Governing Body

25 January 2017

Details	Part 1	**Yes**	Part 2	**No**	Agenda Item No.	**9**
Title of Paper:	Performance Report					
Board Member:	Margaret O'Dwyer, Director of Commissioning and Business Delivery					
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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 October 2016 (current period).

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

Of the indicators presented in the dashboards within Appendices A, B and D, the following are currently reported as underachieving:

- A&E waiting times : 4 hour waits (E.B.5-QPC4);
- Cancer 62 day waits: NHS screening referral (E.B.13);
- Ambulance : Category A (Red 1) 8 minutes (E.B.15.i – QPC6);
- Ambulance : Category A (Red 2) 8 minutes (E.B.15.ii);
- Ambulance : Category A 19 minutes (E.B.16);
- Ambulance Handover > 30 minutes (E.B.S.7.i);
- Ambulance Handover > 60 minutes (E.B.S.7.ii);
- Mixed sex accommodation breaches (E.B.S.1);
- Cancelled Operations (28 day guarantee) : PHAT (E.B.S.2.ii); and
- Trolley Waits in A&E : over 12 hours (E.B.S.5).

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

To deliver improved outcomes and reduce health inequalities for patients through better preventative strategies			**X**
To deliver service re-design in priority areas through innovation			
To develop primary care to become excellent and high performing commissioners			
To develop the CCG leadership to work with the Local Authority to be excellent integrated commissioners			
To develop robust and effective working relationships will all stakeholders and partners to drive integrated commissioning			
To deliver long term financial sustainability through effective commissioning and innovative investment across the wider system			
To develop and influence the provider landscape through development of a Locality Care Organisation (LCO)			
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 October 2016 (current published data), whilst also reflecting the cumulative year-to-date position. Where available, recovery trajectories are also included in the report.

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 Performance Committee and Governing Body as appropriate.

3.0 Performance Summary

3.1 From the position reported in December 2016 (September 2016 data), the CCG continues to report full achievement of the performance, for each month year to date, in the following areas:

- 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);
- Urgent Operations Cancelled for a second time (E.B.S.6).

3.2 The following indicator has returned to full performance in October, having experienced a breach during September:

- Cancer 62 day waits: first definitive treatment following Consultant decision to upgrade priority (E.B.14).

3.3 Of particular note, achievement was reached against the following indicators during October:

- **Referral to Treatment (RTT): Incomplete Patients Waiting >18 Weeks (E.B.3-QPC3)**

3.4 Following two months of underachievement for this indicator, the Bury CCG position has recovered in October 2016 with performance at 92.3% against a 92% target and the Year to Date (YTD) figure is now 92.6%, as shown below:

Indicator	Period	Period Target	Aug	Sep	Oct		YTD
E.B.3-QPC3	Oct-16	92.0%	91.8%	91.4%	92.3%		92.6%

3.5 Data for Pennine Acute Hospitals Trust (PAHT) shows performance hitting the 92% constitutional target once again in October though this remains below the recovery trajectory set by PAHT, as shown below:

Target 92%	Q1 (Avg)	Jul-16	Aug-16	Sept-16	Q2 (Avg)	Oct-16	Nov-16 (at 27/11)	Dec-16 (at 18/12)
Performance (Trajectory) - PAHT	**94.12%**	92.88%	92.88%	92.96%	**92.91%**	93.06%	93.06%	93.06%
Performance (Actual) – PAHT	**94.03%**	92.36%	92.03%	92.06%	**92.15%**	92.1%	92.04%*	91.9%*

**Provisional figures taken from the PAHT NE Sector Elective Care Tactical Performance Group pack for week ending 18th December. These figures are provisional and are a partial month position.*

3.6 PAHT has indicated confidence in sustaining overall achievement of the constitutional target, both during the remainder of 2016/17 and into 2017/18.

3.7 The main pressure areas experienced by PAHT across recent months continue to be in the following specialities:

3.8 **Speciality**	**Steps Taken / Assurance**
Gastroenterology	• Unvalidated back-log numbers for both admitted & non-admitted pathways have reduced. • PAHT reported a high level of confidence in early November that Gastro has been recovered. This position was reiterated during the PAHT contract meeting at the end of November. • Recovery of the RTT Gastro position has always been linked to the achievement of the Diagnostic target and this was met during October. • Achievement of diagnostic target will allow workforce emphasis to be brought to the front end of the pathway. • A Business Case is being developed to further increase the Consultant Gastroenterologist establishment at PAHT.
Trauma & Orthopaedics (T&O)	• Additional locum support has been secured. • Business case for additional Clean Air Theatre for FGH has been approved for Q4 and should be in place for the start of 2017/18. This will support the move of elective Arthroplasty from ROH to FGH which has in part become necessary due to trauma procedures resulting in the cancellation of some elective work at ROH. • PAHT focus has moved from Gastro to T&O. • Internal review taking place into recovery trajectory for T&O and a new plan is awaited. • November updates suggest the T&O waits are increasing, particularly around admitted RTT timeframes. • Extra sessions have been requested though only taken up by middle grades, locum and the Clinical Director. • Clinics are being converted to operating lists where possible. • Capacity is being sought from the private sector, though approval

	to proceed not yet received. • It is possible that the position will not be recovered before summer 2017. • PAHT has commissioned Dr Foster to implement the "My Practice" module which will highlight differing practices between T&O Consultants.
General Surgery / Colorectal	• Inpatient and day case backlog relates mostly to laparoscopic cholecystectomy and hernias (both incisional and inguinal). • A new Consultant has been recruited and extra theatre capacity has been created. • Laparoscopic and Hernia repair patients are to be moved to RI to meet capacity issues across PAHT sites. Further detail from PAHT is awaited regarding the pathway that has been implemented. • Operating lists are reviewed weekly by Directorate Manager. • An invite process to be implemented by booking & scheduling team to reduce DNA rate. • Compliance is expected by Quarter 4 though PAHT have raised some risks around this. • Identified workforce issues are being dealt with internally.
Urology	• PAHT Urology performance is improving and a new Directorate Manager is now place. • A position statement relating to 18 weeks and diagnostic performance for Urology is awaited. • Full achievement continues to be expected by March 2017.
Oral Surgery (Adults)	• Measures are in place to alleviate capacity issues that have been developing mainly in relation to surgery: o 7 extra clinics added in October & 6 in November (240 slots). o 115 additional surgical slots added Oct-Nov. • Process in place so that capacity & potential RTT breaches are escalated. • Additional sessions also to be added in December and full achievement expected by the end of Quarter 4.

3.9 PAHT has undertaken a comparison of GP and GDP referrals, comparing April to October for 2015 and 2016. Significant increases have been identified for Urology and General Surgery. Work is being undertaken to understand the reasons for the increases, including how many of these translated into first outpatient attendances.

3.10 To ease the impact of winter pressures on RTT, Day Case Unit hours will be extended at Rochdale Infirmary and options for ring fencing elective capacity at Fairfield General Hospital are currently being explored.

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

3.11 Achievement by Bury CCG against the diagnostic 6 week indicator is noted in October for the first time during the current financial year, with performance at 1.0% against the same target. The YTD position has improved to 4.6%, as shown below:

Indicator	Period	Period Target	Aug	Sep	Oct		YTD
E.B.4	Oct-16	1.0%	7.1%	4.7%	1.0%		4.6%

3.12 Within PAHT, the overall performance recorded in October for diagnostic tests taking place <6 weeks was 99.2%, with 99.3% achievement at a CCG level.

3.13 Unvalidated data received from PAHT indicates that the target was also achieved during November 2016, as shown in the table below.

3.14 Progress against this target will continue to be monitored closely to ensure performance is now maintained, particularly as improved performance has been in the context of capacity being sought from other providers of care. Contracts with these providers have been put in place until the end of March 2017.

3.15 A summary of PAHT performance against the Diagnostics recovery trajectory is shown below:

6 Weeks Diagnostic Trajectory

Target 1%	Q1 (Avg)	Jul-16	Aug-16	Sep-16	Q2 (Avg)	Oct-16	Nov-16
Performance (Trajectory) - PAHT		5.82%	5.87%	6.69%		0.99%	0.99%
Performance (Actual) - PAHT	**4.34%**	8.59%	9.23%	5.44%	**7.73%**	0.76%	0.73%*

**Unvalidated data for November taken from PAHTs CCG Performance Pack distributed on 21/12/2016.*

National Updates

3.16 As part of the planning round for 2017/18, new and updated targets are currently being reviewed and these will be reported against from the start of the new financial year.

3.17 With regard to mental health performance, NHS Trusts will be expected to start to collect data from April 2017 to support the introduction of waiting time targets for patients experiencing emergency mental health crisis, whether that be via A&E services or on a hospital ward. Targets against which these will be measured will be introduced at a later date.

Local Updates

3.18 Local performance is as outlined in the report. Where a trajectory has been provided by a provider to recover from under-performance, a comparison between this and the actual performance is provided. Where possible, a rolling three month view of data will be displayed within the body of the report to support comparison with data from the previous two months.

3.19 The recovery trajectories referred to in the paragraph above, provided by both Pennine Acute Hospitals Trust (PAHT) and Pennine Care Foundation Trust (PCFT), can be seen at Appendix C.

3.20 The Greater Manchester (GM) Cancer Access Policy has now been adopted by all GM CCGs and it is envisaged that changes will result in improved and more consistent performance. The changes are shown in Appendix E.

Performance Dashboard

3.21 The performance dashboard shown in Appendix A 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 / Five Year Forward View 'Must Dos'

3.22 The following areas, as included in the dashboards at Appendix A and Appendix D, have underachieved against the required standard for the reporting period:

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

3.23 PAHT failed the 95% A&E (4 hour wait) target in October 2016 with performance reported at 81.6% across all PAHT hospital sites and performance specific to Fairfield General Hospital reported slightly higher at 83.1%. The YTD position to the end of October also remains under target at 84.6%.

Indicator	Period	Period Target	Aug	Sep	Oct		YTD
E.B.5 QPC4	Oct-16	95.0%	87.1%	84.7%	81.6%		84.6%

3.24 The unpublished position for November 2016 shows a drop in performance at 79.5% with December showing 84.4% against the 95% target.

3.25 Performance for the YTD to the end of December 2016 is 4.3% lower than the same YDT position in 2015/16 whilst activity across all sites is 0.99% higher for the same YTD comparison.

Target: 95%		**Q1 2016**	**Q2 YTD**	**Oct 2016**	**Nov 2016**	**Dec 2016**	**Q3 YTD**	**YTD 16/17** ***To Dec***	**YTD 15/16** ***To Dec***	**Variance**
FGH	Attend.	**16,421**	**16,574**	5,587	5,181	16,574	**16,492**	**49,487**	**47,600**	1,887
	Perf.	**84.64%**	**84.32%**	83.14%	79.31%	84.32%	**79.67%**	**83.69%**	**85.96%**	-2.6%
NMGH	Attend.	**24,534**	**23,878**	8,532	8,143	23,878	**25,195**	**73,607**	**74,173**	-566
	Perf.	**77.71%**	**76.95%**	77.30%	73.30%	76.95%	**73.42%**	**76.83%**	**84.81%**	-9.4%

RI	Attend.	**12,808**	**12,290**	4,158	3,813	12,290	**12,405**	**37,503**	**39,299**	-1,796
	Perf.	**97.88%**	**96.65%**	97.04%	97.98%	96.65%	**97.17%**	**97.33%**	**98.24%**	-0.9%
ROH	Attend.	**25,941**	**26,118**	8,841	8,419	26,118	**26,147**	**78,206**	**75,391**	2,815
	Perf.	**87.98%**	**85.46%**	77.58%	77.27%	85.46%	**77.41%**	**84.41%**	**86.20%**	-2.1%
PAHT Overall	Attend.	**79,704**	**78,860**	27,118	25,556	78,860	**80,239**	**238,803**	**236,463**	2,340
	Perf.	**85.72%**	**84.39%**	81.62%	79.51%	84.39%	**79.68%**	**83.95%**	**87.72%**	-4.3%

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

3.26 In the table below, A&E performance for PAHT is compared to that of other acute trusts across Greater Manchester where aggregated figures are shown for Quarter 1, Quarter 2, Quarter 3 and the Year to Date for 2016/17 (to end of December).

3.27 The Trusts are ordered by their YTD performance.

Trust	**Q1**	**Q2**	**Q3**	**YTD (to end Dec)**
Central Manchester	93.63%	92.98%	91.01%	93.48%
Wrightington, Wigan & Leigh	92.30%	91.20%	83.54%	89.02%
Salford Royal	92.20%	87.80%	83.55%	87.75%
Tameside	90.40%	86.00%	82.31%	86.23%
UHSM (Wythenshawe)	76.85%	90.80%	86.72%	84.78%
Pennine Acute	85.72%	84.39%	79.68%	83.95%
Bolton	82.30%	85.00%	79.87%	82.39%
Stockport (Stepping Hill)	82.10%	76.70%	75.32%	78.04%

3.28 NHS Bury CCG continues to work with PAHT, as part of the North East Sector (NES) Urgent Care Delivery Board, to support the delivery of the indicator, which is reflected on the CCG's Corporate Risk Register with an assessed score of level 16.

3.29 PAHT had submitted a trajectory to the CCG and NHS Improvement which outlines increased improvement month on month until the 95% target is achieved by March 2017, though more recently has advised that it is highly unlikely that this will be achieved.

3.30 Indicative performance against the trajectory is shown below and includes provisional data for November and December.

Target 95%	**Q1**	**Jul-16**	**Aug-16**	**Sept-16**	**Q2**	**Oct-16**	**Nov-16 *prov***	**Dec-16 *prov***	**Q3**
Perf (Trajectory) - PAHT	**84.4%**	87.1%	86.5%	88.9%	**87.5%**	89.3%	89.5%	86.9%	**87.5%**
Perf (Actual) - PAHT	**85.7%**	81.6%	86.7%	84.7%	**84.2%**	81.6%	79.5%	84.4%	**79.7%**

3.31 The table above shows that performance has fallen below the recovery trajectory each month since September 2016. This has triggered the Greater Manchester (GM) threshold for tripartite meetings between GM Health and Social Care Partnership, NHS Improvement and the local CCG for each relevant hospital site. For example, both North Manchester CCG and Oldham CCG have been invited to meetings though this has not been the case for Bury CCG as FGH has performed at a higher level.

3.32 The CCG also remains committed to supporting the implementation of actions arising from NHS Improvement work undertaken in January 2016 (formerly Trust Development Agency and the Elective Care Intensive Support Team (ECIST)), the recommendations of which

have contributed to a number of PAHT schemes. The successor to ECIST, the Emergency Care Improvement Programme (ECIP), has been re-engaged by PAHT and is working with the Trust and partners.

3.33 PAHT continues to work with the PMO, NHS institute and CCGs on Urgent care pathway flow improvement for the following four drivers:

- matching urgent care workforce capacity and capability to demand;
- creating a sustainable emergency village;
- improving internal patient flow; and
- improving effectiveness of community and primary care.

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

3.35 The new Salford Management Team at PAHT has identified ED recovery (along with financial sustainability and quality implications raised from the CQC visit) as its three short term immediate priorities. It is keen to implement new arrangements at pace to support flow through the hospital. The discharge element of the pathway has a particular focus with initiatives such as Trusted Assessor, simple discharge process and documentation being prioritised with partners.

3.36 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.

3.37 The GM Health and Social Care Partnership has identified some additional non-recurrent funds to support urgent care resilience over winter, of which a proportion has been identified for the North East Sector. System-wide proposals have been agreed by GM and are being mobilised.

- **Cancer 62 day waits : first definitive treatment – NHS Screening Referral (E.B.13)**

3.38 Bury CCG achieved all cancer measures during October with the exception of the Cancer 62 day waits following NHS screening referrals indicator for which performance was 85.7% in October 2016 against a target of 90%. Under-performance was noted also in September, as shown below:

Indicator	Period	Period Target	Aug	Sep	Oct		YTD
E.B.13	Oct-16	90.0%	100%	75%	85.7%		87.2%

3.39 There had been 7 treatments as a result of screening referrals during October for Bury patients. Of these, there was 1 breach during the month.

3.40 PAHT is scheduling a meeting with the national team and will subsequently develop a Recovery Plan for this measure.

3.41 Of note, the Bowel Screening Programme is scheduled to take place from January to April 2017.

- **Ambulance Measures**

3.42 There are three ambulance indicators against which NWAS is measured under the NHS Constitution:

- **Ambulance : Category A (Red 1) 8 minutes (E.B.15.i-QPC6)**
- **Ambulance : Category A (Red 2) 8 minutes (E.B.15.ii)**
- **Ambulance : Category A 19 minutes (E.B.16)**

3.43 A summary of NWAS performance against these measures for the last three months is shown below and this demonstrates continued underperformance across all measures for both October and the YTD position.

Indicator	Period	Period Target	Aug	Sep	Oct	YTD
E.B.15.i-QPC6 Red 1	Oct-16	75.0%	72.6%	69.5%	64.6%	71.5%
E.B.15.ii Red 2	Oct-16	75.0%	65.2%	61.7%	63.1%	64.6%
E.B.16 19 mins	Oct-16	95.0%	91.1%	89.0%	88.2%	90.4%

3.44 The position of under-achievement is repeated nationally though despite this poor performance, NWAS remains in the top quartile of ambulance trusts with regards to performance.

3.45 Breaking October performance down a little further, the following table also includes the position for both Greater Manchester and the individual North East Sector CCGs.

3.46 The breakdown shows underachievement in most circumstances though does also show the Red 1 target being met for North Manchester CCG in October.

Month	Region	Red 1 (8 mins) *Tar 75%*	Red 2 (8 mins) *Tar 75%*	19 Mins *Tar 95%*
October	NWAS (overall)	64.59%	63.05%	88.23%
	Greater Manchester	66.09%	62.07%	87.17%
	Bury CCG	***67.27%***	***60.53%***	***84.21%***
	HMR CCG	*69.51%*	*60.15%*	*85.87%*
	North Manchester CCG	*79.25%*	*69.37%*	*88.43%*
	Oldham CCG	*73.12%*	*60.81%*	*88.14%*

3.47 Although the table above shows Red 1 performance for Bury CCG lower than that of other CCG areas, the gap is smaller than that noted in the previous report where performance for Bury had been 56%. A rationale for this performance is awaited from the Lead Commissioner.

3.48 As part of the 2016/17 CQUIN initiative, NWAS carried out further analysis of the Red indicator performance and presented outcomes to the Strategic Partnership Board on 6th October. The conclusions reached were that the following items have had a negative impact on performance:

- Increased handover times (average has increased to 34 mins for 2016/17);
- Increase in activity (overall NWAS activity for the YTD is 9.6% above plan for the three measures. For Bury, the YTD position is 11% above plan;
- Hospital diversions;
- Clinical Pathways; and
- Lack of alternative dispositions.

3.49 To address the performance issues further, NWAS has attended county level Urgent & Emergency Care Network meetings in Greater Manchester, Mersey and Lancashire.

3.50 This has resulted in revised performance forecasts for the three NHS Constitution Measures which take extended Quarter 3 and Quarter 4 turnaround projections into account. There are three variations of the projections based on a turnaround time of 30 minutes (planned turnaround), 34 minutes (current YTD average) and 39 minutes. The forecasts are shown in Appendix E.

3.51 NWAS is working to further develop the following alternative initiatives with a view to improving performance levels:

Initiative	**Notes**
Integrated Virtual Care Hub	• Aims to bring together NWAS with wider Health & Social Care system to deliver integrated service to identify patient needs. • Relies on alignment of 111/999 services. • Pilot underway in Cumbria (since 1st Sept). • Discussions have commenced with BARDOC to define service pilot.
Recruitment (inc international)	• As at 01/10/2016, NWAS (Paramedic Emergency Services) were 4.4% under staffed. • By the end of December, NWAS predicts it will be 30 staff over establishment.
Dispatch on Disposition (DoD)	• Aims to help improve management of demand and allocation of a clinically appropriate response. • DoD element of the Ambulance Response Programme commenced on 04/10/2016.
Use of VAS	• Deploys additional transporting vehicles from voluntary/private providers (23 vehicles per day currently). • Plan to decrease use as vacancies are filled.
Paramedic Pathfinder tool	• Allows clinicians to determine most appropriate care pathway. • Approx 6000 patients per month now referred to GP rather than taken to A&E.
Focus on Acute Visiting Service (AVS)	• Bespoke GP response in 31 of 33 CCGs. • Over 100,000 referrals since launch in 2013. • NWAS now referring approx. 6000 patients per month. • National Audit Office & Kings Fund data suggests over 43,000 bed days avoided.
Handover workshops	• Working with NHSI and ECIP re growing issue of handover delays. • NWAS has attended workshops in each cluster in attempt to reduce handover times back to 2014 levels.

Twice weekly telecom	• Internal calls led by Director of Operations or deputy. • Action plan reviewed on Thursday call.
Increase effectiveness of Community First Responders (CFRs)	• CFR effectiveness reports reviewed during calls.
MPDS Version 13	• Latest software version applied 31/10/2016. • New version assists with quicker identification of critical calls and faster trigger to pre-arrival instructions. • Expected to have a slight impact on performance though too early to say. Bigger impact likely to be on patient experience.
111 to 999 Reduction	• Migration to full 111 contract has resulted in large increase in ambulance response due to application of NHS Pathways tool to patients previously managed by OOH. • 12% of 111 patients result in 999 incident (mainly early evening & weekend mornings).

3.52 If changes, including the above, are not implemented, NWAS may not meet the performance standards for 2016/17.

3.53 In terms of local action and additional investment made, Bury CCG has implemented the following in order to ease the pressures on NWAS:

Initiative	**Detail**
Winter Transport Scheme	Using System Resilience Group monies to implement the winter transport scheme to ease pressure.
Alternative to Transport Scheme	Allows NWAS crew to ring BARDOC for GP advice as an alternative to conveying the patient to A&E.
Green Car Scheme	This scheme now covers Whitefield in addition to Radcliffe. Bury CCG is in discussion with NWAS about adding a second car to the scheme and this would allow one car to be allocated to the North of the borough and one to the South.

3.54 Bury CCG has invited Blackpool CCG to the next Urgent Care work stream meeting in order to specifically discuss NWAS performance for Bury. Confirmation of attendance is awaited.

3.55 In addition to the above initiatives, NWAS sees the reduction of hospital handover times to the specified 30 minutes as crucial to success. This is considered further in the section below.

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

3.56 The Ambulance Handover figures are reported from a PAHT perspective. There were 430 handover delays in this category reported in October 2016. This represents 7.9% of the total handovers (where all timestamps are present) for this month at PAHT.

3.57 The 430 handover delays are broken down to 28 at Fairfield, 199 at Royal Oldham and 201 at North Manchester GH. These figures are also displayed in the table in the section below along with the handover delays that are greater than 60 minutes.

3.58 Early data available for November shows a further deterioration with 459 handover delays >30 minutes.

3.59 Actions developed by PAHT to improve patient throughput in A&E are expected to have a positive effect on the ambulance handover performance.

3.60 Reducing ambulance turnaround times has been identified as a key priority in the context of the wider Emergency Care Improvement Plan and associated work to improve patient flow. Progress and output from this is monitored by the Urgent Care Improvement Board.

Indicator	Period	Period Target	Aug	Sep	Oct	Nov		YTD
E.B.S.7.i	Oct-16	0	292	329	430	459		2778

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

3.61 There were 260 delayed handovers (PAHT level) of greater than 60 minutes during October 2016, which represents 4.8% of total handovers at PAHT (where timestamps are present).

Indicator	Period	Period Target	Aug	Sep	Oct	Nov		YTD
E.B.S.7.ii	Oct-16	0	87	156	260	241		1328

3.62 A summary of performance levels across the PAHT hospital sites for the ambulance handover measures is included below and demonstrates that both North Manchester GH and Royal Oldham were outliers within Greater Manchester during October:

Hospital Site	Handover Delays (30-60 mins)	% of total handovers (where both timestamps exist)	Handover Delays (>60 mins)	% of total handovers (where both timestamps exist)
Fairfield	28	1.7%	9	0.6%
NMGH	201	12.1%	105	6.3%
Royal Oldham	199	9.3%	146	6.8%
PAHT Total	430	7.9%	260	4.8%
GM Comparison	1611	8.4%	854	4.4%

- **Mixed Sex Accommodation Breaches (E.B.S.1)**

3.63 There were 4 breaches reported in October 2016 for Bury CCG patients, with each occurring at North Manchester General Hospital (NMGH).

Indicator	Period	Period Target	Aug	Sep	Oct		YTD
E.B.S.1	Oct-16	0	3	7	4		21

3.64 The breakdown by specialty for these breaches noted in October is shown below:

Month	Speciality	No of Breaches
October	General Surgery	3
	General Medicine	1

3.65 At a PAHT level, there were 19 breaches reported for the same period, all of which related to North East Sector CCG patients.

- **Cancelled Operations (28 day guarantee) PHAT (E.B.S.2.ii)**

3.66 PAHT has reported 4 breaches to this indicator during October 2016, taking the YTD figure to 32, as shown below. None of these breaches noted in October related to Bury CCG patients.

Indicator	Period	Period Target	Aug	Sep	Oct		YTD
E.B.S.2.ii	Oct-16	0	5	4	4		32

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

3.67 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).

3.68 Any patient who remains within A&E following the above criteria being satisfied, for a period of 12 hours or more, is classed as a breach.

3.69 October saw an increase in the number of trolley waits. Of breaches at PAHT during the month, 14 of these related to Bury CCG patients.

3.70 PAHT attributes the increase in breaches during October to high levels of demand coupled with increased acuity in October which was compounded by the impact of delayed transfers of care, continued pressures with capacity and demand for bed stock and continued challenges regarding medical staffing.

3.71 The Decision to Admit Policy has not yet been implemented in full due to pressures in the current system.

3.72 Procedures are in place to ensure that patients comfort and nutritional needs are met.

3.73 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.

Current Areas of Underperformance against Mental Health Indicators

3.74 As can be seen in the Mental Health dashboard at Appendix B, achievement was noted against all four IAPT measures during September 2016 for the first time during the current financial year.

3.75 Indicative data from PCFT also shows the IAPT measures being achieved in October 2016 and it is anticipated that this will remain the case once NHS Digital data becomes available for October as there is now less discrepancy between the PCFT data (primary and refresh) and the NHS Digital published data.

3.76 As reported last month, the improvement in the variance between PCFT data and NHS Digital data is mainly due to a change in methodology in the reporting of IAPT measures in that rounding of data will no longer be applied by NHS Digital. As such rounding is believed to have been a contributing factor in the discrepancy between PCFT and NHS Digital reported data, the PCFT data should become more reliable. The impact of this change will be kept under review over the coming months.

3.77 Although achievement has been noted against the IAPT six week wait indicator, with 76.8% achievement in September and PCFT data reporting 80.4% for October against a 75% target, this falls below the 82% target set by PCFT as part of the recovery trajectory. However, primary data supplied by PCFT for November shows the trust performing beyond the improvement trajectory with a figure of 83.2%.

3.78 Performance against the PCFT recovery trajectory for the six week wait indicator is shown below and includes both primary and refresh data from PCFT along with the published data from NHS Digital:

Target 75%	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Improvement Trajectory - PCFT	58.0%	63.1%	64.6%	69.5%	75.2%	82.0%	82.0%	82.0%
Performance - PCFT (primary)	61.0%	59.1%	67.9%	71.3%	73.0%	76.2%	80.4%	83.2%
Performance - PCFT (refreshed)	61.2%	59.9%	67.2%	71.2%	72.5%	76.0%	79.4%	TBC
Performance (Actual) - NHS Digital	58.0%	58.3%	63.8%	68.0%	72.1%	76.8%	TBC	TBC

3.79 PCFT have recently engaged with NHS England with regard to carrying out Capacity and Demand Modelling. PCFT report that early indications suggest they are working with a staff deficit though are working with NHSE and Lancashire Care Partnership to model appropriate services and guide commissioning with regard to investment.

4.0 Recommendations

4.1 The Governing Body is asked to:

- receive the performance report; and
- note the updates provided.

Susan Sawbridge
Performance Manager
January 2016

Appendix A : NHS Constitution Performance Dashboard

NHS Constitution Measures Summary									Period Actual Performance								
Indicator	Description	Workstream & Lead	QP	Nat Must Do's	F	Monitored Org	Period	Period Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	YTD
E.B.3-QPC3	Referral To Treatment: Incomplete patients waiting 18 weeks or later	Elective Care Cath Tickle	✓	✓	M	CCG	Oct-16	92.0%	94.2%	93.6%	92.8%	92.3%	91.8%	91.4%	92.3%		92.6%
E.B.4	Diagnostic test waiting times (6 weeks waits)	Elective Care Cath Tickle	✗	✓	M	CCG	Oct-16	1.0%	4.7%	4.0%	3.9%	6.6%	7.1%	4.7%	1.0%		4.6%
E.B.5-QPC4	A&E waiting time (4hr waits) (PAHT ALL)	Urgent Care David Latham	✓	✓	M	PAHT	Oct-16	95.0%	85.8%	86.5%	84.8%	81.6%	87.1%	84.7%	81.6%		84.6%
E.B.6-QPC5	Cancer 2 week waits: GP Referral for suspected cancer	Cancer David Latham	✗	✓	M	CCG	Oct-16	93.0%	93.2%	96.0%	94.5%	95.1%	93.5%	94.8%	95.6%		94.6%
E.B.7	Cancer 2 week waits: Urgent referral for breast symptoms where cancer was not initially suspected	Cancer David Latham	✗	✓	M	CCG	Oct-16	93.0%	94.9%	93.6%	92.6%	77.8%	69.0%	92.0%	94.9%		89.0%
E.B.8	Cancer 31 day waits: First definitive treatment within 1 month of diagnosis	Cancer David Latham	✗	✓	M	CCG	Oct-16	96.0%	96.3%	100.0%	98.7%	98.3%	96.4%	97.0%	96.0%		97.4%
E.B.9	Cancer 31 day waits: Subsequent cancer treatment - Surgery	Cancer David Latham	✗	✓	M	CCG	Oct-16	94.0%	100.0%	100.0%	91.7%	85.7%	90.0%	100.0%	100.0%		94.8%
E.B.10	Cancer 31 day waits: Subsequent cancer treatment - Anti cancer drug regimens	Cancer David Latham	✗	✓	M	CCG	Oct-16	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
E.B.11	Cancer 31 day waits: Subsequent cancer treatment - Radiotherapy	Cancer David Latham	✗	✓	M	CCG	Oct-16	94.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	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	Oct-16	85.0%	81.6%	91.3%	84.6%	77.1%	79.2%	91.1%	85.7%		84.7%
E.B.13	Cancer 62 day waits: First definitive treatment within 2 months of NHS cancer screening referral	Cancer David Latham	✗	✓	M	CCG	Oct-16	90.0%	85.7%	83.3%	90.0%	100.0%	100.0%	75.0%	85.7%		87.2%
E.B.14	Cancer 62 day waits: First definitive treatment within 2 months of consultant decision to upgrade priority	Cancer David Latham	✗	✓	M	CCG	Oct-16	85.0%	50.0%	90.0%	83.3%	100.0%	100.0%	90.0%	100.0%		87.0%
E.B.15.i-QPC6	Ambulance clinical quality: Category A (Red 1) 8 minute response time	Urgent Care David Latham	✓	✓	M	NWAS	Oct-16	75.0%	76.5%	74.3%	73.1%	70.5%	72.6%	69.5%	64.6%		71.5%
E.B.15.ii	Ambulance clinical quality: Category A (Red 2) 8 minute response time	Urgent Care David Latham	✗	✓	M	NWAS	Oct-16	75.0%	67.5%	66.3%	66.2%	62.7%	65.2%	61.7%	63.1%		64.6%
E.B.16	Ambulance clinical quality: Category A 19 minute transportation time	Urgent Care David Latham	✗	✗	M	NWAS	Oct-16	95.0%	92.0%	91.5%	91.5%	89.8%	91.1%	89.0%	88.2%		90.4%
E.B.S.1	Mixed Sex Accommodation Breaches	Quality Carolyn Trembath	✗	✗	M	CCG	Oct-16	0	1	4	1	1	3	7	4		21
E.B.S.2.i	Cancelled Operations (28 day guarantee) - Quarterly	Elective Care Cath Tickle	✗	✗	Q	PAHT	Q2 - 16/17	0			17			12			29
E.B.S.2.ii	Cancelled Operations (28 day guarantee) - (PAHT Actual Breaches Indicative)	Elective Care Cath Tickle	✗	✗	M	PAHT	Oct-16	0	10	3	3	3	5	4	4		32
E.B.S.3	Mental Health: Care Programme Approach	Mental Health Usman Darsot	✗	✓	M	CCG	Oct-16	95.0%	81.8%	100%	100%	100%	92.9%	100%	100%		96.7%
E.B.S.4	Referral To Treatment: 52 week waits	Elective Care Cath Tickle	✗	✗	M	CCG	Oct-16	0	0	0	0	2	1	0	0		3
E.B.S.5	Trolley waits in A&E (12 hour waits)	Urgent Care David Latham	✗	✗	M	PAHT	Oct-16	0	20	20	31	63	6	36	129		305
E.B.S.6	Urgent operations cancelled for a second time	Elective Care Cath Tickle	✗	✗	M	PAHT	Oct-16	0	0	0	0	0	0	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	Nov-16	0	283	358	277	348	294	329	430	459	2,778
E.B.S.7.ii	Ambulance handover time: delays of over 60 minutes (£1,000 fine per patient)	Urgent Care David Latham	✗	✗	M	PAHT	Nov-16	0	127	117	137	203	87	156	260	241	1,328

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	YTD
E.A.3.i	**IAPT Prevalence** (People entering IAPT services as a % of those estimated to have anxiety/depression) - (HSCIC)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	Sep-16	1.25%	1.30%	1.55%	1.42%	1.12%	1.66%	1.38%			8.42%
E.A.3.ii	**IAPT Prevalence** (People entering IAPT services as a % of those estimated to have anxiety/depression) - (PCFT Monthly Indicative) - Annual target of 15%	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	Oct-16	1.25%	1.27%	1.53%	1.40%	1.08%	1.63%	1.36%	1.25%		9.51%
E.A.S.2.i	IAPT Recovery Rate (Moving to recovery) (HSCIC)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	Sep-16	50.0%	40.79%	56.52%	50.00%	51.06%	51.52%	50.00%			49.74%
E.A.S.2.ii	IAPT Recovery Rate (Moving to recovery) (PCFT Monthly Indicative)	Mental Health Usman Darsot	✗	✗	✗	M	CCG (PCFT)	Oct-16	50.0%	40.96%	55.36%	43.35%	51.32%	50.31%	50.56%	50.93%		48.45%
	IAPT Roll-out (Prevalence) (PCFT Monthly Indicative) (Quality Premium) (Locally stretched target - 17%)	Jeff Schryer	✗	✓	✗	M	CCG	Oct-16	1.41%	1.27%	1.53%	1.40%	1.08%	1.63%	1.36%	1.25%		9.51%
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)	Sep-16	75.0%	57.5%	58.3%	63.8%	68.0%	72.1%	76.8%			65.3%
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)	Oct-16	75.0%	61.2%	59.9%	67.0%	71.2%	72.6%	76.0%	80.4%		68.6%
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)	Sep-16	95.0%	96.3%	97.2%	97.1%	96.0%	97.1%	96.4%			96.7%
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)	Oct-16	95.0%	96.5%	96.7%	97.1%	96.7%	95.5%	97.1%	99.6%		96.9%
QP8-Ip2	Increase in the number of patients with Long Term Conditions referred to IAPTS	Long Term Conditions Usman Darsot	✗	✗	✗	M	CCG	Oct-16	45	155	143	92	121	115	123	93		842
QP8-Ip2i	Increase in the number of patients with medically unexplained physical symptoms referred to IAPTS	Long Term Conditions Usman Darsot	✗	✗	✗	M	CCG	Oct-16	1.67	81	102	38	80	70	57	64		492
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		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		2.30%									
	Early Intervention in Psychosis Waiting Times	Mental Health Usman Darsot	✗	✗	✓	M	CCG	Oct-16	50.00%	50.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%		96.00%
E.A.S.1-C2.	Estimated diagnosis rate for people with dementia (indicative)	Mental Health Usman Darsot	✗	✗	✓	M	CCG	Oct-16	66.7%	79.7%	80.3%	79.9%	80.0%	80.7%	80.7%	80.3%		80.3%
E.B.S.3	Mental Health: Care Programme Approach	Mental Health Usman Darsot	✓	✗	✗	M	CCG	Oct-16	95.0%	81.8%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%		96.7%

Appendix C : Recovery Trajectories

Pennine Acute Hospital Trust

A&E 4 hours

Target 95%	Apr-16	May-16	Jun-16	Q1	Jul-16	Aug-16	Sep-16	Q2	Oct-16	Nov-16 *Prov*	Dec-16	Q3	Jan-17	Feb-17	Mar-17
Performance (Trajectory) - PAHT	83.4%	84.3%	85.5%	84.4%	87.1%	86.5%	88.9%	87.5%	89.3%	89.5%	86.9%		91.3%	93.6%	95.6%
Performance (Actual) - PAHT	85.8%	86.5%	84.8%	85.7%	81.6%	86.7%	84.7%	84.2%	81.6%	79.6%					

Cancer 62 Days Trajectory

Target 85%	Apr-16	May-16	Jun-16	Q1	Jul-16	Aug-16	Sep-16	Q2	Oct-16	Nov-16	Dec-16	Q3	Jan-17	Feb-17	Mar-17
Performance (Trajectory) - PAHT	85.25%	85.44%	85.02%	85.23%	85.22%	85.36%	85.07%	85.21%	85.02%	85.32%	85.14%		85.07%	85.21%	85.29%
Performance (Actual) - PAHT	86.55%	90.87%	77.82%	84.83%	83.70%	87.78%	83.56%	85.93%	81.86%						

6 Weeks Diagnostic Trajectory

Target 1%	Apr-16	May-16	Jun-16	Q1 Avg	Jul-16	Aug-16	Sep-16	Q2	Oct-16	Nov-16	Dec-16	Q3	Jan-17	Feb-17	Mar-17
Performance (Trajectory) - PAHT	4.98%	5.82%	5.82%	5.54%	5.82%	5.87%	6.69%		0.99%	0.99%	0.99%		0.99%	0.99%	0.99%
Performance (Actual) - PAHT	5.00%	3.90%	4.20%	4.37%	8.60%	9.23%	5.445	7.73%	0.76%						

RTT Incomplete Trajectory

Target 92%	Apr-16	May-16	Jun-16	Q1	Jul-16	Aug-16	Sep-16	Q2	Oct-16	Nov-16	Dec-16	Q3	Jan-17	Feb-17	Mar-17
Performance (Trajectory) - PAHT	94.74%	94.73%	92.88%	94.12%	92.88%	92.88%	92.96%	92.91%	93.06%	93.06%	93.06%		92.78%	93.06%	93.42%
Performance (Actual) - PAHT	94.73%	94.10%	93.34%	94.03%	92.36%	92.03%	92.06%	92.15%	92.10%						

Pennine Care Foundation Trust

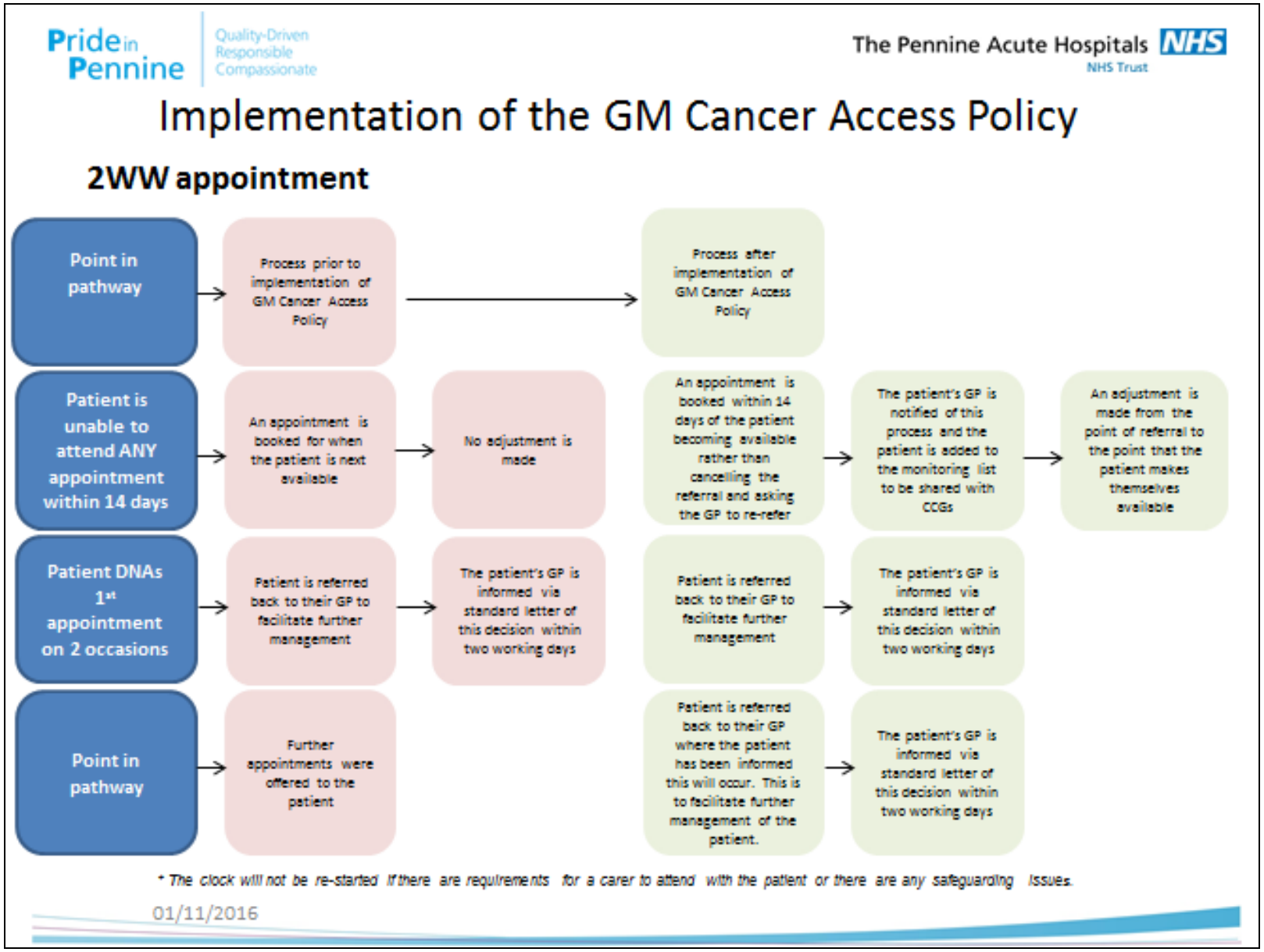
IAPT 6 Weeks

Target 75%	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Performance Trajectory - PCFT	58.0%	63.1%	64.6%	69.5%	75.2%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%
Performance - PCFT (primary)	61.0%	59.1%	67.9%	71.3%	73.0%	76.2%	80.4%	83.2%				
Performance - PCFT (refresh)	61.2%	59.9%	67.2%	71.2%	72.5%	76.0%	79.4%	TBC				
Performance (Actual) - published NHS Digital	58.0%	58.3%	63.8%	68.0%	72.1%	76.8%	TBC	TBC				

Appendix D : Five Year Forward View Must Do

NHS Planning Guidance - 'Must Dos' 2016/17									Period Actual Performance								
Indicator	Description	Indicator description	Workstream & Lead	Constitution Measure	F	Monitored Org	Period	Period Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	YTD
E.B.5-QPC4	Access standards for A&E and Ambulance waits	A&E waiting time (4hr waits) (PAHT ALL)	Urgent Care David Latham	✓	M	CCG	Oct-16	95%	85.8%	86.5%	84.8%	81.6%	87.1%	84.7%	81.6%		84.6%
E.B.15.i-QPC6		Ambulance clinical quality: Category A (Red 1) 8 minute response time	Urgent Care David Latham	✓	M	NWAS	Oct-16	75%	76.5%	74.3%	73.1%	70.5%	72.6%	69.5%	64.6%		71.5%
E.B.15.ii		Ambulance clinical quality: Category A (Red 2) 8 minute response time	Urgent Care David Latham	✓	M	NWAS	Oct-16	75%	67.5%	66.3%	66.2%	62.7%	65.2%	61.7%	63.1%		64.6%
E.B.3-QPC3	Referral to Treatment	Referral To Treatment: Incomplete patients waiting 18 weeks or later	Elective Care Cath Tickle	✓	M	CCG	Oct-16	92%	94.2%	93.6%	92.8%	92.3%	91.8%	91.4%	92.3%		92.6%
E.B.12	62 day cancer waiting standard	Cancer 62 day waits: First definitive treatment within 2 months of urgent GP referral	Cancer David Latham	✓	M	CCG	Oct-16	85%	81.6%	91.3%	84.6%	77.1%	79.2%	91.1%	85.7%		84.7%
E.B.8		Cancer 31 day waits: First definitive treatment within 1 month of diagnosis	Cancer David Latham	✓	M	CCG	Oct-16	96%	96.3%	100.0%	98.7%	98.3%	96.4%	97.0%	96.0%		97.4%
E.B.6-QPC5		Cancer 2 week waits: GP Referral for suspected cancer	Cancer David Latham	✓	M	CCG	Oct-16	93%	93.2%	96.0%	94.5%	95.1%	93.5%	94.8%	95.6%		94.6%
E.B.4		Diagnostic test waiting times (6 weeks waits)	Elective Care Cath Tickle	✓	M	CCG	Oct-16	1%	4.7%	4.0%	3.9%	6.6%	7.1%	4.7%	1.0%		4.6%
		1-year cancer survival for all-cancers combined and for breast, colorectal, and lung cancer	Cancer David Latham	✗	A	CCG	2015	75%	69.7%								69.7%
		Proportion of staged cancers diagnosed early (at stage 1 and 2)	Cancer David Latham	✗	A	CCG	2013/14	n/a	53.1%								53.1%
	Two new Mental Health access standards	Early Intervention in Psychosis Waiting Times	Mental Health Usman Darsot	✗	M	CCG	Oct-16	50.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		96.0%
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)	Sep-16	75%	57.5%	58.3%	63.8%	68.0%	72.1%	76.8%			65.3%
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)	Sep-16	95%	96.3%	97.2%	97.1%	96.0%	97.1%	96.4%			96.7%
E.A.S.1-C2.13		Estimated diagnosis rate for people with dementia (indicative)	Mental Health Usman Darsot	✓	M	CCG	Oct-16	66.7%	79.7%	80.3%	79.9%	80.0%	80.7%	80.7%	80.3%		80.3%

Appendix E : GM Cancer Access Policy

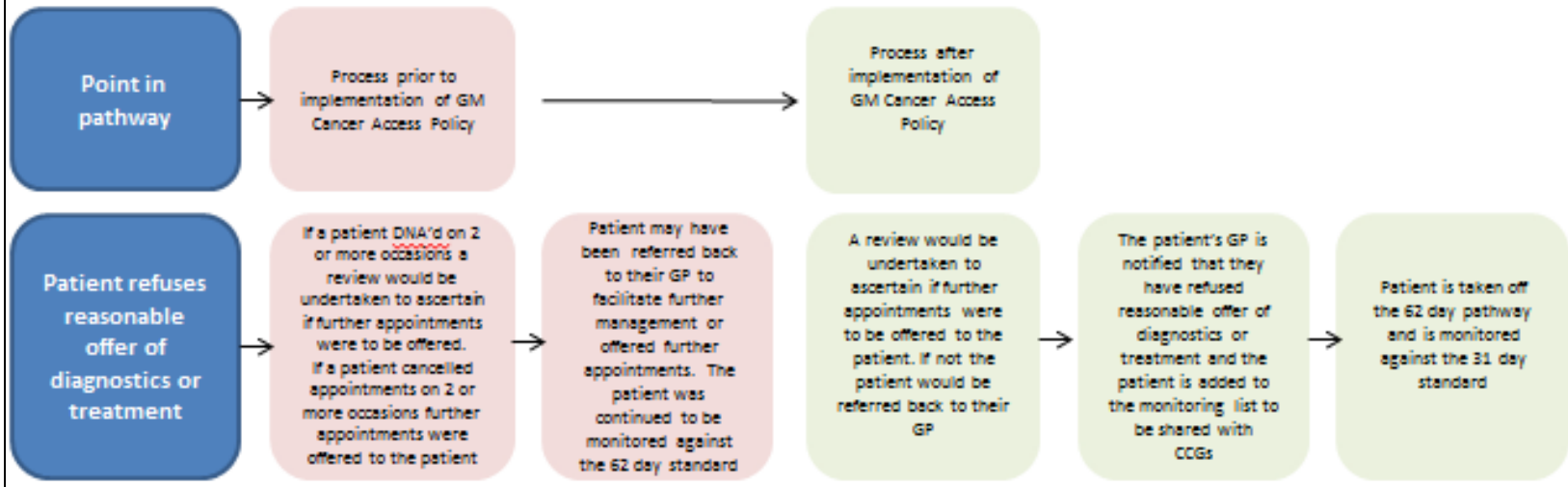


Pride in Pennine | Quality-Driven Responsible Compassionate

The Pennine Acute Hospitals NHS Trust

Implementation of the GM Cancer Access Policy

Patient refuses reasonable offer of diagnostics or treatment



Reasonable offer of diagnostics or treatment is defined as not less than 24 hours' notice.

Refusal of all reasonable offers is defined as:
Any 2 or more DNA of appointments
Any 2 or more occasions where declines and cancellations have caused a delay.

As the 62 day standard waiting times are not applicable to patients who refuse all reasonable offers of diagnostics or treatments these patients will be monitored against the 31 day standard.

01/11/2016