Meeting: Strategic Commissioning Board			
Meeting Date	05 October 2020	**Action**	Receive
Item No	7	**Confidential / Freedom of Information Status**	No
Title	Performance Report		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
Author	Susan Sawbridge, Head of Performance		
Clinical Lead	-		
Council Lead	-		

Executive Summary

The CCG, alongside other CCGs in Greater Manchester, has challenges in achieving the national Constitutional Standards in a number of key areas. This report sets out the current position against a number of the main CCG Performance Indicators along with an overview of the impact to these during the current response to the COVID-19 pandemic. A further, more detailed, report setting out the position on all the indicators is presented to the Quality and Performance sub-committee on a monthly basis and to the Governing Body every two months.

This report also includes a summary of the CCG's COVID-19 Phase 3 activity submission made on 14th September.

Recommendations

It is recommended that the Strategic Commissioning Board:

- Receives this performance update, noting the areas of challenge and action being taken.

Links to Strategic Objectives/Corporate Plan	Choose an
Does this report seek to address any of the risks included on the Governing Body / Council Assurance Framework? If yes, state which risk below:	Choose an item.
Add details here.	

Implications						
Are there any quality, safeguarding or patient experience implications?	Yes	☒	No	☐	N/A	☐
Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report?	Yes	☐	No	☒	N/A	☐

Have any departments/organisations who will be affected been consulted ?	Yes	☐	No	☐	N/A	☒
Are there any conflicts of interest arising from the proposal or decision being requested?	Yes	☐	No	☒	N/A	☐
Are there any financial implications?	Yes	☒	No	☐	N/A	☐
Are there any legal implications?	Yes	☐	No	☒	N/A	☐
Are there any health and safety issues?	Yes	☐	No	☐	N/A	☐
How do proposals align with Health & Wellbeing Strategy?						
How do proposals align with Locality Plan?						
How do proposals align with the Commissioning Strategy?						
Are there any Public, Patient and Service User Implications?	Yes	☒	No	☒	N/A	☒
How do the proposals help to reduce health inequalities?						
Is there any scrutiny interest?	Yes	☒	No	☐	N/A	☐
What are the Information Governance/ Access to Information implications?						
Has an Equality, Privacy or Quality Impact Assessment been completed?	Yes	☐	No	☒	N/A	☐
Is an Equality, Privacy or Quality Impact Assessment required?	Yes	☐	No	☒	N/A	☐
Are there any associated risks including Conflicts of Interest?	Yes	☐	No	☒	N/A	☐
Are the risks on the CCG /Council/ Strategic Commissioning Board's Risk Register?	Yes	☒	No	☐	N/A	☐
Additional details	*NB - Please use this space to provide any further information in relation to any of the above implications.*					

Governance and Reporting		
Meeting	**Date**	**Outcome**
N/A		

1. Introduction

1.1. The purpose of this report is to provide an overview of performance in the key areas of urgent, elective, cancer and mental health care along with an overview of the impact of the COVID-19 response to these areas as the locality moves through the phases of the COVID response.

2. Background

2.1. This paper is a summary of the information presented to the CCG's Quality and Performance Committee in September which related to the published position as at June 2020. However, as some July data has now been published, this too is referenced within this report.

2.2. A summary of NHS Bury CCG's performance against key NHS Constitution standards is shown at Appendix A and this includes a comparison with the Greater Manchester (GM), North West and England averages. The period to which the data relates is included for each metric. This varies across the metrics, firstly because data is published at different times and secondly due to some data collections having been paused as part of the COVID-19 response.

2.3. During this unprecedented period, there will be an impact, both positive and negative, on health care delivery and performance. Although some of the data that allows us to fully understand the impact will not become available for some time, some information has started to be presented and is considered below.

2.4. National planning with regard to the COVID-19 response has been split into three phases. Phase one covered the period March to the end of April, Phase 2 from April to July and Phase three from August through to March 2021.

2.5 Phase 3 guidance set the following as the main areas of focus for localities:

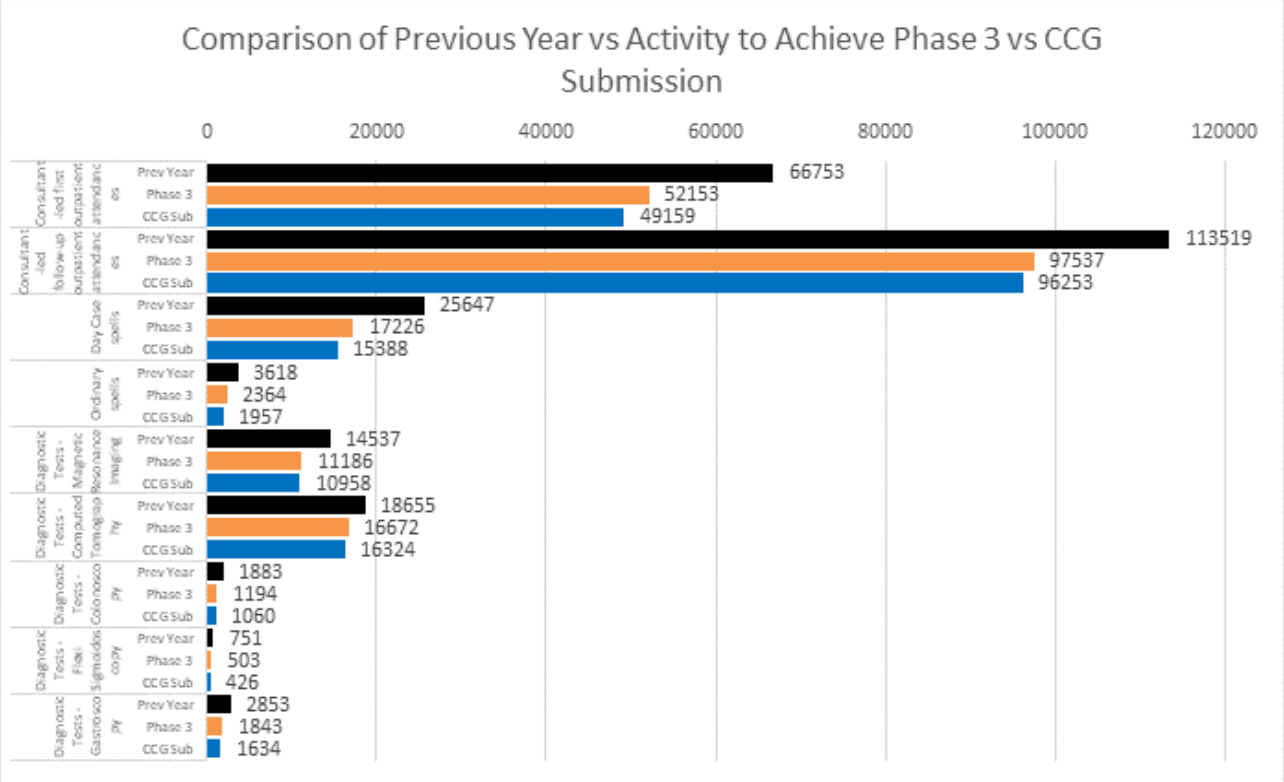
- Accelerate a return to near-normal levels of non-COVID health services, optimising opportunities of available capacity, including the independent sector, between now and the winter period. This includes planning for:
    - Suspected cancer referrals to return to the pre-COVID-19 level;
    - Elective activity to reach 80% of the 2019-20 level in September, rising to 90% in October;
    - Diagnostic activity for Magnetic Resonance Imaging (MRI), Computerised Tomography (CT) and Endoscopy to be at 90% of 2019-20 levels immediately, reaching 100% in October; and
    - Outpatient activity to be at 90% of the 2019-20 level in August, rising to 100% in September.
- Prepare for winter pressures with continued vigilance for COVID spikes; and
- Lock in benefits and lessons learned from the first COVID peak and to tackle challenges such as support for staff and action on inequalities and prevention.

2.6 To support the Phase 3 requirements, both CCGs and NHS acute provider organisations submitted data returns that set out intended activity levels between September 2020 and March 2021. Locally, the Bury return was submitted to the Greater Manchester Health and Social Care Partnership (GMHSCP) for inclusion in

a single Greater Manchester (GM) plan to be submitted on 21st September. The Bury CCG plan was accompanied by a narrative submission outlining the methodology adopted in formulating the plan along with details of some of the schemes to be implemented across the locality to realise the plan.

2.7 As far as possible, the Bury CCG plan is aligned with those of the main local acute providers, particularly the Northern Care Alliance (NCA) organisations. The outcome of this is that in some areas the plans do not reach the ambition of the Phase 3 requirements. However, this should also be seen in the context of CCG and NCA plans reflecting alignment to the recovery programme of the Bury system which, in part, has a focus on reducing demand for secondary care services. This includes the schemes to reform outpatient care delivery as part of the elective care programme.

2.8 The chart below shows a high-level view of Bury's plan against the Phase 3 requirements. The black bar shows the activity levels for 2019-20 against the various points of delivery whilst the orange bar shows the activity level required to meet the Phase 3 requirements with the blue bar showing Bury's plan against this target.



3. Constitutional Standards and COVID-19 Impact Review

Planned (Elective) Care

3.1 In terms of waiting list management, the target changed in April to an expectation that there will be no more patients waiting in January 2021 than there were in January 2020. This sets the target for Bury for there to be no more than 15800 patients waiting to commence treatment by January 2021.

3.2 In June there were 15348 patients waiting, 2.9% lower than there had been in January. This is in the context of demand into secondary care being much lower across Q1 than in previous months (COVID effect). Q4 had also seen waiting list validation take place at both PAHT and SRFT, resulting in some patients being removed from waiting lists. The waiting list had increased to 15973 by the end of July, marking a 1.1% increase on the January 2020 position.

3.3 Bury's Phase 3 plan predicts the waiting list will increase to 19318 by March 2021. If realised, this would be 22.3% above the January 2020 threshold.

3.4 Similarly, Bury's Phase 3 plan shows a significant increase in the number of patients waiting in excess of 52 weeks with a prediction that this figure will reach 982 by March 2021. The June figure stood at 200 for Bury with an increase to 371 noted in July data.

3.5 At the lowest point, GP referrals had reduced by 79% in April when compared to the average for 2019-20. There has since been a month on month increase with referrals in July being 26% below the 2019-20 average and 34% below the July 2019 position.

3.6 Available data also shows a month on month increase in outpatient attendances taking place. In particular, there has been a significant swing towards telephone consultants which accounted for just 2.0% of outpatient contacts in the first 18 weeks of 2019-20 compared to 53.5% for the same period this year.

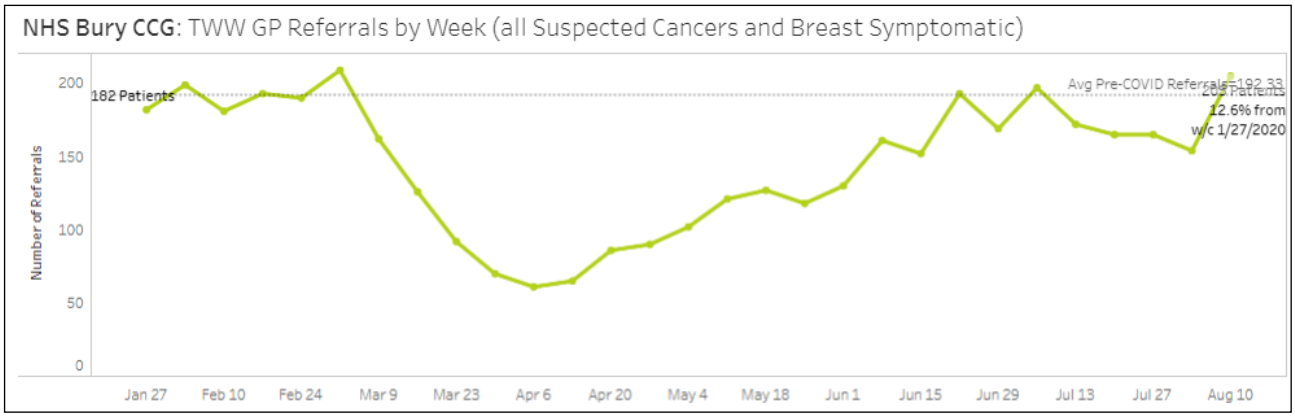
3.7 Restoration of diagnostic services, particularly imaging and endoscopy, is another key requirement of Phase 3 planning. A Single System Management approach across GM is being applied to endoscopy to ensure that capacity is increased and that there is equity in access across GM. Plans include a new mobile endoscopy unit being placed at a PAHT site where the need across GM is considered to be the greatest.

Cancer Care

3.8 During the COVID-19 response period, the system management and oversight of cancer services across GM has been delegated to The Christie NHS FT and a number of cancer treatment hubs have been set up across GM with Rochdale Infirmary being the host for the Surgical Hub.

3.9 Phase 3 guidance is for suspected cancer referrals (2WW) and cancer treatment to be restored to their pre-COVID levels and this ambition has been reflected in the CCG plan.

3.10 Data shows that 2WW referral levels have increased more quickly in Bury than in many other localities. The chart below combines 2WW and 2WW breast symptomatic referral levels for Bury CCG patients with a comparison between week commencing (w/c) 27th January and w/c 10th August. This demonstrates a gradual increase in referrals following the initial decline. There can be fluctuation from week to week though referrals in w/c 10th August are shown to be 12.6% higher than w/c 27th January.



Source: GM Tableau: Cancer > Cancer PTL Metrics > GP referrals by type (taken on 25/08/2020)

3.11 The variance between CCGs for these two given weeks ranges from +12.6% for Bury CCG to -21.4% for Wigan Borough CCG. Across all GM providers, referrals were 9.6% lower in the same reference period.

3.12 In terms of the latest in-month performance, July data shows that all 2WW and 31-day wait standards were achieved in Bury. The main challenge remains with 62 day waits, particularly following GP referral, with diagnostic delays, particularly for endoscopy, being a major factor in this. Risk stratification using the Faecal Immunochemical Test (FIT) is now underway for those patients awaiting a scope procedure and new referral pathways for use across GM have been shared with general practice colleagues.

Urgent Care

A&E Attendances

3.13 At 88.8%, A&E performance at PAHT in June remained below the constitutional standard of 95%. For Fairfield General Hospital (FGH) specifically, performance was 99.8% in June, placing FGH third best Type 1 unit across GM in Q1. Type 1 refers to what might be classed as a 'traditional' A&E department with a full resuscitation facility. In Q2 (to the end of August), FGH was second best with only the children's hospital performing better.

3.14 In terms of A&E attendances, to February 2020 there had been a 7.3% increase in Type 1 attendances at PAHT (7.0% at FGH specifically) when compared to the previous year. The impact of 'lockdown' on 23rd March resulted in the year end increase being 4.7% at PAHT and 4.5% at FGH.

3.15 Moving into 2020-21, there were almost 28,000 fewer Type 1 attendances at PAHT sites between April and August than in the same period of 2019. This equates to a 23.2% decrease with a similar reduction of 24.3% noted for FGH specifically. The PAHT variance at the end of April had been -44.8% (-44.0% at FGH) though a month on month reduction in this variance has been evident since then.

3.16 In terms of daily attendances at FGH, the average between December and February was 212 per day. This dropped to 123 in April before increasing to 152 in May and 173 in June, averaging 149 per day across Q1 as a whole. Moving into

Q2, the average at FGH to the end of August has been 185 per day with attendances exceeding 200 per day having been seen on a number of occasions. This Q2 average of 185 compares to an average of 213 attendances per day in July and August 2019.

Stranded Patients

3.17 A patient is considered to be 'stranded' if their admission to an inpatient bed lasts for seven days or more. The term 'super stranded' relates to those admissions of 21 days or more. Data for this section is sourced from the GMHSCP tableau dashboard.

3.18 Across Q1, PAHT had the best stranded patient rate in GM; 30.5% compared to a GM average of 45.4%, though a month on month increase in the rate was noted. In Q2 (to end of August), PAHT has dropped to 3rd best with a rate of 40.1% against a GM average of 46.5%. Tameside & Glossop FT and Bolton FT are currently above PAHT.

3.19 Similarly, with a super-stranded patient rate of 9.1% against a GM average of 16.8%, PAHT also performed best across GM on this measure in Q1 though the trust has dropped to 4th best in Q2 (to the end of August) with a rate of 13.0% against a GM average of 16.8%.

3.20 Good stranded and super-stranded rates are in the context of the Integrated Discharge Team (IDT) working with a new rapid discharge process with regular conference calls taking place with health and social care partners to ensure patient flow is optimised.

Mental Health

3.21 As anticipated, published data to May shows the Improving Access to Psychological Therapies (IAPT) prevalence and 6 week wait measures remaining a challenge despite strong performance in previous years. This picture is expected to continue with more positive performance evident for the IAPT Recovery and 18 week wait measures.

3.22 Demand and capacity modelling work carried out jointly between the CCG and PCFT had demonstrated that if fully staffed, the PCFT service is funded sufficiently to deliver against the national targets, albeit in terms of the existing therapy offer which is acknowledged to not fully align with the IAPT guidance. This baseline position will be revisited to ensure that the new model of working that includes digital therapy is reflected and that the service can develop to meet the anticipated growth in demand and that the workforce model is aligned to national guidance.

3.23 National modelling suggests that demand will increase following COVID with the increase being a combination of 'suppressed' demand and new COVID-generated demand.

3.24 The implementation of a digital therapy solution was expedited as part of the COVID-19 response with Phase 2 of the project having gone live in June. This phase sees service users able to self-refer and supports the move towards a 'Digital

First' model where it is envisaged eventually that 70% of service users will receive digital therapy rather than face to face.

3.25 Most IAPT therapy is currently taking place via telephone whilst various video platforms are tested. PCFT has contacted all existing patients on a waiting list, many of whom have positively received the offer of redirection to digital support whilst they continue to wait

3.26 The Phase 3 requirements included the CCG submitting plans for performance against a number of mental health and learning disability metrics. These included access to mental health services for children and young people, perinatal mental health service access, the reliance on inpatient care for CCG-commissioned and NHSE-commissioned learning disability inpatients and health checks being completed for patients on the learning disability register. Trajectories for these metrics were agreed with relevant commissioning and clinical leads within the CCG.

4 Actions Required

4.1 The audience of this report is asked to:

- Receive this report.

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September 2020

Appendix A: Greater Manchester Constitutional Standards Summary

Measure Name	Standard	Latest Data	GM	Bury	North West	England
Patients Admitted, Transferred Or Discharged From A&E Within 4 Hours	95.0%	Aug-20	86.2%	85.3%	87.9%	89.3%
A&E 12 Hour Trolley Wait	0	Aug-20	5	0	14	326
Delayed Transfers of Care - Bed Days *(PAHT)*	200	Feb-20	2425	35.1	917.1	5371.8
Delayed Transfers of Care - Bed Days *(PCFT)*				30.1		
Delayed Transfers of Care - Per 100,000	Null	Feb-20	19.2	12.2	15.6	12.4
Stranded Patients (LOS 7+ Days)	2196	Jul-20	1836	356	4970	
Super-Stranded Patients (LOS 21+ Days)	Null	Jul-20	628	117	1796	
Referral To Treatment - 18 Weeks	92.0%	Jul-20	46.1%	47.4%	47.7%	46.8%
Referral To Treatment - 52+ Weeks	0	Jul-20	5526	371	10445	83799
Diagnostics Tests Waiting Times	1.0%	Jul-20	47.6%	47.6%	41.3%	39.6%
Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93.0%	Jul-20	87.1%	93.2%	90.7%	90.4%
Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93.0%	Jul-20	70.7%	95.0%	80.1%	86.4%
Cancer - 31-Day Wait From Decision To Treat To First Treatment	96.0%	Jul-20	95.5%	97.2%	95.0%	95.1%
Cancer - 31-Day Wait For Subsequent Surgery	94.0%	Jul-20	93.5%	100.0%	84.7%	87.9%
Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98.0%	Jul-20	99.5%	100.0%	99.5%	99.3%
Cancer - 31-Day Wait For Subsequent Radiotherapy	94.0%	Jul-20	99.7%	100.0%	98.2%	96.0%
Cancer - 62-Day Wait From Referral To Treatment	85.0%	Jul-20	73.7%	73.0%	75.8%	78.4%
Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Service	90.0%	Jul-20	23.1%	0.0%	30.0%	25.4%
Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade	Null	Jul-20	79.7%	73.7%	82.6%	85.2%
Cancer - 104-Day Wait	0.0%	Jul-20	92	11	210	1462
Breast Cancer Screening Coverage (Aged 50-70)	70.0%	Jan-20	68.8%	75.2%	71.1%	72.1%
Bowel Cancer Screening Uptake (Aged 60-74)	60.0%	Jan-20	63.1%	64.4%	64.3%	65.1%
Cervical Cancer Screening Coverage (Aged Under 50)	80.0%	Jan-20	71.3%	73.1%	72.4%	70.0%
Cervical Cancer Screening Coverage (Aged 50-64)	80.0%	Jan-20	76.0%	76.3%	75.7%	76.1%
MRSA	0.0%	Jul-20	6	0	10	48
E.Coli	Null	Jul-20	149	15	353	3207
Estimated Diagnosis Rate for People with Dementia	66.7%	Jul-20	69.60%	76.2%	66.8%	63.2%
Improving Access to Psychological Therapies Access Rate	5.3%	Jun-20	3.25%	1.89%	2.96%	3.20%
Improving Access to Psychological Therapies Recovery Rate	50.0%	Jun-20	48.3%	48.1%	46.5%	49.6%
Improving Access to Psychological Therapies Seen Within 6 Weeks	75.0%	Jun-20	78.5%	54.3%	84.9%	86.5%
Improving Access to Psychological Therapies Seen Within 18 Weeks	95.0%	Jun-20	96.8%	97.1%	97.6%	97.4%
Early Intervention in Psychosis - Treated Within 2 Weeks of Referral	56.0%	Jun-20	80.4%	89.0%	72.8%	73.0%
First Treatment For Eating Disorders Within 1 Week Of Urgent Referral	95.0%	Jun-20	97.5%	100.0%	94.7%	76.4%
First Treatment For Eating Disorders Within 4 Weeks Of Routine Referral	95.0%	Jun-20	97.6%	100.0%	97.1%	81.7%
Access Rate to Children and Young People's Mental Health Services	33.2%	Jun-20		46.6%	39.50%	39.1%
CPA follow up within 7 days	95.0%	Dec-19	96.2%	98.1%	96.6%	95.5%
Mixed Sex Accommodation	0.0%	Feb-20	1.9	1.5	1.3	3.00
Cancelled Operations	Null	Dec-19	1.7%	2.0%	1.3%	1.1%
Ambulance: Category 1 Average Response Time	420	Jul-20	6:34	06:35	07:06	06:47
Ambulance: Category 1 90th Percentile	900	Jul-20	10:35	10:08	11:55	12:02
Ambulance: Category 2 Average Response Time	1080	Jul-20	22:29	22:52	20:54	16:39
Ambulance: Category 2 90th Percentile	2400	Jul-20	44:44	20:36:00	42:02	32:33
Ambulance: Handover Delays (>60 Mins)	Null	Jul-20	0.5%	0.8%	0.4%	0.6%
Cancer Patient Experience	Null	Apr-18	8.88	8.72	8.87	8.80
General Practice Extended Access	Null	Mar-19	100.0%	100.0%		

Data source: GM Tableau on 13/07/2020