Bury COUNCIL

NHS Bury Clinical Commissioning Group

Meeting: Strategic Commissioning Board			
Meeting Date	03 August 2020	**Action**	Consider
Item No	10	**Confidential / Freedom of Information Status**	No
Title	Performance Report		
Presented By	Will Blandamer, Executive Director of Strategic Commissioning		
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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 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.

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 item.
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	Yes	☐	No	☐	N/A	☒

Implications						
will be affected been consulted ?						
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 care, elective care, cancer and mental health along with an overview of the impact of the COVID-19 response to these areas following the United Kingdom's entrance into a period of 'lockdown' on 23rd March 2020.

2. Background

2.1. This paper is a summary of the information presented to the CCG's Quality and Performance Committee in July which related to the published position as at April 2020. However, as some May 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 relating to the COVID-19 pandemic, 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 will be 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. To reduce the burden on providers, Phase 1 saw NHSE/I suspend some routine provider reporting for the period April to June though data to support A&E performance, cancer care and referral to treatment continued to be collected in order to determine the impact of COVID and the associated required recovery. Of the measures suspended, the following are most relevant to the CCG's performance management function in terms of being able to feed updates through the CCG's governance structure:

- Friends and family test;
- Urgent operations cancelled;
- Delayed Transfers of Care (DToC);
- Cancelled elective operations;
- Audiology; and
- Mixed sex accommodation.

2.6 The March advice also led to the following quarterly CCG returns being stood down for Quarter 4 2019-20 and Quarter 1 2020-21:

- Personal Health Budgets;

- Wheelchair waits;
- Improving Access to Psychological Therapies (IAPT) Workforce; and
- Diabetes Transformation.

2.7 At the end of April, NHSE launched the second phase of the COVID-19 response. The NHSE communication set out the broad operating environment and approach to be adopted over subsequent weeks. This included the expectation for COVID-19 testing to take place upon admission for non-elective patients and pre-admission for elective admissions and upon discharge to care homes. The communication also focused on stepping some key services back up such as frailty services and same day emergency care.

2.8 Further NHSE/I communication dated 6th July advises the following:

- Governance & Board meetings:
  - Should be stepped up and held virtually. Where this is not possible, e.g. AGM, such meetings should be deferred to later in the year.
- Reporting & Assurance. Although some reporting remains suspended to manage the burden on providers, the following is to be re-instated:
  - National clinical audits and outcome review programmes. The Healthcare Quality Improvement Partnership (HQIP) will work with providers to determine which will recommence.
  - Referral to Treatment (RTT) Patient Tracking List (PTL). This will allow a deeper understanding of waiting lists and waiting times as localities move towards recovery.
  - Ambulance Clinical Outcomes. This is particularly important for patients on urgent and critical care pathways.
  - Quarterly provider data collections will also resume for children & young people's eating disorder waiting times, physical health checks for people with a severe mental illness and out of area placements. This will be from Quarter 2 onwards (October data collection).
- Vulnerable staff:
  - Localities to proactively support members of staff in vulnerable groups, e.g. those shielding, those from Black and Asian Minority Ethnic (BAME) backgrounds and those with other risk factors.
- Annual Leave:
  - Organisations should adhere to their usual annual leave policy with staff strongly encouraged to spread leave across the year. Senior leaders are asked to role model this behavior.

2.9 Phase 3 of the recovery planning is expected to be launched later in the summer where localities will be asked to put plans in place for the rest of the financial year. This will include winter planning, ongoing recovery of NHS services and ensuring sufficient capacity remains in place to deal with any resurgence of COVID-19.

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 April there were 14297 patients waiting, 9.5% lower than there had been in January. This is believed to be primarily attributable to the waiting list cleansing exercise undertaken at both PAHT and SRFT during Q4 but also impacted by fewer patients being referred to secondary care in the early phase of the COVID response. The waiting list had increased to 15365 by the end of May which is 2.8% lower than the January 2020 position.

3.3 In terms of GP referrals made via the eReferral Service (eRS), data for April and May shows the following:

- There were 1448 referrals made by Bury GPs in April and 2058 in May, representing a 79% (Apr) and 70% (May) reduction when compared to the average seen in 2019-20.
- Routine referrals reduced by 83% Year to Date (YTD) to May when compared with the same period last year whilst urgent referrals were 63% lower.
- For both routine and urgent referrals, the biggest reductions were seen for diagnostic imaging, physiotherapy, trauma & orthopaedics (T&O) and paediatric services.
- With regard to outpatient attendances, data available within weekly Payment by Results (PbR) extracts shows the following:
    - In the first 11 weeks of 2020-21 (to w/e 14th June), there were 38.4% fewer outpatient attendances than in the same period last year. Attendances are increasing with the reduction having been 43.9% in the first four weeks, 38.7% in the next four weeks and 30.7% in the final three-week period.
    - In the same 11-week period of 2019-20, telephone consultations accounted for just 2% of outpatient attendances. This has increased to 50% of attendances in 2020-21 in this same period.

Cancer Care

3.4 NHSE/I guidance has been issued to both primary and secondary care providers which outlines steps to take to ensure that cancer treatment is maintained during the outbreak. From a primary care perspective, the advice is to continue to manage referrals in line with NICE guidance (NG12) wherever possible. If, however, a GP feels it is more of a clinical risk to refer the patient at this time, they must ensure that the patient is appropriately safety netted and monitored and that they can be followed up as required *(source: publication 001559, NHSE/I, March 2020).*

3.5 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.

3.6 Following a dip in performance in April against the cancer Two Week Wait (2WW) standard, the target was achieved in May with performance of 98.5% noted against the 93% target and provisional PAHT data suggests it will be achieved in June also. The 2WW breast symptomatic standard was also achieved in May (100% performance). Both targets were achieved in the context of reduced demand during the COVID response period.

3.7 Sub-standard performance remains for 62 day waits. Information shared via a regional COVID forum suggests that increased scrutiny is to be placed on this standard as waiting times have deteriorated more in the North West (NW) than other regions, despite the NW being the second-best performing region before the pandemic.

3.8 By the end of April, 2WW referrals into NCA had dropped by 54% when compared to the pre-COVID period (Jul 2019 – Apr 2020). There has been a gradual increase since that time with NCA level referrals standing 26% lower in early July than they were pre-COVID.

3.9 When comparing 2WW referral rates across GM for two specific weeks, data shows that in week commencing (w/c) 22nd June, there were 16.1% fewer referrals that there had been in w/c 27th Jan. The variance between these two weeks ranges from +7.8% at SRFT to -29.5% at Stockport whilst the variance at PAHT stood at -16.3%.

3.10 At a CCG level, the same data shows that referrals in Bury were 7.6% higher in w/c 22nd June than the reference week. With Bury being the only CCG to have seen an increase in referrals, the variance at a CCG-level ranges from +7.6% at Bury to -31.2% at Heywood, Middleton & Rochdale. The biggest increase for Bury was for suspected skin cancer referrals and may be explained by a lower referral threshold used by GPs in view of fewer face to face GP appointments thus resulting in lower dermatascope use. Lower GI also saw an increase in referrals in these two comparison weeks.

Urgent Care

A&E Attendances

3.11 At 93.1% against the 95% target, A&E performance at PAHT in May is the highest level seen since July 2015. For Fairfield General Hospital (FGH) specifically, performance was 93.8% in May and places FGH third best Type 1 unit across GM. Type 1 refers to what might be classed as a ‘traditional’ A&E department with a full resuscitation facility.

3.12 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.

3.13 Across Q1 of 2020-21, there were almost 22,000 fewer Type 1 attendances at

PAHT than in Q1 2019-20. This equates to a 30.7% reduction at a trust-level and similar reduction of 31.2% at FGH. This reduction had been 44.8% at PAHT in April and -37.8% to the end of May.

3.14 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. The increasing pattern has continued into July with an average of 177 attendances per day in the first six days of July.

3.15 Since lockdown, there have been four occasions where attendances at FGH have exceeded 200 per day (1st, 8th, 29th June and 6th July). Each of these days is a Monday.

Stranded Patients

3.16 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.

3.17 Across Q1, PAHT has had the best stranded patient rate in GM; 30.5% compared to a GM average of 45.4%. It is noted, however, that this increased each month, standing at 20.2% in April, 29.8% in May and 38.5% in June.

3.18 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.

3.19 Lower 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

3.20 As anticipated, published data to March shows the Improving Access to Psychological Therapies (IAPT) prevalence and 6 week wait measures remaining a challenge despite strong performance in previous years. Indicative Pennine Care Foundation Trust (PCFT) data for these two measures shows under-performance continuing through April and May also. The target increases in 2020-21 to a prevalence rate of 25%. The IAPT Recovery and 18 week wait targets were met fairly consistently across 2019-20.

3.21 Demand and capacity modelling work carried out jointly between the CCG and PCFT demonstrated that if fully staffed, the PCFT service is funded sufficiently to deliver against the targets. However, this has not been achieved due to the level of vacancies that exist within the service, some of which are the result of existing staff taking up High Intensity Therapy training posts. It is acknowledged that this work now needs to be revisited to reflect any amended national guidance subsequent to COVID-19 along with the impact of digital therapy on the modelling of IAPT services

and the expected increased demand for psychological therapies, much of which is expected to be trauma focused.

3.22 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.

3.23 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

4 Actions Required

4.1 The audience of this report is asked to:

- Receive this report.

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July 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%	Jun-20	90.5%	88.8%	91.7%	92.8%
A&E 12 Hour Trolley Wait	0	Jun-20	0	0	12	161
Delayed Transfers of Care - Bed Days *(PAHT)*	200	Feb-20	2425	280.8	6337.8	58636.6
Delayed Transfers of Care - Bed Days *(PCFT)*				240.8		
Delayed Transfers of Care - Per 100,000	Null	Feb-20	108.3	89.9		
Stranded Patients (LOS 7+ Days)	2196	Apr-20	2312	324	5150	29572
Super-Stranded Patients (LOS 21+ Days)	Null	Apr-20	1205	135	2510	12445
Referral To Treatment - 18 Weeks	92.0%	May-20	63.5%	62.9%	63.8%	62.2%
Referral To Treatment - 52+ Weeks	0	May-20	1629	98	2883	26437
Diagnostics Tests Waiting Times	1.0%	May-20	61.5%	57.7%	60.2%	58.4%
Cancer - Two Week Wait from Cancer Referral to Specialist Appointment	93.0%	May-20	95.0%	98.5%	95.6%	94.2%
Cancer - Two Week Wait (Breast Symptoms - Cancer Not Suspected)	93.0%	May-20	83.5%	100.0%	88.6%	93.7%
Cancer - 31-Day Wait From Decision To Treat To First Treatment	96.0%	May-20	94.6%	87.9%	94.5%	93.9%
Cancer - 31-Day Wait For Subsequent Surgery	94.0%	May-20	90.5%	92.9%	87.1%	88.5%
Cancer - 31-Day Wait For Subsequent Anti-Cancer Drug Regimen	98.0%	May-20	100.0%	100.0%	99.2%	99.0%
Cancer - 31-Day Wait For Subsequent Radiotherapy	94.0%	May-20	99.1%	100.0%	99.1%	96.3%
Cancer - 62-Day Wait From Referral To Treatment	85.0%	May-20	63.4%	60.0%	68.6%	69.9%
Cancer - 62-Day Wait For Treatment Following A Referral From A Screening Servic	90.0%	May-20	50.0%	100.0%	51.2%	47.9%
Cancer - 62-Day Wait For Treatment Following A Consultant Upgrade	Null	May-20	72.7%	65.0%	76.7%	78.1%
Cancer - 104-Day Wait	0.0%	May-20	51	3	128	897
Breast Cancer Screening Coverage (Aged 50-70)	70.0%	Nov-19	68.4%	75.2%	70.8%	71.8%
Bowel Cancer Screening Uptake (Aged 60-74)	60.0%	Nov-19	61.9%	63.7%	63.4%	64.3%
Cervical Cancer Screening Coverage (Aged Under 50)	80.0%	Nov-19	71.2%	72.9%	72.4%	70.0%
Cervical Cancer Screening Coverage (Aged 50-64)	80.0%	Nov-19	76.2%	76.4%	75.8%	76.2%
MRSA	0.0%	May-20	4	0	12	64
E.Coli	Null	May-20	116	5	329	2844
Estimated Diagnosis Rate for People with Dementia	66.7%	May-20	70.80%	77.5%	67.6%	64.0%
Improving Access to Psychological Therapies Access Rate	5.3%	Apr-20	4.74%	3.09%	4.29%	4.09%
Improving Access to Psychological Therapies Recovery Rate	50.0%	Apr-20	47.8%	49.5%	45.8%	48.3%
Improving Access to Psychological Therapies Seen Within 6 Weeks	75.0%	Apr-20	75.2%	46.7%	83.1%	86.2%
Improving Access to Psychological Therapies Seen Within 18 Weeks	95.0%	Apr-20	95.5%	97.8%	96.9%	97.4%
Early Intervention in Psychosis - Treated Within 2 Weeks of Referral	56.0%	Mar-20	75.5%	75.0%	74.5%	71.9%
First Treatment For Eating Disorders Within 1 Week Of Urgent Referral	95.0%	Mar-20	97.6%	100.0%	100.0%	73.9%
First Treatment For Eating Disorders Within 4 Weeks Of Routine Referral	95.0%	Mar-20	95.9%	100.0%	94.5%	81.3%
Access Rate to Children and Young People's Mental Health Services	33.2%	Mar-20	46.3%	44.2%	38.20%	38.2%
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	Mar-20	7:33	07:55	07:50	08:07
Ambulance: Category 1 90th Percentile	900	Mar-20	12:12	12:22	13:14	14:22
Ambulance: Category 2 Average Response Time	1080	Mar-20	50:38	53:15	37:37	32:06
Ambulance: Category 2 90th Percentile	2400	Mar-20	1:49:21	01:54:39	01:25:29	1:09:01
Ambulance: Handover Delays (>60 Mins)	Null	May-20	2.4%	1.6%	1.8%	4.2%
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