NHS BOLTON CLINICAL COMMISSIONING GROUP
Public Board Meeting

AGENDA ITEM NO: ……9……

Date of Meeting: ……24th November 2017…….

TITLE OF REPORT:	CCG Corporate Performance Report	
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PRESENTED BY:	Barry Silvert - Clinical Director of Commissioning	
PURPOSE OF PAPER: (Linking to Strategic Objectives)	The purpose of the attached report is to highlight performance against all the key delivery priorities for the CCG in 2017/18 against which NHS Bolton Clinical Commissioning Group is nationally measured	
LINKS TO CORPORATE OBJECTIVES (tick relevant boxes):	**Deliver Year 2 of the Bolton Locality Plan.**	
	Ensure compliance with the NHS statutory duties and NHS Constitution.	
	Deliver financial balance.	
	Regulatory Requirement.	
	Standing Item.	X
RECOMMENDATION TO THE BOARD: (Please be clear if decision required, or for noting)	Members are requested to note the content of the report and actions being taken where required to improve performance	
COMMITTEES/GROUPS PREVIOUSLY CONSULTED:	Performance is reported to: CCG Executive Contract Performance Group Quality and Safety Committee	
REVIEW OF CONFLICTS OF INTEREST:	N/A	
VIEW OF THE PATIENTS, CARERS OR THE PUBLIC, AND THE EXTENT OF THEIR INVOLVEMENT:	Patients' views are not specifically sought as part of this monthly report, but it is recognised that many of these targets such as waiting times are a priority for patients.	

OUTCOME OF EQUALITY IMPACT ASSESSMENT (EIA) AND ANY ASSOCIATED RISKS:	N/A

CCG Corporate Performance Report

1 Introduction

1.1 This report highlights NHS Bolton Clinical Commissioning Group's performance against all the key delivery priorities for the month of September 2017 (Month 6).

1.2 Sections 2 and 3 provide highlights of performance against key commissioning and quality and safety performance indicators.

1.3 Key performance indicators showing an under-performance for September 2017 are summarised in Appendix 2. Exception reports and recovery plans for these indicators are included in Appendix 1.

1.4 This month, a full report on performance of the stroke and transient ischaemic attack (TIA) service at Royal Bolton Hospital has also been included (Appendix 3).

2 Performance Summary: Commissioning

2.1 The CCG's cancer performance remains strong for the majority of key targets in September, in particular with regards to the 31 day wait from diagnosis to treatment and two week wait from referral to first outpatient appointment targets. Recent underperformance against the two week wait for symptomatic breast target continues for the sixth month. However, as highlighted to the board previously, this underperformance was due to staffing issues in the department. Performance is improving as expected at 37.3% in September (against a target of 93%). Details are included in Appendix 1 of the actions being taken to remedy performance to achieve the 93% target.

2.2 A&E performance has shown some improvement since the last report. October's 4 hour performance was 87.84% which was the highest year to date (YTD). However unvalidated November data at the time of writing indicates a deterioration of this position to 81.18%. Actions being taken as a health and social care system are outlined in Appendix 1.

2.3 As anticipated in the last report, the 18 week referral to treatment (RTT) target for patients on an incomplete non-emergency pathway has marginally failed for the first time in five years in September with performance of 91.96% against a target of 92%. It is expected that achievement of the 92% target will continue to be challenging in the current climate.

2.4 Initial performance data from the new Ambulance Response Programme (ARP) is now available to CCGs for two key targets:

- Category 1 call mean response time of 7.5 minutes or less
- 90% of Category 1 calls to receive a response within 15 minutes

Backdated performance data from August onwards indicates NWAS has failed to achieve both the new targets. Further information is included in the exception report in Appendix 1 and detailed monitoring is expected by December.

2.5 Key performance indicators showing an under-performance for September 2017 are summarised in Appendix 2. Exception reports and recovery plans for these indicators are included in Appendix 1.

3 Performance Summary: Quality and Safety

3.1 A comprehensive report has been produced to update the board on the effectiveness of the stroke and transient ischaemic attack (TIA) pathways for Bolton patients. The TIA service at Royal Bolton Hospital has failed to meet the target of 60% of high risk TIA cases investigated and treated within 24 hours so far in 2017/18 with YTD performance of 28.26%. The full report with a recovery plan and next steps is included as Appendix 3.

3.2 Mixed sex accommodation breaches at Bolton NHS Foundation Trust (FT) increased threefold in September to 18, from 6 in August. An exception report has been included in Appendix 1. No adverse impact on patient experience has been reported.

4 Performance Summary: Locality Plan and Transformation Fund

4.1 Key Performance Indicators

The following metrics are included as part of the Bolton Transformation Fund Investment Agreement and are therefore considered critical indicators of the success of the Locality Plan:

- Elective and daycase admissions
- Non-elective admissions
- A&E attendances
- Outpatient first attendances
- Outpatient follow up attendances

September data demonstrates a positive trend YTD in non-elective admissions and outpatient first and follow up attendances.

Elective and daycase activity remains a challenge for the locality and joint work between the CCG and FT continues to ensure data quality in this area. Work is undergoing with the FT to develop plans to reduce pressure in this area, including further developing work on use of surgical checklists and compliance with Effective Use of Resources (EUR) policies, as well as detailed capacity and demand planning with all specialties which will be presented to December's System Sustainability and Transformation Board (SSTB). A full update will also be presented to the January board meeting regarding elective care, diagnostics and cancer services.

Delivery of the Locality Plan outcomes is monitored and reported monthly via the SSTB where performance is discussed and recovery plans formulated.

The next quarterly update on the Locality Plan will be presented to the board in January with more detailed information on progress to date and the impact on outcomes.

5 Recommendations

5.1 The Board is asked to note the performance for September 2017 and the actions being taken to rectify areas of performance which are below standard.

Melissa Laskey – Director of Service Transformation
21st November 2017

APPENDIX 1

Exception Report and Recovery Plan: Referral to Treatment Incomplete Pathway

Performance

The key performance measure for elective care is the 18 week referral to treatment (RTT) standard, which is monitored through the incomplete pathway measure.

Of all patients waiting for treatment in September 2017, 91.96% were waiting less than 18 weeks against a target of 92%. Performance against this standard has been steadily declining through 2017/18 although September is the first month RTT has failed.

Latest Update

It should be noted that elective performance regionally and nationally has seen a declining trend, with the incomplete standard being failed at Greater Manchester level in September 2017. There are a number of factors influencing this, including the impact of non-elective activity on elective capacity (particularly for inpatient work), workforce issues affecting core capacity; and increasing demand for some specialties and diagnostics (for example, endoscopy). However, local demand for elective services at aggregate level remains steady. In recognition of this, a Greater Manchester Elective Care Programme is currently being established by the GM Health and Social Care Partnership, and Bolton will be a participant in this regional programme as it develops further.

At a local level, Bolton FT has undertaken analysis of patients currently waiting longer than 18 weeks, and is developing recovery plans to ensure that these patients are treated as soon as possible. This is a key agenda item for discussion at the Planned Care Strategy and Planning Group in November, and will be reported through System Sustainability and Transformation Board in December for agreement. It should be noted however that the upcoming winter period is likely to further impact on elective capacity and recovery.

Bolton FT is in the process of developing robust elective capacity and demand analyses to inform operational planning and future demand management schemes. The CCG is working collaboratively with the FT to develop and review capacity and demand approaches at specialty level, with these being reported via the Planned Care Strategy and Planning Group.

A comprehensive update on elective care, diagnostics and cancer services will be presented to the board in January.

Recovery

Current Outcome: The incomplete pathway standard has failed in September

Expected Outcome: A forecast trajectory for when achievement of the incomplete standard may be expected is currently being worked up. Elective performance may deteriorate further during the busy winter period which will further put 2017/18 performance at risk

Lead Commissioning Manager: Jen Riley

Exception Report and Recovery Plan: Diagnostic Test Waiting Times

Performance

Performance against the diagnostic test waiting times standard (patients waiting for a diagnostic test should have been waiting less than 6 weeks from the time of referral) has failed in September 2017, with 1.6% of patients waiting more than 6 weeks against a threshold of 1%.

Latest Update

The failure of this standard relates to 69 patients waiting over 6 weeks for diagnostic test, with these patients being seen across a number of providers, with the majority of breaches for the CCG occurring at Bolton FT, Salford Royal FT, and Manchester FT. The highest number of breaches (27) in a single modality was seen for patients awaiting an MRI at Salford Royal NHS FT, MFT and BMI Beaumont. The next highest number of breaches (11) in a single diagnostic area was seen for patients awaiting colonoscopy, with the majority of these breaches being at Bolton FT.

It should be noted that at a provider level Bolton FT has continued to meet this standard in 2017/18. Diagnostic capacity and demand is forming part of the detailed work currently being undertaken at the FT to inform future service planning, and this is being supported by the CCG through collaborative working and via the Planned Care Strategy and Planning Group. Diagnostic capacity at a GM level is also being reviewed via the GMHSCP Elective Care work programme.

Endoscopy is the diagnostic area under particular risk, having seen marked increases in demand (following changes in NICE referral guidance and public health campaigns on bowel cancer signs and symptoms). In order to meet this demand in the future a number of projects are underway, including:

- Implementation of straight to test pathways
- The development of an additional endoscopy suite at Royal Bolton Hospital
- A partnership project between Bolton FT and the community provider of endoscopy services (In Health) to progress the potential for joint working to ensure patients are seen quickly and in the most appropriate service

These projects are monitored via the Planned Care Strategy and Planning Group.

Diagnostic performance and planned service developments will be included in the full update on elective care to January's board.

Recovery

Current Outcome: The diagnostic waiting times standard has failed in September 2017

Expected Outcome: As detailed above, this indicator is at risk for 2017/18, with 4 months of 6 having failed. Diagnostic performance may deteriorate further during the busy winter period which would further put 2017/18 performance at risk

Lead Commissioning Manager: Jen Riley

Exception Report and Recovery Plan: Cancer 2 Week Wait – Breast Symptomatic

Performance

Performance against the 2 week wait symptomatic breast target (where symptoms do not initially suggest cancer) failed for the sixth consecutive month in 2017 at 37.3% against against a target of 93%. This is an improvement on August's performance of 24.8%.

Latest Update

Performance has started to recover in this specialty, with performance increasing from 24.8% in August 2017.

With agreement from the CCG, the FT has been prioritising breast patients on the 2 week wait pathway where cancer is suspected. The Quality and Performance Group have been assured that no harm is anticipated to those patients on the symptomatic pathway.

The challenges regarding an increase in activity from out of area patients and long term staff sickness meaning demand has been greater than the available capacity have been previously reported in detail to Board.

As reported in last month's Corporate Performance Report, one of the appointed consultants has commenced maternity leave and locums are being used to maintain consultant capacity. The FT is monitoring performance and activity weekly and have reported that they anticipate that the symptomatic standard will be achieved by the end of December 2017 (one month behind plan).

Performance YTD means it is unlikely the CCG will be able to recover 2 week wait breast symptomatic performance in 2017/18.

Recovery

Current Outcome: The 2 week wait breast symptomatic target has failed for September 2017

Expected Outcome: Performance is expected to recover late in Q3, subject to revised trajectories being provided by the trust. Due to continued poor performance, it is unlikely this indicator will recover in 2017/18

Lead Commissioning Manager: Jen Riley

Exception Report and Recovery Plan: Cancer 62 Day Wait – Referral from Screening

Performance

Performance against the cancer 62 day wait from referral from screening to treatment failed in September at 57.1% against a target of 90%. This is the third consecutive monthly deterioration in performance. Prior to July of this year, performance had consistently been at 100% for 2017/18 and there were no performance concerns in the previous financial year.

Latest Update

The CCG reviews all breaches with Bolton FT to investigate the reason for these.

There are currently significant pressures on endoscopy capacity at Bolton FT following changes to the National Bowel Cancer Screening Programme and increased elective demand. These pressures are replicated across Greater Manchester and nationally. These increases are being considered as part of the elective capacity and demand modelling being overseen by the Planned Care Strategy and Planning Group. Specific actions regarding endoscopy capacity have been outlined in the exception report for diagnostic test waiting times as these two measures are linked.

More detailed information regarding future service developments in diagnostics to support delivery of this target will be included as part of the elective care update to January's board.

Recovery

Current Outcome: The cancer 62 day wait from referral from screening to treatment failed in July at 57.1% against a target of 90%

Expected Outcome: September is the third consecutive month in which this standard has failed. It is unlikely this measure will recover in Q3 of 2017/18 and Q4 delivery (and therefore 2017/18 performance) is at risk

Lead Commissioning Manager: Jen Riley

Exception Report and Recovery Plan: A&E 4 Hour Target

Performance

A&E 4 hour performance (target 95%) for October 2017 was 87.84%, which is an improvement in performance since September (at 84.73%). Both of these months represent a significant improvement on the lowest performance YTD in August of 78.2%.

Performance in November to 15th November has declined since October with a month to date figure of 81.18% at the time of writing. A local target of 90% remains in place to support the recovery to the national 95% target.

Latest Update

Work continues with Bolton FT, Bolton CCG and the whole urgent care system to improve patient flow, reduce delays and match capacity and demand. This includes ongoing work to:

- Improve the flow through A&E for mental health patients, developing a stream through GMMH earlier in the patient's pathway from the end of December)
- Identify frail elderly patients who can return home from A&E with the help of the Home 1st Team. This team are in A&E between the hours of 8am and 8pm currently and further work is ongoing to increase activity and streamline pathways
- Bolton FT have gone live with a new rapid assessment model in CDU for all medical patients which will take all GP expected patients, thereby avoiding any need for them to attend A&E
- Develop a pathway from Paediatric A&E to GP surgeries ensuring children are safely diverted to their GP practice on the same day of ED attendance where clinically appropriate

The medically optimised patients are reviewed daily, which is having a positive effect in the reduction of length of stay for these patients. The whole system continues to resolve discharges for more complex patients.

Bolton FT is continuing to work with NHS Improvement, with focus on further embedding the SAFER bundle and 'Red 2 Green' on the wards which are tried and tested methodologies for improved patient flow and outcomes.

The Urgent and Emergency Care Board have an agreed work plan consisting of a number of key programmes to improve patient experience and work towards sustaining A&E performance of 90% throughout winter 2017/18. These are closely monitored on a monthly basis with remedial action taken as required.

Recovery

Current Outcome: Failing 95% target, although improvements were seen through September and into October. Performance has deteriorated in November and remains highly dependent on flow and capacity.

Expected Outcome: Performance in Q3 is expected to be better than the previous two quarters but achievement of the local 90% target is a challenge given the pressures experienced by the system in the winter months.

Timescale for Recovery: Some improvement is expected to be seen for the remainder of Q3, although maintaining this consistently through to Q4 will be dependent upon the severity and impact of winter months.

Lead Commissioning Manager: Gill Baker

Exception Report and Recovery Plan: Ambulance Performance

Performance

Following the recent implementation of the Ambulance Response Programme (ARP), the first high level performance report is now available (for Category 1 times).

The two targets for Category 1 are for a mean response time of 7.5 minutes, and for at least 90% of cases to receive a response within 15 minutes. As demonstrated below, improvements have been made on a monthly basis although the targets have not been achieved.

	Aug-17	Sep-17	Oct-17
Category 1 response times - Mean	10:07	09:49	09:28
Category 1 response times - 90th Percentile	15:59	16:21	15:36

Latest Update

An unanticipated negative impact of the implementation of ARP was a reduction in call pick up response times. This occurred because some calls, which require the call handler to remain on the line until the ambulance arrives, now have a longer target response time. This increased the average call length and as such reduced the availability of call handlers to answer incoming 999 calls. Performance against this target has now returned back to previous levels, averaging between 85 and 90% of calls answered within 60 seconds. No patient harm has been reported as a result of these delays however this is being investigated by NWAS.

The actions that have been taken to address this include:

- A number of processes and procedures have been changed to streamline the call taking time and this has increased call taker availability.
- Clinical supervision in the call taking and dispatch suite is being trialled with early indications of success.
- A recruitment plan is underway to increase call taking (by 23 WTE) and will be deployed in December.

It is expected that more detailed monitoring data for the new measures will be available by December.

Recovery

Current Outcome: Failing against the new ARP targets. Gradual improvements have been seen since the implementation of ARP

Expected Outcome: Improvements are anticipated to continue over the remainder of Q3 as the organisation continues to learn and improve practices in line with ARP

targets. Once fully embedded, ARP is still anticipated to improve overall performance and patient safety.

Timescale for Recovery: Performance continues to improve through Q3, though with January and February traditionally seeing a higher level of demand within ambulance services, this may not be sustainable into Q4.

Lead Commissioning Manager: Gill Baker

Exception Report and Recovery Plan: Improving Access to Psychological Therapies

Performance

Performance against the access rate to IAPT in September failed at 14.3% against the national target of 16.8%. However this is an improvement on August's performance of 13.6%.

Latest Update

September's performance is an improvement on August's performance, however it should be noted the access rate usually declines in August due to the peak holiday period and, as such, an improvement in the autumn months would be expected.

The new 16.8% target required by the end of 2017/18 would require performance of at least 19.2% each month from October onwards to achieve this. To achieve the 17.5% stretch target would require 20.6% per month. GMMH and 1 Point are confident that the 17.5% target will be achieved by March 2018 as a result of additional capacity provided through the Transformation Fund (GMMH and Silver Wellbeing through 1 Point.) 1 Point have had 16 referrals to the new service since September but formal pathways are still being developed so numbers will significantly increase once formally rolled out and communicated locally.

Links are continuing to be further developed in to long term conditions, older adults and perinatal support.

Both providers continue to move towards new IT systems (separate systems due to governance but both will use PCMIS) which will also support the ability to improve self-referrals. Additional therapists and admin staff have been recruited at 1 Point and are due to be filled by November, and further PWP and admin posts at GMMH by December 2017.

Recovery

Current Outcome: Failing to meet the national target of 16.8%

Expected Outcome: Failure of Q2

Timescale for Recovery: Service is expected to be fully staffed by December 2017 which will aid recovery but the interim stretch target of 17.5% is not expected to be achieved until the end of March 2018

Lead Commissioning Manager: Rachael Sutton

Exception Report and Recovery Plan: Out of Area Placements (OAPs)

Performance

Performance against the NHS England target of zero acute out of area placements (OAPs) by 20/21 fell short again for the sixth consecutive month, with 12 people placed outside the GMMH footprint in September 2017. This brings the YTD total to 25.

Latest Update

There was a higher than average number of Bolton OAPs for September. The GMMH team carried out a prompt investigation into the reasons and remedial actions have been put in place. The 12 placements were as follows:

Patient referred by	OAP Start Date	Gender	Patient CCG	Bed Type	OA Location	OAP End Date	Bed Nights
RAID	06/09/2017	M	Bolton	Acute Adult	Priory Nottingham	07/09/2017	1
RAID	09/09/2017	M	Bolton	Acute Adult	Priory Darlington	14/09/2017	5
HBT	09/09/2017	M	Bolton	Acute Adult	Priory Altrincham	10/09/2017	1
CMHT North	09/09/2017	F	Bolton	Acute Adult	Priory Cheadle Royle	12/09/2017	3
HBT	10/09/2017	M	Bolton	Acute Adult	Priory Altrincham	19/09/2017	9
RAID/HBT	16/09/2017	F	Bolton	Acute Adult	Priory Darlington	18/09/2017	2
/	17/09/2017	M	Bolton	Acute Adult	Priory Darlington	21/09/2017	4
RAID/HBT	18/09/2017	M	Bolton	PICU	Priory Roehampton	25/09/2017	7
RAID	18/09/2017	M	Bolton	Acute Adult	The Dene Hassocks	25/09/2017	8
/	18/09/2017	M	Bolton	Acute Adult	The Dene Hassocks	21/09/2017	4
RAID	30/09/2017	F	Bolton	Acute Adult	Priory Thornton Park		
HBT	30/09/2017	F	Bolton	Acute Adult	Priory Roehampton	17/10/2017	18

Of the 12 OAPs patients this month, 4 were repatriated within the 72 hour time limit.

Work is in place to review pathways, community provision and wider services such as the council commissioned crisis / respite house to enable an increase in the number of crisis beds and introduce the facility for discharge to assess beds. The CCG and GMMH have looked to neighbouring CCGs and trusts to consider how pressures are being managed in other areas e.g. the reintroduction of additional acute beds, additional home based treatment staff, step down beds and financial risk share arrangements. The CCG Chief Finance Officer is to discuss this with the GMMH Director of Finance.

An initial piece of work has been completed by GMMH on the acute care pathway and the local bed position which was presented at the Joint Executive meeting on the 17th November. Other parts of GMMH continue to see a similar increase in levels of activity attributed to current acuity. This has been confirmed by GMMH as an increase of 15.8% in admissions across Bolton, Salford and Trafford. (previously it was thought activity may have increased by up to 30%). Manchester has seen an increase of 10% in admissions but it was noted there has been no use of Bolton, Salford or Trafford beds by Manchester registered patients. Bolton were also shown to be the lowest exporter of beds across the GMMH footprint (at 4% compared to 11% in Salford) and the second lowest importer (bed nights used by other parts of the GMMGH footprint) at 6% compared to 12% in Trafford.

Length of stay across the GMMH footprint has increased, particularly relating to those with a stay of more than 50 days, which is thought to be contributing to the ability to discharge patients and therefore free up beds to avoid OAPs. This will be further considered and support sought from other parts of the system to address. GMMH are also putting additional measures in place to support those admitted to beds for less than 72 hours to aid capacity across the system.

There is a trust wide focus on this issue and a wider performance report is being presented to this board meeting which includes OAPs. The CCG have requested a formal action plan to address these pressures and as discussed in last month's report, a range of interim measures have been put in place by GMMH to support patient flow. The full time patient flow and capacity manager post holder returns at the end of November following an extended period of absence, so this will also aid continuity and support the wider infrastructure.

Recovery

Current Outcome: Failing to meet the national target of zero OAPs

Expected Outcome: Failure of Q2 and Q3

Timescale for Recovery: It is unlikely recovery will be achieved in this financial year

Lead Commissioning Manager: Rachael Sutton

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Exception Report and Recovery Plan: Rapid Assessment Interface and Discharge (RAID)

Performance

Performance against the A&E emergency referrals assessed within 1 hour fell for the fourth consecutive month in September to 64.0% against a target of 75%.

Latest Update

The Bolton RAID Team responded to 64% of all referrals received within 1 hour, falling short of the 75% target in September. This is due to a combination of factors including staff sickness, ongoing vacancies and an increase in demand. The team has now successfully recruited to posts with the new starters commencing in October and November 2017. Steps have been taken to improve the position by re-deploying staff from other areas as an interim measure. The RAID Team continues to provide comprehensive mental health assessments and work closely with the Royal Bolton clinical teams.

Mental health triage in A&E and the ability to provide ambulatory care will commence at the end of December (with the full model being operational by February 2018) which will have a positive impact on reducing waiting times in A&E and reducing referral numbers to RAID by providing alternatives (including The Sanctuary and GMMH staff for those requiring an assessment/clinical intervention) with re-direction to community mental health services as clinically appropriate.

Recovery

Current Outcome: Failing to meet the national target of 75%. YTD performance is 70.1%

Expected Outcome: Failure of Q2

Timescale for Recovery: Service is expected to be fully staffed by November 2017 which will aid recovery in Q3.

Lead Commissioning Manager: Rachael Sutton

Exception Report and Recovery Plan: Delayed Transfers of Care and Non-Elective Length of Stay

Performance

In September, delayed transfers of care (DTOCs) were at 6% (as a percentage of total occupied bed days). This is significantly above the plan of 3.3% (a Greater Manchester target) and is the worst monthly performance in 2017/18.

Non-elective length of stay (LoS) remains above plan for September at 4.7 days (against a target of 4.4 days).

Latest Update

The Bolton locality is working collaboratively to help to reduce pressure on the hospital and improve timely discharges to reduce length of stay and delayed transfers. The following are the key priorities to achieve this:

- Full implementation of the Integrated Discharge Team – which is now functioning as a single team and working to an agreed list of patients where daily actions are progressed to facilitate timely discharge. This has helped to significantly reduce the number of beds days "lost" as a result of patients who are medically optimised remaining in a hospital bed – which helps to reduce the overall average length of stay
- A multi-disciplinary team approach is being tested on the respiratory wards (D1 and D2) to help to expedite discharge of patients – with a focus on people going back to their own home where possible. This will be rolled out to all wards by the end of 2017/18. The reablement capacity is being enhanced to support this
- The discharge to assess process has been agreed and this is being rolled out for people being discharged home. This will be expanded to Extra Care (pilot from January 2018) and CHC assessments (in dedicated Care Home beds expected from February 2018). This will help to reduce DToCs.

The impact of the above initiatives will have a positive impact from November onwards but, as the additional capacity will not be fully in place until March 2018, this, together with the winter season, means that the DToC and LoS targets are unlikely to be achieved in 2017/18.

Recovery

Current Outcome: DTOC and LoS both failed for September 2017.

Expected Outcome: Both measures are expected to fail for Q3 and are unlikely to recover fully in this financial year

Timescale for Recovery: The plans in place for recovery are longer term and the targets are not expected to be achieved in 2017/18.

Lead Commissioning Manager: Paul Beech

Exception Report and Recovery Plan: Ambulance Call Outs to Care Homes

Performance

The CCG target for Ambulance callouts to Care Homes is 175 per month (April to December 2017). In September, there were 216 callouts, which is 23% above plan. The target reduces to 134 from January 2018.

Latest Update

A number of schemes have been put in place across care homes in Bolton to provide proactive and reactive support to reduce avoidable emergency transfers and admissions to hospital. These include:

- Enhanced primary care to care homes through a new service specification with GP Practices (one practice per care home) which has been approved and is being implemented from December once the contract variations have been signed and returned.
- 24/7 telehealth clinical support and triage has been commissioned (Immedicare) for all care homes, with 17 homes to be on line by the end of November
- Multi-disciplinary community services (including mental health for dementia care) being put in place to provide holistic support to care homes (for both proactive and reactive care)
- A falls coordinator is now in place to provide additional support to all care homes
- Training and support to all homes is being put in place through the Care Homes Excellence Group

The full impact of all the above programmes will be seen from January 2018.

Recovery

Current Outcome: Ambulance call outs to care homes are above plan by 1,153 (19%) YTD.

Expected Outcome: The target is to reduce callouts from Care Homes to 134 per month from January 2018 – when the full impact of the schemes will take effect. The CCG is confident that this target will be achieved by the end of Q4.

Timescale for Recovery: Improvements are expected to be seen in December with the full impact from January to March 2018.

Lead Commissioning Manager: Paul Beech

Exception Report and Recovery Plan: Hospital Acquired Infections

Performance

There were 5 Clostridium Difficile toxin (CDT) post 72 hour positive cases reported by Bolton FT in September 2017, of which 4 had lapses of care. YTD the FT has reported 21 cases, (of which 11 have had lapses in care) against a threshold of 19 cases.

Latest Update

The root cause analyses (RCAs) have been presented to the FT's CDT harm free care panels and learning shared at the Bolton Infection Prevention and Control Committee (IPCC).

Other actions being taken to support the reduction in CDT cases have been reported to previous Board meetings.

As anticipated in last month's report, Bolton FT has exceeded the maximum number of 19 CDT cases for 2017/18.

The CCG is continuing to support the FT in its' appeals process against the MRSA case apportioned to the trust. This was reported in last month's Board report.

Recovery

Current Outcome: Exceeded the CDT threshold of 19 cases for 2017/18

Expected Outcome: Failure of 2017/18 confirmed

Timescale for Recovery: This indicator has already failed for the year, although the actions outlined above are intended to minimise future CDT cases

Lead: Mike Robinson

Exception Report and Recovery Plan: Mixed Sex Accommodation

Performance

In September, there were 18 mixed sex accommodation (MSA) breaches at Bolton FT. This is a threefold increase from August's 6 breaches and represents a reverse in the improving trend seen over the summer months. This is largely due to the increased pressure on the system as the health economy moves into the winter months.

Latest Update

As updated in previous Board reports, MSA breaches continue to be an ongoing problem that requires significant estates changes to fully mitigate. Policy and practices have been reviewed by the trust and CCG. All breaches related to patients from within their High Dependency Unit (HDU) and the ongoing capacity issues within the trust's bed base. This issue remains a concern both internally and externally and the CCG is assured the Trust remains focused on eliminating MSA, prioritising the issue at daily bed meetings but prioritising patient safety over the requirement to move patients. Patient experience is gathered for all breaches and there have been no adverse reviews reported.

Recovery

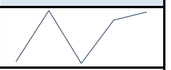
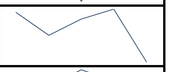
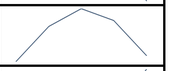
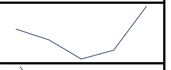
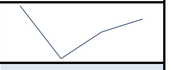
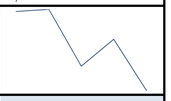
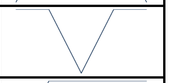
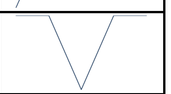
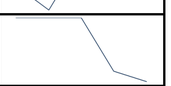
Current Outcome: Failing to meet the target of zero MSA breaches

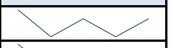
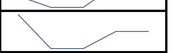
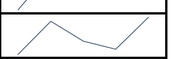
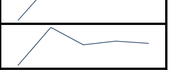
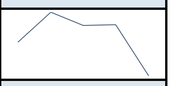
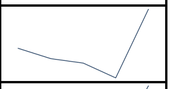
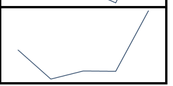
Expected Outcome: Failure of this target in 2017/18

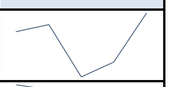
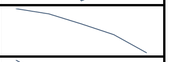
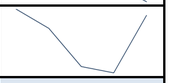
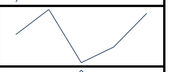
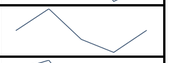
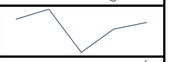
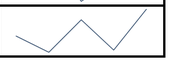
Timescale for Recovery: Not recoverable in 2017/18 due to ongoing estates issues previously reported to Board

Lead: Mike Robinson

NHS BOLTON CCG EXCEPTION REPORT

	Indicator Reference and Description	Target	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2017	Feb 2017	Mar 2017	Trend
BOLTON CCG															
Commissioning	**RTT**														
	Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	79.5%	82.7%	79.4%	82.1%	82.6%	79.8%							
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	91.0%	90.3%	90.8%	91.1%	89.5%	89.0%							
	Patients on an Incomplete pathway	92%	92.1%	92.7%	93.0%	92.8%	92.2%	91.96%							
	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	95%	1.2%	1.0%	0.7%	0.9%	1.5%	1.6%							
	Number of patients waiting more than 52 weeks - (Bolton CCG view) Incomplete	0	5	1	3	4	2	2							
	Cancer patients - 2 week wait -All Providers, CCG view														
	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	94.60%	98.70%	98.80%	96.90%	97.50%	97.90%							
	Maximum two week wait for first out patient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	89.40%	91.30%	44.70%	66.70%	24.80%	37.30%							
	Cancer waits - 31 days - All Providers, CCG View														
	Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96.0%	99.0%	99.10%	99.10%	99.10%	99.00%	98.20%							
	Maximum 31 day wait for subsequent treatment where that treatment is surgery	94.0%	100.0%	100.00%	95.20%	100.00%	100.00%	95.50%							
	Maximum 31 day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	98.0%	96.4%	100.00%	100.00%	100.00%	100.00%	100.00%							
	Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	94.0%	100.0%	100.00%	97.30%	100.00%	100.00%	100.00%							
	Cancer waits - 62 days - All Providers, CCG View														
	Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85.0%	90.2%	88.50%	92.20%	91.70%	92.90%	84.90%							
	Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90.0%	100.0%	100.00%	100.00%	83.30%	80.00%	57.10%							
	Maximum 62 day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)		83.3%	70.00%	72.70%	86.70%	85.70%	92.30%							

	Indicator Reference and Description	Target	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2017	Feb 2017	Mar 2017	Trend
Quality and safety	Mixed sex accommodation breaches - Bolton FT														
	Zero tolerance MSA breaches	0	21	10	11	10	6	18							
	HCAI-Healthcare Associated Infections														
	CDIFF-Post 72 hrs (Hospital)	19	4	2	1	6	3	5							
	MRSA-Post 48 hrs (Hospital)	0	0	1	0	0	0	0							
	Serious Incidents and Never Events														
	Serious Incidents	0	3	0	2	0	2	0							
	Never Events	0	1	0	0	0	0	0							
	Falls and Incidents - Bolton FT														
	Falls with at least moderate harm - Moderate	0	1	0	0	2	3	2							
	Falls with at least moderate harm - Severe	0	2	0	0	1	1	2							
	Medication Incidents	<100	100	114	94	100	122	152							
Transformation Fund	Transformation Fund														
	Elective and Daycase	-3%	-4.5%	16.2%	11.4%	11.5%	9.2%	802.0%							
	Non Elective	-4.08%	-9.9%	-4.1%	-7.6%	-9.0%	-3.4%	0.7%							
	Outpatient First	0%	-13.7%	-8.5%	-9.3%	-8.4%	-9.3%	-13.9%							
	Outpatient Follow Up	-2.52%	-10.7%	7.8%	-0.8%	1.1%	0.0%	-1.1%							
	Accident and Emergency	-3.49%	-3.8%	-1.3%	-1.3%	-2.1%	-1.2%	-1.7%							
Urgent Care	A&E Waits - Bolton FT														
	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - Bolton FT	95%	82.54%	86.40%	84.70%	84.80%	78.20%	84.50%							
	Category A ambulance calls - NWAS position														
	Category 1 response times - Mean	7.5 mins					10:07	09:49							
	Category 1 response times - 90th Percentile	15 mins					15:59	16:21							
	All handovers between ambulance and A&E must take place within 15 minutes (no of patients waiting >30 mins<59 mins) Bolton FT	0	270	245	235	199	364	319							
	All handovers between ambulance and A&E must take place within 15 minutes (no of patients waiting >60 mins) Bolton FT	0	133	64	83	82	226	183							

	Indicator Reference and Description	Target	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2017	Feb 2017	Mar 2017	Trend
Childrens and Maternity	**Childrens and Maternity**														
	% Completed Bookings by 12+6 weeks	90%	87.60%	88.20%	83.70%	85.00%	89.20%	90.20%							
	% of Admissions to E5 from A&O	<40%	33.00%	32.50%	31.60%	30.60%	28.90%	38.30%							
	% Conversion rate from A & E attendance to F5		9.20%	8.90%	8.30%	8.20%	9.10%	11.70%							
Mental Health	**Mental Health**														
	IAPT Access rate - (GMW, 1 point and Think Positive) Internal data	16.8% National 17.5% local	11.4%	14.7%	15.1%	15.0%	13.6%	14.3%							
	IAPT Recovery rate - (GMW, 1 point and Think Positive) Internal data	50.0%	59.0%	65.0%	65.3%	60.4%	60.5%	54.4%							
	RAID (Emergency seen in 1hr)	75.0%	71.2%	75.4%	66.5%	69.1%	74.7%	64.0%							
	Out of Area placements (New)	0	1	2	5	2	3	12							
Integrated and Community Care	**Integrated and Community Care**														
	DTOC as a percentage of occupied bed base - Bolton FT position	3.3%	5.5%	5.8%	2.9%	4.2%	3.9%	6.0%							
	Non Elective Los	<4.4	5.1	4.9	5.1	4.5	4.7	4.7							
	Pressure ulcers in Community	Reduce	12	17	10	7	12	11							
	Non Elective Admissions due to falls (Community - harm free care)	<15 per month	15	18	5	12	14	14							
	Ambulance call outs to care homes	<1,807	185	170	200	172	210	216							

Update on the provision of Stroke Care for the Bolton population

1. Introduction

The following section updates the CCG board on the current effectiveness of the Stroke and Transient Ischaemic Attack (TIA) pathways for the Bolton GP registered population. The paper looks at three key areas:

- TIA pathways
- Hospital Stroke Care pathways
- Community Stroke services

2. TIA pathways

The current NICE Guideline (Stroke and TIA in over 16s: diagnosis and initial management **CG68**) recommends stratification of patients suspected of a TIA using the ABCD² score, with high risk patients seen within 24 hours.

In January 2017 however, NICE announced that it will update this advice having considered "How accurately do scoring systems predict which patients with suspected TIA need to be referred urgently for specialist assessment?". Their topic experts advised that the current recommendations on using the ABCD² score to triage people with suspected TIA are no longer appropriate.

At the time of developing the guideline, stroke service capacity was more limited than it is now and was an important consideration. Topic experts thought that stroke services have now developed sufficiently that assessing people with suspected TIA within 24 hours is achievable. Additionally, the ABCD² score does not help to decide who to refer for specialist assessment and the RCP Clinical Guideline for Stroke 2016 has recently updated its advice to remove risk stratification.

Currently, the nine stroke units across GM offer different TIA services for their residents, with none able to fully assess all patients within 24 hours (i.e. offer a 7 day service):

- CMFT – 5 day service at MRI and Trafford General Hospital (triage Fairfield General Hospital – establishing 7 day service for Bury, Oldham, North Manchester & Rochdale.
- Wigan Infirmary – partial 7 day service as Doppler not available at weekends.
- Bolton FT – 5 day service looking to establish a 7 day service.
- SRFT – establishing a 7 day service, limited access to Doppler.
- Stepping Hill Hospital – establishing 7 day service for Stockport & Eastern Cheshire.
- Tameside General Hospital – 5 day service.
- UHSM - 5 day service.

An audit of TIA referrals across GM also revealed there were approximately, 50 referrals/month, at weekends and that roughly half of the referrals were not diagnosed as TIAs.

In 2011, under the auspices of the Cardiovascular Clinical Network, work was undertaken to establish a Greater Manchester TIA service. However, no agreement was reached and a city wide service was not established. The challenges in providing a 7 day service for all suspected TIA patients are mainly two-fold and relate to limitations at weekends of:

- Staffing to support a specialist assessment
- Diagnostics - availability of CT, MR, Doppler, ECG and venepuncture
- Administrative support
- Access to vascular surgeons

The GM Stroke Operational Delivery Network (GM SODN) considered how to take forward 7 day TIA services at its Clinical Effectiveness Group in July 2017. It was agreed that it was unlikely that a GM wide solution was possible but that a "sector" approach could be taken to ensure services met the RCP guideline in all localities.

In May 2017 the CCG took the decision to continue developments with SRFT to transfer the Bolton TIA service. The Urgent Care Commissioning Team have worked with colleagues at SRFT and tracked the progress of the developments to ensure a 7 day service was achievable prior to serving any notice to Bolton FT's service.

In August 2017, it became apparent that SRFT were struggling to recruit the necessary consultant cover and Doppler access to provide the 7 day service for Bolton patients. As a result of this, the commissioning team escalated the challenges to senior management at SRFT for any further reassurance that the service would be available. Unfortunately this assurance has not been given due to the national shortage of specialist stroke consultants hindering the ability to recruit to the posts for the 7 day service.

Alongside the development work with SRFT, the performance of the Bolton FT TIA service has continued to be monitored. The following table shows the performance to date for 2017/18:

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD
Stroke care - high risk TIA cases investigated and treated within 24 hours Target - >=60%	0.00%	42.90%	20.00%	60.00%	20.00%	48.60%	28.26%

The Bolton FT service has seen some improvement which has been achieved through the development of an additional clinic and increasing the service from a 4 day clinic service to a 5 day clinic service.

In light of the lack of assurance from SRFT, aligned with the marginal improvement of the Bolton FT performance, the Urgent Care Commissioning team, along with Bolton FT colleagues, have approached the GM SODN to explore the options of any sector wide developments for a TIA service.

The CCG is unaware of any adverse outcomes for patients as a result of the current pathway. Continued discussions will take place with SRFT, WWL and the GM SODN and updates will be provided to the CCG Executive accordingly.

3. Hospital Stroke Care pathways

Following the centralisation of GM hospital stroke services in 2015, the hospital care pathway has continued to improve over time. Residents in all 13 of the CCG areas served by the GM pathway now receive an 'A' rating in the national stroke audit (SSNAP) that measures 44 indicators of care known to improve patient outcomes. This is not replicated anywhere else in England.

The performance of the hyper-acute units and district stroke centres (DSC), including Bolton FT, is closely monitored by the GM SODN with improvements made in conjunction with CCG's and Providers.

The total number of strokes in GM increased by 17% in the year following centralisation (March 2015) with a 13% increase in strokes on the acute pathway (i.e. not haemorrhages on neurosurgical pathways). Total strokes are projected to decline 7% in 2016/17, and Bolton FT has experienced a slight fall in activity following centralisation.

Overall, 85% of GM stroke patients are conveyed by ambulance to hospital and 96% of conveyances by ambulance to hospital are appropriate. There has been a 27% decrease in stroke assessments in A&E at DSCs and there has been a 72% decrease in the volume of mimics and TIAs at hyper-acute stroke units (HASUs) which is likely due to better recognition by ambulance crews.

All direct admissions at DSCs are now reported as appropriate as they meet the exclusions for being treated at a HASU, and in all cases, potentially eligible patients seen at a DSC are being discussed with the relevant HASU to determine if they should be transferred.

There has been a 9% increase in the % of strokes identified <4hours from time of onset and a 13% decrease in the % of strokes identified between 4 to 48 hours, suggesting better recognition and more rapid conveyance to hospital. There are also more patients presenting at HASUs eligible for thrombolysis.

Overall GM HASU patient centred scores have increased by 20 points since 2014, compared to only a 10 point increase nationally. There is a similar picture of improvement at our DSCs, with all scoring above the national average and the GM DSC average is 10 points higher than the national average for patient centred scores.

All nine stroke units are now rated 'A' for case ascertainment, meaning they are uploading almost all stroke cases onto the audit programme. Audit compliance is also good and currently 'A' rated at Bolton FT.

Ten key indicators highlight the quality of care being delivered by each stroke team and the GM HASUs score well, with most domains rated 'A' or 'B' with a single 'C' at SRFT for speech and language therapy (SALT).

DSCs have more variable scores for the key indicators of care but most are delivering 'A' or 'B' rated care in almost all domains. SALT remains an issue for most units and is rated 'E' at Bolton FT. There are on-going issues in Bolton for patients arriving in a designated stroke bed within 4 hours of arrival and spending 90% of their time on a stroke unit. These remain a challenge in some hospitals due to internal bed management processes and other factors such as delayed discharges although Bolton was rated 'A' for discharge processes. Previous concerns regarding the ability of SRFT to repatriate patients back to Bolton FT, following their hyper-acute management, appear to have settled and both Trusts are working closely on this.

One of the main risks to the hospital pathway at present is the ability of SRFT, as the only 24/7 7 days/week service (the other 2 HASU's at Stockport and Fairfield are not 24/7), to cope with the high volumes of stroke. SRFT is the largest stroke unit in the country and this high volume will be further exacerbated when the Intra-arterial intervention service (IAT) is implemented in 2018. The GM SODN is currently exploring a number of options as to how to best address this.

All 9 GM Trusts are in the top 100 in England (out of 228) with the HASU's at Fairfield and Salford being ranked 1st and 2nd respectively and Bolton currently being ranked 85th.

4. Community Stroke services

The CCG's Integration Team has undertaken a review of the current Community Stroke Team (CST) and mapped out the service pathways along with current staffing. The CCG has worked with the service to produce a gap analysis based on the GM SODN recommendations. The CCG is unaware of any adverse outcomes for patients as a result of these gaps.

Joint working has commenced with the CCG and the service to develop the Early Supported Discharge and Complex stroke pathways. The CCG is looking into community data regarding the service and assessing the need within each pathway. Recommendations are being developed to reduce the service gap across both pathways in conjunction with wider services. Bolton CCG aims to produce these recommendations by the end of February 2018.

Areas for improvement	Action	Timescale
Neuro-psychologist: The ODN has recommended close links with a neuro-psychologist through the service. Options are being looked into with the current service to assess how these links can be built alongside other community teams.	Service looking into how this can be supported by acute neuro-psychologist. The CCG will review how this will impact on acute division.	February 2018
Social worker: Links to social workers have been recommended and the CCG is working to improve these links within the stroke pathways.	CCG to review options available with other services such as INT.	January 2018
Links with Reablement: The CCG is looking at how the CST and Reablement services can work more closely to support patients.	Meet with the Reablement lead to review onward referral	January 2018

	within the pathway and the implications for the team.	
Contact with the acute service: Improving links between the CST and acute services features within the ODN's recommendations. Work has been undertaken to improve links between SRFT and Bolton FT.	Members of the CST have met with Salford and visit ward rounds twice weekly.	Complete
Service response to patients – The ODN has recommended CCGs and services review access and intensity with regard to stroke treatment. The CCG is working with the service to produce options on how these recommendations can be supported.	Fully costed options to be produced jointly with the service.	January 2018
Full 6 days per week CST: The GM SODN has recommended a 6 day/week service. The CCG is looking into what further input the team's pathways needs on Saturdays with regard to the current 6 day arrangements.	The service sees new patients for assessments on Saturdays but does not undertake follow ups. The CCG will review the needs of the service and produce options.	December 2018
Discharge after 6 months: The CCG is working with the CST to identify how patients can be discharged within the GM SODN's recommended 6 month timescales.	The CCG and CST will review onward referral routes and the impact on other services. The CCG will assess the numbers of patients that are currently with the service after 6 months.	February 2018
Young people support groups: The CCG has been looking into what support stroke patients can receive from the voluntary sector for young people suffering from stroke.	Meeting to be arranged with the Voluntary Sector groups to develop appropriate links.	February 2018
6 and 12 month reviews: The CCG has been looking into options regarding 6 and 12 monthly reviews and how these reviews can be undertaken within the current stroke pathway.	A pilot is being undertaken for 6 month reviews and is on-going. Options are being costed on support for reviews within the team or by the voluntary sector.	December 2017

5. Next Steps

Sector wide TIA services are being developed and updates will be brought through CCG Executive in due course.

The GM Hospital Stroke pathway is generally performing well with areas for improvement highlighted and governed via the GM SODN Clinical Effectiveness Group. A number of areas for improvement have been identified within community stroke services, the performance data is still being assessed and further

development will be a continued focus for the CCG's Integrated Commissioners, Bolton FT and the GMSODN.

The CCG's Integrated Commissioning team will continue to develop a 7 day service for TIA patients with NW Partnership providers and the GM SODN, as described above.

The CCG's Integrated Commissioning team will review the funding streams for the hospital stroke and community pathways to ensure appropriate distribution between the HASU's, DSC's and Community Services and to maximise patient long term outcomes.

The CCG will also review current provision against NICE Quality Standard 2 'Stroke in Adults' (QS2) to direct the CCG in improving the structure, process and outcomes of stroke care.

The Board is asked to note the current provision for stroke care, current performance and the above actions.