Governing Body

27 July 2016

Details	Part 1	**Yes**	Part 2	**No**	Agenda Item No.	**11 Paper 8b**
Title of Paper:	Performance Report					
Board Member:	Margaret O'Dwyer, Director of Commissioning and Business Delivery					
Author:	Lisa Featherstone, Deputy Director of Business Delivery					
Presenter:	Margaret O'Dwyer, Director of Commissioning and Business Delivery					
Please indicate:	For Decision		For Information		For Discussion	**X**

Executive Summary

Summary

For the Clinical Commissioning Group (CCG) to commission an effective and sustainable health care service it needs robust systems which enable Performance Monitoring. These systems need to allow monitoring of the performance of the CCG and of those services it commissions.

The purpose of this report is to provide an updated position on the CCG's performance against the national performance indicators set out in the NHS Constitution, as monitored by NHS England.

The report presents the CCG's performance position for April 2016 (current period).

The report also outlines any proposed changes to performance at a national level.

Of the indicators presented in the dashboards within the appendices, 35 indicators include performance data. Of these, 13 are currently reported as underachieving :

- Diagnostic Waiting Times (E.B.4);
- A&E waiting times : 4 hour waits (E.B.5-QPC4);
- Cancer 62 day waits : first definitive treatment – GP referral (E.B.12);
- Cancer 62 day waits : first definitive treatment – screening referral (E.B.13);
- Cancer 62 day waits : first definitive treatment – consultant upgrade (E.B.14);
- Ambulance : Category A (Red 2) 8 minutes (E.B.15.ii);
- Ambulance : Category A 19 minutes (E.B.16);
- Mental Health Care Programe Approach (E.B.S.2ii)
- Trolley Waits in A&E : over 12 hours (E.B.S.5);
- Ambulance Handover > 30 minutes (E.B.S.7.i);
- Ambulance Handover > 60 minutes (E.B.S.7.ii);
- IAPT Recovery (E.A.S.2ii); and
- IAPT 6 week waits (E.H.1).

For each indicator that has not achieved the required standard, a summary position has been provided, which includes actions being undertaken either regionally or locally to address concerns.

Risk	**High**		**Medium**	**X**	**Low**	
	The key risks in respect of the performance report are : • local and system wide performance of A&E; and • performance against indicators associated with ambulance response and handover times.					
Recommendations	The Governing Body is asked to: • receive the performance report; • note the updates provided					

Strategic themes

Deliver improvement in outcomes for patients			**X**
Deliver service improvement through system redesign in priority areas			
Develop NHS Bury CCG and Primary Care capability as commissioners and leaders			**X**
Deliver through the Health and Wellbeing Board improved population health and reduction in inequalities			
Deliver the CCG element of QIPP through effective system management and working with partners and stakeholders and ensuring a culture with focus on quality, fostering innovation, improving health outcomes and reducing inequalities.			
Equality Analysis Assessed?		Supports NHS Bury CCG Governance arrangements	**X**

1.0 Introduction

1.1 The purpose of this report is to provide an updated position on the CCG's performance against the national performance indicators as set out in the following documents and as monitored by NHS England:

- Everyone Counts : Planning for Patients 2014/15 to 2018/19; and
- CCG Outcome Indicator Set.

1.2 The report presents the CCG's performance position for April 2016 (current published data), whilst also reflecting the cumulative year-to-date position.

2.0 Background

2.1 The dashboard presented reflects on that developed during the 2015-16 reporting period and has been updated to reflect the performance requirement of 2016-17.

2.2 The information provided within the report reflects a specific reporting period, which is 2 months behind the actual period as there is a time delay between the publishing of the performance data for the reporting period and presentation of the report. This is due to the validation process and availability of the data nationally.

2.3 Where possible, current performance and potential issues will be articulated and brought to the attention of the Quality and Risk Committee and Governing Body as appropriate.

3.0 Performance Summary

3.1 This is the first performance report for 2015-16 and therefore there is no comparison information or trend analysis available.

3.2 At this first month position, the CCG reports full achievement of the required performance indicators in the following areas:

- Cancer 31 day waits: Subsequent cancer treatment – surgery (E.B.9);
- Cancer 31 day waits: Subsequent cancer treatment – anti-cancer drug regimes (E.B.10);
- Cancer 31 day waits: Subsequent cancer treatment – radiotherapy (E.B.11);
- Mixed Sex Accommodation Breaches (E.B.S.1);
- Referral to Treatment 52 week waits (E.B.S.4); and
- Urgent Operations Cancelled for a second time (E.B.S.6).

3.3 Reflecting this is the first month report, no comparison is provided in respect of indicators which have improved since the last reporting period, or those which have improved.

3.4 The summary position for April 2016 shows the following indicators currently underachieving as follows:

- 11 Constitution indicators;
- 3 Mental Health Indicators – one which is also a constitution measure;
- 1 constitution indicators where data is not yet available; and
- 7 Mental Health indicators where data is not yet available.

3.5 Each underperforming indicator is explored in more detail in the following sections of the report.

National Updates

3.6 In response to the planning guidance and technical definitions for each of the indicators included within the guidance, the CCG has submitted activity information to NHS England in respect of each Constitution indicator to be measured as part of the process for developing the operating plan 2016/17.

3.7 Additionally, the Improvement and Assessment Framework, which is a new performance and assurance system applicable to CCGs for the 2016-17 financial year, will outline the CCG's performance against a range of indicators which will be made available through the My NHS data portal, with the first scorecard due imminently.

3.8 The IAF will look at performance against six crucial areas including cancer, dementia, diabetes, mental health, learning disabilities and maternity care. Additionally the IAF will report on CCG Performance in 29 areas, including new models of care, efficiency and conflicts of interest management.

3.9 Drawing together the NHS Constitution, performance and finance metrics, the IAF will play an important part in delivering the five year forward view.

Local Updates

3.10 Local performance is as outlined in the report. The dashboard has been improved to reflect the national 'must dos' from the five year forward view and also has an appendix which outlines each of the indicators being monitored to provide additional clarity and context to the report.

Performance Dashboard

3.11 The performance dashboard provides summary information for each indicator in respect of:

- indicator code, description, work stream and lead;
- whether the indicator is reported as a NHS Constitution or Quality Premium measure;
- reporting frequency and period currently reporting;
- organisation monitored by the indicator;
- target to be achieved; and
- current performance, including reporting period, year-to-date and end of year forecast.

Current Areas of Underperformance against NHS Constitution Indicators

3.12 The following areas, as included in the dashboard at Appendix A have underachieved against the required standard for the reporting period:

- **Diagnostic Test waiting Times (E.B.4)**

3.13 The target of 99% was not achieved in April 2016, with 95.3% achieved at Bury CCG level. This is a slight deterioration of 0.47% from the position reported in March 2016.

3.14 Pressures in demand and capacity for endoscopy type test modalities are still the primary driver behind the pressures.

3.15 Pennine Acute Hospital's NHS Trust (PAHT) continues to work with Independent Sector providers to source additional capacity and a revised trajectory for recovery has been shared with commissioners. The provider is not expected to recover the position until October 2016.

3.16 Trajectories for improvement have been shared with the Elective care Tactical Group and a recovery plan is in place with progress against milestones reported to the Elective Tactical Care Group on a fortnightly basis for monitoring and assurance.

3.17 The revised trajectory, which is due to the increased demand and recent industrial action, is aligned to the Sustainability Transformation Fund (STF) trajectory which has been shared with NHS England.

- **A&E waiting times : 4 hour waits (E.B.5-QPC4)**

3.18 Pennine Acute Hospitals NHS Trust (PAHT) failed the 95% A&E (4 hour wait) target in April 2016 with performance reported at 85.8% across all PAHT hospital sites and performance specific to Fairfield General Hospital reported at 82.7%.

3.19 The following table below shows a breakdown by PAHT site performance in relation to attendance levels and the respective performance standard achieved. Overall there is a reduction of 7.1% on activity reported for the same period 2015/16, with performance levels significantly lower across all sites when compared with the same reporting period in 2015/16, with the exception of Rochdale Infirmary.

		April 2016	May 2016	June 2016	Q1	YTD 16/17	YTD 15/16	Variance
FGH	Attendance	5132	5825	5464	16421	16421	15696	725
	Performance	82.72%	84.74%	86.33%	84.64%	84.64%	90.64%	-6.0%
NMGH	Attendance	7799	8668	8067	24534	24534	25338	-351
	Performance	80.20%	77.90%	75.11%	77.71%	77.71%	91.59%	-13.9%
RI	Attendance	4187	4539	4082	12808	12808	13636	-828
	Performance	97.90%	97.27%	98.53%	97.88%	97.88%	97.99%	-0.11%
ROH	Attendance	8137	9217	8587	25941	25941	25153	788
	Performance	86.89%	90.39%	86.44%	87.98%	87.98%	92.63%	-4.6%
PAHT Overall	Attendance	25255	28249	26200	79704	79704	79823	-119
	Performance	85.8%	86.50%	84.81%	85.72%	85.72%	92.82%	-7.1%

(FGH = Fairfield General Hospital; NMGH = North Manchester General Hospital; RI = Rochdale Infirmary; ROH = Royal Oldham Hospital)

3.20 NHS Bury CCG continues to work with PAHT, as part of the North East Sector (NES) Systems Resilience Group (SRG) and the Urgent Care Improvement Group, which is co-chaired by the CCG's Chief Officer, to support the delivery of the indicator, which is reflected on the CCG's Corporate Risk Register with an assessed score of level 16.

3.21 Within the 2016/17 planning guidance, the 'must do' ask in respect to delivering the 4 hour A&E indicator suggests progression towards achievement during 2016/17 and is not explicit in that the indicator must be achieved. PAHT have submitted a trajectory to NHS England which outlines increased improvement month on month until the 95% target is achieved. In line with Commissioner requirements an improved trajectory has been submitted which aims to achieve 95% by March 2017.

3.22 The CCG also remains committed to supporting the implementation of actions arising from the Trust Development Agency (TDA) work undertaken in January 2016 and the Elective Care Intensive Support Team (ECIST) recommendations and has contributed to a number of PAHT schemes.

3.23 Actions put in place to address performance include

- a review of the medical staffing rota review with daily executive level assurance;
- cross-site cover has been put in place;
- development of a safety matrix; and
- approval of recruitment to vacant posts.

3.24 Additionally, a Rapid Process Improvement Workshop for the North Manchester General Hospital site was undertaken in June 2016 and estates work has been completed for an ambulance triage area, enabling delivery of Rapid Assessment and Treatment at peak times. Point prevalence studies were undertaken in May and June and the learning included in the Recovery Plan.

3.25 Performance for Quarter 1 against the A&E target is a challenge across the wider health economy and not just within the North East Sector.

3.26 There have been, and continue to be, a number of discussions and actions being taken around improvements and support that is needed for some of the services provided by The Pennine Acute Hospitals NHS Trust. Health and social care organisations within Manchester and across Greater Manchester have come together through the Quality Improvement Board to provide support for some of the more pressured services. This includes A&E.

3.27 Under the leadership of Sir David Dalton from Salford Royal NHS Foundation Trust, and with the support of other organisations across Greater Manchester, a range of immediate actions are being put in place. More activity will take place in the coming weeks to continue to ensure Pennine Acute is able to provide high quality and safe care across all of its hospitals.

3.28 From an out of hospital perspective, the CCG will need to ensure sufficient capacity to meet the on-going needs of patients who may not be immediately able to return home, but who do not need the clinical input and infrastructure of a hospital setting. The CCG through its Urgent Care Group has deployed its System Resilience Resources to support extra community capacity at Bealeys Hospital and Intermediate

Care and Reablement. Some of the SRG monies has also been invested in PAHT to provide further resilience within hospital.

- **Cancer 62 day waits : first definitive treatment – GP referral (E.B.12)**

3.29 Performance in April 2016 underachieved at 81.6% against a target of 85%.

3.30 There were 9 breaches in April 2016, due to a combination of late referral, patient choice and medical delays due to complex pathways involving multiple diagnostics.

3.31 The reasons for each breach recorded are entered onto the database manually by the provider. There is no definitive description and therefore there is the potential for a high level of subjectivity. This has been discussed through the Cancer MDT and work has been undertaken internally to further refine and categorise each breach.

3.32 In the instance of late referral, the breach reason relates to the time between the GP referral being received (source of referral) by the provider and progression to the appropriate provider of service delivery. Late referrals can be categorised into two areas, avoidable and unavoidable.

3.33 Unavoidable late referral delays are determined by the provider to reflect complex pathways and patient needs that need to be considered prior to onward progression to treatment. These are minimised, however there are instances where these still occur.

- **Cancer 62 day waits : first definitive treatment – screening referral (E.B.13)**

3.34 Overall, performance against this indicator is routinely achieved 100%, however during April 2016 the performance levels achieved was only 85.7%

3.35 The number of patients on this pathway is low; therefore any breaches have a significant impact on overall performance. On this occasion, the breach related to one patient on the pathway and was due to a medical need.

- **Cancer 62 day waits : first definitive treatment - consultant upgrade (E.B.14)**

3.36 This indicator is no longer an operational standard within the contract, however forms a component of the national 'must dos' and therefore will be reported through the CCG's performance report.

3.37 Performance is reported at 50% against an indicator of 85%.

3.38 Again low numbers of patients means any breach adversely impacts performance to below the required target level. There were 8 patients on the pathway in total, with four breached due to late referral, patient choice and capacity.

3.39 Cancer performance is reviewed through the North East Sector (NES) Elective Tactical Group (ETG) and monitored on a monthly basis. A number of initiatives have been implemented, including working with GPs and patients to increase awareness, understanding and importance of appointments. Additionally, the CCGs across the

NES have distributed monitoring of tumour sites to enable an increased level of analysis and scrutiny of the data and information to inform required actions.

- **Ambulance : Category A (Red 2) 8 minutes (E.B.15.ii)**

3.40 Reporting an underperformance at the NWAS level in April 2016, reflective of the consistent underachievement for the 2015-16 reporting period, with reported performance at 67.5% against a target of 75%.

3.41 For NHS Bury CCG, activity for April 2016 was 16.7% above plan with local performance reported at 65.3%. This increase in activity has also been experienced across the NWAS footprint.

- **Ambulance : Category A 19 minutes (E.B.16)**

3.42 Performance in April 2016 reported at 92.0% against a target of 95% for the NWAS position.

3.43 Locally, cumulative performance for Bury is 88.2% which is below the Greater Manchester cumulative position of 91.6% for the same period.

3.44 Overall activity in April 2016, across all ambulance measures, was 5.7% above the planned level.

3.45 Performance continues to be discussed at the Ambulance Strategic Partnership Board.

- **Mental Health Care Programme Approach (CPA) (E.B.S.3)**

3.46 Ordinarily this indicator is routinely achieved, however 1 breach in April 2016 due to paperwork not being submitted, presents performance at 77.8% against a target of 95%. Patient care was not compromised.

3.47 It should be noted that this is routinely a quarterly indicator and therefore as the number of CPAs reported over the period increases, the impact of a breach on the overall indicator will reduce.

- **Trolley waits in A&E : Over 12 hours (E.B.S.6)**

3.48 The waiting time for an emergency admission is measured from the time when a decision to admit that patient has been made, or when the treatment provided within Accident and Emergency is completed (whichever is the latter).

3.49 Any patients who remain within A&E following the above criteria being satisfied, for a period of 12 hours or more are classed as a breach.

3.50 Pennine Acute Hospitals NHS Trust reported 20 trolley waits exceeding 12 hours reported for April 2016, which includes 5 specific to NHS Bury CCG. Root Cause Analysis' will be completed and appropriate actions implemented as part of the Urgent Care Improvement Plan.

3.51 Following significant increases in breaches from November 2015, the numbers of reported braches appear to be falling.

3.52 PAHT also advised in April 2016 that 12 hour trolley waits reported on StEIS have now been validated against the NHS England definition of a 12 hour breach i.e.

where a patient waits in the A&E Department for more than 12 hours from the Decision to Admit (DTA).

3.53 The current level of underperformance against this indicator is included on the CCG's Corporate Risk Register as a high level risk, and is reported to the Governing Body.

- **Ambulance Handover > 30 minutes (E.B.S.7.i)**

3.54 Figures reported within the dashboard reflect the PAHT position and not the wider NWAS position.

3.55 There were 283 handover delays reported in April 2016. This represents 4.59% of the total handovers for these months at PAHT.

- **Ambulance Handover > 60 minutes (E.B.S.7.ii)**

3.56 There were 127 delayed handovers (PAHT level) of greater than 60 minutes during April 2016, which represents 2% of total handovers at PAHT.

3.57 The lower level of activity in April 2016, when compared with recent months, has also seen an improvement in the recording of handover and associated timestamps, with FGH achieving 94% which is above the 92.5% recorded at a Greater Manchester level and 91.5% recorded for NWAS.

Current Areas of Underperformance against Mental Health Indicators

3.58 The following areas, as included in the Mental Health dashboard at Appendix B have underachieved against the required standard for the reporting period:

- **IAPT Recovery Rate (E.A.S.2i)**

3.59 Performance continues to fluctuate on this indicator, however is usually within 1% of being achieved or underachieved.

3.60 Performance in April 2016 was at 41% (indicative), against a target of 50%, which is the lowest recorded performance figure for Bury CCG over the previous 12 months.

3.61 Focus on the waiting list and the impact of agency staff have been advised as rationale to support this significant change, and assurance has been provided that performance will move back on track. Indicatively the performance reported for May 2016 is 55.5%

3.62 The significant challenge is around this indicator is sustaining performance over a long term period.

3.63 Reports continue to be submitted to NHS England and also the System Resilience Group for additional oversight, assurance and holding to account.

- **IAPT 6 Week Wait (E.H.1)**

3.64 This is a new indicator, which was introduced during 2015-16 with a view to being fully achieved and delivered by 31 March 2016, and sustained thereafter.

3.65 Set at 75%, the CCG has determined that this should be achievable immediately as this is already included within the access and recovery delivery plan.

3.66 There has been some fluctuation in performance levels achieved, with capacity issues within the provider adversely impacting upon delivery.

3.67 Performance reported indicatively for April 2016 is at 61.2%, which is a worsening position from that indicatively reported in March 2016, however is above the recovery trajectory of 58% for the same period.

3.68 Capacity issues continue to be indicated as adversely impacting upon delivery in addition to the clearance of backlog activity as although posts were recruited to by Pennine Care NHS Foundation Trust (PCFT) on a temporary basis, the approach to recording and reporting has not been as robust as PCFT would have expected.

3.69 Work continues on ensuring data quality is also achieved between the indicative information provided by PCFT at first and second submission and that subsequently published by the HSCIC.

3.70 The methodology applied by the HSCIC and NHS England is also being explored to support consistency with local reporting and colleagues from NHS England have attended the Access and Waiting Times group where the performance and common concerns of the commissioners of the service are collectively discussed.

4.0 Recommendations

4.1 The Governing Body is asked to:

- receive the performance report;
- note the updates provided

Lisa Featherstone
Deputy Director of Business Delivery
July 2016

Appendix A : NHS Constitution Performance Dashboard

NHS Constitution Measures Summary			QP	Must Do's	F	Monitored Org	Period	Period Target	Period Actual Performance												
Indicator	Description	Workstream & Lead							Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
E.B.3-QPC3	Referral To Treatment: Incomplete patients waiting 18 weeks or later	Elective Care Cath Tickle	✓	✓	M	CCG	May-16	92.0%	94.2%												94.2%
E.B.4	Diagnostic test waiting times (6 weeks waits)	Elective Care Cath Tickle	✗	✗	M	CCG	May-16	1.0%	4.7%												4.7%
E.B.5-QPC4	A&E waiting time (4hr waits) (PAHT ALL)	Urgent Care David Latham	✓	✓	M	PAHT	May-16	95.0%	85.8%												85.8%
E.B.6-QPC5	Cancer 2 week waits: GP Referral for suspected cancer	Cancer David Latham	✗	✓	M	CCG	May-16	93.0%	93.2%												93.2%
E.B.7	Cancer 2 week waits: Urgent referral for breast symptoms where cancer was not initially suspected	Cancer David Latham	✗	✓	M	CCG	May-16	93.0%	94.9%												94.9%
E.B.8	Cancer 31 day waits: First definitive treatment within 1 month of diagnosis	Cancer David Latham	✗	✓	M	CCG	May-16	96.0%	96.3%												96.3%
E.B.9	Cancer 31 day waits: Subsequent cancer treatment - Surgery	Cancer David Latham	✗	✓	M	CCG	May-16	94.0%	100.0%												100.0%
E.B.10	Cancer 31 day waits: Subsequent cancer treatment - Anti cancer drug regimens	Cancer David Latham	✗	✓	M	CCG	May-16	98.0%	100.0%												100.0%
E.B.11	Cancer 31 day waits: Subsequent cancer treatment - Radiotherapy	Cancer David Latham	✗	✓	M	CCG	May-16	94.0%	100.0%												100.0%
E.B.12	Cancer 62 day waits: First definitive treatment within 2 months of urgent GP referral	Cancer David Latham	✓	✓	M	CCG	May-16	85.0%	81.6%												81.6%
E.B.13	Cancer 62 day waits: First definitive treatment within 2 months of NHS cancer screening referral	Cancer David Latham	✗	✓	M	CCG	May-16	90.0%	85.7%												85.7%
E.B.14	Cancer 62 day waits: First definitive treatment within 2 months of consultant decision to upgrade priority status	Cancer David Latham	✗	✓	M	CCG	May-16	85.0%	50.0%												50.0%
E.B.15.i-QPC6	Ambulance clinical quality: Category A (Red 1) 8 minute response time	Urgent Care David Latham	✓	✓	M	NWAS	May-16	75.0%	76.5%												71.8%
E.B.15.ii	Ambulance clinical quality: Category A (Red 2) 8 minute response time	Urgent Care David Latham	✗	✓	M	NWAS	May-16	75.0%	67.5%												65.3%
E.B.16	Ambulance clinical quality: Category A 19 minute transportation time	Urgent Care David Latham	✗	✗	M	NWAS	May-16	95.0%	92.0%												88.2%
E.B.S.1	Mixed Sex Accommodation Breaches	Quality Michael Hargreaves	✗	✗	M	CCG	May-16	0	0												0
E.B.S.2.i	Cancelled Operations (28 day guarantee)	Elective Care Cath Tickle	✗	✗	Q	PAHT	Q1 - 16/17	100.0%													
E.B.S.2.ii	Cancelled Operations (28 day guarantee) - (PAHT Actual Breaches Indicative)	Elective Care Cath Tickle	✗	✗	M	PAHT	Apr-16	0	0												0
E.B.S.3	Mental Health: Care Programme Approach	Mental Health Usman Darsot	✗	✓	M	CCG	May-16	95.0%	77.8%												22.2%
E.B.S.4	Referral To Treatment: 52 week waits	Elective Care Cath Tickle	✗	✗	M	CCG	May-16	0	0												0
E.B.S.5	Trolley waits in A&E (12 hour waits)	Urgent Care David Latham	✗	✗	M	PAHT	May-16	0	20												20
E.B.S.6	Urgent operations cancelled for a second time	Elective Care Cath Tickle	✗	✗	M	PAHT	May-16	0	0												0
E.B.S.7.i	Ambulance handover time: delays of over 30 minutes (£200 fine per patient)	Urgent Care David Latham	✗	✗	M	PAHT	May-16	0	283												283
E.B.S.7.ii	Ambulance handover time: delays of over 60 minutes (£1,000 fine per patient)	Urgent Care David Latham	✗	✗	M	PAHT	May-16	0	127												127

Appendix B : Mental Health Performance Dashboard

Mental Health Summary			Constitution Measure	Quality Premium	Must Do's	F	Monitored Org	Period	Period Target	Period Actual Performance												
Indicator	Description	Workstream & Lead								Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
E.A.3.i	IAPT Roll-out (Prevalence) (HSCIC)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	Apr-16	1.25%													
E.A.3.ii	IAPT Roll-out (Prevalence) (PCFT Monthly Indicative)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	May-16	1.25%	1.27%												1.27%
E.A.S.2.i	IAPT Recovery Rate (Moving to recovery) (HSCIC)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	Apr-16	50.00%													
E.A.S.2.ii	IAPT Recovery Rate (Moving to recovery) (PCFT Monthly Indicative)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	May-16	50.0%	41.0%												41.0%
	IAPT Roll-out (Prevalence) (PCFT Monthly Indicative) (Quality Premium) (Locally stretched target)	Jeff Schryer	✗	✓	✗	M	CCG	May-16	1.41%	1.27%												1.27%
E.H.1	People that wait 6 weeks or less from referral to entering course of IAPT treatment against the number of people who finish a course of treatment. (HSCIC)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	Apr-16	75.0%													
E.H.1.i	People that wait 6 weeks or less from referral to entering course of IAPT treatment against the number of people who finish a course of treatment. (PCFT)	Mental Health Usman Darsot	✗	✗	✓	M	CCG (PCFT)	May-16	75.0%	61.2%												61.2%
E.H.2	People that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment. (HSCIC)	Mental Health Usman Darsot	✗	✗	✓	M	CCG (PCFT)	Apr-16	95.0%													
E.H.2.i	People that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment. (PCFT)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	May-16	95.0%	96.5%												96.5%
QP8-Ip2	Increase in the number of patients with Long Term Conditions referred to IAPTS	Long Term Conditions Usman Darsot	✗	✗	✗	M	CCG	May-16	45	127												127
QP8-Ip2i	Increase in the number of patients with medically unexplained physical symptoms referred to IAPTS	Long Term Conditions Usman Darsot	✗	✗	✗	M	CCG	May-16	1.67	51												134
QP4	Mental Health: Reduction in number of people with severe mental health illness who are smokers (Indicative Local Data - Primary Care)	Mental Health Usman Darsot	✗	✗	✗	M	CCG	Apr-16	58.0%													
C3.17-QP5	Mental Health: Increase in the proportion of adults with secondary mental health conditions who are in paid employment	Mental Health Usman Darsot	✗	✗	✗	Q	CCG	Q1 - 16/17	2.30%													
	Early Intervention in Psychosis Waiting Times																					
E.A.S.1-C2.13	Estimated diagnosis rate for people with dementia (indicative)	Mental Health Usman Darsot	✗	✗	✓	M	CCG	May-16	66.7%	79.7%												79.7%
E.B.S.3	Mental Health: Care Programme Approach	Mental Health Usman Darsot	✓	✗	✗	M	CCG	May-16	95.0%	77.8%												22.2%