trajectories for the first time in this tool, which means estimates for some STPs have changed. In order to support STPs to transition to the updated prevalence estimates we have developed a phased activity trajectory which apportions the national ambition each year as follows:

- 2019/20 uses access target of 22% - this is the last year of using 2000 APMS prevalence estimates.

- 2020/21 uses national access target of 25% of the total national prevalence taken from CCG plans for 2019/20, this is apportioned using a phased approach to close the gap between the prevalence estimates from 2000 and 2014.
- 2021/22 apportions the LTP 1.6 million national ambition using a phased approach to close the gap between the prevalence estimates from 2000 and 2014
- 2022/23 apportions the LTP 1.8 million national ambition using a phased approach to close the gap between the prevalence estimates from 2000 and 2014
- 2023/24 apportions the LTP 1.9 million national ambition using the 2014 APMS prevalence estimates.

Progress is monitored each month firstly as a yearly coverage rate i.e. the access target of 22% for 2019/20, this is translated into a monthly rate one twelfth of this 1.8% each month, or as a rolling quarterly rate of 5.4%.

The second target is a recovery rate where 50% of patients who complete an IAPTs intervention, are expected to report as having recovered.