NHS England

Aligning the Publication of Performance Data: Outcome of Consultation

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Aligning the Publication of Performance Data

Outcome of Consultation

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1 Aligning the Publication of Performance Data: Outcome of Consultation

1.1 Summary

Between 3 August and 1 September 2015, NHS England sought comments and views from data producers and users on proposals related to the coordinated collection and publication of performance statistics. This document summarises the responses received and next steps. The main outcomes are:

- Most timetables for the submission of data will be unchanged or changed by only one or two days.
- We will extend the scope of the publication to include monthly hospital activity information and other suitable series; and we will continue to improve the format.
- We will start to collect new referral to treatment data on clock starts and incomplete pathways with a decision to admit, but the collection of data on validation removals will be postponed pending further review.

1.2 Background and purpose

Simon Stevens, Chief Executive of NHS England, asked Sir Bruce Keogh to review some of the current waiting time measures to ensure they make sense for patients and are operationally well designed. There was concern that, in a small number of instances, some targets were provoking perverse behaviours and the complexity of others was obscuring their purpose and meaning.

This work concluded that current arrangements for reporting performance were uncoordinated. We standardised reporting arrangements so that performance statistics for A&E, Referral to Treatment (RTT), cancer, diagnostics, ambulances, NHS 111 and delayed transfers of care (DTOC) are all collected monthly and published on one day each month.

The consultation invited comments on:

- the dates of submission of the data to NHS England;
- the content and form of the publication;
- discontinuing the collection of referral to treatment (RTT) admitted adjusted data from October; and
- the collection of new RTT data items on clockstarts, patients with a decision to admit and validation and validation removals.

The consultation ran from 3 August to 1 September 2015.

This document summarises the responses received and next steps.

1.3 Number and nature of responses

In all there were **39** responses to the consultation via the website, and email. Of these responses, **1** was received from the Department of Health, **4** from NHS England, **9** from NHS commissioners, **22** from NHS providers and **3** from non-NHS analysts.

1.4 Comments on the proposal

Respondents provided the following numbers of comments against each of the topic areas:

Topic	No. of responses
Timetable	28
Publication material	22
A&E	21
Delayed transfers of care	19
Diagnostics	17
RTT	34
Cancer	20
Ambulance and NHS111	6

1.5 Decision

1.5.1 Timetable

Nine of the comments on the timetable were supportive of the proposal. Of the other comments, some related to the timetable for specific collections and these are covered in the relevant sections below. The remaining comments covered the following areas:

- One respondent said they would like to be able to submit data to existing timetable, even where submission deadlines have been extended. The submission timetable for most of the collections will be unchanged. We will typically enable suppliers to submit data as soon as possible after the previous month's data have been published or in some cases from the first working day after the end of the month, so we are generally able to accommodate early submission of data.
- Four respondents stated that the publication dates would delay production of board reports and other documents. However, local information can be used by providers and commissioners prior to the publication of the official statistics. For those series collected at "provider by commissioner" level, this will be available to commissioners as soon as providers have submitted the data on the Unify2 data collection system. In addition or alternatively, commissioners may be able to access local information through bespoke data sharing arrangements.
- One respondent requested that we ensure that there is one universal date when commissioners can download data for reporting and analytical purposes as opposed to a provisional and publication date. As illustrated by the preceding point, some commissioners value being able to make use of local information before publication in order to take earlier management action. Moreover, commissioners are expected to assure and sign-off the data that providers submit relating to their patients. For those two reasons, we will continue to enable commissioners to access their local information prior to publication through the Unify2 data collection system.
- One response requested that other information, including data from the Monthly Activity Return (MAR), be included in the combined performance report. These data on hospital activity are currently published one day after

the combined performance statistics report. Their inclusion within the combined report would enable users to relate the performance figures to trends in activity such as referrals, outpatient appointments, and elective and non-elective admissions. We will bring forward publication of those statistics by a day. We will also consider what other statistical series could be included and would offer users additional insight.

- One respondent requested that revisions should no longer be made six monthly on the same day as the publication of the latest month's data as it requires them to process lots of data on the same day. We will continue to release revisions on the same day, as we feel this is in line with the principle of orderly release set out in the Code of Practice for Official Statistics and ensures the revisions are sufficiently visible.

1.5.2 Publication material

There were five responses that were supportive of the concept of a single overarching document. The responses were as follows:

- Four responses asked for data, including historical data, to be published in csv as well as xls format. In addition, one response asked for time series for all providers and commissioners to be published, as well as at England level. We are working with the managers of the Unify2 system to put a solution in place to facilitate the production and release of such files.
- Respondents suggested presenting the data as an interactive dashboard including historical data, benchmarking and charts. We will continue to make improvements to the format of both the combined and individual publications. We are engaged in a related programme of work to rationalise the set of dashboards generated by NHS England that draws on best practice across the organisation, with the intention of making those outputs available to the NHS. In addition, an increasing amount of performance information is being made available through My NHS. This includes provider level information on A&E and referral to treatment and high level information from the other publications.
- One response requested a further split of "X24" data on NHS England commissioned services into a more granular level. We will keep this under review, but in the short term we do not intend to split "X24" because of the

burden on the NHS, the quality of the resultant data and the availability of information from other sources such as Hospital Episode Statistics (HES) and the Secondary Uses Service (SUS).

- One respondent asked for the data to be available as extracts on Unify as well as Excel files on the NHS England website. The requested extracts are already available on Unify. We recommend the respondent contacts the Unify mailbox on unify2@dh.gsi.gov.uk if they are having trouble accessing these extracts.

1.5.3 A&E

There were ten responses relating to the A&E collection. Of these, six related to the frequency and timeliness of the collection. The timeliness point was also raised in relation to information on delayed transfers of care and diagnostics. In contrast, a number of providers supported the extra time available to submit the data. The benefits of combined publication in terms of coherence and burden on the NHS were articulated by Sir Bruce Keogh in his review and are not revisited here. The combined publication is released as quickly as possible after the end of the month, whilst achieving a level of quality for all the series that is fit for purpose. As referred to above, commissioners may be able to access local information through bespoke data sharing arrangements.

One respondent suggested that a SUS feed for A&E might be preferable to the current system of uploading data to Unify2. It is our long term goal to derive these statistics from SUS and we have a programme in place to work towards that. However, at present there are too many uncertainties about the quality of the data to discontinue the aggregate collection. For example, some of the increase in attendances recorded in SUS has been a product of improved quality; and in particular improvements in the coverage of type 3 accident and emergency units.

One respondent asked for the calculations used to generate the estimated historical monthly time series from the weekly time series. The procedure was to divide the weekly totals by seven to get a daily estimate and then add those daily estimates together by calendar month to get monthly estimates.

One respondent asked for site level data to be incorporated into the A&E collection so that multiple site hospitals could better understand what is driving performance. We have no plans to introduce such site level data because of the increased burden. Commissioners may be able to access such local information through analysis of A&E Hospital Episode Statistics or through bespoke data sharing arrangements.

One respondent asked for the A&E data to be available as an extract on Unify as well as excel files on the NHS England website. The requested extracts are already available on Unify. We recommend the respondent contacts the Unify mailbox on unify2@dh.gsi.gov.uk if they are having trouble accessing these extracts.

1.5.4 Delayed transfers of care

There were three additional comments relating to the Delayed Transfer of Care collection.

One response observed that the delay in submission allowed more time for validation checks should they be needed.

One response said that the Thursday snapshot is arbitrary and therefore unnecessary. We agree that the information on the month end position is a snapshot and is not therefore necessarily representative of the month as a whole. We disagree however with the statement that it is unnecessary. In our analysis, we have found that the snapshot can provide valuable context to the total delayed days figure. We will continue to collect this information.

One response suggested that the data could be submitted by provider per CCG. This collection relates to providers and local authorities only. We recognise that such information would be of some value to commissioners of health services, but as collecting the information by CCG as well as local authorities would significantly increase the burden on the NHS we do not intend to introduce this change.

1.5.5 Diagnostics

There were sixteen additional comments relating to the monthly Diagnostics Waiting Times and Activity collection.

Thirteen of these responses stated that they were happy with the proposal to move the provider submission deadline back by two days.

One respondent suggested that the data captured in the monthly collection should be reviewed. Currently, waiting time data is collected by taking a snapshot of the waiting list at the end of the month. The respondent suggested that we should begin monitoring the length of time a patient waits between referral and test, citing that it would increase the transparency of diagnostic testing. In contrast, the focus of monitoring for referral to treatment has shifted away from the time a patient waits for treatment and instead centres on the time that patients have been waiting for treatment, as this better supports the appropriate management of waiting lists. There are consequently no plans to change the way that diagnostic data is captured.

Another respondent suggested that we should review the benefit of submitting both the monthly data and the quarterly diagnostic census. The census collects data on patients waiting six weeks or more for a diagnostic test, and includes tests outside the scope of the monthly collection. The respondent stated that it was difficult to see the benefit of the census in its current format, given the recent review of tests to include in the monthly collection. We agree that the census should be reviewed and plan to do so this year.

One respondent suggested that there should be further sub-categories for PET-CT scans and Cardiac MRI scans, saying that it would accurately reflect the specialised level of diagnostic scans. Currently, both of these scans would be reported under a more generalised grouping. There are currently no plans to split tests into further categories within the monthly diagnostic data.

1.5.6 Referral to Treatment (RTT)

Background

The consultation document outlined the proposals for collecting the following new RTT data items:

- number of new RTT clock starts
- incomplete pathways with a decision to admit (DTA) for treatment
- validation removals from RTT waiting list.

We asked for feedback from:
(i) providers of data on the issues associated with the generation and submission of such information, including issues associated with data quality; and
(ii) potential users of such information on the value to them, including what they would use the information for and what difference it would make.

Summary of feedback relating to the new RTT data items

In total, 40 of the responses included some reference to RTT issues. Of these, 36 commented on the proposed new data items, 22 of these responses were from data providers and 14 from data users of various types.

Five responses (4 from users and 1 from a provider) endorsed the need for the new data items and one response (from a data user) suggested going further by collecting the validation removals data item in more detail (by weekly time band).

Fourteen of the 22 data providers that responded raised concerns about the additional burden created by the new data items, half of these were particularly concerned about the validation removals data item, for example:

- "I suspect that most trusts will just estimate the validation removals by calculating the difference in the position reported this month in the RTT return vs. what was reported last month."
- "We believe it is technically possible to provide this information. However, this would be a manual process currently and whilst technically possible this would require a more robust solution to be built and tested. There would be a lead time for this work to be completed which would be an increased short term burden on

NHS organisations. Careful consideration would need to be given to the timescale for NHS organisations starting to report this element as systems may not be routinely in place."

There was also a desire for more information about the suggestion that recording the number of new clock starts and validation removals from the waiting list allows providers and commissioners to ensure that waiting lists 'balance' month-on-month, within a reasonable tolerance. Six data providers raised this issue, including:

- How will "Did Not Attends" (DNAs) be taken account of in the check of whether waiting lists balance?
- How will inter-provider transfers be taken into account?
- One data provider queried whether a target would be set to check validation is within a certain percentage of the following month end waiting list position.
- One data provider said it would be useful to have had more detail about the reference made to a tolerance being applied, perhaps through a pilot return period before commencing formal submissions.

One data provider stated that they cannot identify whether "To Come In" (TCI) dates are for first definitive treatment or not so couldn't comply with the definition of incomplete pathways with a decision to admit (DTA) for treatment.

Three data providers raised concerns about being asked to supply new data items for October 2015, one of these related to specific issues with implementing a new Patient Administration System in October.

Our response

There were few concerns about two of the three data items: new RTT clock starts and incomplete pathways with a decision to admit (DTA) for treatment. The majority of trusts already submit these data items in the weekly RTT Patient Tracker List (PTL) return.

We have introduced these items to the October 2015 Unify2 data return as planned. Feedback received from some providers following the consultation is that they would prefer to submit information for incomplete pathways with a DTA based only on those

cases where a clinical decision to admit to a hospital bed **for first definitive treatment** has been made, rather than all decisions to admit. For that reason, we have adopted that definition.

Most feedback about the new data items related to the validation removals item. The responses suggest that some providers are currently not able to capture and report this information easily. One data provider suggested that many trusts would submit estimated data based on the difference between the waiting list last month and this month. As a result of this feedback, we will carry out further work with data providers to determine how best to measure RTT validation removals. This will include further exploration of the value and feasibility of the proposal to extend the validation removals data item so that it is broken down by cohort (those waiting up to one week, those waiting more than 1 and up to 2 weeks, etc) on the basis that this would assist the identification of cases where validation is not carried out thoroughly at all stages of patients' treatment pathways. The introduction of this data item will therefore be postponed until 2016.

The changes to Unify2 RTT reporting requirements implemented from October 2015 data onwards can therefore be summarised as follows:

- there is no longer a requirement to submit admitted adjusted data ;
- unadjusted admitted and non-admitted completed pathway data is still required;
- the requirement to report incomplete pathway data remains unchanged – and has always been an unadjusted submission; and
- two new data items have been added to the Unify2 data return: incomplete pathways for patients with a decision to admit and new RTT periods.

The template is available on Unify2. Data providers should direct any queries relating to the new data items to England.RTT@nhs.net.

Other feedback

There were also a number of responses which did not directly relate to the consultation questions about the new RTT data items, including:

- Two responses seemed to be based on a misunderstanding that data will no longer be collected for completed admitted and non-admitted pathways. To clarify:
    - Unadjusted admitted and non-admitted completed pathway data is still required and will still be published, but we will no longer present the percentage treated within 18 weeks because of the refocusing of those operational standards;
    - For the October 2015 data period onwards, there will no longer be a requirement to report admitted adjusted data;
    - The requirement to report incomplete pathway data remains unchanged - and has always been an unadjusted submission.
- Another respondent suggested that as well as measuring incomplete pathways, it would be useful to measure "average wait for treatment and the distribution". This information is all available in the routine monthly publication files for admitted, non-admitted and incomplete pathways and will continue to be published.
- There were a number of queries about why the facility to report patient-initiated pauses has been removed. As such pauses were only applicable to data for completed admitted pathways, the need to report pauses no longer exists because of the removal of the admitted standard The requirement has always been to supply incomplete pathway data without adjustment for clock pauses. Many patients will choose to be seen at the earliest opportunity. However, patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances. Delays as a result of patient choice are taken account of in the tolerance of 8% set for achievement of the incomplete pathway waiting time operational standard. In many trusts, we would expect delays as a result of patient choice to account for the bulk of this tolerance.
- One response noted that the current proposals would appear to incentivise Trusts not to find out clock start dates where they are not supplied with the referral or the Inter-Provider Transfer Administrative Minimum Data Set (particularly from referrers who tend to refer on quite late in the pathway) as there is no facility to report unknown clockstarts in the incomplete return. As noted in the RTT recording and reporting guidance, providers are responsible for the proper validation of any patient who may have an incomplete RTT pathway and it is

important that clock starts can be accurately identified for all patients on an RTT pathway to ensure the patient receives timely treatment.

- One response requested that data collection templates include all treatment functions as per the data dictionary, instead of the subset currently included. Our view is that rather than obtaining this information through an expansion of the monthly aggregate return, we should look to the longer term goal of deriving more detailed information on pathways from SUS.

1.5.7 Cancer

A range of respondents supported the publication of monthly cancer data, and the earlier publication of data.

Comments were received on the change to 24 working days submission timetable. Responses from a range of provider organisations, including several tertiary centres, indicated the change to 24 working days deadline was achievable and would not impact on the quality or coverage of data submitted. Respondents observed that in order for this deadline to be achieved it requires a close working relationship between providers which share patients. Given this is true for the current timetable of 25 working days, a change to 24 days does not present significant additional risk.

No comments were received on a preference for when the change to 24 working days will be made over the course of the next 6 months. The change to the timetable has been announced on the HSCIC website at: http://systems.hscic.gov.uk/ssd/cancerwaiting/prop_reports

Comments were received on the possible change to 20 or 15 working days submission timetable. All respondents said that a reduction to 15 working days would materially affect the quality of data submitted due to availability of critical pieces of information in the timescales, for example, the availability of histology reports. The same point was made for a move to 20 working days, albeit, for this change, some providers felt this was achievable given sufficient notice.

In light of these comments, we will not make a reduction to 20 or 15 days in 2016, but will keep under review making a smaller, additional improvement to the submission date.

Comments were received on where data are published. In particular a request was made for data to be put on Unify. Cancer Waiting Times data is in the main available via Open Exeter for internal reporting, and NHS England website for official statistics publications. Whilst both these will continue, we will investigate publishing on Unify also.

1.5.8 Ambulance and 111

There were two responses specific to Ambulance and/or NHS 111 data.

The first said it "would be useful if Ambulance data was available at a commissioner level as well as a provider level"; we assume this is a request for data for all Clinical Commissioning Groups separately. This would require NHS England to collect and publish data for over 209 different geographical areas instead of the current 11; and Trusts would need to supply such data, greatly increasing the burden upon data suppliers. Therefore this is not a change we will make now, but will add this to our record of feedback in the Quality Statement for ambulance data at www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators.

The second respondent suggested extra tables in the Ambulance and NHS 111 publications, displaying data in layouts more useful for users. We will include additional tables in the publications.

2 Annex A: General Consultation Questions

1. For producers of statistics

Timetable

We have proposed some changes to the timetable for the relevant data collections:

Collection	Timetable change
A&E	Move from a weekly collection to a calendar month collection. Proposed submission date for monthly return is 16th working day after month end.
DTOC	Submission deadline extended by two weeks to the 18th working day after month end.
RTT	No change, submission deadline remains 13th working day after month end.
Cancer waiting times	Proposed that submission deadline reduced from 25 to 24 working days in the next six months.

1. Do these changes help you manage your workload? Are there any other timetable changes you would like to see?
2. What, if any, effect will the changes have on the quality of the information that you can supply?
3. To what extent will the changes reduce the burden to you of providing data?

2. For users of the statistics:

Consolidated monthly publication of performance figures

1. What use would you make of a new overarching document covering the 7 areas of performance?
2. What type of material would be of most benefit to you in an overarching document?
3. How would you like to see this material presented?
4. Are there any changes that we can make to the presentation of the individual reports that would improve coherence?
5. Do you have any further suggestions as to how to improve the coherence of the material?