Meeting Date	**30th May 2019**	**Agenda Item**	**3.3**
Report Title	**Integrated Performance Report**		
Report Author	Hannah Roan, Performance and Contracting Manager		
Report Sponsor	Darren Griffiths, Associate Director of Performance		
Presented by	Darren Griffiths, Associate Director of Performance		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide an update on the current performance of the Health Board at the end of the most recent reporting window in delivering key performance measures outlined in the 2019/20 NHS Wales Delivery Framework.		
Key Issues	This Integrated Performance Report provides an overview of how the Health Board is performing against the National Delivery measures and key local quality and safety measures. Actions are listed where performance is not compliant with national or local targets as well as highlighting both short term and long terms risks to delivery. In preparation for the transfer of Bridgend to Cwm Taf Morgannwg (CTM) University Health Board from 1st April 2019, the performance work stream has been working on disaggregating historic data, where logical to do so, to facilitate comparative trends on a Swansea Bay University (SBU) Health Board basis. For consistency, all charts in this report follow the same format of solid coloured bars representing Swansea Bay UHB and striped bars for Abertawe Bro Morgannwg University (ABMU) Health Board or Bridgend (as relevant). A suite of performance report cards are included in this report as a detailed summary of end of 2018/19 quarter four performance. The report cards can be found in section ten of this report. In addition, the NHS Delivery Framework contains a number of qualitative measures that are reported via self-assessment templates. Internal Audit has recommended that the committee should have sight of the		

<table>
<tr><td></td><td colspan="4">submissions, therefore copies of the reporting templates submitted to Welsh Government in April 2019 are included in section eleven of this report.
Additional measures for Primary and Community Services and Mental Health & Learning Disabilities were to be included in this month's report however further work is required to gain agreement on the best measures that represent the Units as well as establishing robust data flows to enable accurate monthly reporting. The Primary and Community Services Unit have undertaken a significant amount of engagement with the heads of services and agreed that the following measures will be reported in the July 2019 report:
• Common Ailment Scheme: Number of consultations provided
• Dentistry:
o Flouride Varnish rates
o Restorative Dentistry RTA within 26 weeks
• Children and young people
o Compliance with the Healthy Child Wales Programme
o HPV vaccine rates
• Community Resource Team
o Hospital admissions of USC admissions avoided
o Bed days saved
• GP Out of Hours: Reporting on new national standard
• Eye care: Numbers of patients receiving care from Eye Health Examination Wales (EHEW) and Low Vision Services
• Workforce: Variable pay

Further work is required to agree on measures for Mental Health and Learning Disabilities and Public Health. The anticipated date for reporting all of the new measures is July 2019.</td></tr>
<tr><td rowspan="2">Specific Action Required</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
<tr><td></td><td></td><td>✓</td><td></td></tr>
<tr><td>Recommendations</td><td colspan="4">Members are asked to:
• note current Health Board performance against key measures and targets and the actions being taken to improve performance.</td></tr>
</table>

	• note the self-assessment templates submitted to Welsh Government

Governance and Assurance		
Link to Enabling Objectives *(please choose)*	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☐
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
The performance report outlines performance over the domains of quality and safety and patient experience, and outlines areas and actions for improvement. Quality, safety and patient experience are central principles underpinning the National Delivery Framework and this report is aligned to the domains within that framework.		

There are no directly related Equality and Diversity implications as a result of this report.

Financial Implications

At this stage in the financial year there are no direct impacts on the Health Board's financial bottom line resulting from the performance reported herein except for planned care. The Health Board is currently discussing additional funding for backlog reduction with Welsh Government which may result in additional funds being available, but also the possibility of a clawback mechanism if funding is to flow.

Legal Implications (including equality and diversity assessment)

A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.

Staffing Implications

A number of indicators monitor progress in relation to Workforce, such as Sickness and Personal Development Review rates. Specific issues relating to staffing are also addressed individually in this report.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The '5 Ways of Working' are demonstrated in the report as follows:

- **Long term** – Actions within this report are both long and short term in order to balance the immediate service issues with long term objectives. In addition, profiles have been included for the Targeted Intervention Priorities for 2019/20 which provides focus on the expected delivery for every month as well as the year end position in March 2020.
- **Prevention** – the NHS Wales Delivery framework provides a measureable mechanism to evidence how the NHS is positively influencing the health and well-being of the citizens of Wales with a particular focus upon maximising people's physical and mental well-being.
- **Integration** – this integrated performance report brings together key performance measures across the seven domains of the NHS Wales Delivery Framework, which identify the priority areas that patients, clinicians and stakeholders wanted the NHS to be measured against. The framework covers a wide spectrum of measures that are aligned with the Well-being of Future Generations (Wales) Act 2015.
- **Collaboration** – in order to manage performance, the Corporate Functions within the Health Board liaise with leads from the Delivery Units as well as key individuals from partner organisations including the Local Authorities, Welsh Ambulance Services Trust, Public Health Wales and external Health Boards.
- **Involvement** – Corporate and Delivery Unit leads are key in identifying performance issues and identifying actions to take forward.

Report History	This is a routine bi-monthly report to the board but it is also noted by the Performance and Finance Committee on a monthly basis, with a drilled down version produced for the Quality and Safety Committee.

Appendices	None.

Summary of performance against national and local measures

1. OVERVIEW

The following summarises the key successes, along with the priorities, risks and threats to achievement of the quality, access and workforce standards.

Successes	Priorities
• The Health Board achieved the internal target of 2,042 for the number of patients waiting over 36 weeks for treatment by attaining 1,976 in April 2019. This continues to be the best position since January 2014. • Therapy waiting times continue to be maintained at (or below) 14 weeks. • Sustained improvement in 4 hour stroke performance in Morriston since September 2018 as a result of the front door pilot. In April 2019, the internal profiles were achieved for CT scan within 1 hour, consultant assessment within 24 hours and thrombolysis within 45 minutes. • In April 2019, the internal profiles for healthcare acquired infections were achieved for C. difficile and E.Coli Bacteraemia. • Successful visit by the Health Minister to Cwmtawe Cluster to see progress made on transformation	• Review and monitor the impact of the boundary change on ambulance resources within Swansea Bay – particularly in relation to Category A response times. • Implementation of unscheduled care improvement plans agreed as part of our annual plan for 2019/20, and embedding the improvement actions from previous quarters. • Improve ambulatory emergency care pathways for medicine • Development of a stroke early support discharge service/ stroke remodelling. • Ensure delivery of Q1 planned care profiles through implementation of a modest outsourcing programme and maximising core capacity. • Morriston to develop and implement step change plans to maintain continual improvement in the reduction of long waiting patients.
Opportunities	**Risks & Threats**
• Implementation and embedding the models of care to provide more timely discharge and value based care for frail older people including ICOP service at Singleton, the OPAS service at Morriston, and the enabling ward and early supported discharge service at NPTH. • Acute Deterioration Service in Morriston from 1st May 2019 which will provide 24/7 hospital handover arrangements for sickest patients. • Development of long term posts in therapies and pharmacies to support winter plans in a sustainable format • Review of pilot focusing on early communication and additional support to aid early return to work for short-term absences.	• Continued impact of Bridgend Boundary Change in relation to accurate data reporting for workforce metrics such as staff turnover • Delay in NWIS receiving the new postcode file in order to update the postcode look-ups that feed into clinical apps will have a short term impact on LTA monitoring. • Peaks in demand/ patient acuity above predicted levels of activity in Morriston Emergency Department. • Capacity gaps in Care Homes, CRT and capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit' • HMRC taxation changes has been escalated within Welsh Government as a risk to the delivery of additional planned care capacity through loss of flexible opportunities.

2. TARGETED INTERVENTION PRIORITY MEASURES SUMMARY (HEALTH BOARD LEVEL) – April 2019

			Quarter 1			Quarter 2			Quarter 3			Quarter 4			All-Wales benchmark position
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	74.5%												6th
		Profile	*77.1%*	*80.0%*	*81.9%*	*83.8%*	*84.6%*	*85.5%*	*85.7%*	*84.3%*	*84.4%*	*85.0%*	*86.2%*	*86.0%*	
	12 hour A&E waits	Actual	653												4th
		Profile	*484*	*374*	*273*	*283*	*266*	*238*	*273*	*279*	*211*	*185*	*187*	*180*	
	1 hour ambulance handover	Actual	732												6th**
		Profile	*320*	*233*	*201*	*220*	*193*	*200*	*208*	*248*	*241*	*176*	*148*	*145*	
Stroke	Direct admission within 4 hours	Actual	62.0%												4th**
		Profile	*76%*	*77%*	*78%*	*78%*	*79%*	*80%*	*80%*	*81%*	*82%*	*82%*	*83%*	*84%*	
	CT scan within 1 hour	Actual	*62%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	4th**
		Profile	*47%*												
	Assessed by Stroke Specialist within 24 hours	Actual	96%												3rd**
		Profile	*87%*	*89%*	*92%*	*89%*	*91%*	*94%*	*91%*	*93%*	*96%*	*93%*	*95%*	*96%*	
	Thrombolysis door to needle within 45 minutes	Actual	*27%*												5th**
		Profile	*20%*	*25%*	*25%*	*30%*	*30%*	*30%*	*35%*	*35%*	*35%*	*40%*	*40%*	*40%*	
Planned care	Outpatients waiting more than 26 weeks	Actual	*236*												2nd *(Feb-19)*
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
	Treatment waits over 36 weeks	Actual	*1,976*												5th *(Feb-19)*
		Profile	*2,042*	*2,038*	*2,125*	*2,148*	*2,132*	*2,137*	*1,989*	*2,024*	*2,153*	*2,057*	*1,960*	*1,921*	
	Diagnostic waits over 8 weeks	Actual	*401*												6th *(Feb-19)*
		Profile	*480*	*400*	*390*	*370*	*330*	*250*	*180*	*150*	*130*	*100*	*50*	*0*	
	Therapy waits over 14 weeks	Actual	*0*												Joint 1st *(Feb-19)*
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
Cancer	NUSC patients starting treatment in 31 days	Actual	94%												6th** *(Feb-19)*
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	
	USC patients starting treatment in 62 days	Actual	88%												6th** *(Feb-19)*
		Profile	*91%*	*94%*	*93%*	*96%*	*96%*	*94%*	*94%*	*94%*	*95%*	*95%*	*95%*	*96%*	
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	3												7th
		Profile	17	12	12	15	12	9	12	12	12	13	14	11	
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	14												7th
		Profile	11	14	12	13	12	11	11	15	15	10	16	11	
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	27												6th
		Profile	41	36	37	40	38	39	40	32	34	40	36	39	

**RAG status derived from performance against trajectory*

*** All-Wales benchmark highlights the Health Board's positon in comparison with the other seven Health Boards however some measures are only applicable to six of the seven Health Board as Powys HB has been excluded*

3. INTEGRATED PERFORMANCE DASHBOARD

The following dashboard provides an overview of the Health Board's performance against all NHS Wales Delivery Framework measures and key local measures.

STAYING HEALTHY- People in Wales are well informed and supported to manage their own physical and mental health

Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	ABMU Apr-18	ABMU May-18	ABMU Jun-18	ABMU Jul-18	ABMU Aug-18	ABMU Sep-18	ABMU Oct-18	ABMU Nov-18	ABMU Dec-18	ABMU Jan-19	ABMU Feb-19	ABMU Mar-19	SBU Apr-19
Childhood Immunisation & Health Visiting	% children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	National	Q3 18/19	96%	95%			95.3%							96%			96%				
	% of children who received 2 doses of the MMR vaccine by age 5	National	Q3 18/19	91%	95%	92%	✗	92.3%				91%			90%			91%				
	% 10 day old children who have accessed the 10-14 days health visitor contact component of the Healthy Child Wales Programme	National	Q3 18/19	89%	4 quarter ↑ trend			90.4%				81%			73%			89%				
Influenza	% uptake of influenza among 65 year olds and over	National	Mar-19	68.3%	75%	70%	✗	67.8%								42.5%	59.3%	66.1%	67.5%	68.0%	68.3%	
	% uptake of influenza among under 65s in risk groups	National	Mar-19	44.0%	55%	65%	✗	42.8%								25.3%	34.0%	40.4%	41.7%	42.6%	44.0%	
	% uptake of influenza among pregnant women	National	2017/18	93.3%	75%		✓	72.7%														
	% uptake of influenza among children 2 to 3 years old	National	Mar-19	49.3%		40%	✓	48.1%								20.4%	35.9%	46.0%	47.2%	47.7%	49.3%	
	% uptake of influenza among healthcare workers	National	Mar-19	54.5%	60%	50%	✓									43.2%	50.4%	52.3%	53.8%	54.1%	54.5%	
Smoking	% of pregnant women who gave up smoking during pregnancy (by 36- 38 weeks of pregnancy)	National	2017/18	4.4%	Annual ↑			27.1%														
	% of adult smokers who make a quit attempt via smoking cessation services	National	Feb-19	2.3%	5% annual target	2.9%	✗	2.2%		0.2%	0.5%	0.7%	0.9%	1.1%	1.3%	1.5%	1.7%	1.8%	2.1%	2.3%		
	% of those smokers who are co-validated as quit at 4 weeks	National	Q3 18/19	55.4%	40% annual target	40.0%	✓	43.8%				62%			57%			55%				
Learning Disabilities	% people with learning disabilities with an annual health check	National			75%					*Awaiting publication of 2018/19 data.*												
Alcohol	European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales	National			4 quarter ↓					*New measure for 2019/20. Awaiting publication of data*												

SAFE CARE- People in Wales are protected from harm and supported to protect themselves from known harm

Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	ABMU Apr-18	ABMU May-18	ABMU Jun-18	ABMU Jul-18	ABMU Aug-18	ABMU Sep-18	ABMU Oct-18	ABMU Nov-18	ABMU Dec-18	ABMU Jan-19	ABMU Feb-19	ABMU Mar-19	SBU Apr-19
Prescribing	Opioid average daily quantities per 1,000 patients	National			4 quarter ↓					New measure for 2019/20- awaiting publication of data.												
	Patients aged 65 years or over prescribed an antipsychotic	National			qtr on qtr ↓					New measure for 2019/20- awaiting publication of data.												
	Total antibacterial items per 1,000 STAR-PUs	National	Q3 18/19	331	4 quarter ↓			265.5				307			289			331				
	Fluroquinolone, cephalosoporin, clindamycin and co-amoxiclav items as a % of total antibacterial items prescribed	National	Q3 18/19	8%	4 quarter ↓			7.6%				10%			10%			8%				
	Number of administration, dispensing and prescribing medication errors reported as serious incidents	Local	Mar-19	0	12 month ↓	0	✗	2		0	0	0	0	0	0	0	0	1	0	0	0	
Antimicrobial Audits	% indication for antibiotic documented on medication chart	Local	Jan-19	90%		*95%*	✗						*87%*		*94%*		*90%*		*90%*			
	% stop or review date documented on medication chart	Local	Jan-19	56%		*95%*	✗						*61%*		*54%*		*56%*		*56%*			
	% of antibiotics prescribed on stickers	Local	Jan-19	47%		*95%*	✗						*77%*		*73%*		*78%*		*47%*			
	% appropriate antibiotic prescriptions choice	Local	Jan-19	96%		*95%*	✓						*96%*		*97%*		*95%*		*96%*			
	% of patients receiving antibiotics for >7 days	Local	Jan-19	13%		*20%*	✓						*8%*		*15%*		*9%*		*13%*			
	% of patients receiving surgical prophylaxis for > 24 hours	Local	Jan-19	46%		*20%*	✗						*25%*		*8%*		*73%*		*46%*			
	% of patients receiving IV antibiotics > 72 hours	Local	Jan-19	47%		*30%*	✗						*41%*		*49%*		*42%*		*47%*			
Infection control	*Number of E.Coli bacteraemia cases (Hospital)*	National	*Apr-19*	*10*		*12*	✓			*10*	*15*	*10*	*20*	*16*	*15*	*17*	*23*	*15*	*11*	*15*	*21*	*10*
	Number of E.Coli bacteraemia cases (Community)	National		*17*		*29*	✓			*32*	*28*	*31*	*31*	*30*	*34*	*24*	*30*	*23*	*17*	*16*	*22*	*17*
	Total number of E.Coli bacteraemia cases	National		*27*		41	✓			42	43	41	51	46	49	41	53	38	28	31	43	27
	Number of S.aureus bacteraemias cases (Hospital)	National	*Apr-19*	*11*		*6*	✗			*6*	*8*	*7*	*8*	*9*	*7*	*7*	*7*	*5*	*9*	*9*	*4*	*11*
	Number of S.aureus bacteraemias cases (Community)	National		*3*		*5*	✓			*8*	*13*	*12*	*9*	*11*	*3*	*5*	*10*	*6*	*9*	*7*	*7*	*3*
	Total number of S.aureus bacteraemias cases	National		*14*		11	✗			14	21	19	17	20	10	12	17	11	18	16	11	14
	Number of C.difficile cases (Hospital)	National	*Apr-19*	*2*		*13*	✓			*20*	*13*	*10*	*24*	*8*	*5*	*15*	*9*	*5*	*3*	*4*	*3*	*2*
	Number of C.difficile cases (Community)	National		*1*		*4*	✓			*6*	*5*	*5*	*5*	*7*	*4*	*4*	*1*	*11*	*4*	*3*	*5*	*1*
	Total number of C.difficile cases	National		*3*		17	✓			26	18	15	29	15	9	19	10	16	7	7	8	3
	Number of Klebsiella cases (Hospital)	National	*Apr-19*	*2*		3	✓			3	5	6	1	6	6	11	5	11	10	15	4	2
	Number of Klebsiella cases (Community)	National		*3*		6	✓			7	9	3	6	6	6	9	9	1	6	5	4	3
	Total number of Klebsiella cases	National		*5*		9	✓			10	14	9	7	12	12	20	14	12	16	20	8	5
	Number of Aeruginosacases (Hospital)	National	*Apr-19*	*3*		1	✗			1	2	1	2	1	0	2	4	2	0	0	0	3
	Number of Aeruginosa cases (Community)	National		*0*		0	✓			0	3	2	1	0	3	0	2	3	0	2	0	0
	Total number of Aeruginosa cases	National		*3*		1	✗			1	5	3	3	1	3	2	6	5	0	2	0	3
	Hand Hygiene Audits- compliance with WHO 5 moments	Local	Apr-19	96%		95%	✓			95%	96%	95%	96%	97%	98%	97%	97%	98%	96%	96%	95%	96%
Incidents & Risks	Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale	National	Q3 18/19	0	0			2				2			-			0				
	Of the serious incidents due for assurance, the % which were assured within the agreed timescales	National	Apr-19	70%	90%	75%	✗	27.1%		79%	85%	85%	81%	87%	86%	56%	82%	89%	80%	68%	43%	70%
	Number of new Never Events	National	Apr-19	0	0	0	✓	2		0	0	0	0	0	0	0	0	0	0	0	1	0
	Number of risks with a score greater than 20	Local	Apr-19	72		12 month ↓	✓			58	57	60	67	77	73	66	45	48	53	54	51	72
	Number of risks with a score greater than 16	Local	Apr-19	167		12 month ↓				New local measure for 2019/20												167
	Number of Safeguarding Adult referrals relating to Health Board staff/ services	Local	Apr-19	15		12 month ↓	✗			8	12	10	22	14	7	13	8	12	6	17	15	15
	Number of Safeguarding Children Incidents	Local	Apr-19	6		0	✗			5	11	5	12	14	3	10	9	3	13	7	7	6
Pressure Ulcers	Total number of pressure ulcers acquired in hospital	Local	Apr-19	29		12 month ↓	✓			48	47	39	56	45	53	47	40	40	50	45	64	29
	Total number of pressure ulcers acquired in hospital per 100k admissions	Local	Apr-19	312		12 month ↓	✓			582	505	457	635	496	601	499	432	468	549	508	671	312
	Number of grade 3+ pressure ulcers acquired in hospital	Local	Apr-19	1		12 month ↓	✓			6	1	2	3	1	1	6	3	3	4	10	7	1
	Total Number of pressure ulcers developed in the community	Local	Apr-19	34		12 month ↓	✓			67	80	81	68	88	71	60	62	58	77	62	47	34
	Number of grade 3+ pressure ulcers developed in the community	Local	Apr-19	10		12 month ↓	✗			11	14	15	11	13	8	9	12	13	16	11	10	10
Inpatient Falls	Number of Inpatient Falls	Local	Apr-19	210		12 month ↓	✓			333	357	326	300	290	328	293	291	300	341	276	326	210
Self Harm	Rate of hospital admissions with any mention of intentional self-harm of children and young people (aged 10-24 years)	National	2017/18	3.14	Annual ↓			4.00		2017/18= 3.14												
Mortality	Amenable mortality per 100k of the European standardised population	National	2016	142.9	Annual ↓			140.6		2016= 142.9												
HAT	Number of potentially preventable hospital acquired thromboses (HAT)	National	Q3 18/19	2	4 quarter ↓			16			1			3			2					
Sepsis	% in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' 1st hour care bundle within 1 hour of positive screening	National	Mar-19	43%	12 month ↑			93%		31%	26%	18%	34%	23%	40%	50%	40%	53%	18%	43%	43%	
	% patients who presented at ED with a positive sepsis screening who have received all elements of the 'Sepsis Six' 1 hour care bundle within 1 hour of positive screening	National	Nov-18	55%	12 month ↑			83%		38%	48%	34%	44%	41%	53%	75%	55%	-	-	-	-	

EFFECTIVE CARE- People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that acre successful																								
										ABMU														SBU
Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
DTOCs	Number of mental health HB DToCs	National	Apr-19	18	12 month ↓	27	✔			28	22	30	27	30	29	28	26	25	29	26	21	18
	Number of non-mental health HB DToCs	National	Apr-19	49	12 month ↓	70	✖			34	64	75	74	85	69	84	125	117	104	87	112	49
Mortality	% of universal mortality reviews (UMRs) undertaken within 28 days of a death	National	Apr-19	86%	95%	95%	✔	77.0%		95%	92%	95%	97%	97%	94%	98%	97%	94%	81%	99%	98.1%	86.0%
	Stage 2 mortality reviews required	Local	Apr-19	10						23	14	16	12	19	19	16	22	17	7	10	22	21
	% stage 2 mortality reviews completed	Local	Feb-19	40%		100%				87.0%	64.3%	62.5%	50.0%	44.0%	47.4%	25.0%	27.3%	40.0%	28.57%	20.00%		
	Crude hospital mortality rate (74 years of age or less)	National	Mar-19	0.77%	12 month ↓			0.72%		0.81%	0.81%	0.80%	0.79%	0.77%	0.76%	0.77%	0.77%	0.77%	0.76%	0.76%	0.77%	
NEWS	% patients with completed NEWS scores & appropriate responses actioned	Local	Apt-19	90.6%		98%	✔			96.5%	98.3%	98.1%	99.2%	99.3%	97.9%	97.5%	99.0%	98.4%	98.2%	99.0%	94.0%	90.6%
Info Gov	% compliance of level 1 Information Governance (Wales training)	National	Apr-19	84%	85%					62%	64%	66%	71%	74%	77%	78%	81%	83%	83%	84%	85%	84%
Coding	% of episodes clinically coded within 1 month of discharge	National	Mar-19	92%	95%	96%	✖	86.5%		94%	93%	94%	95%	93%	96%	95%	88%	91%	93%	95%	92%	
	% of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	National	2018/19	91%	Annual ↑			92.3%		2018/19= 91.2%												
E-TOC	% of completed discharge summaries	Local	Apr-19	59%		100%	✖			68.0%	64.0%	60.0%	59.0%	62.0%	61.0%	67.0%	63.0%	61.0%	62.0%	60.0%	61.0%	59.0%
Treatment Fund	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	National	Q2 18/19	100%	100%	100%	✔	98%				100%			100%							
Research	Number of Health and Care Research Wales clinical research portfolio studies	National	Q3 18/19	78	10% annual ↑	79	✖					60			67			78				
	Number of Health and Care Research Wales commercially sponsored studies	National	Q3 18/19	31	5% annual ↑	35	✖					17			22			31				
	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	National	Q3 18/19	1,463	10% annual ↑	1,821	✖					732			1,116			1,463				
	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	National	Q3 18/19	99	5% annual ↑	316	✖					46			59			99				

DIGNIFIED CARE- People in Wales are treated with dignity and respect and treat others the same																								
										ABMU														SBU
Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
Patient Experience	Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	National	2016/17	5.97	Annual ↑			6.19		2016/17= 5.97												
	Number of new formal complaints received	Local	Apr-19	93		12 month ↓ trend	✔			119	119	90	126	126	114	140	91	84	138	96	114	93
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	National	Feb-19	83%	75%	78%	✔	58.5%		80%	83%	80%	81%	81%	83%	88%	90%	80%	84%	83%		
	% of acknowledgements sent within 2 working days	Local	Apr-19	100%		100%	✔			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	% of adults (aged 16+) who had a hospital appointment in the last 12 months, who felt they were treated with dignity and respect	National								New measure for 2019/20.												
	% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at their GP/family doctor	National	2017/18	83.4%	Annual ↑			85.5%		2017/18= 83.4%												
	% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital	National	2017/18	89.0%	Annual ↑			89.8%		2017/18= 89.0%												
	Number of procedures postponed either on the day or the day before for specified non-clinical reasons	National	Feb-19	3,373	> 5% annual ↓			14,896			4,187		3,528	3,544	3,490	3,332		3,364		3,373		
Dementia	% of patients aged>=75 with an Anticholinergic Effect on Condition of >=3 for items on active repeat	National	Q2 18/19	8.0%	4 quarter ↓			7.2%				8.0%			8.0%			7.9%				
	% of people with dementia in Wales age 65 years or over who are diagnosed (registered on a GP QOF register)	National	2017/18	57.6%	Annual ↑			53.1%		2017/18= 57.6%												
	% GP practices that completed MH DES in dementia care or other direct training	National	2017/18	16.2%	Annual ↑			16.7%		2017/18= 16.2%												

TIMELY CARE- People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care										ABMU												SBU
Sub Domain	**Measure**	**National or Local Target**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**
Primary Care	% people (aged 16+) who found it difficult to make a convenient GP appointment	National	2017/18	48.0%	Annual ↓			42.2%		2017/18= 48%												
	% of GP practices offering daily appointments between 17:00 and 18:30 hours	National	Mar-19	89%	Annual ↑	95%	✗	86%		82%	82%	82%	84%	78%	88%	88%	88%	88%	89%	89%	89%	
	% of population regularly accessing NHS primary dental care	National	Sep-18	62.4%	4 quarter ↑			55%				62.5%			62%							
Out of Hours/ Unscheduled Care	% 111 patients prioritised as P1CH that started their definitive clinical assessment within 1 hour of their initial call being answered	National			90%					New measure for 2019/20. Awaiting publication of data												
	% 111 patients prioritised as P1F2F requiring a Primary Care Centre (PCC) based appointment seen within 1 hour following completion of their definitive clinical assessment	National			90%					New measure for 2019/20. Awaiting publication of data												
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	National	Apr-19	0%	65%	65%	✓	71.2%		78%	77%	78%	77%	79%	78%	75%	75%	75%	73%	78%	73%	0%
	Number of ambulance handovers over one hour	National	Apr-19	732	0	320	✗	2,544		526	452	351	443	420	526	590	628	842	1,164	619	928	732
	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	National	Apr-19	74.5%	95%	77.1%	✗	78%		75.6%	78.9%	81.0%	79.9%	77.9%	77.5%	78.0%	77%	76%	77%	77%	76%	75%
	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	National	Apr-19	653	0	484	✗	4,472		737	624	476	590	511	588	680	665	756	986	685	862	653
	% of survival within 30 days of emergency admission for a hip fracture	National	Jan-19	72.4%	12 month ↑			80.1%		72.4%	85.0%	78.3%	70.8%	81.3%	76.8%	83.9%	72.4%	75.0%	74.6%			
Stroke	Direct admission to Acute Stroke Unit (<4 hrs)	National	Apr-19	62%	59.7%	76%	✗	52.6%		34%	37%	40%	38%	29%	54%	56%	56%	53%	35%	53%	51%	62%
	CT Scan (<1 hrs)	Local	Apr-19	62%	54.40%	47%	✓	58.8%		41%	43%	51%	40%	41%	48%	53%	48%	49%	48%	48%	51%	62%
	Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)	National	Apr-19	96%	84.0%	87%	✓	84.7%		84%	93%	88%	81%	91%	69%	83%	75%	86%	75%	76%	86%	96%
	Thrombolysis door to needle <= 45 mins	Local	Apr-19	27%	12 month ↑	20%	✓	33.9%		0%	11%	38%	21%	0%	11%	18%	15%	29%	40%	20%	30%	27%
	% patients receiving the required minutes for occupational therapy, physiotherapy, psychology and speech and language therapy	National			12 month ↑					New measure for 2019/20. Awaiting publication of data												
	% patients who receive a 6 month follow up assessment	National			Qtly ↑trend					New measure for 2019/20. Awaiting publication of data												
Planned Care	% of patients waiting < 26 weeks for treatment	National	Apr-19	88.8%	95%			88.6%		87.8%	88.1%	88.7%	89.3%	89.1%	89.1%	89.1%	88.8%	88%	89%	89%	89%	89%
	Number of patients waiting > 26 weeks for outpatient appointment	Local	Apr-19	236	-	0	✗	17,235		166	120	55	30	105	89	65	125	94	153	315	207	236
	Number of patients waiting > 36 weeks for treatment	National	Apr-19	1,976	0	2,042	✗	13,272		3,398	3,349	3,319	3,383	3,497	3,381	3,370	3,193	3,030	3,174	2,969	2,630	1,976
	% of ophthalmology R1 patients to be seen by their clinical target date or within 25% in excess of their clinical target date for their care or treatments	National			95%					New measure for 2019/20. Awaiting publication of data												
	Number of patients waiting > 8 weeks for a specified diagnostics	National	Apr-19	401	0	480	✓	3,458		702	790	915	740	811	762	735	658	693	603	558	437	401
	Number of patients waiting > 14 weeks for a specified therapy	National	Apr-19	0	0	0	✓	77		0	1	0	0	0	0	0	0	0	0	0	0	0
	Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (planned care specs only)	National	Feb-19	23,044	12 month ↓	15,341		152,350		24,628	24,288	24,469	24,954	24,813	24,200	22,553	22,091	22,931	23,026	23,044	23,604	
Cancer	% of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)	National	Apr-19	94%	98%	98%	✗	97.5%		92%	90%	95%	99%	97%	96%	96%	96%	96%	98%	97%	93%	94%
	% of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral	National	Apr-19	88%	95%	76%	✓	85.2%		77%	89%	83%	92%	94%	83%	84%	88%	88%	85%	82%	84%	88%
Mental Health	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	National	Mar-19	77%	80%	80%	✗	78.1%		84%	86%	82%	84%	80%	76%	84%	78%	83%	73%	80%	77%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	National	Mar-19	87%	80%	80%	✓	84.1%		79%	81%	80%	79%	90%	89%	92%	88%	85%	87%	88%	87%	
	% of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA	National	Mar-19	99%	100%	100%	✗	100%				100%			100%			100%			99%	
	% patients waiting < 26 weeks to start a psychological therapy in Specialist Adult Mental Health	National	Apr-19	100%	95%	95%	✓			62%	61%	62%	50%	61%	62%	62%	62%	63%	68%	100%	100%	100%
CAMHS	% of urgent assessments undertaken within 48 hours from receipt of referral (Crisis)	Local	Mar-19	97%		100%	✗			100%	100%	100%	100%	100%	100%	96%	98%	98%	88%	97%	97%	
	% Patients with Neurodevelopmental Disorders (NDD) receiving a Diagnostic Assessment within 26 weeks	National	Mar-19	47%	80%	80%	✗			94%	95%	91%	91%	87%	81%	76%	68%	62%	47%	50%	47%	
	P-CAMHS - % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral	Local	Mar-19	16%		80%	✗			43%	38%	34%	23%	22%	18%	25%	13%	4%	2%	27%	16%	
	P-CAMHS - % of therapeutic interventions started within 28 days following assessment by LPMHSS	Local	Mar-19	85%		80%	✓			62%	76%	80%	57%	93%	72%	83%	91%	91%	92%	91%	85%	
	S-CAMHS - % of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)	Local	Mar-19	92%		90%	✓			75%	71%	76%	75%	75%	74%	74%	79%	96%	91%	92%	92%	
	S-CAMHS - % of Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral	Local	Mar-19	90%		80%	✓			63%	73%	70%	60%	52%	67%	69%	66%	56%	70%	76%	90%	

INDIVIDUAL CARE- People in Wales are treated as individuals with their own needs and responsibilities

Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	ABMU Apr-18	ABMU May-18	ABMU Jun-18	ABMU Jul-18	ABMU Aug-18	ABMU Sep-18	ABMU Oct-18	ABMU Nov-18	ABMU Dec-18	ABMU Jan-19	ABMU Feb-19	ABMU Mar-19	SBU Apr-19
Helplines	Rate of calls to the mental health helpline C.A.L.L. per 100k pop.	National	Q3 18/19	120.0	4 quarter ↑			161.1				101.2			103.6			120.0				
	Rate of calls to the Wales dementia helpline per 100k pop.	National	Q3 18/19	8.3	4 quarter ↑			7.7				5.4			5.1			8.3				
	Rate of calls to the DAN helpline per 100k pop.	National	Q3 18/19	24.4	4 quarter ↑			29.6				33.7			30.1			24.4				
Mental Health	% residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan (CTP)	National	Mar-19	91%	90%	90%	✔	89.3%		90%	90%	88%	88%	90%	91%	92%	91%	91%	91%	91%	91%	
	% residents assessed under part 3 to be sent their outcome assessment report 10 working days after assessment	National	Mar-19	100%	100%	100%	✔	100.0%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Patient Experience	Number of friends and family surveys completed	Local	Apr-19	3,350		12 month ↑	✖			4,607	4,106	6,234	5,581	5,609	4,804	5,536	5,616	3,864	4,607	4,044	4,141	3,350
	% of who would recommend and highly recommend	Local	Apr-19	95%		90%	✔			95%	95%	96%	96%	95%	96%	96%	96%	94%	95%	95%	95%	95%
	% of all-Wales surveys scoring 9 out 10 on overall satisfaction	Local	Apr-19	91%		90%	✔			87%	89%	85%	85%	87%	89%	86%	88%	82%	90%	78%	89%	91%

Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	ABMU Apr-18	ABMU May-18	ABMU Jun-18	ABMU Jul-18	ABMU Aug-18	ABMU Sep-18	ABMU Oct-18	ABMU Nov-18	ABMU Dec-18	ABMU Jan-19	ABMU Feb-19	ABMU Mar-19	SBU Apr-19
DNAs	% of patients who did not attend a new outpatient appointment *(selected specialities only)*	Local	Apr-19	5.6%	12 month ↓		✔	6.2%		6.2%	5.7%	5.5%	6.0%	5.4%	5.7%	5.7%	5.4%	6.1%	5.6%	5.2%	4.8%	5.6%
	% of patients who did not attend a follow-up outpatient appointment *(selected specialities only)*	Local	Apr-19	6.3%	12 month ↓		✔	7.5%		6.7%	6.8%	6.2%	7.0%	6.6%	6.6%	7.2%	6.3%	6.7%	6.4%	5.9%	5.9%	6.3%
Theatre Efficiencies	Theatre Utilisation rates	Local	Apr-19	75.0%		90%	✖			72%	76%	74%	69%	62%	74%	73%	74%	67%	80%	72%	69%	75%
	% of theatre sessions starting late	Local	Apr-19	43.0%		<25%	✖			41%	41%	41%	38%	42%	39%	41%	41%	44%	46%	45%	39%	43%
	% of theatre sessions finishing early	Local	Apr-19	36.0%		<20%	✖			39%	37%	39%	40%	36%	36%	39%	40%	43%	40%	37%	39%	36%
Critical Care	% critical care bed days lost to delayed transfer of care	National								New measure for 2019/20. Awaiting publication of data												
Prescribing	Biosimilar medicines prescribed as % of total 'reference' product plus biosimilar	National	Q2 18/19	77.0%	Quarter on quarter ↑			87.0%			20.9%				77.0%							
Primary Care	% adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	National			4 quarter ↓					New measure for 2019/20. Awaiting publication of data												
Workforce	% of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	National	Apr-19	64%	85%	68%	✖	68.1%		64%	63%	63%	65%	65%	65%	67%	69%	69%	70%	70%	69%	64%
	% staff who undertook a performance appraisal who agreed it helped them improve how they do their job	National	2018	55%	Improvement			54%		2018= 55%												
	Overall staff engagement score – scale score method	National	2018	3.81	Improvement			3.82		2018= 3.81												
	% compliance for all completed Level 1 competency with the Core Skills and Training Framework	National	Apr-19	75%	85%	76%	✔	77.6%		53%	55%	57%	59%	63%	65%	67%	71%	73%	73%	74%	75%	0%
	% workforce sickness and absent (12 month rolling)	National	Mar-19	5.80%	12 month ↓	5.0% (Mar-19)		5.29%		5.77%	5.81%	5.84%	5.87%	5.88%	5.91%	5.90%	5.96%	5.99%	5.95%	5.92%	5.80%	
	% staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	National	2018	72%	Improvement			73%		2018= 72%												

4.1 Unscheduled Care- Overview

Chart 1: % GP practices offering daily appointments between 5pm- 6:30pm

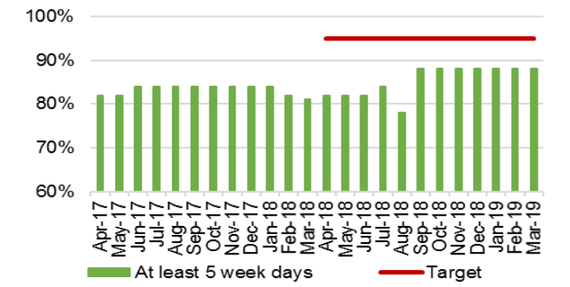


Chart 2: % GP practices offering daily appointments between 5pm- 6:30pm

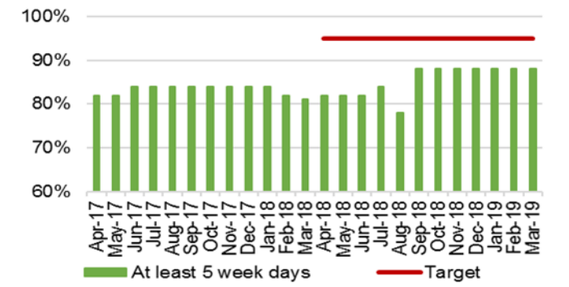


Chart 3: GP Out of Hours

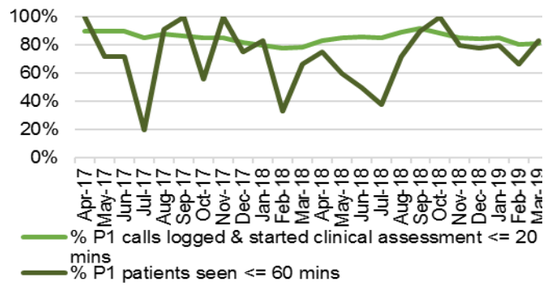


Chart 4: % red calls responded to within 8 minutes

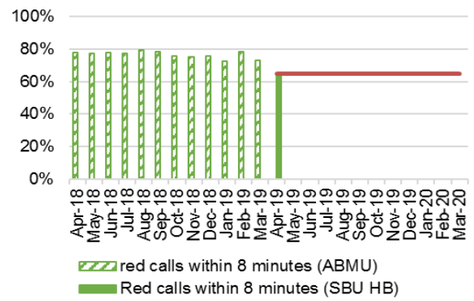


Chart 5: Number of ambulance handovers over 1 hour

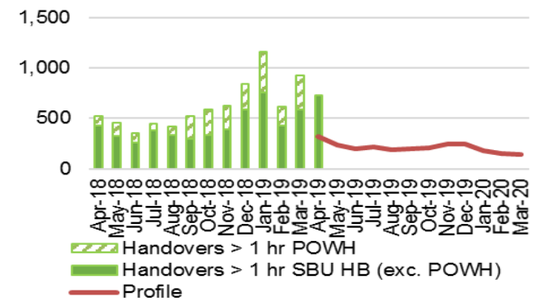


Chart 6: A&E Attendances

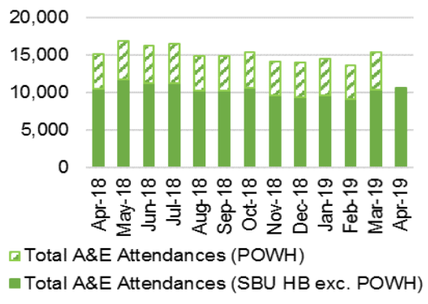


Chart 7: % patients who spend less than 4 hours in A&E

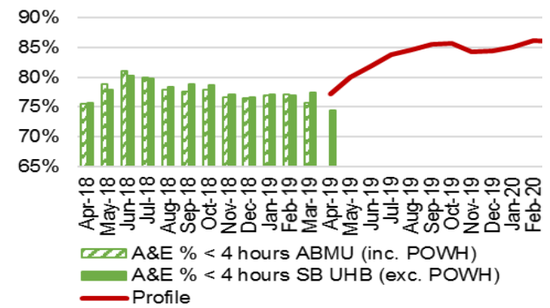


Chart 8: Number of patients waiting over 12 hours in A&E

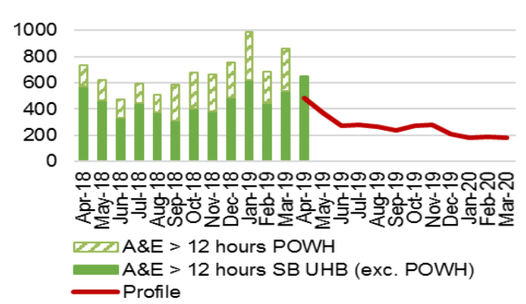


Chart 9: Number of emergency admissions

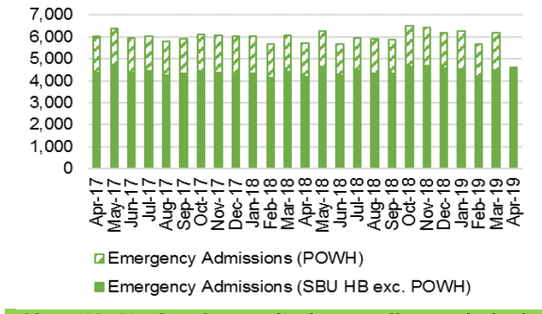


Chart 10: Elective procedures cancelled due to lack of beds

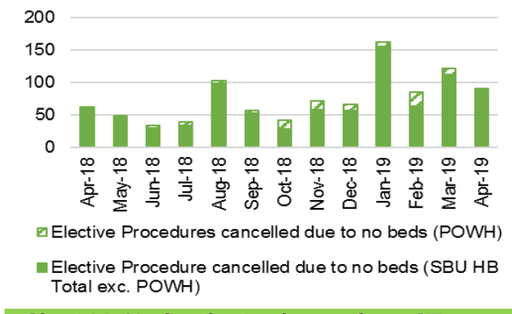


Chart 11: Number of mental health delayed transfers of care

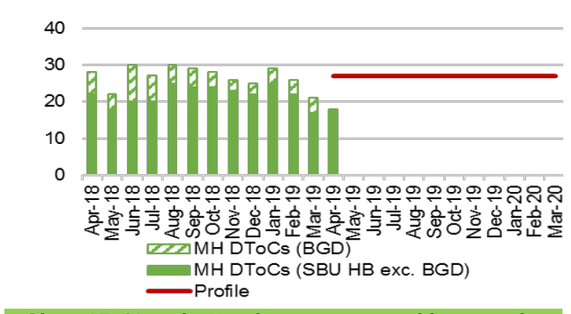


Chart 12: Number of non- mental health delayed transfers of care

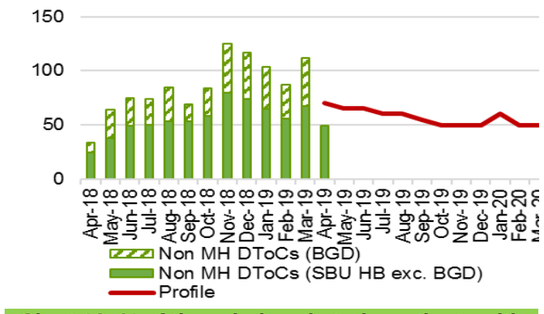


Chart 13: % of patients who have a direct admission to an acute stroke unit within 4 hours

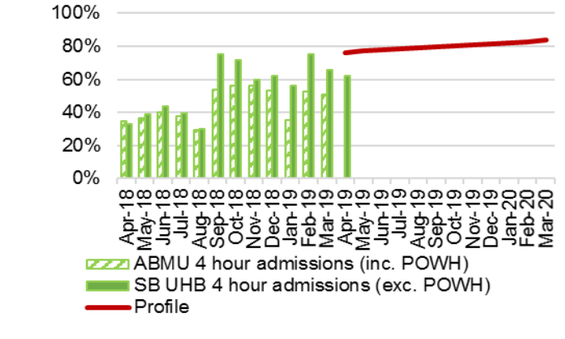


Chart 14: % of patients who receive a CT scan within 1 hour

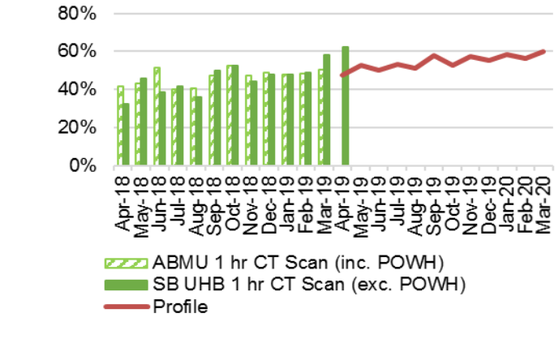


Chart 15: % patients who are assessed by a stroke specialist consultant physician within 24 hours

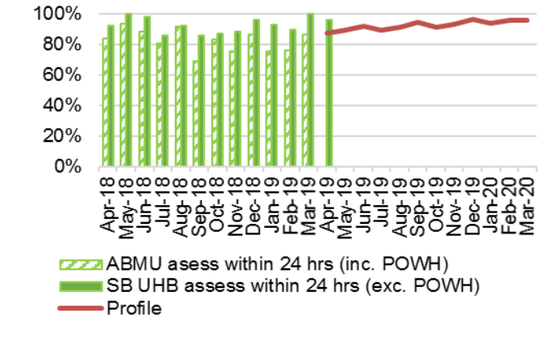
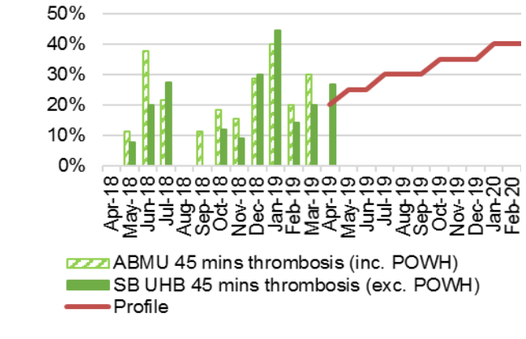


Chart 16: % of thrombolysed stroke patients with a door to door needle time of ≤45 minutes



Unscheduled Care Overview (April 2019)

Primary Care Access

95%
GP practices open during daily core hours *(Mar-19)*

88%
GP practices offering appointments between 5pm-6:30pm *(Mar-19)*

81% (→)
P1 calls started assessment within 20 minutes *(Mar-19)*

83% (17%↑)
P1 calls seen within 60 minutes *(Mar-19)*

Ambulance

65%
Red calls responded to with 8 minutes

732 (24%↑)
Ambulance handovers over 1 hour

3,455
Amber calls

315
Red calls

Emergency Department

10,727 (2%↑)
A&E attendances

74.5% (3%↓)
Waits in A&E under 4 hours

653 (22%↑)
Waits in A&E over 12 hours

1,502 (2%↑)
Patients admitted from A&E

Emergency Activity

4,627 (3%↑)
Emergency Inpatient Admissions

405 (9%↑)
Emergency Theatre Cases

359 (17%↑)
Trauma theatre cases

91 (19%↓)
Elective procedures cancelled due to no beds

Patient Flow

18 (6%↑)
Mental Health DTOCs

49 (27%↓)
Non-Mental Health DTOCs

183 (24%↑)
Medically fit patients

2,740 (8%↑)
Days lost due to medically fit *(Morriston only)*

1,910 (10%↑)
Medical outliers *(Dec-18)*

Overarching Public Health Outcomes *(2016/17- 2017/18)*

43%
Staff uptake of flu vaccine (Oct-18)

20.5% (Wales= 19%)
Adults drinking above recommended guidelines

21.5% (Wales= 19%)
Adults who smoke

667.3 (Wales= 596.6)
Age standardisation rate of hip fractures among older people

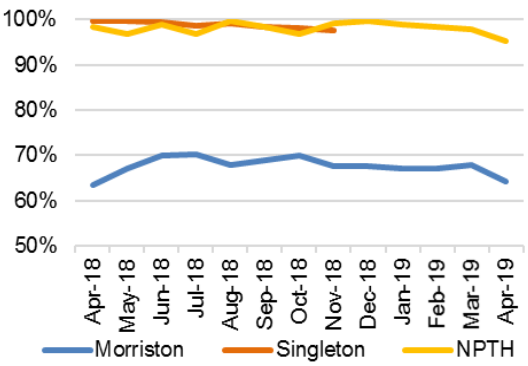
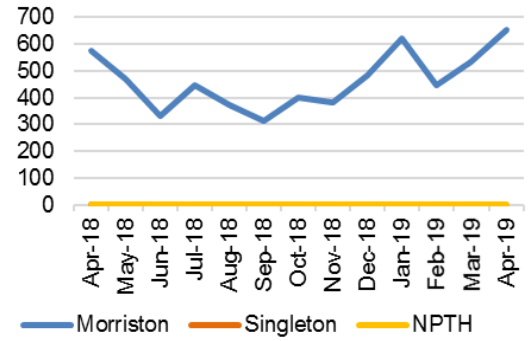
35.3% (Wales= 35.9%)
Older people with healthy weight

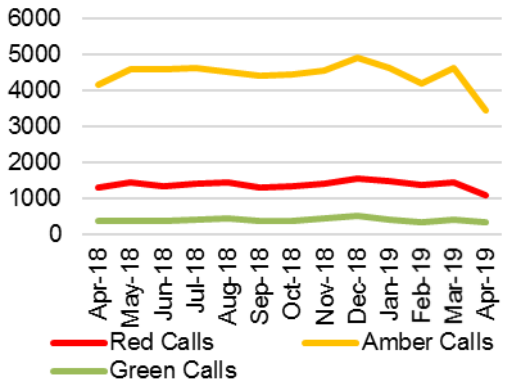
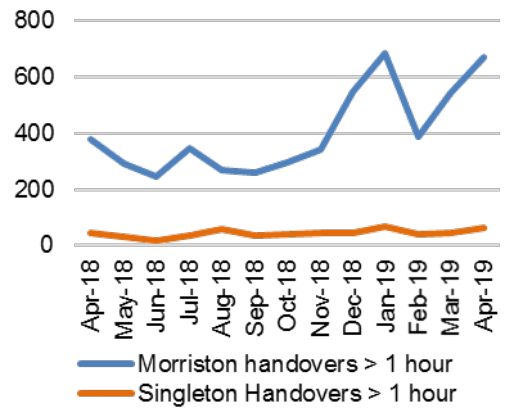
41.8% (Wales= 47.1%)
Older people free from long term life limiting illnesses

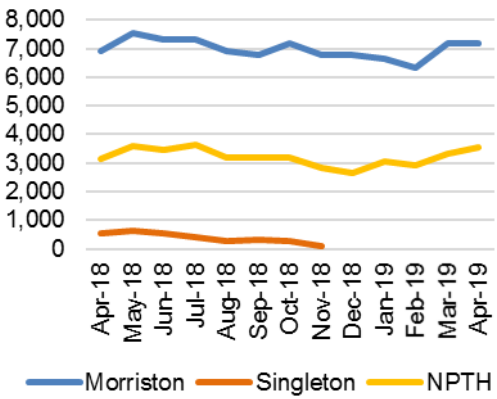
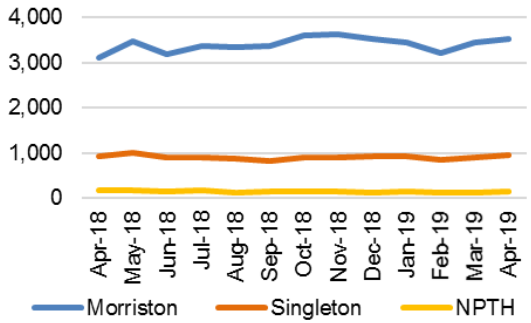
**RAG status and trend is based on in month-movement where disaggregated Swansea Bay UHB data is available*

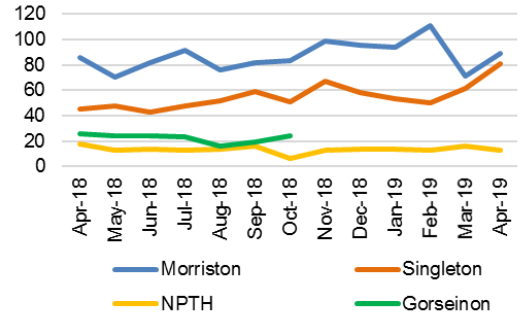
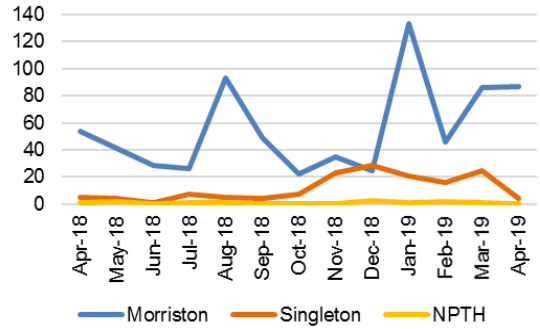
4.2 Unscheduled Care- Updates and Actions

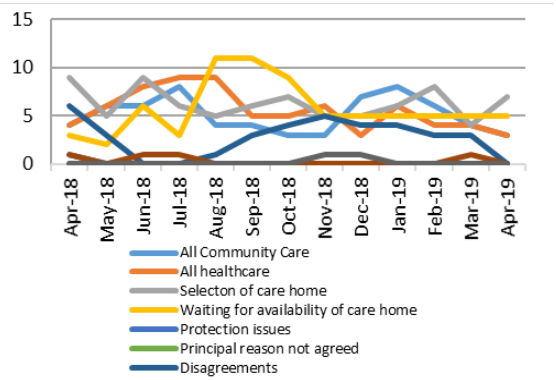
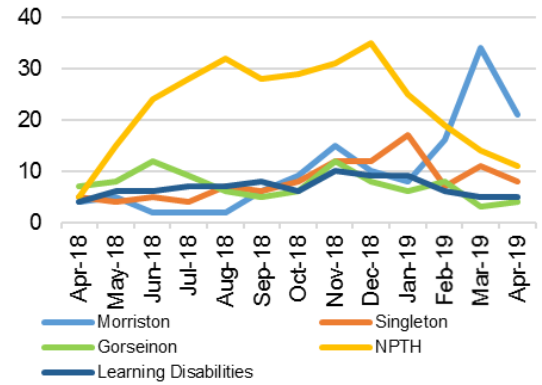
This section of the report provides further detail on key unscheduled care measures.

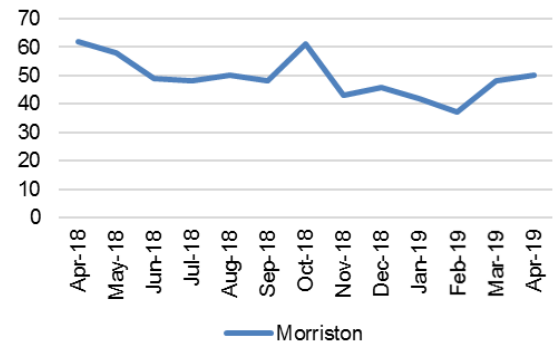
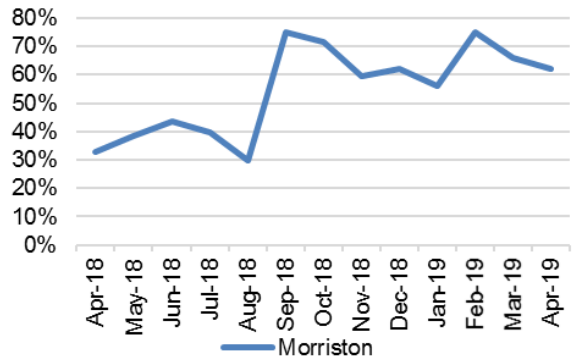
Description	Current Performance	Trend	Actions planned for next period
A&E waiting times The percentage of patients who spend less than 4 hours in all major and minor emergency care facilities from arrival until admission, transfer or discharge	The Health Board's performance against the 4 hour metric in April 2019 deteriorated by 1.2% from the April 2018 position, and also declined by 3% when compared with the reported performance for March 2019, reflecting a particularly challenging month and increases in demand and patient acuity. Neath Port Talbot Hospital continues to exceed the national target of 95% but Morriston hospitals was below profile, achieving 64.18 %. However Morriston hospital's 4 hour performance improved by 0.72% when compared with April 2018	**% patients waiting under 4 hours in A&E** 	• Surge capacity is being sustained on all of our major hospital sites and additional surge capacity will continue to be accessed where possible. However Singleton hospital lost 10 oncology beds as a result of the fire on Ward 12 at the end of March. • Concluding the evaluation of the impact of the remaining winter pressures funded schemes which ended on 31st March. • Planning for the May bank holiday weekends to ensure the system is as resilient as possible. • Continue to recruit to staff vacancies. • Respond to and implement to the Kendall Bluck report recommendations on ED staffing at Morriston hospital. • Focussing on eliminating un-necessary patient delays to deliver improved patient flow and ambulance handover performance. • Heightened focus on infection prevention measures as a result of the increased capacity lost in April for infection reasons.
A&E waiting times The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	In April 2019, performance against this measure deteriorated. There were 653 patients in Morriston ED waiting over 12 hours for admission, discharge or transfer in April 2019 which is an increase of 79 patients when compared with April 2018. There was also an increase of 119 patients waiting over 12 hours at Morriston hospital when compared with March 2019.	**Number of patients waiting over 12 hours in A&E** 	

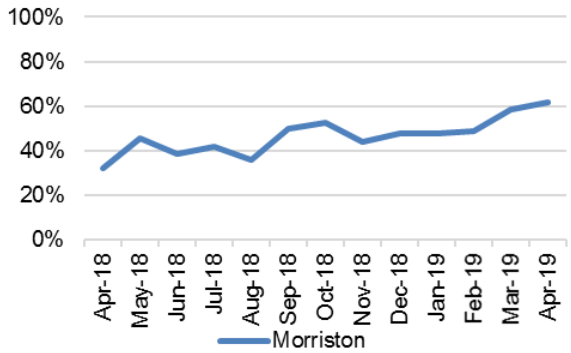
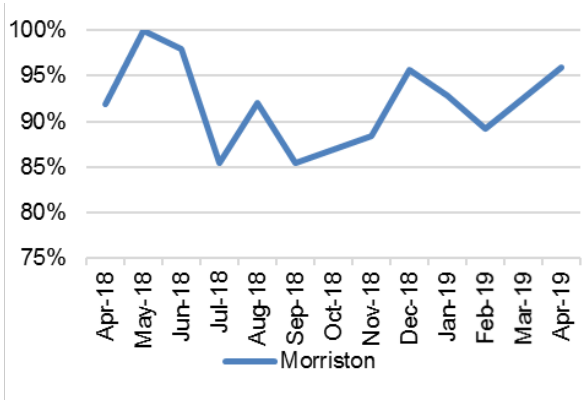
Description	Current Performance	Trend	Actions planned for next period
Ambulance responses The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes. The number of responses to ambulance calls.	Ambulance response times are consistently above the national target and local profile of 65%. However performance against this measure declined in April to 66% (Swansea Bay) from 72.8% in March 2019 (ABMU). The number of red call conveyances increased by 48 (26%) compared with April 2018.	**Number of ambulance call responses** 	• Working with WAST to direct patients to appropriate services or pathways, ensuring emergency ambulance capacity is utilised appropriately. • Implement the recommendations of the WAST internal audit report on hospital handovers. • Implement a suite of additional immediate and short term actions agreed with the National Collaborative Commissioning Unit (NCCU) and the Ambulance Commissioner in early May, to target a reduction in the longer ambulance handover delays at Morriston. • Singleton hospital to continue to support Morriston through the downgraded 999 and treat and transfer protocols to redirect appropriate demand. • Singleton hospital is implementing additional actions to reduce ambulance handovers including the greater promotion and use of the Fit to sit handover guidance, assigning responsibility for ambulance handover to specific job roles in and out of hours, developing an ambulance rapid triage protocol and implementing manager of the day rota for the escalation of any handover delays over 35 minutes. • Develop a case to sustain the AGPU triage of ambulance calls which had a positive impact on reducing ambulance conveyances during the winter funded pilot.
Ambulance handovers The number of ambulance handovers over one hour	The number of ambulance handovers to local hospitals taking over 1 hour continues to be over profile which is a reflection of the increased pressures felt across the wider unscheduled care system in April. In April 2019, Morriston Hospital saw an increase of 289 compared with April 2018 (from 380 to 669). Singleton also saw an increase of 18 (from 45 to 63). There was also an overall increase of 137 delays when compared with March 2019.	**Number of ambulance handovers over one hour** 	

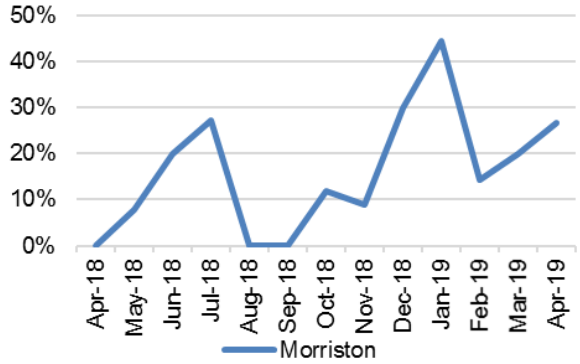
Description	Current Performance	Trend	Actions planned for next period
A&E Attendances The number of attendances at emergency departments in the Health Board	Attendances at our ED and Minor Injuries Unit (MIU) increased overall by 133 patients (1.3%) from 10,589 in April 2018 to 10,727 in April 2019. Singleton MIU remained closed during March as a result of refurbishment work. 547 patients were managed by this service in April 2018. April 2019 experienced some of the highest demand days for the whole of 2018/19 with NPT hospital experiencing a 13% increase in demand compared with April 2018.	**Number of A&E attendances** 	• 111 awareness campaign programme and communication of Choose Well pathways. • Encourage and promote the use of the Health Board's community pharmacies, 95% of whom are now in a position to offer the Common Ailment Service. • Maximise use of telephone first model to support practices to manage demand. • Implementation of the Cwmtawe cluster transformation work to test a cluster led integrated health & social care system. • Working with WAST to identify training/ capacity to further reduce patient conveyance to ED via an ambulance e.g. respiratory pathway.
Emergency Admissions The number of emergency admissions across the Health Board by site	In April 2019, there were 4,627 emergency admissions across the Health Board which is 434 (10%) more admissions than in April 2018. April 2019 saw the second highest number of emergency admissions at Morriston hospital in the last 12 months. Surgical, regional, orthopaedic and paediatric admissions accounted for the biggest increases experienced between April 2018 and April 2019, whilst medical admissions reduced. The number of emergency admissions in the over 75 age group increased for the first time in several months.	**Number of emergency admissions** 	• Ongoing roll out of the *I fell down* tool in the Local Authority owned care homes in Swansea and NPT. This tool supports a reduction in the number of 'long lie' residents in care homes following a fall. • Acute Care Teams working in close liaison with WAST to redirect and manage patients in the community where capacity allows as opposed to a conveyance to hospital. • Maximise and expand the alternative models to admission that have been developed during 2018/19 such as ambulatory and day unit facilities, hot clinics and direct to speciality admission pathways. The positive progress made during 2018/19 to date has been recognised, following a recent DU review.

Description	Current Performance	Trend	Actions planned for next period
Medically Fit The number of patients waiting at each site in the Health Board that are deemed discharge/ medically fit	In April 2019, there were on average 183 patients who were deemed medically/ discharge fit but were still occupying a bed in one of the Health Board's Hospitals. It must be noted that data collection has significantly improved which will in part reflect the increase in numbers.	**The number of discharge/ medically fit patients by site**  ** Data for Gorseinon Hospital has not been available since November 2018.*	• Promote and implement the SAFER flow principles. Embedding the safety huddle approach to managing patient flow – as part of the Good hospital care Implementation group. • Implement the programme of work agreed through the new Good Hospital Care Implementation Group to reduce variation in compliance against the SAFER flow bundles with a particular focus on ensuring that senior review is undertaken in a consistent way to ensure the provision of an agreed clinical management plan. First meeting of this group is on 29th May. • Implement actions outlined in the section on delayed transfers of care below.
Elective procedures cancelled due to lack of beds The number of elective procedure cancelled across the hospital where the main cancellation reasons was	In April 2019, there were 91 elective procedures cancelled due to lack of beds on the day of surgery. This is 52% more than April 2018 (60 to 91). In March 2019, 87 of the 91 cancelled procedures were attributed to Morriston Hospital. The ringfenced orthopaedic ward was breached at Morriston on occasions during April owing to the increase in emergency admissions, which resulted in an increased number of elective cancellations for bed availability reasons.	**Total number of elective procedures cancelled due to lack of beds** 	• Continued implementation of models of care that mitigate the impact of unscheduled care pressures on elective capacity – such as ambulatory emergency care models and enhanced day of surgery models. • Maximise utilisation of surgical unit at NPTH hospital, which is not affected by emergency pressures.

Description	Current Performance	Trend	Actions planned for next period
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board- Mental Health (all ages)	The number of mental health related delayed transfers of care in April 2019 was 18 which is below the internal profile of 27.	**Number of Mental Health DToCs** 	• Maintain expanded capacity of early supported discharge service in NPT to increase the number of discharges (up to 28 patients have been managed through this service). • Maximise use of reablement capacity in Bonymaen house in Swansea. • WG investment into the British Red Cross service at Morriston ED from April to September to support the expansion of hospital to home service. • Implementation of the clinically led DToC improvement programme focussing on reducing delayed transfers of care within our Health Board. This includes: o Standardising the approach taken across all Units at weekly stranded patient meetings o Establishing centralised senior manager monthly DTOC validation scrutiny meeting and monthly debrief meeting o Improving and quickening the assessment process between organisations o Improving communication between organisations o Implement and developing new pathways of care to support discharge • A Hospital to Home transformation bid to improve system capacity has been submitted to WG and formal feedback is awaited. Alternative plans are also being progressed to develop discharge capacity in the community using ICF monies should positive approval for the transformation bid not be forthcoming
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board - Non Mental Health (age 75+)	In April 2019, the number of non-mental health and Learning disability delayed transfers of care was 49 which is below the internal profile of 70.	**Number of Non Mental Health DToCs** 	

Description	Current Performance	Trend	Actions planned for next period
Stroke Admissions The total number of stroke admissions into the Health Board	In April 2019, there were 50 confirmed stroke admissions in Morriston Hospital.	**Total number of stroke admissions** 	• Roll out and support impact of the Directed Enhanced Service for INR and Direct-Acting Oral Anticoagulants (DOAC) service. • Delivery of revised QIMs for Stroke. • Additional middle tier Medical staff appointed into Morriston – some rota gaps remain but improvements in overall establishment have been achieved. Any rota gaps are requiring them to act down on occasions. Unit to continue to try and cover all gaps to address rota and service pressures. • Stroke Champion discussions held with key medical staff – but impact of rota gaps reducing abilities to introduce change.
Stroke 4 hour access target % of patients directly admitted to a stroke unit within 4 hours of clock start	In April 2019 only 31 out of 50 patients had a direct admission to an acute stroke unit within 4 hours (62%). The 4 hour target appears to be a challenge across Wales. The all-Wales data for March 2019 confirms that performance ranged from 41.7% to 68.5%. The Health Board achieved 50.6% in March 2019 and Morriston Hospital achieved 66%.	**Percentage of patients admitted to stroke unit within 4 hours** 	• Point of care testing within ED to enable more timely access to thrombolysis intervention is ongoing. • Actions to improve 4 hour target has seen improvements on the Morriston site but increased unscheduled care pressures is impacting on its performance – particularly in accessing beds. • Early warning information / Communication of Stroke patients into ED is ongoing with WAST. • Thrombolysis Review recommendations are being worked through for implementation – further monitoring of implementation planned with the DU in June.

Description	Current Performance	Trend	Actions planned for next period
Stroke CT scan Percentage of patients who receive a CT scan within 1 hour	In April 2019, the Health Board achieved 62% which was in above the internal profile of 47%.	**Percentage of patients receiving CT scan within 1 hour** 	• Morriston to review pathway for accessing CT within 1 hour for all stroke patients. • IBG has considered the case for the development of an Early Supportive Discharge service at Morriston / Singleton hospitals. • At Singleton the team continues to examine all processes including senior review / early discharge / effective Board rounds on ward 7. • Assessments and criteria between Ward F and ward 7 to continue.
Stroke assessment within 24 hours Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	In April 2019, the Health Board achieved 96% which was above the internal profile of 87%.	**Percentage of patients assessed by stroke consultant within 24 hours** 	

Description	Current Performance	Trend	Actions planned for next period
Thrombolysed Patients with Door-to-Needle <= 45 mins	In April 2019, 27% of eligible patients were thrombolysed and 6 of the 20 patients were thrombolysed within the 45 minutes (door to needle) standard. This is above the internal profile of 20%	**Percentage of eligible thrombolysed patients within 45 minutes** 	• As above

5.1 Planned Care- Overview

Chart 1: Number of GP Referrals into secondary care

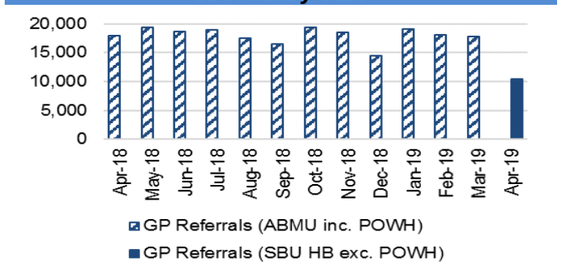


Chart 2: Number of patients waiting over 26 weeks for an outpatient appointment

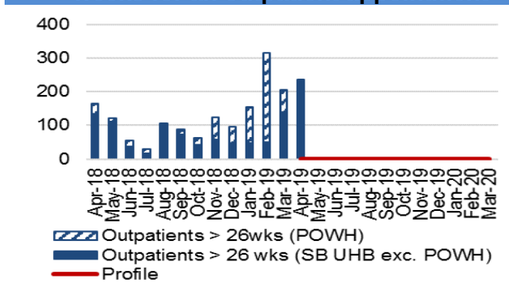


Chart 3: Number of patients waiting over 36 weeks for treatment

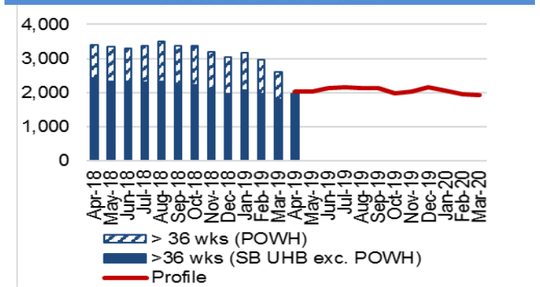


Chart 4: % patients waiting less than 26 weeks from referral to treatment

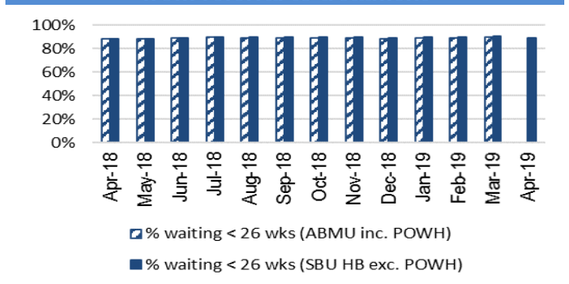


Chart 5: Number of patients waiting for reportable diagnostics over 8 weeks

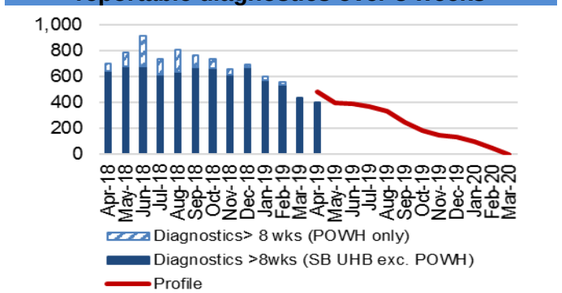


Chart 6: Number of patients waiting for reportable Cardiac diagnostics over 8 weeks

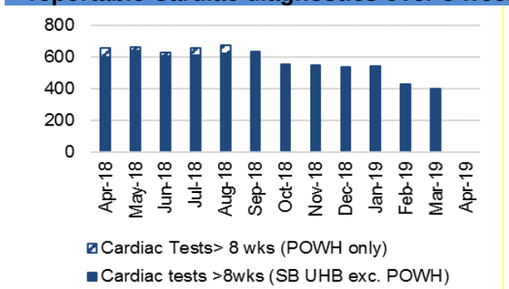


Chart 7: Therapies over 14 weeks

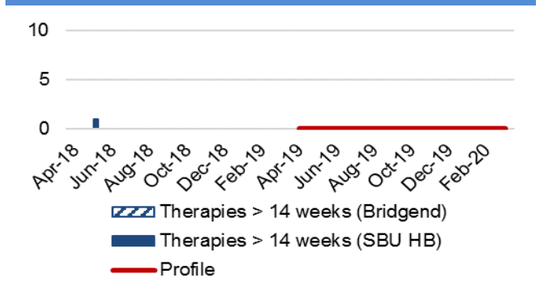


Chart 8: Cancer referrals

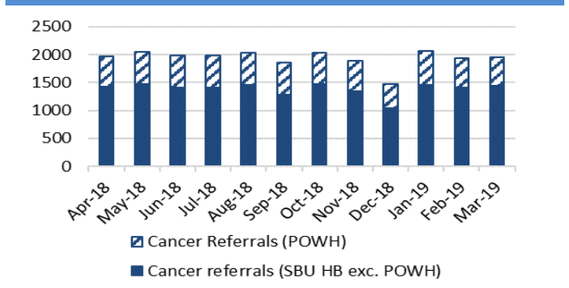


Chart 9: % patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days

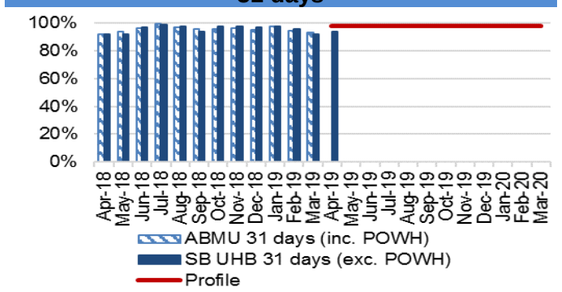


Chart 10: % patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to & including) 62 days of receipt of referral

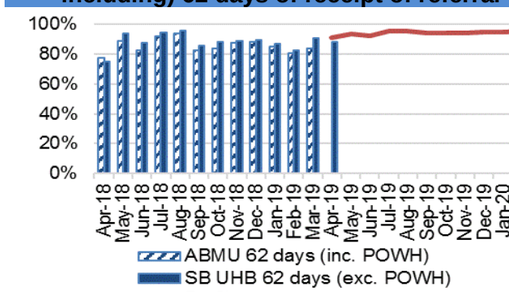


Chart 11: % of patients who did not attend a new outpatient appointment *(for selected specialties)*

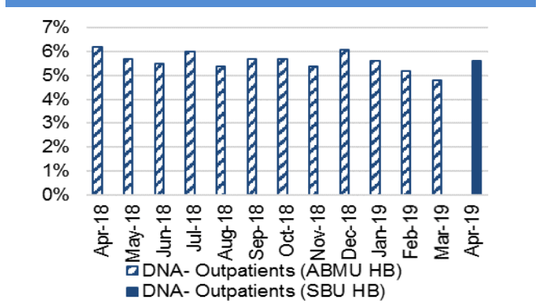


Chart 12: Number of patients waiting for an outpatient follow-up who are delayed past their target date (planned care specialities only)

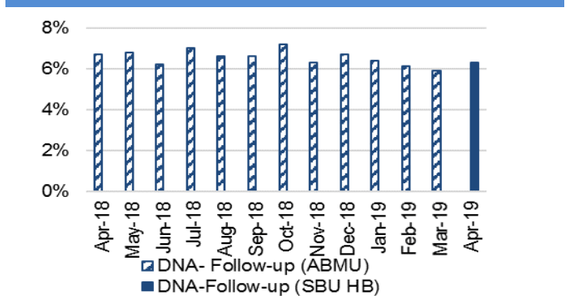


Chart 13: Number of patients without a documented clinical review date

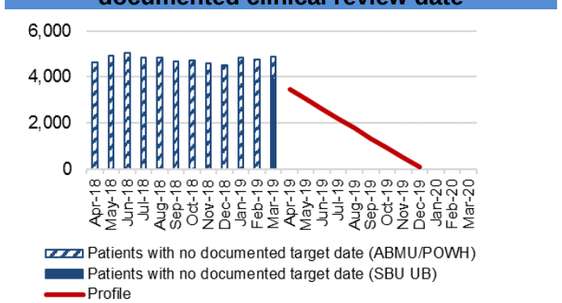


Chart 14: Ophthalmology patients without an allocated clinical risk factor

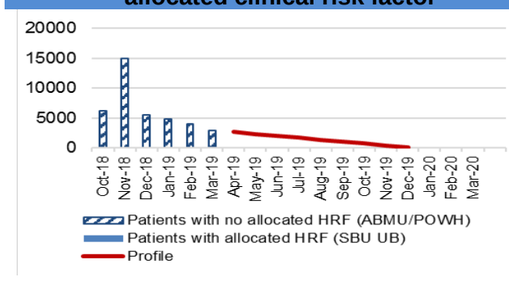


Chart 15: Total number of patients on the follow-up waiting list

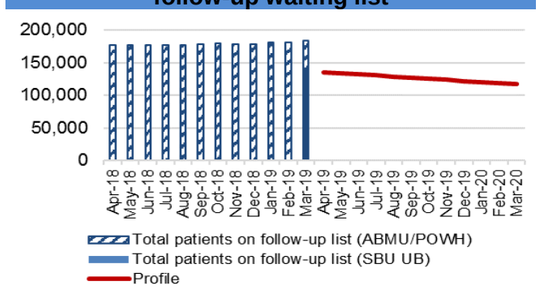
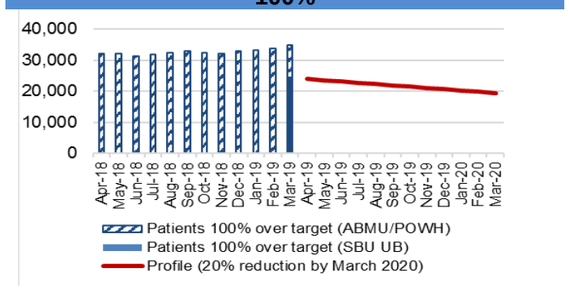


Chart 16: Number of patients delayed by over 100%



** April 2019 delayed follow-up data for Swansea Bay UHB not available at the time of writing this report*

Planned Care- Overview (April 2019)

Demand

10,367
Total GP referrals

6,158
Routine GP referrals

4,209
Urgent GP referrals

Waiting Times

236 (69%↑)
Patients waiting over 26 weeks for a new outpatient appointment

1,976 (11%↑)
Patients waiting over 36 weeks for treatment

714 (1%↓)
Patients waiting over 52 weeks for treatment

88.8% (1.2%↓)
Patients waiting under 26 weeks from referral to treatment

0 (100%↓)
Patients waiting over 8 weeks for reportable diagnostics

401 (6%↓)
Patients waiting over 8 weeks for Cardiac diagnostics

0 (→)
Patients waiting over 14 weeks for reportable therapies

67,908 (2%↑)
Patients waiting for an outpatient follow-up who are delayed past their target date *(Mar-19)*

Outpatient Efficiencies

5.6%
% of patients who did not attend a new outpatient appointment (all specialties)

6.3%
% of patients who did not attend a follow-up outpatient appointment (all specialties)

Cancer

1,435 (1%↑)
Number of USC referrals received *(Mar-19)*

104
USC backlog over 52 days

88% (3%↓) *draft*
USC patients receiving treatment within 62 days

94% (2%↑) *draft*
NUSC patients receiving treatment within 31 days

Theatre Efficiencies

75%
Theatre utilisation rate

43%
% of theatres sessions starting late

36%
% of theatres sessions finishing early

45%
Operations cancelled on the day

Overarching Public Health Outcomes (2016/17- 2017/18)

50% (Wales= 53.2%)
Adults meeting physical activity guidelines

20.8% (Wales= 23.8%)
Adults eating 5 fruit or vegetables a day

73.3% (Wales= 72.9%)
Children age 5 of healthy weight or underweight

76.6% (Wales= 75.9%)
Adolescents of healthy weight

39.2% (Wales 39.2%)
Working age adults of healthy weight

35.3% (Wales= 35.9%)
Older people of healthy weight

1.2 (Wales=1.2)
Average decayed, missing or filled teeth among 5 year olds

73.3% (Wales=75.9%)
Working age adults in good health

55% (Wales 56.7%)
Older people in good health

67.5% (Wales= 73)
Working age adults free from life limiting long term illnesses

41.8% (Wales= 47.1%)
Older people free from life limiting long term illnesses

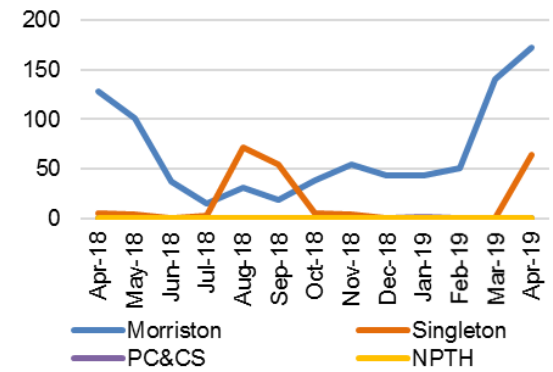
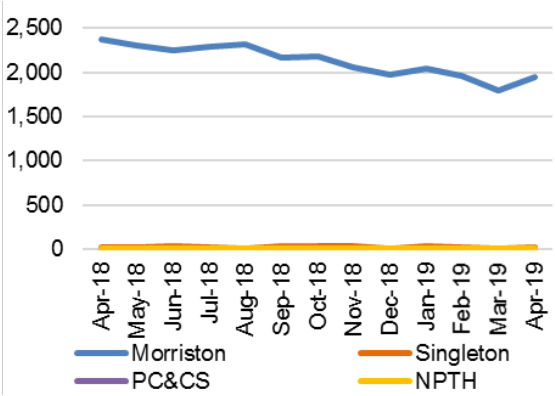
**RAG status and trend is based on in month-movement where disaggregated Swansea Bay UHB data is available*

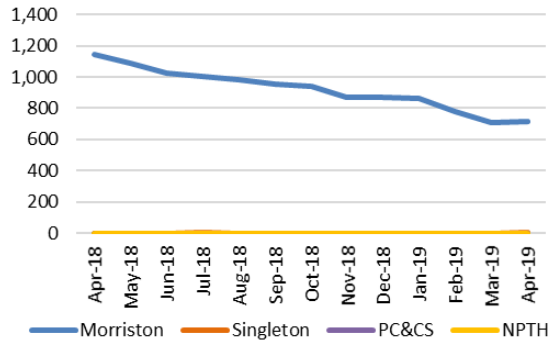
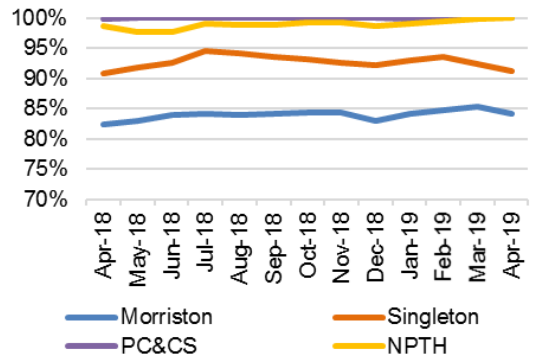
5.3 Theatre Efficiencies Dashboard

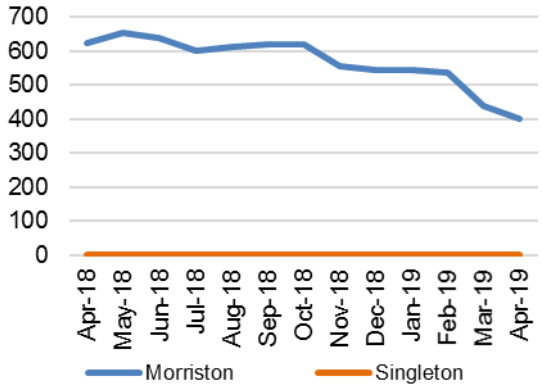
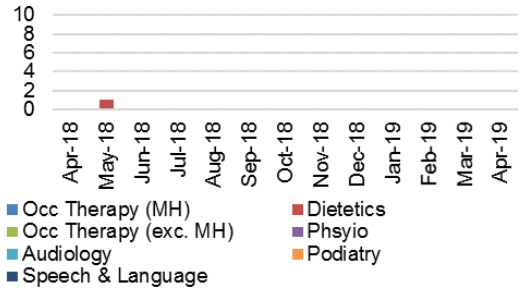
Measure			Report Period	Current Performance	Initial Target	Target Status	In-month trend	Annual Comparison	Performance Trend	ABMU Apr-18	ABMU May-18	ABMU Jun-18	ABMU Jul-18	ABMU Aug-18	ABMU Sep-18	ABMU Oct-18	ABMU Nov-18	ABMU Dec-18	ABMU Jan-19	ABMU Feb-19	ABMU Mar-19	SBU Apr-19
Number of cancelled operations	Morriston		Apr-19	484						305	433	471	409	390	396	458	368	377	507	443	472	484
	NPTH		Apr-19	132						148	149	161	135	174	182	181	177	121	177	179	164	132
	Singleton		Apr-19	165						161	202	169	170	217	158	223	235	193	222	243	250	165
	POWH									336	323	399	376	287	322	363	322	364	301	337	372	
	HB Total		Apr-19	781						950	1,107	1,200	1,090	1,068	1,058	1,225	1,102	1,055	1,207	1,202	1,258	781
% of cancelled operations on the day	Morriston		Apr-19	49%	10%					40%	32%	28%	27%	35%	34%	44%	39%	40%	41%	41%	35%	49%
	NPTH		Apr-19	29%						24%	29%	29%	24%	25%	21%	22%	32%	29%	23%	21%	22%	29%
	Singleton		Apr-19	45%						50%	49%	41%	38%	31%	42%	48%	47%	57%	51%	43%	40%	45%
	POWH									34%	31%	35%	33%	37%	28%	31%	32%	29%	36%	28%	28%	
	HB Total		Apr-19	45%						37%	34%	32%	31%	33%	31%	38%	37%	38%	39%	35%	32%	45%
Reasons for cancellations on the day	Hospital Clinical		Apr-19	25%						35%	30%	31%	32%	26%	32%	25%	29%	29%	31%	30%	28%	25%
	Hospital Non-Clinical		Apr-19	47%						34%	42%	42%	41%	49%	41%	46%	48%	49%	39%	52%	53%	47%
	Other		Apr-19	0%						0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Patient		Apr-19	26%						30%	28%	26%	27%	24%	26%	29%	22%	22%	29%	18%	18%	26%
	Unknown		Apr-19	1%						0%	1%	1%	0%	1%	1%	0%	0%	0%	0%	1%	1%	1%
Late Starts	Morriston		Apr-19	43%	<25%					45%	37%	37%	37%	49%	38%	35%	35%	42%	45%	42%	37%	43%
	NPTH		Apr-19	36%						39%	28%	30%	36%	20%	36%	36%	41%	43%	42%	42%	36%	36%
	Singleton		Apr-19	46%						42%	52%	55%	43%	43%	45%	53%	54%	54%	52%	52%	41%	46%
	POWH		Apr-19	0%						38%	44%	40%	35%	38%	38%	42%	37%	37%	46%	44%	43%	
	HB Total		Apr-19	43%						41%	41%	41%	38%	42%	39%	41%	41%	44%	46%	45%	39%	43%
Early Finishes	Morriston		Apr-19	32%	<20%					39%	33%	33%	34%	30%	25%	34%	37%	44%	42%	35%	38%	32%
	NPTH		Apr-19	61%						39%	60%	58%	61%	59%	62%	62%	59%	66%	50%	58%	51%	61%
	Singleton		Apr-19	31%						44%	34%	33%	36%	38%	34%	34%	36%	31%	29%	30%	34%	31%
	POWH									37%	36%	44%	43%	35%	41%	38%	39%	39%	39%	35%	40%	
	HB Total		Apr-19	36%						39%	37%	39%	40%	36%	36%	39%	40%	43%	40%	37%	39%	36%
Theatre Utilisation Rate	Morriston		Apr-19	82%	90%					78%	85%	79%	75%	70%	82%	80%	80%	69%	89%	78%	74%	82%
	NPTH		Apr-19	64%						69%	63%	62%	63%	44%	67%	70%	66%	70%	65%	64%	60%	64%
	Singleton		Apr-19	64%						60%	61%	63%	55%	53%	62%	62%	64%	61%	70%	63%	62%	64%
	POWH									72%	76%	77%	71%	61%	72%	70%	74%	66%	77%	72%	69%	
	HB Total		Apr-19	75%						72%	76%	74%	69%	62%	74%	73%	74%	67%	80%	72%	69%	75%
Theatre Activity Undertaken	Morriston	Day cases	Apr-19	324						312	269	310	302	368	272	371	339	300	373	305	344	324
		Emergency cases	Apr-19	371						354	387	374	375	391	373	335	310	286	276	247	340	371
		Inpatients	Apr-19	469						527	630	543	497	486	522	572	540	403	516	498	486	469
	NPTH	Day cases	Apr-19	224						267	240	214	234	190	290	347	297	202	295	240	260	224
		Emergency cases	Apr-19	8						3	5	9	6	5	8	5	9	6	2	3	9	8
		Inpatients	Apr-19	120						126	147	138	122	89	116	133	126	104	150	113	115	120
	Singleton	Day cases	Apr-19	465						462	526	500	445	456	423	516	528	371	565	486	523	465
		Emergency cases	Apr-19	26						35	38	52	45	44	34	34	42	40	36	30	23	26
		Inpatients	Apr-19	100						124	127	120	90	102	98	141	132	94	129	105	97	100
	POWH	Day cases								350	429	449	408	301	393	455	365	274	434	335	364	
		Emergency cases								107	125	120	120	126	101	107	98	110	124	79	121	
		Inpatients								262	238	252	251	236	223	264	263	172	259	230	209	

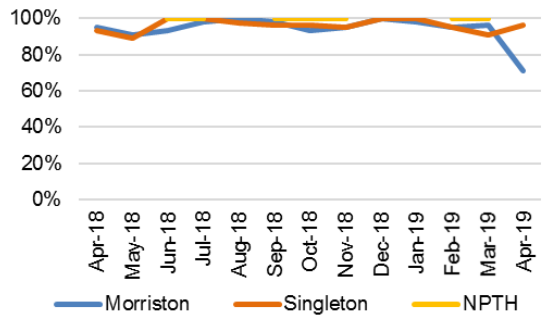
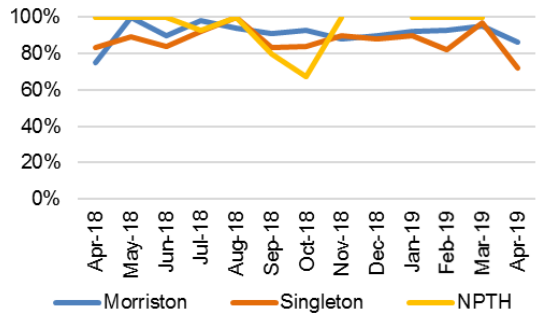
5.4 Planned Care Updates and Actions

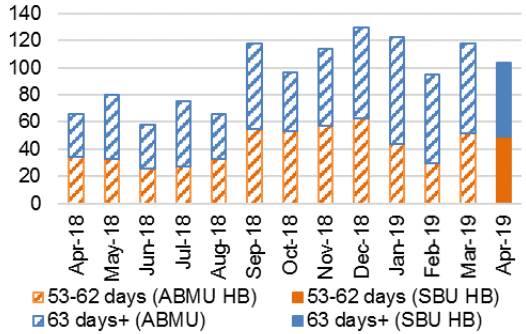
This section of the report provides further detail on key planned care measures.

Description	Current Performance	Trend	Actions planned for next period
Outpatient waiting times The number of patients waiting more than 26 weeks for an outpatient appointment (stage 1)	The number of patients waiting over 26 weeks for a first outpatient appointment continues to be significantly lower than in previous years. In April 2019, there were 236 patients waiting over 26 weeks. Oral Maxillo Facial Surgery accounted for the majority of breaches with 167 (70%). The increase at Singleton is largely due to Ophthalmology pressures.	**Number of stage 1 over 26 weeks** 	• Core capacity will continue to be maximised across all specialties. • The HMRC taxation changes has been escalated within Welsh Government as a major risk to the delivery of additional capacity. A cohort of Consultants have already advised they will be unable to undertake additional clinics through April. The risk is largely within OMFS, General Surgery and Gastro where a high percentage of activity is delivered through WLIs. • Consultant sickness in OMFS along with the above is reporting a deterioration in April. The return of a retired consultant is providing an element of backfill.
Total waiting times The number of patients waiting more than 36 weeks for treatment	The number of patients waiting longer than 36 weeks from referral to treatment continues to be a challenge. In March 2019 there were 1,976 patients waiting over 36 weeks, therefore achieving the internal profile of 2,042. This is the best position since January 2014. Orthopaedics accounts for 60% of the breaches, followed by General Surgery with 11%.	**Number of patients waiting longer than 36 weeks** 	• Following a tender process, formal contracts have been awarded and the outsourcing programme has been implemented for April to support delivery of the profile. The HMRC risk as set out above may have a negative impact on the outsourcing plan although this is yet to be clarified. • Maintaining and enhancing resilience of core theatre capacity to maximise activity that can be undertaken off the Morriston hospital site, with a specific focus on ENT, General Surgery and OMFS at Singleton and Orthopaedics at NPT. • Focussed validation across all specialities to maximise opportunity consistent with RTT rules.

Description	Current Performance	Trend	Actions planned for next period
Total waiting times The number of patients waiting more than 52 weeks for treatment	The number of patients waiting over 52 weeks mirrors that of the 36 week position with Orthopaedics and General Surgery accounting for the vast majority of breaches. In April 2019 there were 714 patients waiting over 52 weeks.	**Number of patients waiting longer than 52 weeks** 	• The actions relating to > 52 week patients are the same as 36 week patients. • Targeted treat in turn and clinical discussions to prioritise longest waiting patients. • Morriston challenged to produce sustainable step change plans to maintain continual improvement and compress the tail end of the longest waiting patients.
Total waiting times Percentage of patients waiting less than 26 weeks from referral to treatment	Throughout 2018/19 the overall percentage of patients waiting less than 26 weeks from referral to treatment has been consistently around 89%. In April 2019 the percentage was 88.8%.	**Percentage of patient waiting less than 26 weeks** 	• Plans as outlined in previous tables.

Description	Current Performance	Trend	Actions planned for next period
Diagnostics waiting times The number of patients waiting more than 8 weeks for specified diagnostics	In April 2019, there were 401 patients waiting over 8 weeks for specified diagnostics. The noticeable increase in breaches is due to the introduction of new Cardiac diagnostic tests in April 2018. All 401 breaches in April 2019 were for Cardiac tests.	**Number of patients waiting longer than 8 weeks for diagnostics** 	• Sustain Nil position for Endoscopy by maximising backfill and waiting list initiatives • Sustain Nil position for all other diagnostics • Plan for additional Cardiac CT/MR capacity is in place well with small improvements being seen.
Therapy waiting times The number of patients waiting more than 14 weeks for specified therapies	There has been significant improvement in Therapy waiting times over the last 12 months and there have been no patients waiting over 14 weeks since May 2018.	**Number of patients waiting longer than 14 weeks for therapies** 	• Continuation of current plans to manage patients into early appointments to provide headroom for re-booking any late cancellations.

Description	Current Performance	Trend	Actions planned for next period
Cancer- NUSC waiting times- Percentage of patients newly diagnosed with cancer, not via urgent route that started definitive treatment within 31 days of diagnosis	April 2019 figures will be finalised on the 31st May. Draft figures indicate a possible projected achievement of 94% of patients' starting treatment within 31 days. At the time of writing this report there are 6 breaches across the Health Board in April 2019: • Lower Gastrointestinal: 3 • H&N: 1 • Breast: 1 • Urological: 1 The improvement will arise as numbers of patients treated are validated	**Percentage of NUSC patients starting treatment within 31 days of diagnosis** 	• Gynaecology to utilise theatre capacity in Hywel Dda from mid May (delayed from April), will help to reduce overall waits to surgery for both Hywel Dda and Swansea Bay. • Chemotherapy Day Unit assessment during April and May to establish if the changes to the delivery model Implemented as part of previous Service Improvement projects are still working and to consider further changes to ensure maximum utilisation of chair time.
Cancer- USC waiting times- Percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within 62 days of receipt of referral	April 2019 figures will be finalised on the 31st May. Draft figures indicate a possible projected achievement of 88% of patients starting treatment within 62 days*. At the time of writing this report there are 12 breaches in total across the Health Board in April 2019: • Breast: 3 • Gynaecological: 3 • Lower Gastrointestinal: 3 • Lung: 1 • Skin: 1 • Haematological: 1 **Working to an approximation of 100 patients treated following boundary change.*	**Percentage of USC patients starting treatment within 62 days of receipt of referral** 	• 4th Gynae-oncology Consultant starting in post in May 2019 • Head and Neck Lump pathway to be partially implemented from late April, with full implementation in July when the new consultant commences in post – this will streamline time to diagnosis for head and neck and haematological cancers. • Detailed Radiology Demand and Capacity plan including reporting time requirements is being worked through; live dashboard has been introduced with a further performance view planned.

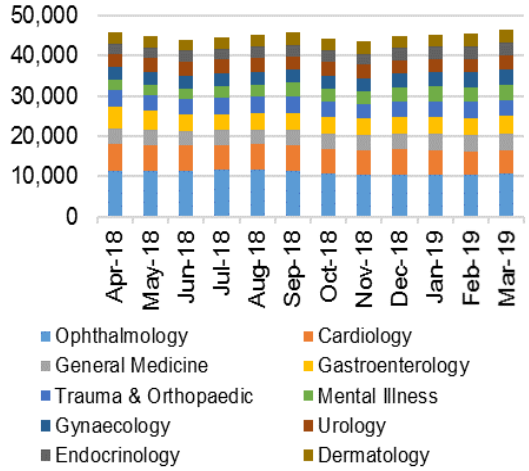
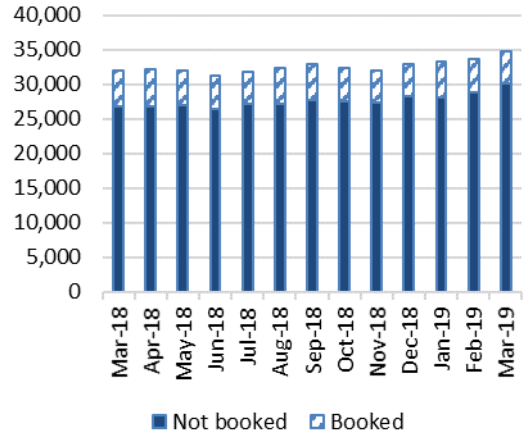
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>USC backlog
The number of patients with an active wait status of more than 53 days</td>
<td>End of March 2019 backlog by tumour site:
<table>
<tr><th>Tumour Site</th><th>53 - 62 days</th><th>63 ></th></tr>
<tr><td>Breast</td><td>9</td><td>6</td></tr>
<tr><td>Gynaecological</td><td>12</td><td>12</td></tr>
<tr><td>Haematological</td><td>0</td><td>3</td></tr>
<tr><td>Head and Neck</td><td>2</td><td>4</td></tr>
<tr><td>Lower GI</td><td>5</td><td>4</td></tr>
<tr><td>Lung</td><td>3</td><td>4</td></tr>
<tr><td>Other</td><td>4</td><td>13</td></tr>
<tr><td>Skin</td><td>4</td><td>0</td></tr>
<tr><td>Upper GI</td><td>2</td><td>6</td></tr>
<tr><td>Urological</td><td>8</td><td>3</td></tr>
<tr><td>Grand Total</td><td>49</td><td>55</td></tr>
</table>
</td>
<td>Number of patients with a wait status of more than 53 days
 
</td>
<td>

Backlog has fluctuated during April, however it must be noted that a Tracker 7 error meant some POW patients were reporting as Swansea Bay. NWIS have since corrected the problem which will enable us to manage this better going forward.
Future planned pathway changes and increased capacity will also help reduce the backlog, which is being monitored very closely within the Units.

</td>
</tr>
<tr>
<td>USC First Outpatient Appointments
The number of patients at first outpatient appointment stage by days waiting</td>
<td>Week to week through April 2019 the percentage of patients seen within 14 days to first appointment/ assessment ranged between 27% and 35%.</td>
<td>The number of patients waiting for a first outpatient appointment (by total days waiting) - End of April 2019
<table>
<tr><th></th><th>≤10</th><th>11-20</th><th>21-30</th><th>>31</th><th>Total</th></tr>
<tr><td>Breast</td><td>0</td><td>2</td><td>27</td><td>91</td><td>120</td></tr>
<tr><td>Gynaecological</td><td>3</td><td>11</td><td>5</td><td>87</td><td>106</td></tr>
<tr><td>Haematological</td><td>1</td><td>0</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Head and Neck</td><td>15</td><td>21</td><td>5</td><td>0</td><td>41</td></tr>
<tr><td>Lower GI</td><td>9</td><td>21</td><td>18</td><td>1</td><td>49</td></tr>
<tr><td>Lung</td><td>3</td><td>2</td><td>0</td><td>0</td><td>5</td></tr>
<tr><td>Other</td><td>28</td><td>22</td><td>3</td><td>2</td><td>55</td></tr>
<tr><td>Sarcoma</td><td>0</td><td>0</td><td>1</td><td>0</td><td>1</td></tr>
<tr><td>Skin</td><td>10</td><td>45</td><td>5</td><td>0</td><td>60</td></tr>
<tr><td>Upper GI</td><td>1</td><td>2</td><td>2</td><td>0</td><td>5</td></tr>
<tr><td>Urological</td><td>2</td><td>7</td><td>9</td><td>0</td><td>18</td></tr>
<tr><td>Total</td><td>72</td><td>133</td><td>75</td><td>181</td><td>461</td></tr>
</table>
</td>
<td>

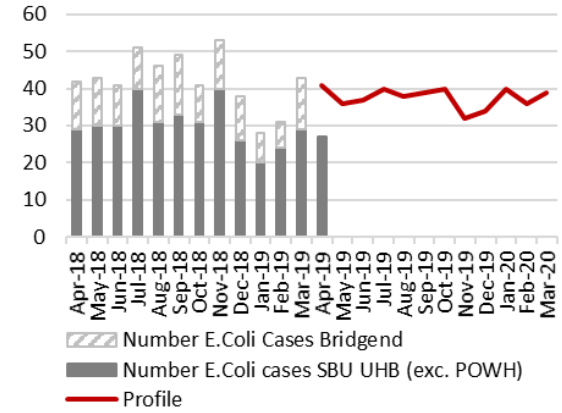
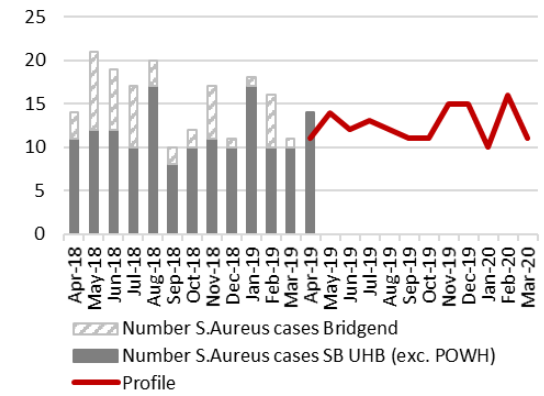
New first outpatient OMFS pathway stage agreed and taken forward with Primary Care, due to triage queries the plan to commence in April has been delayed to 1st June 2019.
Again is should be noted that during April, the same Tracker 7 error effecting meant some POW patients were reporting as Swansea Bay.

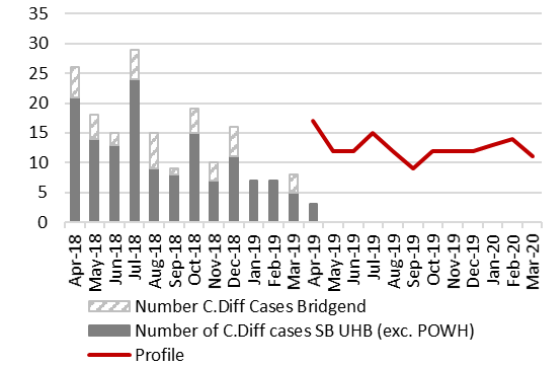
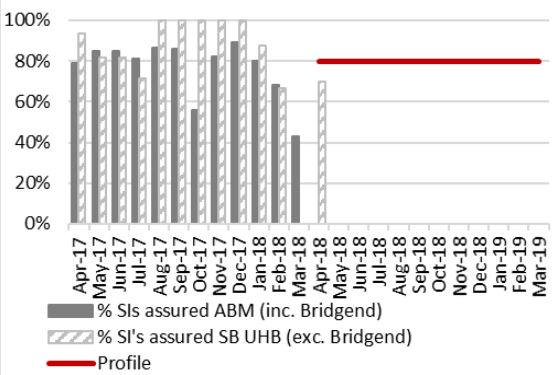
</td>
</tr>
</table>

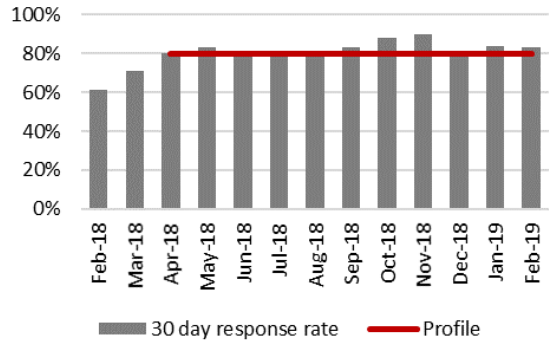
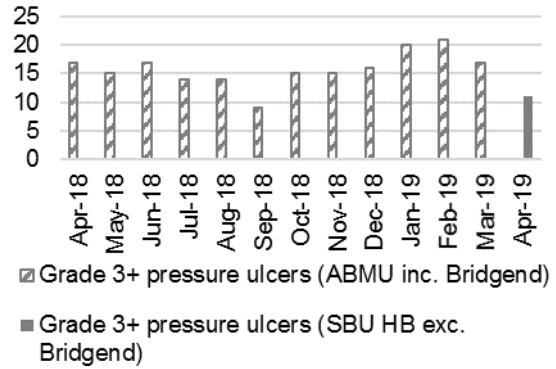
Description	Current Performance	Trend	Actions planned for next period
Delayed follow-ups The number patients delayed past their target date for a follow-up	In March 2019 there were a total of 67,908 patients waiting for a follow-up past their target date. This is above the internal profile for March 2019 and 1,637 (2%) more than March 2018. Of the 67,908 delayed follow-ups in March 2019, 14,783 have appointments and 53,125 are still waiting for an appointment. In addition, 34,781 patients were waiting 100%+ over target date in March 2019. In March 2019, Ophthalmology accounted for 16% of the delayed follow-ups followed by Cardiology with 9%. ***April 2019 data not available at the time of writing this report.***	**Delayed follow-ups: Top 10 Specialties for the largest number of delayed follow-ups**  **Delayed follow-ups: Number of patients waiting 100%+ over target date**  	• Recruit to Validation Team with experienced staff and backfill. Validation Team to commence review of patients and categorisation (May / June 2019) • Identify changes to FunB patients on WPAS to accommodate new definitions / categorisations of activity (e.g. See on Symptom, PROMs, Self-Managed Care, Surveillance patients) (May 2019) • Composition of Outpatient Modernisation Group to be reviewed. Resources required to move programme forward to be agreed with Recovery and Sustainability Group. • Draft programme of work to be agreed. • Continue participation in National Outpatient Modernisation Board. • Continue to progress / Develop Planned Care Programme activities in introducing best practice / digitalisation of activities – ie PKB / PROMs / In Touch etc. • Develop training package for staff • Gold Command activities – Ophthalmology to continue to support changes to service and reduce activity pressures through change management and additional resources – i.e. ODTC development in Cwmtawe Cluster. • Modernisation Group to consider wider alternatives to improve pathways and reduce pressures in both New and follow up arrangements – i.e. considering multi-disciplinary outpatient review on patients with multiple co morbidities / managing frail elderly patients (June 2019)

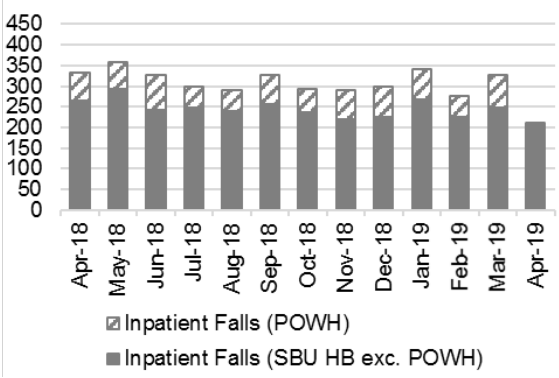
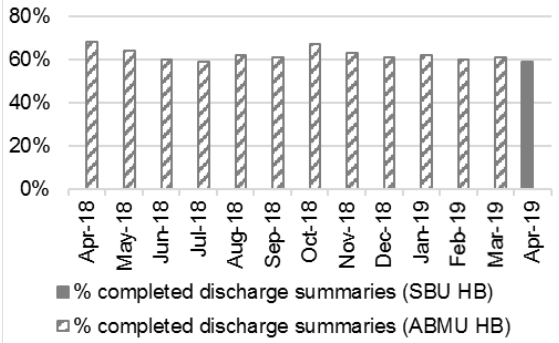
6. QUALITY AND SAFETY INDICATORS

This section of the report provides further detail on key quality and safety measures.

Description	Current Performance	Trend	Actions planned for next period
Healthcare Acquired Infections- E.coli bacteraemia- Number of laboratory confirmed E.coli bacteraemia cases	• 27 cases of *E. coli* bacteraemia were identified in April 2019. This is below the monthly IMTP profile (41 cases). Ratio: 37% hospital acquired to 63% community acquired. • The number of cases in April 2019 is 36% less than the same period of 2018/19. Seasonal variations are common and should be considered when making a comparison with the same time period in 2018/19. *High bed occupancy is a risk to achieving infection reduction.*	**Number of *healthcare acquired E.coli* bacteraemia cases** 	• Delivery Units to focus on increasing the number of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT), with month-on-month improvements. • Delivery Units to progress with PDSA style quality Improvement activities with a focus on urinary catheters, across acute sites. • Delivery Units to explore how to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff. • Improvement work underway to improve HCAI data shared with Delivery Units.
Healthcare Acquired Infections- S.aureus bacteraemia- Number of laboratory confirmed S.aureus bacteraemias (MRSA & MSSA) cases	• There were 14 cases of *Staph. Aureus* bacteraemia in April 2019. This is 3 cases above the projected monthly IMTP profile (11 cases). 79 % were hospital acquired infections, including 4 MRSA cases. • The actual number of cases reported during April is equivalent to the same time period in 2018/19.	**Number of healthcare acquired S.aureus bacteraemias cases** 	• Delivery Units to focus on increasing the number of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT), with month-on-month improvements • Improvement activities will continue to focus on the risk associated with the presence of invasive devices. • Improvement work underway to improve HCAI data shared with Delivery Units. • RCA's are being undertaken for each MRSA case and an increased focus on Mrsa decolonisation in high risk clinical areas

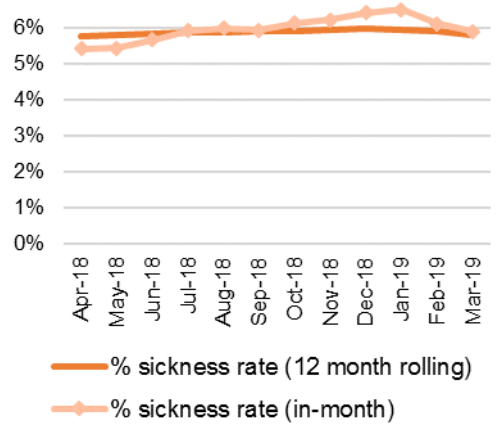
Description	Current Performance	Trend	Actions planned for next period
Healthcare Acquired Infections- **C.*difficile*-** Number of laboratory confirmed C.difficile cases	• There were 3 *Clostridium difficile* toxin positive cases in April. Only 2 considered to be hospital acquired. • This is below the IMTP projected profile (17 cases), equating to approximately 86% fewer cases when compared with the same period in 2018/19. • The Health Board incidence per 100,000 population is 33.47 and continues to be the second highest in Wales. Only two health Boards in Wales achieved the reduction expectation. *High bed occupancy is a risk to achieving infection reduction.*	**Number of healthcare acquired C.difficile cases** 	• Continue to monitor compliance with restriction of Co-amoxiclav, with feedback to Delivery Units • Primary Care antimicrobial guidelines review commenced. Restricting use of Co-amoxiclav more complex in Primary Care than in Secondary Care as limited oral antibiotic alternatives available. Lesser impact on community Clostridium difficile cases anticipated. • Review use of environmental decontamination and develop a plan for a Health Board wide approach – plan to be have a clear direction by 31.08.2019. • Improvement work underway to improve HCAI data shared with Delivery Units.
Serious Incidents- *Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales*	• The Health Board reported 18 Serious Incidents for the month of April 2019 to Welsh Government. • Last Never Event reported was on 13th March 2019. • In April 2019, the performance against the 80% target of submitting closure forms within 60 working days was 70%.	**Number of Serious Incidents** 	• Health Board is supporting the Mental Health & Learning Disabilities Unit to roll out the Serious Incidents Toolkit to ensure consistency of investigation and timeliness of investigations. • The Welsh Risk Pool have suggested that the Pressure Ulcer Improvement methodology be applied to the Falls Improvement work and will coincide with the upcoming relaunch of the Health Board's Fall Prevention and Management Policy.

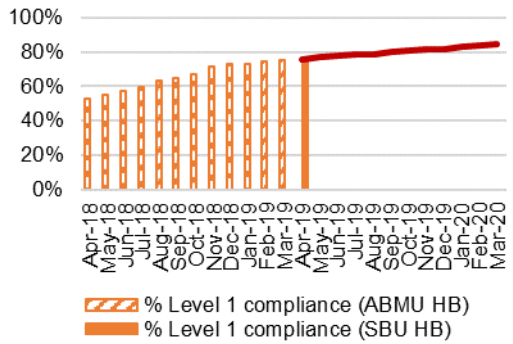
Description	Current Performance	Trend	Actions planned for next period
30 day response rate for concerns- The percentage of concerns that have received a final reply or an interim reply up to and including 30 working days from the date the concern was first received by the organisation	• The overall Health Board response rate for responding to concerns within 30 working days was 83% in February 2019 against the Welsh Government target of 75% and Health Board target of 80%.	**Response rate for concerns within 30 days** 	• Performance is discussed at all Unit performance meetings. For the first 7 months of this financial year the Health Board has achieved 80% in responses for the 30 day target. • Ombudsman's Officer to present to the Consultant Development Day in June 2019. • Concerns, Redress & Assurance Group Terms of Reference to be updated and hold 3 "Putting Things Right" summits with the Units to focus on learning and improvement and key updates in this area.
Number of pressure ulcers Total number of grade 3, grade 4 and unstageable pressure ulcers developed in hospital and in the community	• In April 2019, there were a total of 63 cases of healthcare acquired pressure ulcers. • The number of grade 3+ pressure ulcers in April 2019 was 11, of which 10 were community acquired and 1 was hospital acquired. • In January 2019 Welsh Government changed the reporting criteria to exclude suspected deep tissue injury cases. Since this change the Health Board has not reported any reported pressure ulcers as serious incidents.	**Total number of grade 3+ hospital and community acquired Pressure Ulcers (PU)** 	• PUPSG meet quarterly and receive quality improvement and learning reports from each Service Delivery Unit. • Quarterly analysis of local pressure ulcer causal factors will be undertaken to identify trends and target work streams to reduce risks and achieve a reduction in avoidable pressure ulcers • TVN's continue to collaborate with e-learning Wales to develop an e-learning pressure ulcer prevention education package that can be linked to ESR. • Targeted pressure ulcer prevention and recognition education is ongoing for Morriston A&E and NPTH MIU staff. • A modified SKIN bundle has been developed for use in emergency departments in SBUHB

Description	Current Performance	Trend	Actions planned for next period
Inpatient Falls The total number of inpatient falls	• The number of Falls reported via Datix web for Swansea Bay UHB was 210 in April 2019, compared with 266 in April 2018. • The Health Board has agreed a targeted action to reduce Falls causing harm by 10%.	**Number of inpatient Falls** 	• All Service delivery units are providing Falls management / prevention training. • The training required for completion of the new Falls and Healthy Bone Multifactorial risk assessment has been discussed at the Falls Training Task and Finish group and will now be delivered at SDU's by nominated staff and fed into the Unit Falls groups. • Appropriate documentation has been sent for printing.
Discharge Summaries The percentage of discharge summaries approved and sent to patients' doctor following discharge	• In April 2019 the percentage of electronic discharge summaries signed and sent via eToC was 59% which 2% less than March 2019. • Performance varies between Service Delivery Units (range was 55% to 74% in April 2019) and between clinical teams within the Units.	**% discharge summaries approved and sent** 	• The Executive Medical Director has asked one of the two Deputy Executive Medical Directors to lead on a piece of work to look at e-discharge and improve compliance/completion • Background data presented to Director of Nursing and Patient Experience for consideration through Hospital to Home. • Methodology for addressing variation in performance to be discussed with Assistant Medical Directors • Issue has been discussed at full plenary of Local Medical Committee (LMC) who are supportive of new initiatives

7. WORKFORCE UPDATES AND ACTIONS

This section of the report provides further detail on key workforce measures.

Description	Current Performance	Trend	Actions planned for next period
Staff sickness rates- *Percentage of sickness absence rate of staff*	• The 12-month rolling performance to the end of March 2019 has remained the same as February and stands at 5.90%. • Our in month performance for March 2019 has continued to followed the same improvement we achieved in February 2019, currently standing at 5.80% (down 0.36% on February 2019). • All delivery units have shown an in month improvement for March 2019 performance. With NPT demonstrating the biggest reduction of 0.86%. • Metrics are still for ABMU at this stage	**% of full time equivalent (FTE) days lost to sickness absence (12 month rolling)** 	• Outputs of best practice case study conducted in three areas of good sickness performance (PoW case study), are now incorporated into each DU's attendance action plan deliverable from May 2019. • New attendance audit for Swansea Bay has been developed and is currently in use in MH&LD Delivery Unit with the remaining Delivery Units scheduled for June 2019. • Request for additional resources to support the delivery of the new attendance policy training, to be reviewed by the Executive Team. • Occupational Health (OH) Improvement Plan completed with targets for reductions in waiting times approved by Executive Board. Allied Health Professionals have been recruited to OH using TI monies, resulting in reduced waiting times for management referrals to 2 weeks. Scanning of all OH records has commenced to enable an e-record by Sept 2019 with planned increased efficiencies. • Delivering Invest to Save 'Rapid Access - Staff Wellbeing Advice and Support Service' enabling early intervention for Musculoskeletal (MSk) and Mental Health, ideally within 5 days (90 referrals monthly) and expediting to MSk diagnostics and surgery when required. This model accepted as Bevan Exemplar 2018/19. • 340 Staff Wellbeing Champions now trained to support their teams health and wellbeing and signpost to HB support services, promoting a prevention/early intervention approach. • Monthly 'Menopause wellbeing workshops' commenced March 2019 across the main hospital sites.

Description	Current Performance	Trend	Actions planned for next period
Mandatory & Statutory Training- *Percentage compliance for all completed Level 1 competencies within the Core Skills and Training Framework by organisation*	• Over the past month compliance against the 13 core competencies has risen from 74.37% to 75.30%. This is a 0.93% increase from the previous month and a 20.73% rise since April 2018. • This equates to approximately 2000 new competencies being completed in the last month	**% of compliance with Core Skills and Training Framework** 	• The recent re-audit of previous Internal Audit recommendations reports an improved level of assurance which is now reported as *reasonable* assurance. • E-learning drop in sessions are continuing across the current Health Board and all sites on a regular basis, with the boundary changes coming into effect from end of March and dates programed into POWH will be handed over to Cwm Taff to hold. Dates and location have already been handed over. This is an on-going process • A review of the Mandatory Training framework is being arranged where all relevant Subject Matter Experts will be invited to a workshop to discuss current and to identify new trends that may need to be introduced. • The results of the NWSSP Audit were received and feedback is still to occur, the next audit is being planned for June 2019 • The Mandatory Training Governance Committee has a planned meeting of 31st May to discuss content, recording, regular meetings arranged and compliance Once clarified, this would then be subject to approval via the Executive Team • A date has been arranged June 2019 for further examination of the ESR system, we are awaiting confirmation of the identity of the person from Informatics, as the current person will no longer be involved. • Two new user guides have been created, a longer version which explains in detail and step by step that covers ANTT and a short version that covers Mandatory & Statutory requirements incorporating the updated access and use of e-learning in a simple one click process.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>Vacancies
Medical and Nursing and Midwifery</td>
<td>

Continue to engage nurses from outside the UK to help mitigate the UK shortage of registered nurses. To date we have in our employ:
EU Nurses employed at Band 5 = 70
Philippine nurses arrived in 17/18 & employed at Band 5 = 30
Regionally organised nurse recruitment days which ensure we are not duplicating efforts across hospital sites. These are heavily advertised across social media platforms via our communications team.
11 Health Care Support Workers (HCSW’s) recruited to part time degree in nursing. 7 commenced in Sept-17 on a 4 year programme, the remainder commenced in Jan-18 on a 2 year 9 month programme. We have also secured further external funding to offer similar places to 13 HCSW’s in 18/19 and recruitment to these places is underway.
A further 13 of our HCSW’s are currently undertaking a 2 year master’s programme.

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<td>
Vacancies as at March 2019 – April data is not yet available form reporting.
<table>
<tr><th>Grade - Medical & Dental</th><th>Feb-19</th><th>Mar-19</th></tr>
<tr><td>21000-Consultant (M&D)</td><td>-77.81</td><td>-88.99</td></tr>
<tr><td>21100-Locum Consultant (M&D)</td><td>7.55</td><td>10.07</td></tr>
<tr><td>22110-Associate Specialist (M&D)</td><td>-12.69</td><td>-12.40</td></tr>
<tr><td>22200-Locum Associate Specialist (M&D)</td><td>0.45</td><td>0.46</td></tr>
<tr><td>22250-Specialist Dental Officer</td><td>0.42</td><td>0.42</td></tr>
<tr><td>22260-Senior Dental Officer</td><td>-0.80</td><td>-0.80</td></tr>
<tr><td>22270-Dental Officer</td><td>-1.99</td><td>-2.59</td></tr>
<tr><td>22310-Speciality Doctor (M&D)</td><td>-28.92</td><td>-29.63</td></tr>
<tr><td>22320-Locum Speciality Doctor (M&D)</td><td>-1.00</td><td>-1.00</td></tr>
<tr><td>23100-Specialty Registrar (M&D)</td><td>-142.47</td><td>-111.38</td></tr>
<tr><td>23120-Locum Specialty Registrar (M&D)</td><td>30.20</td><td>36.17</td></tr>
<tr><td>23200-Specialist Registrar (M&D)</td><td>-6.60</td><td>-6.60</td></tr>
<tr><td>23300-Locum Specialist Registrar (M&D)</td><td>-1.20</td><td>-1.20</td></tr>
<tr><td>24100-F2 foundation year 2 (M&D)</td><td>0.08</td><td>-0.26</td></tr>
<tr><td>24110-Locum F2 Foundation year 2 (M&D)</td><td>3.00</td><td>3.00</td></tr>
<tr><td>24400-F1 foundation year 1 (M&D)</td><td>-7.44</td><td>-8.46</td></tr>
<tr><td>24900-Dental Trainees in Hosp Post</td><td>3.96</td><td>3.96</td></tr>
<tr><td>25000-Clinical Assistant (M&D)</td><td>-0.37</td><td>-0.37</td></tr>
<tr><td>25100-Senior Lecturer (M&D)</td><td>-1.90</td><td>-1.90</td></tr>
<tr><td>25300-G.P.Sessions / Staff Fund</td><td>0.81</td><td>-0.06</td></tr>
<tr><td>Total</td><td>-236.72</td><td>-211.56</td></tr>
</table>
<table>
<tr><th>Grade - Nursing & Midwifery</th><th>Feb-19</th><th>Mar-19</th></tr>
<tr><td>2A182-Nurse Consultant Band 8B</td><td>-0.31</td><td>-0.31</td></tr>
<tr><td>2A281-Nurse Manager Band 8A</td><td>7.60</td><td>2.34</td></tr>
<tr><td>2A282-Nurse Manager Band 8B</td><td>6.26</td><td>2.64</td></tr>
<tr><td>2A283-Nurse Manager Band 8C</td><td>4.00</td><td>3.00</td></tr>
<tr><td>2A284-Nurse Manager Band 8D</td><td>-1.80</td><td>-0.80</td></tr>
<tr><td>2A451-Registered Nurse Band 5</td><td>-367.17</td><td>-414.74</td></tr>
<tr><td>2A461-Registered Nurse Band 6</td><td>-14.15</td><td>-16.80</td></tr>
<tr><td>2A471-Registered Nurse Band 7</td><td>-31.35</td><td>-35.79</td></tr>
<tr><td>2A481-Registered Nurse Band 8A</td><td>-1.84</td><td>-0.89</td></tr>
<tr><td>2A482-Registered Nurse Band 8B</td><td>0.00</td><td>1.00</td></tr>
<tr><td>Total</td><td>-398.76</td><td>-460.35</td></tr>
</table>
<table>
<tr><th>Grade - Health Care Support Workers</th><th>Feb-19</th><th>Mar-19</th></tr>
<tr><td>2AA21-Nursing HCA/HCSW Band 2</td><td>-48.13</td><td>-76.17</td></tr>
<tr><td>2AA31-Nursing HCA/HCSW Band 3</td><td>-39.89</td><td>-45.34</td></tr>
<tr><td>2AA41-Nursing HCA/HCSW Band 4</td><td>0.38</td><td>-1.28</td></tr>
<tr><td>Total</td><td>-87.64</td><td>-122.79</td></tr>
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Currently exploring further options of nurses from Dubai and India. We are in the process of preparing a mini tendering exercise which will be aimed at suppliers who are able to provide overseas qualified nurses who already have the requisite English language requirements as this has been the time delay to date in our recruitment timeline.
Work is underway to develop a medical recruitment strategy in partnership with the Medical Director/ Deputy Medical Director team. The initial plans were presented to the Workforce and OD committee in February. This is due for discussion at the May Local Nursing Committee (LNC).

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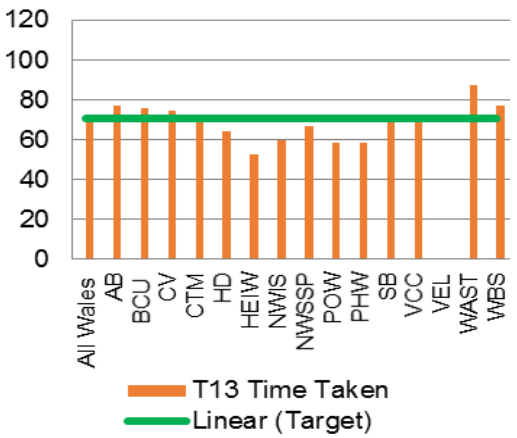
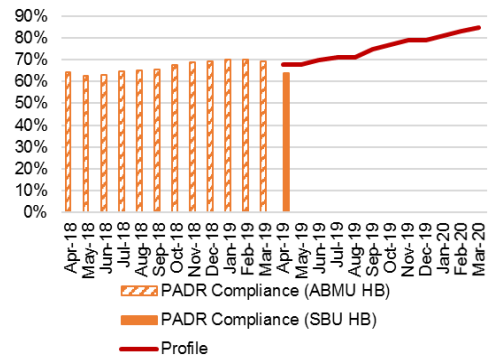
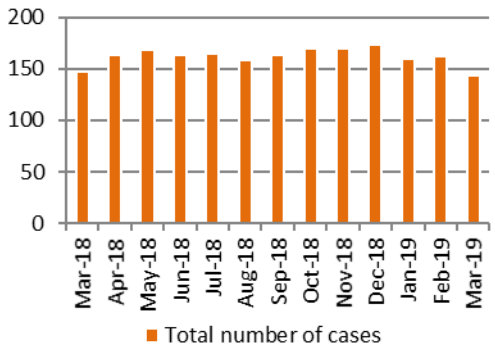
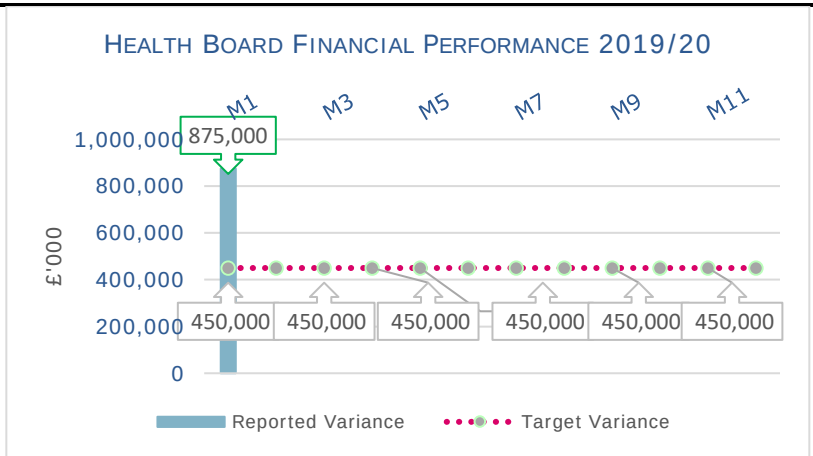
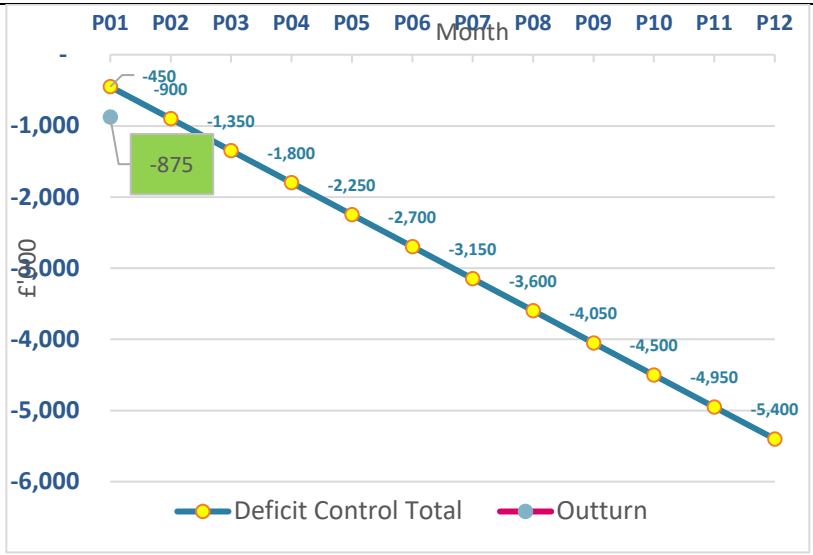
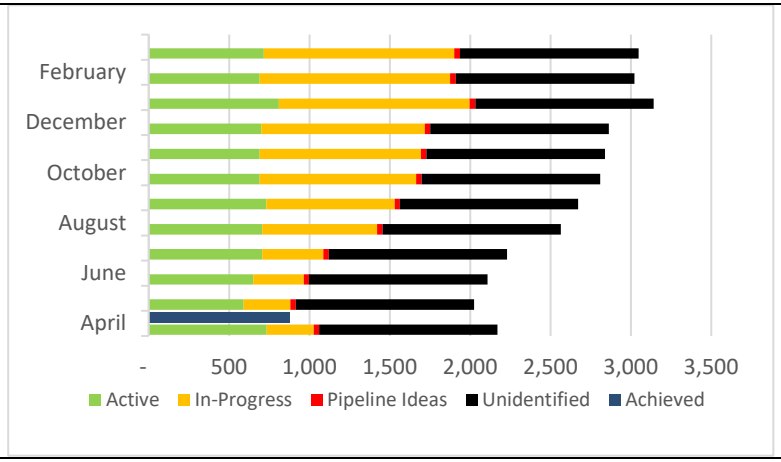
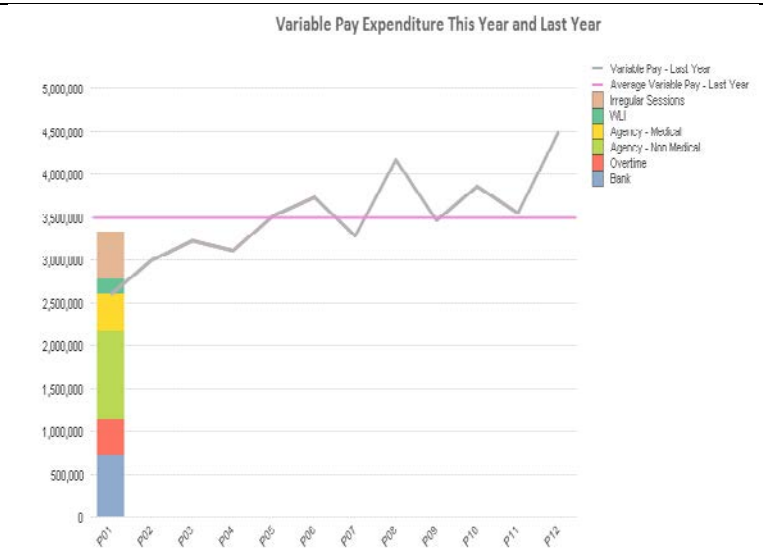
Description	Current Performance	Trend	Actions planned for next period
Recruitment *Metrics provided by NWSSP. Comparison with all-Wales benchmarking*	• Swansea Bay UHB overall performance now matches the target level for NHS Wales. • Of the key measures where we are not yet at target - time to complete sifting has steadily improved towards the three day target and is at six days.	**Vacancy Creation to Unconditional Offer February 2019 (working days: including outliers) T13** 	• Outlier data is passed to Delivery Units for review. • If Outliers (activity well outside the normal expected timescale) are excluded SBU HB is well under the 71 day target. Action to sanitise the data will improve accuracy of the reports.
Turnover *% turnover by occupational group*	• Turnover data reports held with ESR is being affected by the staff who have moved to CTM. The attached figures have been adjusted and show a small reduction in Turnover which still remains below 8% on FTE.	**Turnover Data 1st April 2018 – April 2019** Staff Group / FTE / Headcount / Change Headcount Add Prof Scientific and Technic: 8.23% / 8.50% / ↓ Additional Clinical Services: 6.66% / 7.11% / ↓ Administrative and Clerical: 8.61% / 8.85% / ↑ Allied Health Professionals: 10.05% / 9.99% / ↓ Estates and Ancillary: 5.13% / 5.60% / ↑ Healthcare Scientists: 8.26% / 8.59% / ↑ Medical and Dental: 10.68% / 11.85% / ↓ Nursing and Midwifery: 8.26% / 8.77% / ↓ Overall Rate / FTE / Headcount / Change Headcount Overall Rate: 7.95% / 8.36% / ↓	• Roll out of exit interviews across the Health Board following the pilot in Nursing is being looked into as well as the use of ESR exit interview functionality. This is being managed on an all-Wales basis.

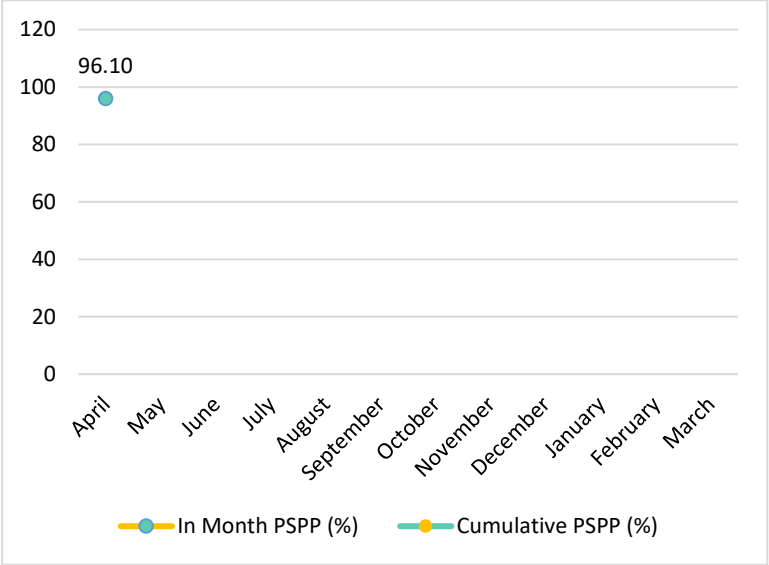
Description	Current Performance	Trend	Actions planned for next period
PADR *% staff who have a current PADR review recorded*	• Staff who have had a Personal Appraisal and Development Review (PADR) as of April 2019 stands at 63.79%. This is a decline of 2.14% from March's figure of 65.93% • Medical and Dentals results have seen a decrease in completed PADR's from 67.03% to 66.88%. This is an overall 0.15% drop in results. • The drop in results can be attributed to the recent boundary change in April.	**% of staff who have had a PADR in previous 12 months** 	• PADR training offered as part of the new Managers Pathway from 1st April 2019. The Managers Pathway will be a mandatory process for all new managers who have people management responsibility, including those who joined the HB over the past 12 months. • Current research project is being undertaken, its purpose is to identify themes/ practices that can be associated with either good or poor practice. On completion, recommendations will be made as to what could be done to improve future compliance. • Internal audit report December 2018, has maintained the audit rating as *limited* assurance. Corporate level actions have been completed but there is continuing non-compliance of recommendations at a local level in some of the audit areas. The audit acknowledged the continuing difficulties of implementing Supervisor Self Service and the roll out of ESR.
Operational Casework *Number of current operational cases.*	• There has been a steady and noticeable reduction in live ER cases over the last 5 months but volume of activity is still significantly increased on averages pre Mid 2016. • There has been a reduction in both Disciplinary cases and in the number of grievances.	**Number of Operational Cases** **Data source has been amended to refelct only SB UHB data over the last 15 months so a comparative picture can be seen over time.** 	• ER system configuration completed. System testing has been completed but IG issues have resulted in a delay in clearance to use the system. No revised date for go live is available yet. User training for case handlers and system admins in preparation for testing has been completed. • IO shortlisting has been completed interviews will be held at the end of May. • ACAS supported training looking at improving partnership working and a programme of work with managers to look at bullying and harassment (targeted on hot spots identified in the 2018 staff survey) has been agreed. All events completed as at 4th Feb. ACAS summary post events is being prepared. ACAS summary post events is being prepared.

8. FINANCE UPDATES AND ACTIONS

This section of the report provides further detail on key workforce measures.

Description	Current Performance	Trend	Actions planned for next period
Revenue Financial Position – expenditure incurred against revenue resource limit	• The reported revenue financial position for April 2019 is an overspend of £0.875m against a forecast overspend of £0.45m. • The key drivers of the overspend are the Diseconomies of Scale of Bridgend Boundary (£0.45m), the required level of savings not identified (£0.3m), costs associated with Bridgend (£0.05) and Operational Pressures (£0.075m)		• Identify further savings and increase delivery confidence • Support the Bridgend Financial Due Diligence exercise • Clarify and agree the continued work required to support Bridgend Boundary Change Identify opportunities to mitigate and manage the operational pressures
Forecast Position – delivery of the £10m forecast deficit	• The core financial plan provides a balanced financial position. • This assumes that the funding provided by Welsh Government non-recurrently in 2018/19 is re-provided. • The current forecast deficit is £5.4m which reflects the diseconomies of scale on corporate and clinical management costs following the Bridgend Boundary Change		• 2019/20 Annual Plan to be re-submitted to WG • Identify plan/opportunities to reduce the diseconomies of scale over time. • Consider impact of savings delivery and operational pressures on forecast position

Description	Current Performance	Trend	Actions planned for next period
Savings Delivery – Performance against the £21.2m savings requirement	• The Health Board financial plan set out a requirement to identify and deliver £21.3m. • To date £17.7m of Green and Amber schemes have been identified, with a further £0.4m of Red schemes. This gives a shortfall of around £3.6m. • The planned savings delivery for April was £1,027m, with £0.877m actually delivered, resulting in slippage of £0.15m.		• Further identification of savings and greater delivery confidence. • Analysis of planned scheme slippage to ensure necessary actions taken to rectify position.
Workforce Spend – workforce expenditure profile	• Workforce expenditure prior year trends have been adjusted for Bridgend Boundary Change. • Workforce expenditure is around £4m per month higher than the same period of the previous year, £3.3m increase on substantive staff and £0.7m variable pay. • Around £2.5m of the substantive staff increase relates to 18/19 and 19/20 pay inflation. • The variable pay increase is within non-medical agency and primarily relates to nursing agency costs which increased significantly during 2018/19 and have continued at this increased level in 2019/20. This in part reflects the additional capacity being utilised across the HB.		• Analysis of the key factors driving the use of variable pay outside of planned budget • Identify actions to cease the use of non-contract nurse agency.

Description	Current Performance	Trend	Actions planned for next period
PSPP – pay 95% of Non-NHS invoices within 30 days of receipt of goods or valid invoice	• In-month performance in April 2019 was 96.1%, which was excellent. • 2018/19 saw strong performance during the later part of the year, however due to poor performance in early 2018/19, the 95% target was not achieved. • The improved performance needs to be sustained to ensure that the target is able to be met • There continue to be significant challenges linked to clearing invoices on hold due to the implementation of the No PO No Pay policy.		• Closely monitor performance improvements and identify impacts of No PO No pay to enable further awareness and training to be undertaken.

9. KEY PERFORMANCE MEASURES BY DELIVERY UNIT

9.1 Morriston Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Unscheduled Care	4 hour A&E waits	Actual	64.2%											
		Profile	*66%*	*70%*	*73%*	*75%*	*72%*	*73%*	*76%*	*73%*	*82%*	*83%*	*82%*	*82%*
	12 hour A&E waits	Actual	653											
		Profile	*484*	*374*	*273*	*283*	*266*	*238*	*273*	*279*	*211*	*185*	*187*	*180*
	1 hour ambulance handover	Actual	669											
		Profile	*320*	*233*	*201*	*220*	*193*	*200*	*208*	*248*	*241*	*176*	*148*	*145*
Stroke	Direct admission within 4 hours	Actual	62%											
		Profile	*76%*	*77%*	*78%*	*78%*	*79%*	*80%*	*80%*	*81%*	*82%*	*82%*	*83%*	*84%*
	CT scan within 1 hour	Actual	62%											
		Profile	*47%*	*52%*	*50%*	*53%*	*51%*	*58%*	*53%*	*58%*	*55%*	*58%*	*56%*	*60%*
	Assessed by Stroke Specialist within 24 hours	Actual	96%											
		Profile	*87%*	*89%*	*92%*	*89%*	*91%*	*94%*	*91%*	*93%*	*96%*	*93%*	*95%*	*96%*
	Thrombolysis door to needle within 45 minutes	Actual	27%											
		Profile	*20%*	*25%*	*25%*	*30%*	*30%*	*30%*	*35%*	*35%*	*35%*	*40%*	*40%*	*40%*
Planned care	Outpatients waiting more than 26 weeks	Actual	172											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	1,952											
		Profile	*2,042*	*2,038*	*2,125*	*2,135*	*2,106*	*2,098*	*1,957*	*1,999*	*2,135*	*2,046*	*1,956*	*1,921*
	Diagnostic waits over 8 weeks	Actual	401											
		Profile	*480*	*400*	*390*	*370*	*330*	*250*	*180*	*150*	*130*	*100*	*50*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	71%											
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	86%											
		Profile	*91%*	*94%*	*93%*	*96%*	*96%*	*94%*	*94%*	*94%*	*95%*	*95%*	*95%*	*96%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	1											
		Profile	*8*	*5*	*6*	*8*	*6*	*5*	*6*	*6*	*6*	*7*	*6*	*6*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	7											
		Profile	*4*	*5*	*3*	*4*	*4*	*3*	*3*	*4*	*3*	*4*	*4*	*4*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	7											
		Profile	*7*	*3*	*6*	*4*	*6*	*4*	*4*	*6*	*6*	*8*	*4*	*5*
Quality & Safety Measures	Discharge Summaries	Actual	59%											
		Profile	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
	Concerns responded to within 30 days	Actual												
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual												
		Profile			*5.97%*			*5.84%*			*5.72%*			*5.59%*
	Personal Appraisal Development Review	Actual	65%											
		Profile			*72%*			*77%*			*80%*			*85%*
	Mandatory Training	Actual	71%											
		Profile			*78%*			*85%*			*85%*			*85%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

9.1 Morriston Delivery Unit- Overview

Successes	Priorities
• Dedicated mental health assessment facility in ED open with opportunity to extend mental health provision in ED. • Significant improvement in the planned care waiting times in 18/19 compared to 17/18. 2,473 July 2017 to 1,801 March 2019. • Weekly scrutiny and review of agency cap breaches. • 37 managers have undergone 'Disciplinary Investigating' training and a register of investigators has been established. • Reduction in disciplinary cases from 25 to 11 from December 2018 to February 2019. • Improvement in Mandatory & Statutory training compliance rates in one month all amber with Social and Wellbeing Act Wales awareness green. • 96% compliance with 30-day response target for complaints. • Despite the high demand for in-patient beds, no increase in informal complaints received.	• Plan to improve ambulatory emergency care pathways for medicine. • ED to plan recruitment programme aligned to the Kendall Bluck workforce model. • Focus on staff survey areas that need attention – stress and bullying prevention and management by ACAS. • Improve and maintain patients awaiting scheduled care throughout the rest of the year from the end of March position. • Implementation of plan to address backlog for pancreatic surgery. • Finalise business case for treat and repatriate cardiology model. • Work with Singleton Hospital to expand their trolley capacity to support elective surgery. • Continued focus on priorities to reduce demand for medical beds in Morriston including expansion of OPAS/IV antibiotic treatments in community/Increased access to Gorseinon Frailty beds. • Detailed and deliverable CIP Plans in place by end of Q1.
Opportunities	**Risks & Threats**
• Physicians Associate has commenced in ED. Very positive feedback received – opens up a new workforce opportunity. • Bid submitted for a share of £3M to implement and support a single cancer pathway. • Maintain outsourcing levels to maximise throughput of patients. • Theatres recruitment drive planned following successful open day • Role redesign review at the weekly workforce panel. • Review of all employment relation cases monthly to recognise themes and provide any additional support. • Review of Clinical workforce undertaken by Kendall Bluck. • Roll out of "Allocate" and "Locum on duty" software. • Sustainable plan for Pancreatic surgery agreed. • 24/7 Hospital handover arrangements for sickest patients scheduled to start from 1st May 2019 (acute deterioration service). • Discussions planned with Hywel Dda re Thyroid surgery service. • Work started on development of a business case for a hybrid theatre for vascular services in South West Wales.	• Medically fit for discharge numbers continues to be at an unprecedented high of 109, with adverse impact on Hospital performance including long ambulance off load delays, staff and hospital morale, planned care pathways and financial position. • Winter surge arrangement continue to be open. • Continued breaching of the clean orthopaedic ward to manage hospital pressures. • Lack of Health Board Escalation Policy (ED), including focus on community services response. • Change to pension taxation arrangements impacting on medical staff undertaking additional clinical work or leadership posts. • Challenges with cardiac theatre scrub cover to maintain cardiac surgery service. • Nursing and Medical vacancies – recruitment challenges. • July start date confirmed for ward refresh programme due to limited decant facilities. • Financial risk of not removing Vanguard at the end of Q1.

9.2 Neath Port Talbot Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Unscheduled Care	4 hour A&E waits	Actual	95.2%											
		Profile	*99%*	*99%*	*99%*	*99%*	*99%*	*99%*	*99%*	*99%*	*99%*	*99%*	*99%*	*99%*
	12 hour A&E waits	Actual	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Planned care	Outpatients waiting more than 26 weeks	Actual	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Therapy waits over 14 weeks	Actual	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	-											
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	-											
		Profile	*76%*	*95%*	*89%*	*96%*	*97%*	*87%*	*89%*	*90%*	*87%*	*82%*	*83%*	*94%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	0											
		Profile	3	3	0	0	0	0	1	1	1	0	1	1
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	1											
		Profile	0	0	0	1	1	0	1	0	1	1	0	0
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	1											
		Profile	0	2	1	2	1	1	3	1	2	2	1	0
Quality & Safety Measures	Discharge Summaries	Actual	74%											
		Profile	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Concerns responded to within 30 days	Actual												
		Profile	*91%*	*94%*	*93%*	*96%*	*96%*	*94%*	*94%*	*94%*	*95%*	*95%*	*95%*	*96%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual												
		Profile			5.00%			4.80%			4.60%			4.30%
	Personal Appraisal Development Review	Actual	80%											
		Profile			75%			80%			85%			90%
	Mandatory Training	Actual	84%											
		Profile			75%			80%			85%			90%

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

9.2 Neath Port Talbot Delivery Unit- Overview

Successes	Priorities
• DToC is at lowest level and lowest bed days lost since May 2018. • RTT targets achieved in all medical specialties; • Rheumatology waiting times for new patients under 15 weeks. • Therapies undertaking multi centre R &D trials; • MIU attained 98% compliance with 4-hour wait time target; • 100% cancer 62-day target compliance, no waits over 31 days; • Nurse Led Virtual Clinics will be commencing in May in Diabetes; • Coproduction has commenced in General Medicine; • Positive evaluation of OT impact on patients care in OPAS via winter pressure monies; • Positive first year evaluation of Macmillan funded Head and Neck Cancer Nutrition and Dietetic Service; • Positive HFEA Inspection Report for WFI at NPTH.	• Support staff and services through Brexit changes; • Develop primary care services for therapies; • Develop MDT neonatal services; • Increase triage staffing in MIU to meet 99% 4-hour target – recruiting; • Recruitment of Registered Nurses; • Undertake Therapy restructure; • Support the development of a stroke ESD service/ stroke remodelling; • Increasing elective surgical activity to support RTT; • Implementation of HEPMA Phase 1 at NPTH; • Active participation in Hospital-to-Home project; • To reduce the FUNB over target in Rheumatology. • Reduce spend on FP10s in Rheumatology.
Opportunities	**Risks & Threats**
• Remodelling of therapy management and financial structures; • Develop primary care OT posts to address the preventative and early intervention needs of our population ; • Development of pharmacist advanced practice and consultant posts, and re-structure of primary care pharmacy team. • Work with our communities to develop sustainable solutions to well-being by developing social enterprise opportunities; • Development of long term posts in therapies and pharmacy to support winter plans in a sustainable format; • MH&LD DU providing ongoing temporary funding for OPAS OT post. • Bid submitted to develop a critical care MDT in line with national guidance and to become a lead in Wales; • Deliver training to clusters and develop outline structure of the Diabetes Community Model. • Andrology waits and developing a one stop service • Further income generation andrology • Negotiate partial funding for cancelled cycles for clinical reasons with WHSSC.	• Capacity within the Community for discharges; • Staffing challenges to support surge capacity; • Loss of pharmacists to cluster & practice based roles; • Recruitment issues for pharmacy technicians; physiotherapists; nursing. • Increased workload from NICE/New Treatment Fund appraisals specifically cancer drugs requiring infrastructure changes; • Impact of Bridgend boundary changes; • Devolved management and financial therapy budgets leads to governance issues and the reduces ability of therapy services to remodel, flex and respond to patients/ service needs; • Brexit – increased equipment costs, risk to pharmaceutical products etc.; • WFI WHSCC activity underperforming; • MIU staffing pressures while awaiting recruitment; • Lack of Therapy provision to neonatal unit in Singleton; • Lack of COSHH policy and guidance for HB; • Recruitment lag in Occupational Therapy senior leadership team; • Potential adverse financial consequences of boundary merger for therapies.

9.3 Singleton Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Unscheduled Care	4 hour A&E waits	Actual												
		Profile	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*
	12 hour A&E waits	Actual												
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	1 hour ambulance handover	Actual	63											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Planned care	Outpatients waiting more than 26 weeks	Actual	64											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	24											
		Profile	*0*	*0*	*0*	*13*	*26*	*39*	*32*	*25*	*18*	*11*	*4*	*0*
	Diagnostic waits over 8 weeks	Actual	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	96%											
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	72%											
		Profile	*91%*	*94%*	*93%*	*96%*	*96%*	*94%*	*94%*	*94%*	*95%*	*95%*	*95%*	*96%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	1											
		Profile	*2*	*1*	*3*	*3*	*1*	*1*	*2*	*2*	*2*	*2*	*2*	*1*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	3											
		Profile	*2*	*0*	*1*	*2*	*1*	*2*	*1*	*1*	*2*	*0*	*1*	*1*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	2											
		Profile	*5*	*4*	*4*	*4*	*4*	*4*	*4*	*2*	*2*	*1*	*1*	*2*
Quality & Safety Measures	Discharge Summaries	Actual	55%											
		Profile	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
	Concerns responded to within 30 days	Actual												
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual												
		Profile			*5.00%*			*5.00%*			*5.00%*			*5.00%*
	Personal Appraisal Development Review	Actual	69%											
		Profile			*70%*			*75%*			*80%*			*85%*
	Mandatory Training	Actual	77%											
		Profile			*70%*			*75%*			*80%*			*85%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

9.3 Singleton Delivery Unit- Overview

Successes	Priorities
• Continued achievement of no patients waiting over 8 weeks for an Endoscopy procedure during April 2019. • Continued achievement of RTT 26, 36 and 52-week target for all medical and surgical specialties. • Quality Management System Business case approved by Investment Benefit Group (IBG) • New electronic request form for DXA - for roll out to GPs. • Funded for end of life support has been agreed for clinical advisor sessions. • Successful evacuation of ward 12 following fire. • Business case approved by IBG, to proceed with workforce plan to implement Quality Management System to ensure compliance to new regulations. • Development of Auto Approval of Radiotherapy Treatment plans, at pilot stage, look to roll out to all treatment sites. • New Oncology Consultant starts 15th May (lung, urology). • The CDU has successfully collaborated with Maggie's centre to implement block immunotherapy pre-assessments.	• Manage RTT pressures in Ophthalmology and Gynaecology following recent workforce challenges. • Service Resign: Redesign Services Ward 4&7, embedding ICOPS model and inpatient capacity. • Develop a plan to support Radiotherapies waiting times. • Improvement in PADR and Mandatory training. • Cancer Performance and scoping of impact of Single Cancer pathway. • Business Cases - PET/CT & replacement Radiotherapy CT. • Developing capacity plans for Chemo-day unit. • Securing additional funding for sustainable plan in relation to Gastroenterology and Endoscopy RTT & Bowel Screening Wales. • Ophthalmology sustainable plan as part of GOLD command • Remedial capital work on ward 12. • Delivering SACT is essential for decreasing the waiting times and delivering NICE approved treatments and clinical trial availability. Plan to utilise the Tenovus mobile unit to deliver SACT.
Opportunities	**Risks & Threats**
• Delivery Unit to support Health Board case for Nerve centre. • Increase activity through Medical Day Unit to support patient flow and review opportunities to support flow from Morriston. • Piloting of Patient Knows Best (PKB) • Revised SARC model. • Development of Children's Emergency Centre (Morriston) and Swansea Wellbeing Centre. • Regional collaboration with Hywel Dda for both Dermatology and Endoscopy Services. • Discussions with the medical school to increase oncology presence. • Pressure ulcer Masterclass training module- pilot to take place at the Welsh Wound Innovation Centre on 4.6.19, potential income to follow. • Lymphoedema national review identified areas of potential within local service.	• Ongoing pressure of cladding mitigated by operational controls. Engineering plan being developed to support rework and implementation. • Patients in Singleton (DGH and Cancer centre) without Specialist Palliative Care Services. • Workforce deficits – Rehab Engineering, Consultant - Gynae & Cardiology, Medical Junior and Middle Grade gaps and Nursing. • Under delivery of Waterfall elements. • Cancer tracking and lack of workforce to support. • Impact of Bridgend boundary changes on Dermatology and Endoscopy services. • Increase in radiotherapy capacity with extended working days not supported at IBG fully and waiting times remains unsatisfactory. • Lymphoedema National review identified skill mix and workforce issue within Swansea Bay Service.

9.4 Mental Health & Learning Disabilities Performance Dashboard

				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Mental Health Measures *(excluding CAMHS)*	% MH assessments undertaken within 28 days	Actual	95%												
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
	% therapeutic interventions started within 28 days	Actual	89%												
		Profile	*80%*												
	% of qualifying patients who had 1st contact with an Independent MH Advocacy (IMHA)	Actual	100%												
		Profile	*100%*												
	% of residents in receipt of secondary MH services who have valid care and treatment plan (CTP)	Actual	91%												
		Profile	*90%*												
	Residents assessed under part 3 of MH measure sent a copy of their outcome assessment report within 10 working days of assessment	Actual	100%												
		Profile	*100%*												
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	0	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	0	0											
		Profile	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	0	0											
		Profile	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*
Quality & Safety Measures	Discharge Summaries completed and sent	Actual	92%	0%											
		Profile	*100%*												
	Concerns responded to within 30 days	Actual													
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	6.18%												
		Profile	*5.73%*			*5.73%*			*5.63%*			*5.53%*			*5.43%*
	Personal Appraisal Development Review	Actual	74%	0%											
		Profile	*85%*			*80%*			*82%*			*83%*			*85%*
	Mandatory Training *(all staff- ESR data)*	Actual	81%	0%											
		Profile	*85%*			*80%*			*82%*			*83%*			*85%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

9.4 Mental Health & Learning Disabilities Delivery Unit- Overview

Successes	Priorities
• The Delivery Unit regularly meets all requirements of sections of the Mental Health Measure. • Maintaining low number of healthcare acquired infections, with each occurrence reviewed for lessons learnt. • Maintaining relatively high levels of compliance with the PADR measures. • Meeting new target for psychological therapies on a sustainable basis. • Reduced waiting times for opiate substance treatment.	• Ongoing intervention with frequent areas of poor compliance. Awareness on importance of timely discharge summaries with all Clinical Staff. • Recruitment and retention of staff for critical nursing, therapies and medical vacancies. • Hold and improve current rate of sickness through, Staff Health & Wellbeing Action Plan 18/19; Pilot Delivery Unit Staff Counsellor; Pilot Performing Medicine Staff Wellbeing programme; Promote Well Being Champions roles (47). • Appoint to medical staffing vacancies or modernise service. • Move with partners to effect transformation of services across MH & LD services.
Opportunities	**Risks & Threats**
• Mandatory training has improved however, Localities are working to improve this further towards compliance. • Terms of reference for the serious incident group have been updated and the format of the reports has been changed in line with the recommendations from the Delivery Unit report to be in line with the rest of the Health Board. A learning matrix has been developed to embed and share the learning identified from serious incidents. RCA Training needs to be provided for investigators. Appointment to training post has been made. • A new system for supporting performance on complaints has been put in place with weekly reviews by the Q&S team lead by the Head of Operations to support the localities to respond within the 30 day time scale. • Plan in place to address backlog in Serious Incident Investigations.	• Capacity gaps in Care Homes. Capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit' and increasing length of stay. • Recruitment market for substantive nursing and medical vacancies. • Security issues in Cefn Coed and Garngoch Hospitals. • Demand and capacity constraints in CMHT's.

9.5 Primary Care & Community Services Delivery Unit- Performance Dashboard

				Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Planned Care	Outpatients waiting more than 26 weeks	Actual	*0*	*0*											
		Profile	*0*	0	0	0	0	0	0	0	0	0	0	0	0
	Treatment waits over 36 weeks	Actual	*0*	0											
		Profile	*0*	0	0	0	0	0	0	0	0	0	0	0	0
	Therapy waits over 14 weeks	Actual	*0*	0											
		Profile	*0*	0	0	0	0	0	0	0	0	0	0	0	0
Primary Care Access	% of GP practices offering daily appointments between 17:00 and 18:30	Actual	89%												
		Profile	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*
	% population regularly accessing NHS primary dental care- 2 year rolling position	Actual													
		Profile													
Healthcare Acquired Infections	Clostridium Difficile cases (Community acquired)	Actual	5	1											
		Profile	*6*	*4*	*3*	*3*	*4*	*4*	*3*	*3*	*3*	*3*	*4*	*4*	*3*
	Clostridium Difficile cases (Community Hospitals)	Actual	1	0											
		Profile	*1*	*0*	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*1*	*0*
	Staph.Aueurs bacteraemia cases - (Community acquired)	Actual	7	3											
		Profile	*7*	*5*	*9*	*8*	*5*	*5*	*5*	*6*	*10*	*9*	*5*	*11*	*6*
	Staph.Aueurs bacteraemia cases - (Community Hospitals)	Actual	0	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*1*	*1*	*0*	*0*	*0*	*0*	*0*	*0*
	E.Coli cases (Community acquired)	Actual	22	17											
		Profile	*30*	*29*	*27*	*26*	*29*	*27*	*30*	*29*	*22*	*24*	*29*	*30*	*32*
	E.Coli cases (Community Hospitals)	Actual	1	0											
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Quality & Safety	Concerns responded to within 30 days	Actual													
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.34%												
		Profile	*5.00%*			*5.28%*			*TBC*			*TBC*			*TBC*
	Personal Appraisal Development Review	Actual	78%	79%											
		Profile	*80%*			*80%*			*82%*			*83%*			*85%*
	Mandatory Training	Actual	74%	86%											
		Profile	*62%*			*85%*			*85%*			*85%*			*85%*

Health Board profiles have been utilised in the absence of agreed Unit level profiles using straight line improvement trajectories

9.5 Primary Care & Community Services Delivery Unit- Overview

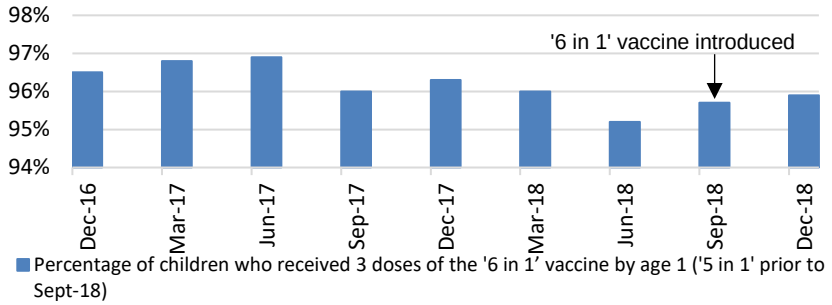
Successes	Priorities
• Significant progress continues to be made within the Cwmtawe Cluster in implementing the Whole System Transformation mode, including full Primary Care Audiology service now operational. In addition good progress with phase 1a Neath Cluster rollout. • Successful visit by the Health Minister to Cwmtawe Cluster to see progress made on transformation • Sexual health service developing outreach services with good links with third sector and other organisations. • Introducing NICE guidelines for Pregnancy Advisory Services, which will provide improved service delivery and cost savings. • District Nursing teams in Swansea have been aligned to the GP Clusters with the attendant changes made to the DN registers and the management of calls through the Single Point of Contact. • The community therapy weekend working operational working group has agreed the pilot site for providing extended hours of therapy cover. • The ongoing use of the DN escalation tool continues to provide a "whole Swansea" picture of the activity and demands upon the service – it is underpinning the ability to mobilise staffing resource on an objective and service/patient need focused manner. • Community Pharmacies delivered 6170 Common Ailments Service (CAS) consultations since October 2018. SBU Health Board third highest number of consultations in Wales. • Lottery funding received to improve the gardens and courtyard at Gorseinon hospital.	• Continue to progress Branch Surgery Closure process following formal request from Amman Tawe Partnership to close their branch site in Cwmllynfell. Patient engagement commenced 8 April until 20 May. • Continue planning for phase 2 whole system transformation roll out to Upper Valleys and Lwychwr in July 2019. • To reduce present waiting lists in the Pregnancy Advisory Service – additional clinics organised held to deal with demand. • District Nursing and Out of Hours working closely to cover and promote continuity of care. • Working through the continued changes to the DN service realignment and mitigating risks to patient care and service delivery. • [April 2019]- Diabetic retinopathy screening service transferred to Mountain View GP practice [Swansea] from Sexual Health. Engagement continues with WAST re: non urgent ambulance transport to the new premise. • Continued implementation of Community Pharmacy Respiratory service into pharmacies in Upper Valleys Cluster [16 July] to improve compliance with inhalers/reduce waste. • Work continues to progress oral surgery medicine pathway • Expressions of Interest sought from GDP practices to deliver new dental pathway for Syrian refugees. • Planning and implementation of 'Hospital to Home' scheme
Opportunities	**Risks & Threats**
• Gender clinic commencing within Sexual Health, providing localised services to those undergoing gender transitions. • The Community multi-disciplinary teams continue to explore and develop opportunities to work closely with the Clusters. • The Swansea Acute Clinical team have met with WAST and with input from the NPT Acute Clinical team are working to improve governance and processes to facilitate the ability to take patients from the stack in a safe and agreed process.	• Tribunal to lift a national GP disqualification to be held 24th May 2019. • Anxiety amongst GPs in relation to the GMS contract negotiations. • The Swansea Council Adult Services restructuring has been commenced and is moving at pace. • Gorseinon Hospital Lead Nurse retires on 31st May 2019.

10. QUARTERLY PERFORMANCE REPORT CARDS
10.1 Staying Healthy

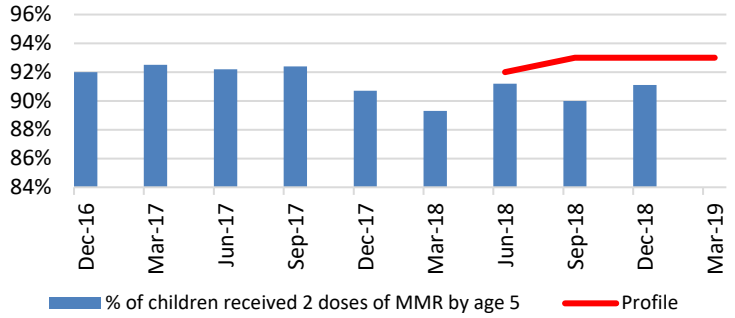
CHILDHOOD IMMUNISATIONS			
NHS Wales Domain:	**STAYING HEALTHY-** People in Wales are well informed and supported to manage their own physical and mental health	**NHS Wales Outcome Statement:**	My children have a good healthy start in life
Health Board Strategic Aim:	Support better health and wellbeing by actively promoting and empowering people to love well in resilient communities	**Health Board Enabling Objective:**	Co-production and Health Literacy
Executive Lead:	Sandra Husbands, Director of Public Health		

	Annual Plan Profile	WG Target	**Period:** December 2018 Current Status *(against target):*	Movement: *(12 month trend)*
Measure 1: % of children who received 3 doses of the '6 in 1' vaccine by age 1	N/A	95%	✓	↓
Measure 2: % of children who received 2 doses of the MMR vaccine by age 5	93%	95%	✗	↑

(1) % of children who received 3 doses of the '5 in 1' vaccine by age 1

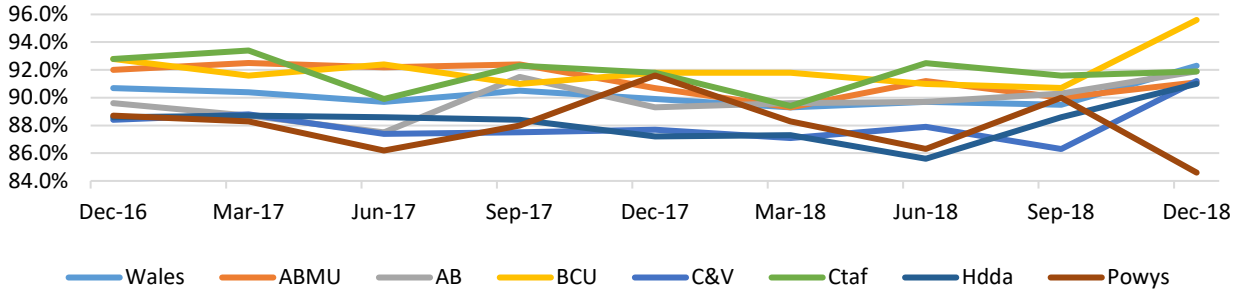


(2) % of children who received 2 doses of the MMR vaccine by age 5



Benchmarking

(3) % of children who received 2 doses of the MMR vaccine by age 5



Source: Public Health Wales COVER Report Oct- Dec 2018 (COVER 129)

Measure 1: % of children who received 3 doses of the '5 in 1' vaccine by age 1
Measure 2: % of children who received 2 doses of the MMR vaccine by age 5

How are we doing?

- Measure 1 – Overall, during this quarter we continue to achieve the Welsh Government target in the percentage of resident children who have received 3 doses of the 6 in 1 vaccine by 1 year of age. However, during this reporting quarter one Local Authority (LA) (Swansea) is below target with uptake rates of 94.5% (Bridgend 96.6%; NPT 97.5%)

- Measure 2 – during this reporting quarter there has been a slight increase in the percentage of resident children who have received 2 doses of the MMR vaccine by age 5, with the COVER report indicating overall uptake rates of 91.1%. Again there is variance between the 3 LA areas Bridgend 93%; NPT 92.3%; Swansea 89%.

What actions are we taking?

- The new process for GP practices cancelling immunisation clinics has now rolled out across the Health Board, following a delay in its initial implementation.
- The current waiting lists and the number of cancelled immunisation clinics are being monitored by the primary care team. Practices with waiting lists have been contacted by the primary care teams for targeted discussions aimed at reducing the waiting lists. The number of children awaiting an immunisation appointment will be monitored at the Children's Immunisation Group and the Strategic Immunisation Group.
- The Strategic Immunisation Group received an SBAR from the Child Health Department in relation to recommendations made following the internal audit in respect of additional resource to perform routine data cleansing to ensure data held on the Child Health Information System is the same as that on GP records. This will improve confidence in the COVER data, whilst enabling health care professionals to target areas with low uptake rates. We currently await the outcome of this SBAR which will be discussed at the May SIG.

What are the main areas of risk?

- During this reporting quarter we are below 95% in the percentage of resident children who have received 2 doses of the MMR by 5 years which is needed for herd immunity. This appears to be a particular issue in Swansea. This level of coverage leaves the population vulnerable to an outbreak. There are reported outbreaks of Mumps in older cohorts of young adults in England. There has been a prolonged and noticeable increase in measles cases, especially in Eastern Europe throughout 2018 and measles is still circulating in many European countries. There is vulnerability to imported cases of measles leading to local outbreaks.
- Health professionals (GP's/HV/SN/PN) are advised to check the immunisation status at every contact.

How do we compare with our peers?

- Measure 1 – ABMU is ranked joint 3rd in comparison to the other Welsh Health Boards and above the Welsh average of 95.7% during this reporting quarter

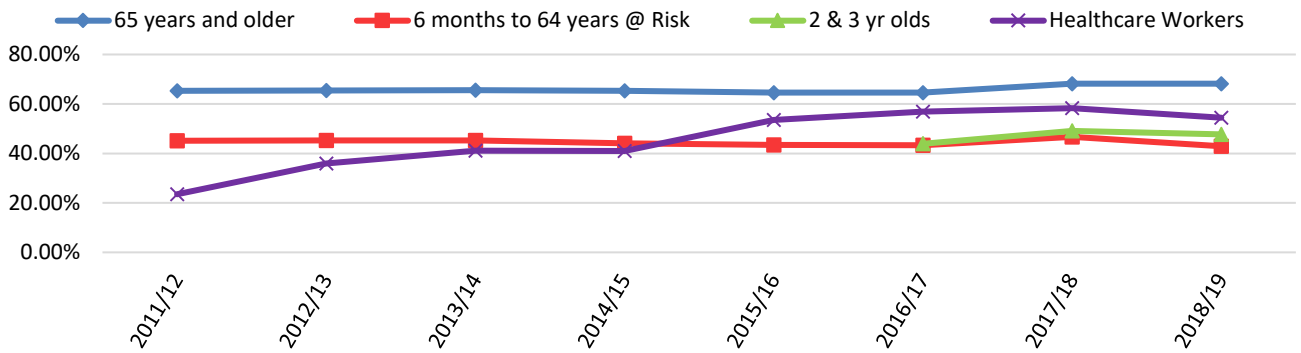
- Measure 2 – ABMU is ranked 4th in comparison to the other Welsh Health Boards and below the Welsh average of 92.3% during this reporting quarter

FLU VACCINATIONS

NHS Wales Domain:	**STAYING HEALTHY**- People in Wales are well informed and supported to manage their own physical and mental health	**NHS Wales Outcome Statement:**	I am healthy and active and do the things to keep myself healthy
Health Board Strategic Aim:	Support better health and wellbeing by actively promoting and empowering people to live well in resilient communities	**Health Board Enabling Objective:**	Co-production and Health Literacy
Executive Lead:	Sandra Husbands, Director of Public Health		

% uptake of the Seasonal Flu Vaccine in the following groups:	**Annual Plan Profile**	**WG Target**	**Period:** March 2019 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: 65 years and older	75%	75%	✗	↑ ●
Measure 2: 6 months to 64 years in at risk groups	55%	55%	✗	↑ ●
Measure 3: Children 2 to 3 year olds	46%	N/A	✓	↑ ●
Measure 4: Healthcare workers who have direct patient contact	50%	50%	✓	↑ ●

(1) 65 years and older, (2) 6 months to 64 years in at risk groups, (3) Children 2 to 3 olds, (4) Healthcare workers who have direct patient contact



** Data up to March 2019*

Benchmarking

% Uptake of Seasonal Flu Vaccine

2018/19	ABMU	AB	BCU	C&V	CTaf	HDdA	Powys	Wales
(1) 65+	68.2%	69.50%	71.00%	69.90%	67.10%	62.90%	65.5%	68.3%
(2) 6 months to 64 years at risk	42.9%	46.80%	47.90%	43.90%	40.00%	38.00%	43.1%	44.0%
(3) 2 to 3 Year Olds	47.7%	47.20%	54.60%	46.60%	50.90%	44.60%	60.5%	49.3%
(4) Health Care Workers	54.5%	**Current uptake for other Health Boards not available*						

Source: Public Health Wales Vaccine Preventable Disease Programme and Communicable Disease Surveillance Centre. IVOR (Influenza Vaccine Online Reporting) March 2019

% uptake of the Seasonal Flu Vaccine in the following groups:
Measure 1: 65 years and older Measure 2: 6 months to 64 years in at risk groups
Measure 3: Children 2 to 3 year olds Measure 4: Healthcare workers who have direct patient contact

How are we doing?

As of 16 April 2019 (IVOR)

- Measure 1. Uptake is 68.2%, which is comparable to Wales (68.3%). Uptake by cluster ranges from 63.4% to 73.0%. Eight practices have achieved the target of 75%.
- Measure 2. Uptake is 43.0%, slightly below the uptake for Wales 44.0%. ABM achieved the target for patients with chronic diabetes (58.3%), and respiratory disease patients with Chronic Obstructive Pulmonary Disease (COPD) (60.9%). Cluster uptake ranges from 36.0 to 47.8%%. Nine clusters have achieved the target for patients with chronic diabetes and eight clusters for patients with COPD. Eight practices have achieved the 55% national target.
- Measure 3. Uptake is 47.7% slightly below the Welsh uptake of 49.3%. No national uptake target for 2 and 3 year olds. Uptake by cluster ranges from 36.8% to 55.2%.
- Measure 4. Uptake of frontline staff is 54.5%; uptake by delivery unit ranges from 46.0% to 64.1%

What actions are we taking?

Primary care flu planning group:

- Plans to reflect and learn from 2018/19 performance in order to inform priorities and agree actions for the 2019/20 season.
- Support and guidance to practices in running patient searches and vaccine ordering

Staff campaign:

- Planning for the 2019/20 flu campaign to commence shortly
- Plan to increase numbers of flu champions for 2019/20 as well as utilising other staff groups to promote and encourage colleagues to get vaccinated
- Plan to increase and improve accessibility for flu training for flu champions for 2019/20 campaign.

What are the main areas of risk?

- Failure to achieve good coverage among healthcare workers leaves staffing vulnerable to illness at busiest time of year re: demand for acute services
- Failure to immunise vulnerable individuals leaves patient cohorts with higher levels of illness than if target was hit with increased adverse outcomes – potentially avoidable harm

How do we compare with our peers?

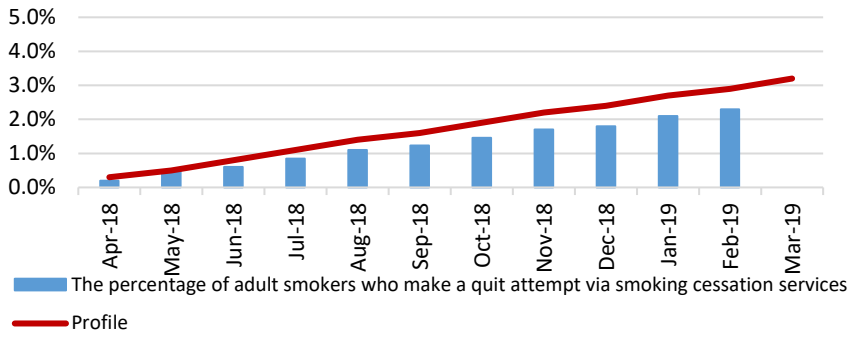
- Compared to other Welsh Health Boards ABMU HB is ranked:
- 4th for patients 65 years and older
- 5th for patients 6m to 64 years at risk
- 4th for children 2 to 3 years
- 6th for staff with direct patient contact

SMOKING CESSATION

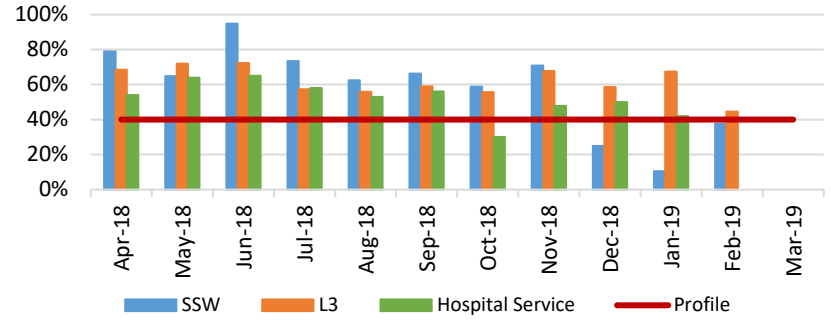
NHS Wales Domain:	**STAYING HEALTHY-** People in Wales are well informed and supported to manage their own physical and mental health	**NHS Wales Outcome Statement:**	I am healthy and active and do the things to keep myself healthy
Health Board Strategic Aim:	Support better health and wellbeing by actively promoting and empowering people to love well in resilient communities	**Health Board Enabling Objective:**	Co-production and Health Literacy
Executive Lead:	Sandra Husbands, Director of Public Health		

	Annual Plan Profile	WG Target	**Period:** February 2019 Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: % Welsh resident smokers make a quit attempt via Smoking Cessation Services	2.9%	5%	✗	↑ ●
Measure 2: % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks	40%	40%	✗	↓ ●

(1) % Welsh resident smokers make a quit attempt via Smoking Cessation Services



(2) % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks



Benchmarking

% making a quit attempt

LHB	Current Q1-Q3 18/19	Previous Q1-Q3 17/18
Wales	2.2%	⇩ 2.3%
ABM	1.9%	⇧ 1.8%
AB	2.4%	⇩ 2.6%
BCU	2.6%	⇩ 2.7%
C&V	1.1%	⇩ 1.2%
CTaf	3.3%	⇩ 3.5%
HDda	2.5%	⇧ 1.9%
Powys	1.4%	⇩ 1.7%

% CO Validated at 4 weeks

LHB	Current Q1-Q3 18/19	Previous Q1-Q3 17/18
Wales	43.8%	⇧ 42.5%
ABM	55.4%	⇧ 53.4%
AB	43.3%	⇧ 40.4%
BCU	37.9%	⇧ 31.8%
C&V	53.3%	⇩ 59.3%
CTaf	36.2%	⇩ 36.2%
HDda	47.1%	⇩ 57.1%
Powys	40.4%	⇩ 41.2%

Source : NHS Wales outcomes framework, all Wales performance summary (March 2019)

Measure 1: % Welsh resident smokers make a quit attempt via Smoking Cessation Services
Measure 2: % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks

How are we doing?

- To achieve the 5% smoking cessation target approximately 4711 smokers need to be treated in ABMU stop smoking services per year, with an average of 393 smokers treated per month. A target of 3.2% has been set for the ABM UHB Annual Plan 2018/19. To achieve this 3.2% target approximately 3015 smokers need to be treated in stop smoking services per year, with an average of 251 smokers treated per month. ABMU services have treated 2169 smokers (monthly activity data) against the cumulative monthly target of 2761, achieving to February 2019 2.3% of the overall target. This is the same performance compared to February 2018 at 2.3%.
- The 40% WG target of CO validated 4 week quits has been achieved for all services other than Stop Smoking Wales (SSW) during Q4. Service performance has been addressed and this is now improving.
- The most recent data from the National Survey for Wales 2017/18 estimates that 21% of ABMU HB's population (aged 16+) smoke. This is the highest smoking prevalence of all Health Boards in Wales, and higher than the Wales average of 19%. Prevalence for Swansea is 19.7%, Bridgend is 20.2% and Neath Port Talbot is 25.8% - this is the highest prevalence of all county areas in Wales

What actions are we taking?

- The Directors of Public Health Leadership Group have agreed that working together to reduce smoking prevalence is a priority in Wales, and work to address implementation of the key components of the cessation system framework have been progressed in Q4. This will be a priority for action in 19/20
- The Health Board is supporting the development of a national delivery plan for the integrated cessation system that will also drive action for local work. The Readiness assessment for implementation against the key components of the cessation system framework has been completed.
- Working group to address performance issues with community pharmacy cessation service established, and an action plan in development
- An options paper for the management of the Health Boards smoking cessation services (hospital and Stop Smoking Wales when moved to Health Boards) has been presented to the Executive team, with the option of Primary care delivery unit managing all services in line with the national integration agenda having been agreed. Planning for this is now in progress.
- Pilot project in progress with primary care, to explore if sending out a letter to smokers from GP practice results in increased number of contacts to Help Me Quit. Text messaging as a method of invitation to commence as a pilot project.

What are the main areas of risk?

- Moving the Stop Smoking Wales service to Health Boards poses risks in maintaining staff engagement, risks to delivery and quality of service during the preparation and transfer of services. The ongoing delay in ratifying the decision increases the risk.
- Migration in the host Delivery Unit for the hospital service to Primary care has caused some staff disgruntlement and may affect performance in the interim
- Commissioned pharmacies are accredited, but not all are actively delivering the service.
- Visibility of Smoking on hospital grounds continues to be a widespread issue despite Health Board smoke free site policy and normalises smoking, undermining clinical interventions.
- Focus currently on cessation services and driving the demand to services, without addressing the broader supportive environments and wider determinants agenda, which affect both uptake of smoking and relapse in those who had quit.
- National Improvement Programme Models for Access to Maternal Smoking Cessation Support (MAMSS) put on hold as a Prevention bid is with Welsh Government, which includes the development of pregnancy smoking cessation service. Risk of reduced engagement with this group while decisions are pending on model of care.

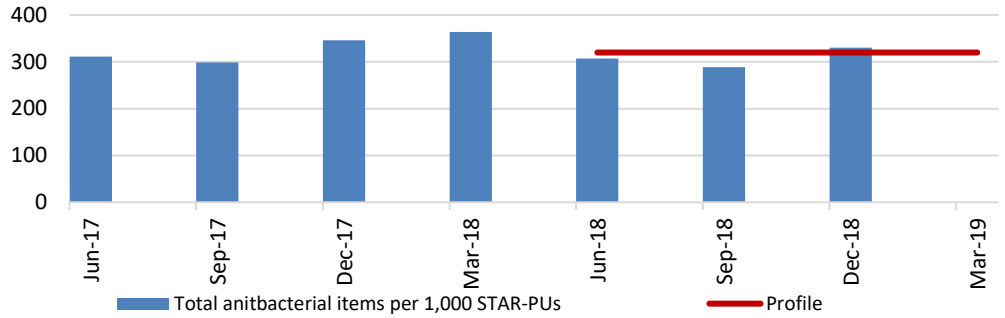
How do we compare with our peers?

- The latest published data available from Welsh Government shows that ABMU was above the all-Wales position for Measure 2, and below for Measure 1.
- ABMU has improved performance for the percentage of resident smokers who are CO Validated as quitting at 4 weeks and the percentage of resident smokers making a quit attempt via smoking cessation services compared to the previous year.

10.2 Safe Care

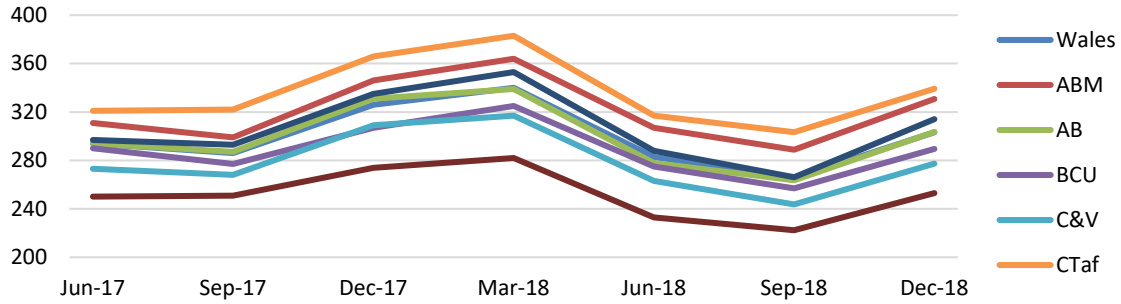
TOTAL ANTIBACTERIAL ITEMS PER 1,000 STAR-PUs						
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm		**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support		
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people		**Enabling Objective:**	Best value outcomes from high quality care: Primary and Community Care		
Executive Lead:	Chris White, Chief Operating Officer				**Period:** December 2018	
		Annual Plan Profile	**WG Target**		**Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)		N/A	4 Quarter reduction trend		✓	↓ ●

(1) Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)



Benchmarking

(1) Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)



Source: NHS Delivery Framework, all-Wales Performance Summary (March 2019)

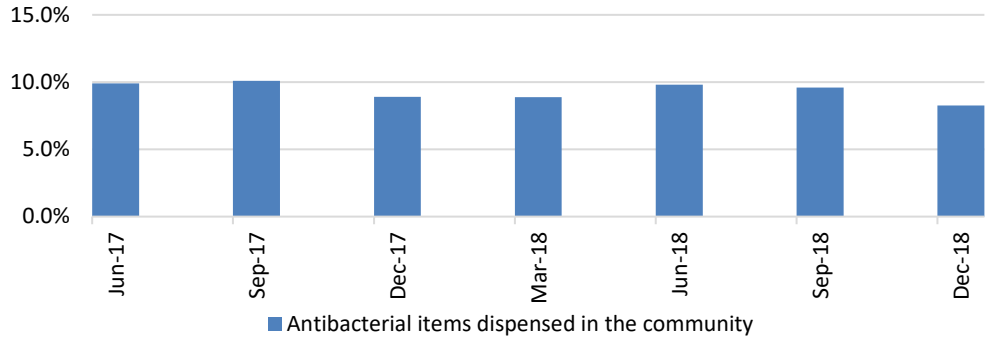
Measure 1: Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)
How are we doing?
• While the long term trend is down, this has seen some slowing and reversal that requires close monitoring.
What actions are we taking?
To maintain focus and build on the legacy of the ABMU Big Fight Campaign, the following are in place: • Analysis of the 2018-19 Prescribing Management Scheme achievement underway • Feedback of co-amoxiclav audit to prescribing leads in March 19 • Inclusion in the 2019-20 Prescribing Management Scheme • Highlighted in every practice's annual prescribing visit • Supported additional audits in target practices • Regular guideline updates • Regular updates via prescribing leads meetings including presentation from microbiologist • Highlighting links and resources to national campaigns • Links with Primary Care & Community Services work with care homes and other projects
What are the main areas of risk?
• The main risk is to maintain and build on progress made. Any increases could increase risk of resistance and C.*difficile.*
How do we compare with our peers?
• ABM had shown significant progress over the last 2-3 years and is no longer the highest in Wales. However, there is still much to do to continue to improve appropriate prescribing.

ANTIBACTERIAL ITEMS DISPENSED IN THE COMMUNITY

NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Primary and Community Care
Executive Lead:	Chris White, Chief Operating Officer		

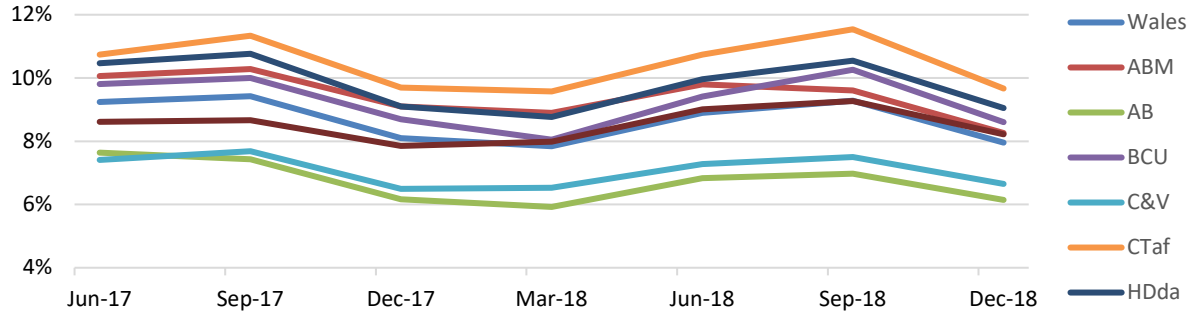
	Annual Plan Profile	**WG Target**	**Period:** December 2018	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community	N/A	Quarter on quarter improvement	✓	↓ ●

(1) Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community



Benchmarking

(1) Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community



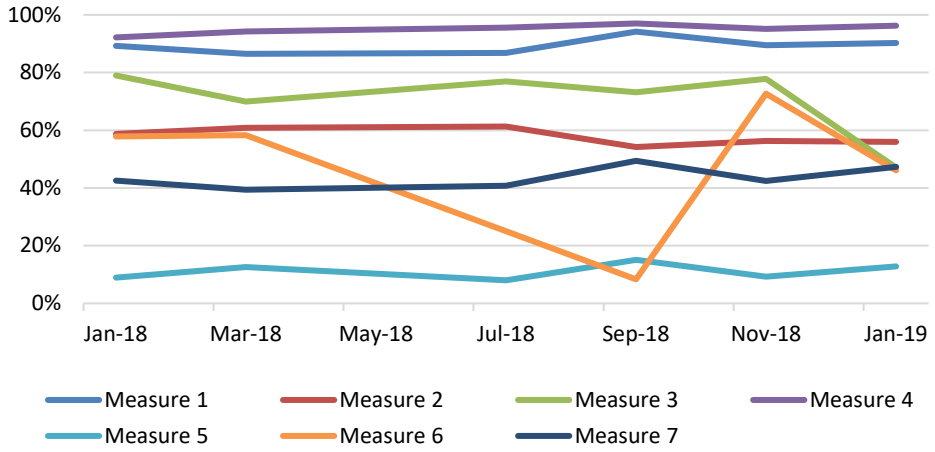
Source: NHS Wales Delivery Framework, all-Wales performance Summary (March 2019)

Measure 1: Fluroquinolone, cephalosoporin, clinamycin and co-amoxiclav items as a percentage of total antibacterial items dispensed in the community
How are we doing?
• After an initial significant reduction 2-3 years ago, these antibiotics have shown some increases, which are being monitored and targeted.
What actions are we taking?
To maintain focus, the following are in place: • Included Prescribing Management Schemes • Feedback of Co-amoxiclav audit to prescribing leads • Highlighted in every practice's annual prescribing visit • Supported additional audits in target practices • Regular guideline updates • Regular updates via prescribing leads meetings including updates from microbiologists • Significant changes in co-amoxiclav use in acute will also impact on primary care prescribing culture
What are the main areas of risk?
• The main risk is to maintain and build on progress made. Any increases could increase risk of resistance and C.Diff.
How do we compare with our peers?
• ABM performance needs to show further improvements as we are above the Welsh average. Co-amoxiclav usage seems to be falling.

Antimicrobial Audits

NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Local Target	**Period:** January 2019 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % indication for antibiotic documented on medication chart	>95%	✗	↑
Measure 2: % stop or review date documented in medication chart	>95%	✗	↓
Measure 3: % of antibiotics prescribed on stickers	>95%	✓	↑
Measure 4: % appropriate antibiotic prescriptions choice	>95%	✗	↓
Measure 5: % of patients receiving antibiotics for more than 7 days	≤20%	✓	↑
Measure 6: % of patients receiving surgical prophylaxis for more than 24 hours	≤20%	✗	↑
Measure 7: % of patients receiving IV antibiotics > 72 hours	≤30%	✗	↑



Jan-19	POWH	Morriston	Singleton	NPTH	MH & LD	HB Total
(1) % indication for antibiotic documented on medication chart	92.5%	93.9%	75.0%	90.0%	100.0%	90.0%
(2) % stop or review date documented on medication chart	62.1%	51.0%	56.3%	63.6%	100.0%	56.0%
(3) % of antibiotics prescribed on stickers	-	100.0%	10.5%	100.0%	88.9%	96.0%
(4) % appropriate antibiotic prescriptions choice	97.1%	96.7%	96.3%	83.3%	100.0%	47.0%
(5) % of patients receiving antibiotics for more than 7 days	8.4%	17.8%	4.2%	8.3%	0.0%	13.0%
(6) % of patients receiving surgical prophylaxis for more than 24 hours	25.0%	62.5%	-	0.0%	-	46.0%
(7) % of patients receiving IV antibiotics > 72 hours	38.2%	55.4%	26.7%	0.0%	-	47.0%

Source: ABMU Pharmacy

Measure 1: % indication for antibiotic documented on medication chart, Measure 2: % stop or review date documented in medication chart, Measure 3: % of antibiotics prescribed on stickers, Measure 4: % appropriate antibiotic prescriptions choice, Measure 5: % of patients receiving antibiotics for more than 7 days, Measure 6: % of patients receiving surgical prophylaxis for more than 24 hours, Measure 7: % of patients receiving IV antibiotics > 72 hours

How are we doing?

- Compliance to guidelines and documentation of indication continue to be at or near target. Further improvements are required for review of IV antibiotics and documentation of stop/review dates. Surgical prophylaxis regimens continued for longer than the guidelines recommend, continue to be observed and is a particular issue in Morriston hospital.

What actions are we taking?

- Audits of surgical prophylaxis regimens are planned via ward pharmacists and theatre recovery staff in Morriston hospital. This data will then be used to identify specialities / surgeons routinely prescribing over 24 hours. This data will be highlighted to the Antimicrobial Stewardship Group and actions agreed to begin discussions with outlying specialities / surgeons.
- Medicine in Morriston will be taking part in a research project called ARK (Antibiotic Review Kit). This will investigate the effect of amending the drug chart to limit antibiotic prescriptions to 3 days initially to ensure that a review and re-prescription (if necessary) occurs for all prescriptions, including a switch to oral when appropriate. The project will be evaluated nationally and locally with further local roll-out to other areas to be considered.
- Princess of Wales are introducing pharmacist prompt stickers for the medical notes to highlight patients on antibiotics but without a documented review by 72 hours to prescribers. They have agreed to share any evaluation and if positive, this could also be considered for Swansea Bay sites.

What are the main areas of risk?

- Over use of antibiotics via unnecessarily prolonged surgical prophylaxis regimens
- Lack of review of IV antibiotics

How do we compare with our peers?

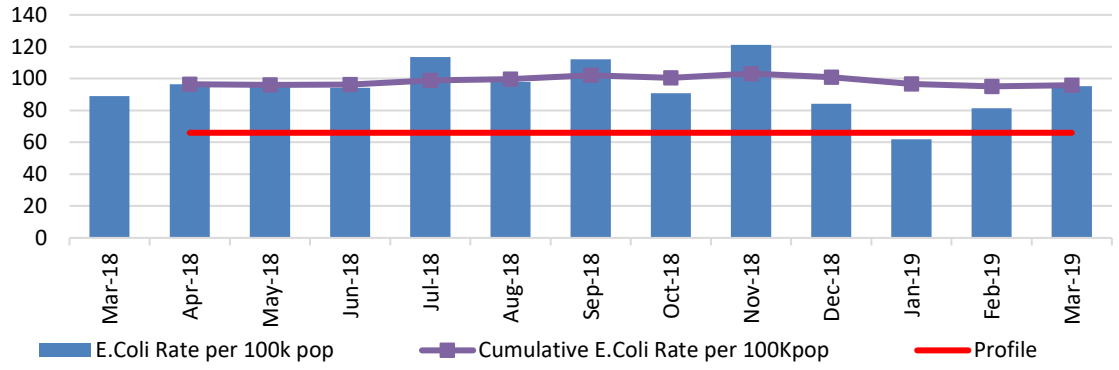
- No comparable data available

E. COLI Bacteraemia

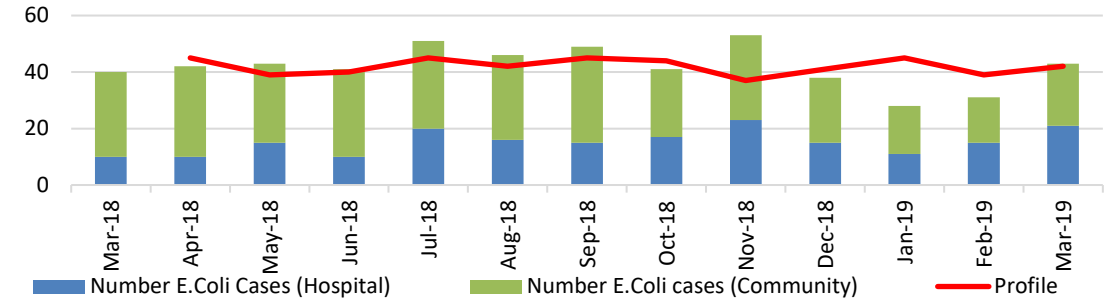
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Rate of E.*coli* bacteraemia cases per 100,000 of the population	66		✗	↑
Measure 2: Number of E.*coli* bacteraemia cases	42		✗	↑
Measure 3: Number of cumulative cases of E.*coli* bacteraemia against March 2019 reduction expectation		356	✗	↑

(1) Rate of E.coli bacteraemia per 100,000 of the population



(2) Number of E.coli bacteraemia cases



Benchmarking

LHB	Cumulative Cases (Apr - Mar 19)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	2482	2094	+388
ABM	505	356	+149
AB	428	358	+70
BCU	574	466	+108
C&V	335	296	+39
Ctaf	277	200	+77
Hdda	350	257	+93

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (March 2019)

Measure 1: Rate of E.Coli bacteraemia cases per 100,00 of the population
Measure 2: Number of E.Coli bacteraemia cases
Measure 3: Number of cumulative cases of E.Coli against March 2019 reduction expectation

How are we doing?

- The number of *E. coli* bacteraemia in March (43 cases) was just above the projected IMTP monthly profile. Of these cases, 47% were hospital acquired; 53% were community acquired.
- The cumulative number of cases (Apr-Mar 2018/19) was 506, which was approximately 4% less than the cumulative number of cases for the same period in 2017/18. Of these cumulative cases for 2018/19, 63% were community acquired.

What actions are we taking?

- Delivery Units to continue with focus to increase numbers of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT), with month-on-month improvements.
- Delivery Units to progress with PDSA style quality Improvement activities with a focus on urinary catheters, across acute sites.
- Delivery Units to explore how to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.
- Improvement work underway to improve HCAI data shared with Delivery Units.

What are the main areas of risk?

- A large proportion of *E. coli* bacteraemia is community acquired, with many patient related contributory factors, particularly in relation to urinary tract infection and biliary tract disease. As such, it will be a challenge to prevent a significant proportion of these.
- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which is frequently close to, or exceeds, 90%.

How do we compare with our peers?

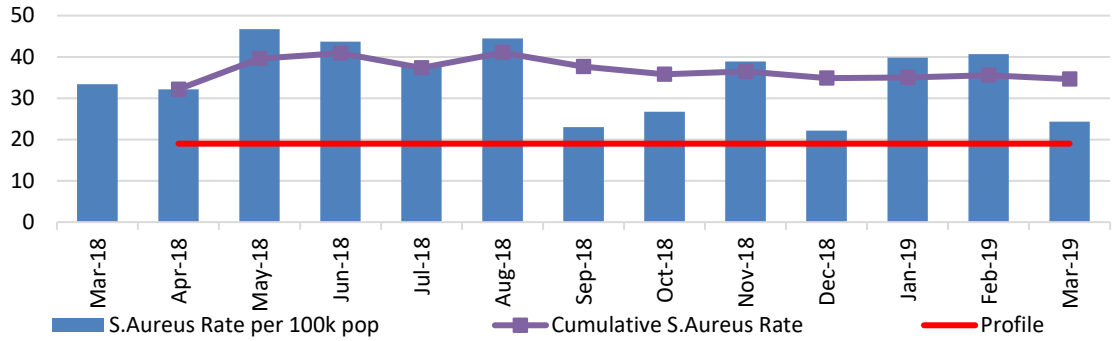
- The incidence of *E. coli* bacteraemia per 100,000 population for March 2019 was 95.19; this was the second highest incidence for the major acute Health Boards in Wales.
- The cumulative incidence of *E. coli* bacteraemia within ABMU for the year 2018/19 was 94.95/100,000 population, the highest incidence for the major acute Health Boards in Wales.

S. AUREUS Bacteraemia

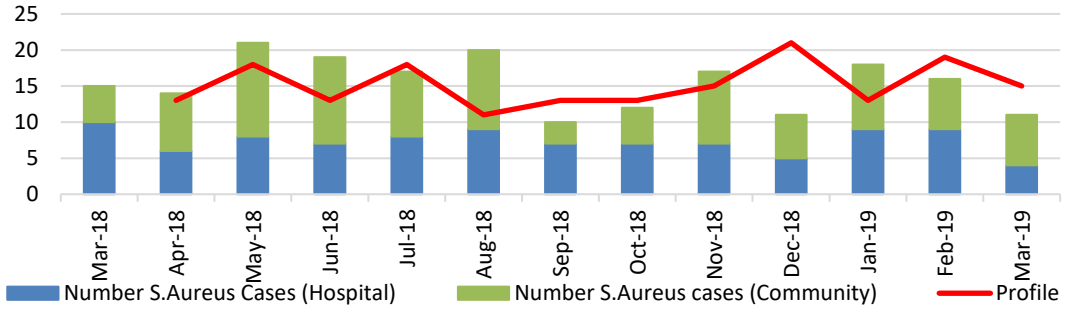
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Rate of *S.aureus* bacteraemia cases per 100,000 of the population	19		✗	↓ ●
Measure 2: Number of *S. aureus bacteraemia* cases	15		✓	↓ ●
Measure 3: Number cumulative cases of *S.aureus* bacteraemia against March 2019 reduction expectation		106	✗	↓ ●

(1) Rate of *S. aureus* bacteraemia per 100,000 of the population.



(2) Number of *S.aureus* bacteraemia cases



Benchmarking

LHB	Cumulative Cases (Apr - Mar 19)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	921	625	+296
ABM	184	106	+78
AB	157	111	+46
BCU	174	139	+35
C&V	173	98	+75
Ctaf	100	59	+41
Hdda	131	76	+55

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (March 2019)

Measure 1: Rate of S.aureus cases per 100,00 of the population
Measure 2: Number of S.aureus cases
Measure 3: Number of cumulative cases of S.aureus against March 2019 reduction expectation

How are we doing?

- There were 11 cases of *Staph. aureus* bacteraemia in March 2019, 4 cases below the projected monthly IMTP profile. 37% were hospital acquired infections.
- The cumulative number of cases (Apr-Mar 2018/19) was 186 cases of bacteraemia, approximately 7% fewer than the cumulative number of cases for the same period in 2017/18.
- Of the total number of cases for the 2018/19 FY, 54% were community acquired; 46% were hospital acquired.

What actions are we taking?

- Delivery Units to continue with focus to increase numbers of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT), with month-on-month improvements
- Improvement activities will continue to focus on the risk associated with the presence of invasive devices.
- Improvement work underway to improve HCAI data shared with Delivery Units.

What are the main areas of risk?

- 54% of *Staph. aureus* bacteraemia is community acquired, with many patient related contributory factors, such as recreational drug use, arthritis, chronic conditions, etc. As such, it is a challenge to prevent a significant proportion of these.
- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which frequently is close to, or exceeds, 90%. Analysis by the Department of Health, reported in Tackling Healthcare associated infections through effective policy action (BMA, June 2009), suggested that when all other variables are constant, an NHS organisation with an occupancy rate above 90 per cent could expect a 10.3% higher MRSA rate compared with an organisation with an occupancy levels below 85%.
- High bed turnover. In the same BMA report, the impact on MRSA rates of turnover intervals were suggested to have a greater impact on MRSA rates than bed occupancy levels.

How do we compare with our peers?

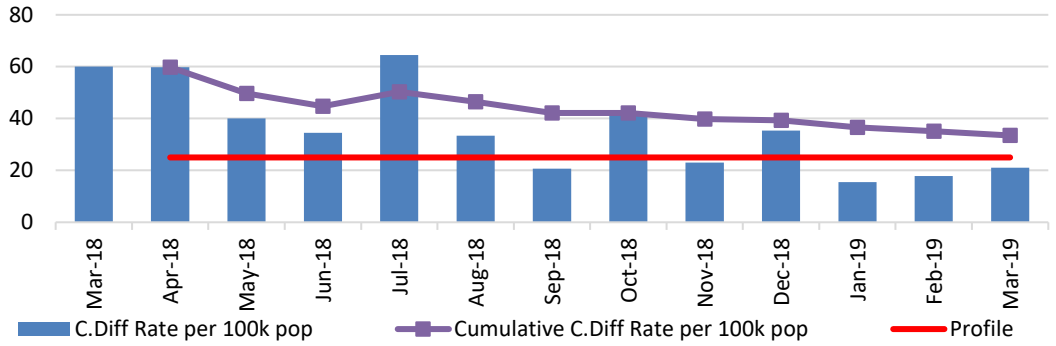
- The incidence of *Staph.aureus* bacteraemia within ABMU in March 2019 was 24.35/100,000 population, the lowest incidence for the major acute Health Boards in Wales.
- To cumulative incidence of *Staph.aureus* bacteraemia within ABMU for the year 2018/19 was 34.60/100,000 population, the second highest incidence for the major acute Health Boards in Wales.

C.*DIFFICILE*

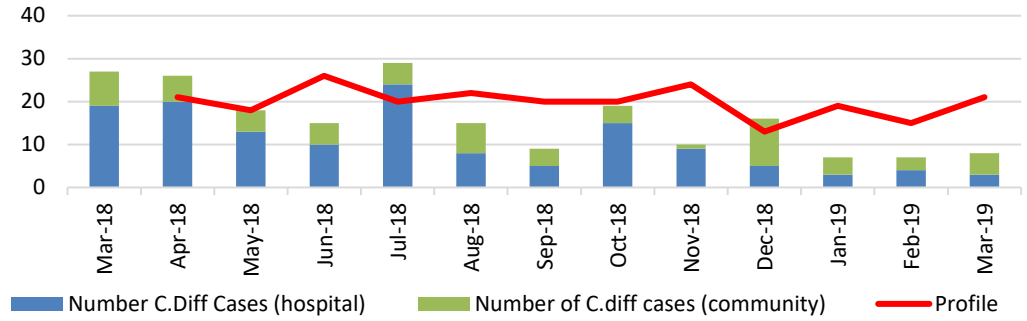
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Rate of C.*difficile* cases per 100,00 of the population	25		✓	↓ ●
Measure 2: Number of C.*difficile* cases	21		✓	↓ ●
Measure 3: Number of cumulative cases of C.*difficile* against March 2019 reduction expectation		138	✗	↓ ●

(1) Rate of C.*difficile cases* per 100,000 of the population.



(2) Number of C.*difficile cases*



Benchmarking

LHB	Cumulative Cases (Apr - Mar 19)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	831	812	+19
ABM	178	138	+40
AB	155	146	+9
BCU	171	181	-10
C&V	107	113	-6
Ctaf	55	53	+2
Hdda	144	99	+45

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (March 2019)

Measure 1: Rate of C.difficile cases per 100,00 of the population
Measure 2: Number of C.difficile cases
Measure 3: Number of cumulative cases of C.difficile against March 2019 reduction expectation

How are we doing?

- There were 8 *Clostridium difficile* toxin positive cases in March. Two cases were considered to be hospital acquired.
- The cumulative position from Apr-Mar 18/19 was 179 cases. This was below the IMTP projected profile, and the cumulative number of cases for the year was approximately 37% fewer cases compared with the same period in 2017/18.
- The cumulative incidence for 2018/19 (33.47/100,000 population) was significantly lower that for 2017/18 (52.52/100,000 population). In 2018/19, 33% of cases were community acquired (compared with 22% in 2017/18); 67% were hospital acquired cases in 2018/19 (compared with 78% in 2017/18).
- The most striking reduction over the financial year has been in the number of hospital acquired cases over 12 months, with a 46% reduction in cases, compared with only 3% reduction in community acquired cases. A number of factors would have contributed to this, including a restriction in the use of pre-emptive beds in Morriston Hospital during Quarter 2 and into Quarter 3, and particularly the implementation of more restrictive antimicrobial guidelines in secondary care, restricting of the use of Co-amoxiclav in secondary care.

What actions are we taking?

- Continue to monitor compliance with restriction of Co-amoxiclav, with feedback to Delivery Units
- Primary Care antimicrobial guidelines review commenced. Restricting use of Co-amoxiclav is more complex in Primary Care than in Secondary Care, as there are limited oral antibiotic alternatives available. As such, a lesser impact on community *Clostridium difficile* cases anticipated.
- Review use of Hydrogen Peroxide Vapour technology, with a view to developing a plan for its use – plan to be completed by 31.08.2019.
- Improvement work underway to improve HCAI data shared with Delivery Units.

What are the main areas of risk?

- Contributory factors: secondary care antibiotic prescribing; impact of high numbers of outliers on good antimicrobial stewardship; use of additional beds in already full bays as part of the pre-emptive bed protocols; suspension of enhanced decontamination technologies; lack of decant facilities which restricts ability to undertake deep-cleaning of clinical areas.
- C. difficile spores may be found in 49% rooms of patients with *C. difficile* infection; 29% rooms of asymptomatic carriers.
- Public Health Wales implemented a new, more sensitive testing methodology for *C. difficile*. The likely impact of this will be a 10-20% increase in the detection of *C. difficile* carriage.

How do we compare with our peers?

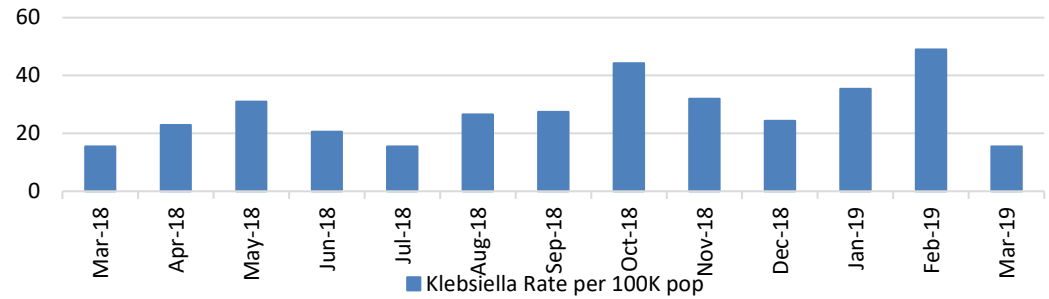
- The Health Board incidence per 100,000 population for March 2019 was 15.50/100,000 population, the second lowest incidence in Wales for the month.
- The Health Board cumulative incidence was 33.47, which was the second highest cumulative incidence in Wales.

Klebsiella spp. *Bacteraemia*

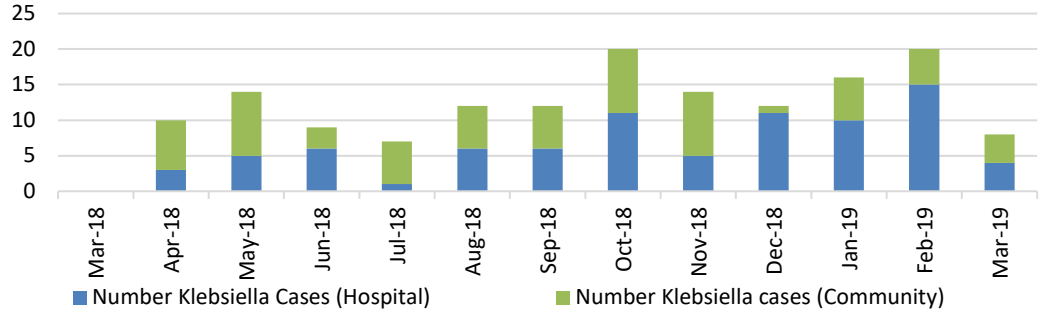
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Rate of Klebsiella spp. bacteraemia cases per 100,000 of the population				
Measure 2: Number of Klebsiella spp. Bacteraemia cases		< 10	✗	↑ ●
Measure 3: Number of cumulative cases of Klebsiella against March 2019 reduction expectation		108	✗	

(1) Rate of Klebsiella spp. bacteraemia per 100,000 of the population.



(2) Number of Klebsiella spp. bacteraemia cases



Benchmarking

LHB	Cumulative Cases (Apr - Mar 19)	Max cumulative cases to achieve Mar-19 reduction	Variance
Wales	628	513	+115
ABM	152	108	+44
AB	122	90	+32
BCU	122	103	+19
C&V	86	100	-14
Ctaf	65	39	+26
Hdda	76	64	+12

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (March 2019)

Measure 1: Rate of Klebsiella spp. Bacteraemia cases per 100,00 of the population
Measure 2: Number of Klebsiella spp. bacteraemia cases
Measure 3: Number of cumulative cases of Klebsiella against March 2019 reduction expectation

How are we doing?

- In March 2019, there were 8 cases of *Klebsiella spp*. bacteraemia in ABMU.
- The cumulative number of bacteraemia cases, April 2018 to March 2019, was 154 cases. Of these 154 cases, 54% were hospital acquired; 46% were community acquired.

What actions are we taking?

- Delivery Units to continue with focus to increase numbers of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT), with month-on-month improvements.
- Delivery Units to progress with PDSA style quality Improvement activities with a focus on urinary catheters, across acute sites.
- Delivery Units to explore how to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.
- Improvement work underway to improve HCAI data shared with Delivery Units.

What are the main areas of risk?

- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which is frequently close to, or exceeds, 90%.

How do we compare with our peers?

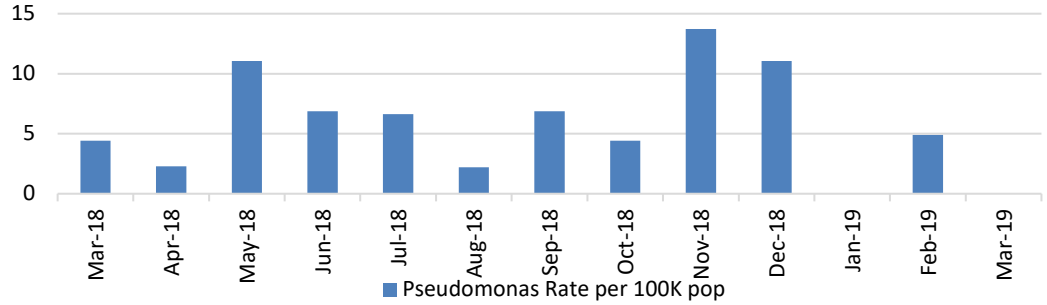
- The incidence of *Klebsiella spp.* bacteraemia per 100,000 population for March 2019 was 15.50; this was the second lowest incidence for the major acute Health Boards in Wales.
- The cumulative incidence of *Klebsiella spp.* bacteraemia within ABMU for the year 2018/19 was 28.58/100,000 population, the highest incidence for the major acute Health Boards in Wales.

Pseudomonas Aeruginosa *Bacteraemia*

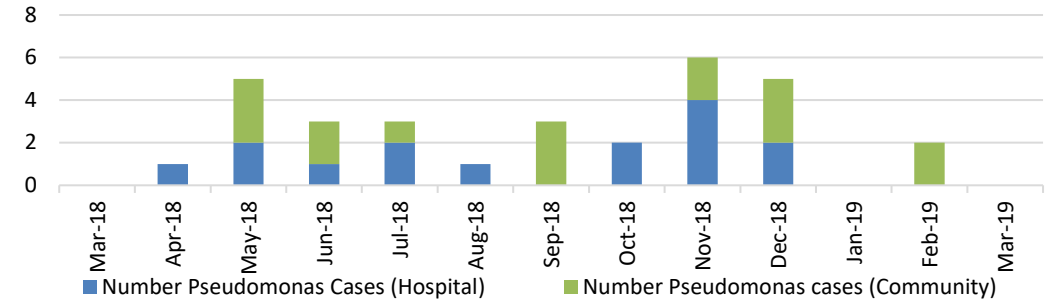
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	IMTP Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: Rate of Pseudomonas aeruginosa bacteraemia cases per 100,000 of the population				
Measure 2: Number of Pseudomonas aeruginosa bacteraemia cases		< 4	✓	↓ ●
Measure 3: Number of cumulative cases of Pseudomonas against March 2019 reduction expectation		36	✓	

(1) Rate of Pseudomonas aeruginosa bacteraemia per 100,000 of the population.



(2) Number of Psuedomonas aeruginosa bacteraemia cases



Benchmarking

LHB	Cumulative Cases (Apr - Mar 19)	Max cumulative cases to achieve Mar-19 reduction	Variance
Wales	196	165	+31
ABM	31	36	-5
AB	30	27	+3
BCU	38	27	+11
C&V	37	31	+6
Ctaf	19	16	+3
Hdda	40	24	+16

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (March 2019)

Measure 1: Rate of Pseudomonas aeruginosa Bacteraemia cases per 100,00 of the population
Measure 2: Number of Pseudomonas aeruginosa bacteraemia cases
Measure 3: Number of cumulative cases of Pseudomonas against March 2019 reduction expectation

How are we doing?

- In March 2019, there were 0 cases of *Pseudomonas aeruginosa* bacteraemia in ABMU.
- The cumulative number of bacteraemia cases, April 2018 to March 2019, was 31 cases. Of these 31 cases, 48% were hospital acquired; 52% were community acquired.

What actions are we taking?

- Delivery Units to continue with focus to increase numbers of staff who have been competence assessed for Aseptic Non Touch Technique (ANTT), with month-on-month improvements.
- Delivery Units to progress with PDSA style quality Improvement activities with a focus on urinary catheters, across acute sites.
- Delivery Units to explore how to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.
- Improvement work underway to improve HCAI data shared with Delivery Units.

What are the main areas of risk?

- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which is frequently close to, or exceeds, 90%.

How do we compare with our peers?

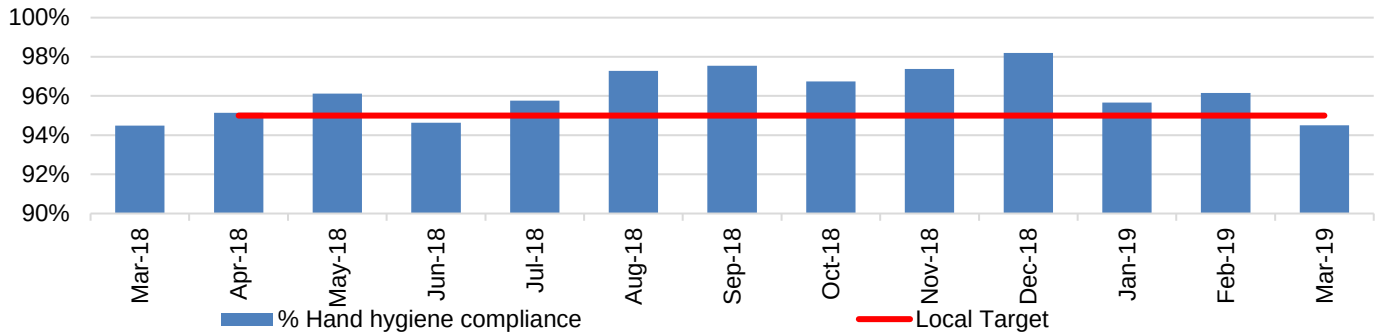
- The incidence of *Pseudomonas aeruginosa* bacteraemia per 100,000 population for March 2019 was 0.00; this was the lowest incidence for the major acute Health Boards in Wales.
- The cumulative incidence of *Pseudomonas aeruginosa* bacteraemia within ABMU for the year 2018/19 was 5.83/100,000 population, one of the lowest incidence for the major acute Health Boards in Wales.

HAND HYGIENE

NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

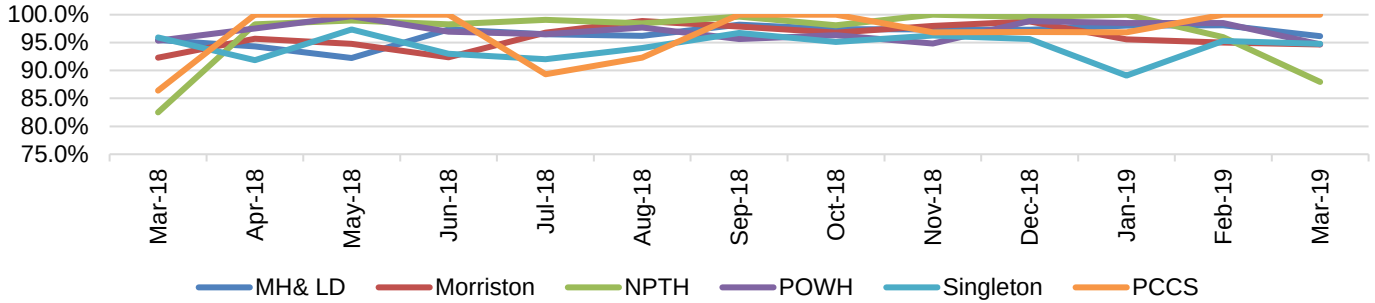
	Local Target	WG Target	**Period:** March 2019	
			Current Status *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % compliance with Hand Hygiene Audits	95%	N/A	✗	↑ ●

(1) % compliance with Hand Hygiene Audits.



Benchmarking

(1) % compliance with Hand Hygiene Audits.



Source: Nursing Care Metrics (March 2019)

Measure 1: % compliance with Hand Hygiene Audits
How are we doing?
• Compliance with hand hygiene (HH) for March 2019 was approximately 95%. • For March 2019, 91 wards/units (63%) reported compliance ≥95%. • 11 wards/departments (8%) reported compliance between 90% and 94%; 18 wards/units (12%) reported compliance of 89% or below. • 24 wards/departments had not uploaded the results of their audits undertaken in March 2019 at the time of updating this report. • Two Service Delivery Units (SDU) reported compliance ≥95% in March 2019 (Primary Care & Community Services and Mental Health & Learning Disabilities). Morriston, Singleton and Princess of Wales reported compliance ≥90% ≤94%; Neath Port Talbot reported compliance at 88%. • Results over time indicate there are challenges to achieving sustained improvements in compliance however, there are recognised limitations with self-assessment.
What actions are we taking?
• Delivery Units can agree internal peer review audit programmes, undertaking these between wards, specialties or Delivery Units. • The updated Hand Hygiene Training programme is being delivered. • Training of ward Hand Hygiene Coaches continues and these continue to deliver approved training at ward level.
What are the main areas of risk?
• Main route of infection transmission is by direct contact, particularly by hands of staff. • Poor compliance with good hand hygiene practice is likely to result in transmission of infection. • Current scoring system may be giving an overly assuring picture of compliance; greater validation of the scores needs to be undertaken. • The current system and format of scoring fails to highlight particular staff groups with lower compliance rates than others.
How do we compare with our peers?
• The Hand Hygeine score has been removed from the all-Wales dashboard because of the inherent difficulty in using one score to represent a whole Health Board.

SERIOUS INCIDENTS

NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
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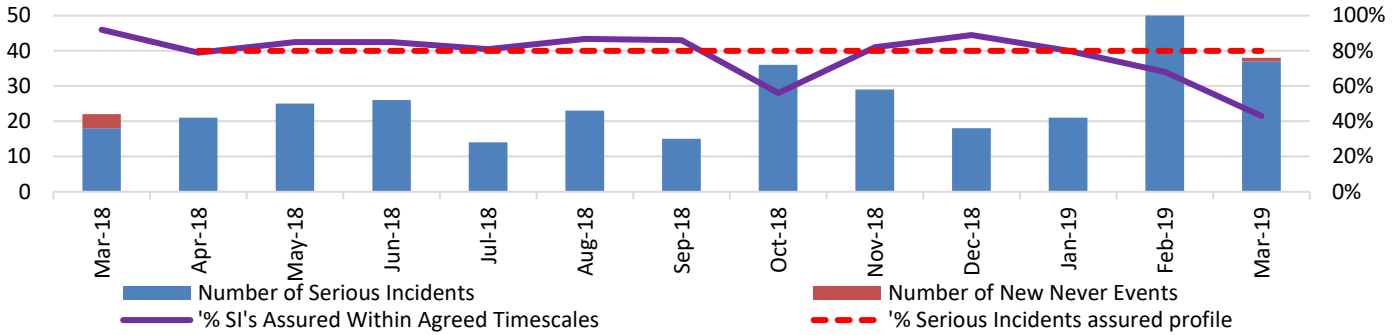
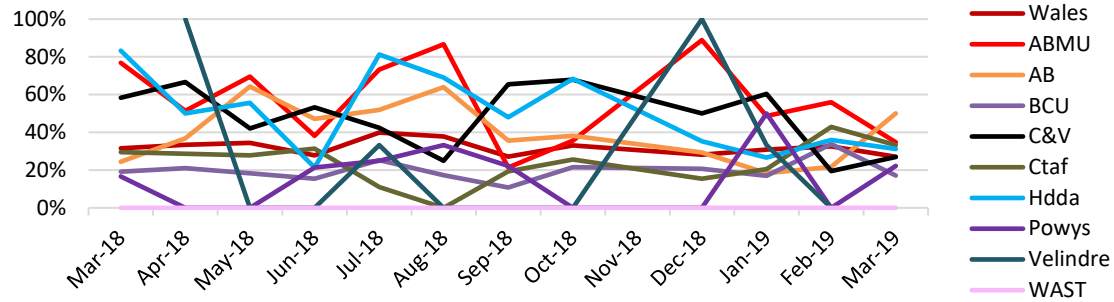
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Annual Plan	WG Target	**Period:** March 2019 Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: Number of new Never Events	0	0	✕	↓
Measure 2: Number of new Serious Incidents (SI's)	0	n/a	✕	↓
Measure 3: % Serious Incidents Assured Within The Agreed Timescales	80%	90%	✕	↓

(1) Number of new Never Events, (2) Number of new Serious Incidents (SI's), (3) % SI's Assured Within The Agreed Timescales



Serious Incidents Assured Within The Agreed Timescales



Never Events

Mar-19	
Wales	2
ABM	1
AB	0
BCU	0
C&V	1
Ctaf	0
Hdda	0
Powys	0
Velindre	0
WAST	0

Source : NHS Wales Delivery Framework, all-Wales performance summary (March 2019)

Measure 1: Number of new Never Events
Measure 2: Number of new Serious Incidents (SI's)
Measure 3: % Serious Incidents Assured Within The Agreed Timescales

How are we doing?

SI Scorecard – completed on 2 May 2019.

- Total number of incidents reported in March 2019 was 2,594. This compares to 2,285 incidents reported in March 2018, an increase of 309 incidents for the month of March (increase of 14%).
- 37 Serious Incidents (SI's) were reported to Welsh Government (WG) in March 2019. In comparison, 19 SI's were reported to WG in March 2018, an increase of 18 incidents (increase of 95%). Of the 37 new serious incidents reported to WG in March 2019, 19 (51%) related to unexpected deaths, 4 (11%) related to patient falls, 4 (5%) related to Infection Control, 5 (14%) related to administrative processes, 2 (5%) related to diagnostic processes/procedures, 1 (3%) related to Behaviour, 1 (3%) related to Therapeutic Processes/Procedures and 1 (3%) related to Neonatal/Perinatal Care.
- In terms of severity of incidents, the percentage of incidents resulting in severe harm for March 2019 was 0.1% (total incidents reported 2,594). The Health Board's target for incidents resulting in severe harm is 0.5% of the total number of incidents reported.
- 1 new Never Event was reported in March 2019. This related to wrong site surgery.
- Performance against the WG target of closing SI's within 60 working days for March 2019 was 43% (April 2019 – 70%) against the WG target of 80%.

What actions are we taking?

- The SI Team continues to trial the new reflective methodology approach to review serious incidents managed by the SI Team. Presentations promoting the approach are being undertaken across the Health Board to help promote an organisational learning culture.
- A new toolbox supporting the revised approach to SI investigations was approved at Quality and Safety in February following which will be rolled-out across the Health Board.
  In addition, the SI team have appointed a new Lead Serious Incident Investigator.
- The reduction in performance was anticipated following the change to Pressure Ulcer reporting and the increase in Mental Health reporting in accordance with Welsh Government criteria. The Mental Health & Learning Disabilities Unit have recruited to two new posts: Serious Incident Investigator and Serious Incident Investigator Support Officer who will both form part of the Unit's Quality and Safety Team. The Assistant Head for Concerns Assurance is also mentoring and supporting the investigation of the most serious incidents reported to WG in the Unit whilst supporting the Unit to develop new processes for ensuring the timely management and reporting of patient serious untoward incidents and closure forms.
- The Mental Health & Learning Disabilities Unit has an improvement plan in place to take forward actions required to increase their performance to achieve the WG target.
- All Units performance against the WG SI target are discussed with the Executive Directors during the performance reviews.

What are the main areas of risk?

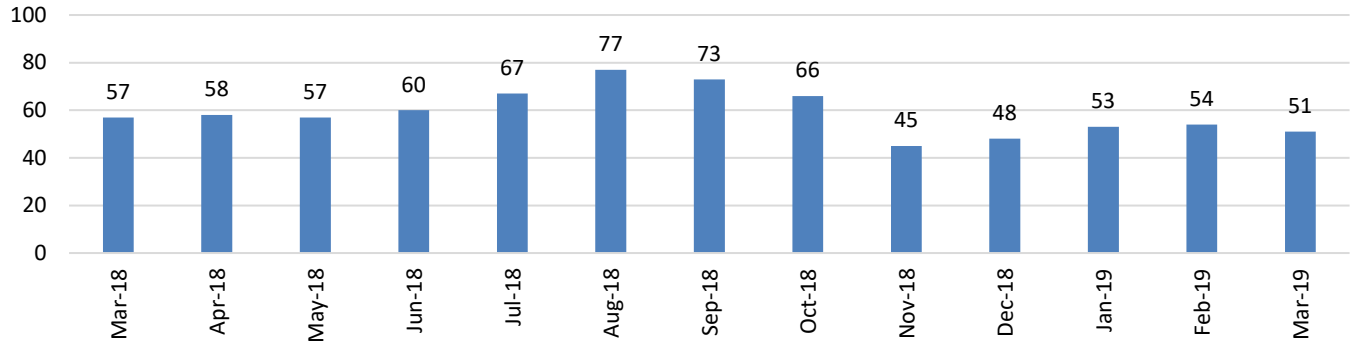
- Maintaining Welsh Government 80% target closure date whilst ensuring quality of investigation reports and robust learning from the incidents.
- Differences between Welsh Government and Health Board data.

How do we compare with our peers?

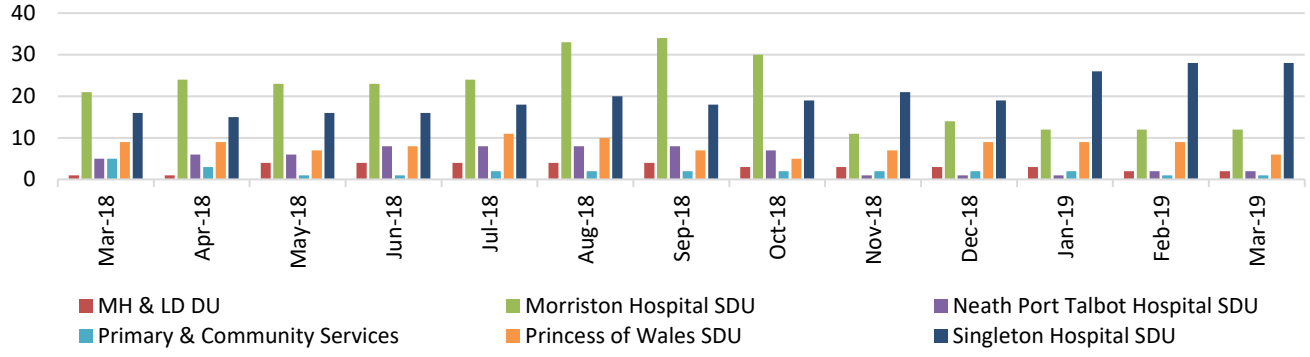
- Comparison data from peer organisations not available

RISKS							
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support				
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience				
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience			**Annual Plan Profile**	**WG Target**	**Period:** March 2019 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Number of risks with score ≥ 20				Reduce	N/A	✓	↓

(1) Number of risks with score ≥ 20



(1) Number of risks with score ≥ 20 (by Service Delivery Unit



Source : Datix System

Measure 1: Number of risks with score ≥ 20

How are we doing?

- 51 operational risks, rated 20 or above.
- Singleton Unit has the highest number of risks rated at 20 or above.

What actions are we taking?

- A Workshop was held in March to discuss and agree a number of recommendations highlighted in the Internal Audit report and a plan is in place to take forward the recommendations.
- Service Delivery Units have been invited to future meetings of the Risk Management Group (RMG) to review their Unit Risk Registers.
- A Standard Operating Procedure has been developed to give guidance on how to escalate a risk to the Health Board Risk Register (HBRR) and will be shared at the next RMG Meeting.
- The Health Board Risk Management Framework and Policy is being reviewed in line with the newly formatted Health Board Risk Register.

What are the main areas of risk?

- The Risk and Assurance team continue to review all high-level risks on the risk register in conjunction with the appropriate Health Board Executives and Service Directors.

Presently the HBRR contains 5 risks which are risk rated at level 20:

- **Capacity within WODS (56)-** Insufficient capacity of Workforce and OD Function within ABMU to support and deliver the strategic and operational workforce agenda, plans and priorities of the Health Board. The Workforce & OD Committee regularly oversee this risk and monitor the actions being taken to mitigate the risk.
- **Brexit (54) -** Failure to maintain services as a result of the potential no deal Brexit. The Emergency Planning & Preparedness Group are overseeing this risk and a number of meetings have been held to prepare in readiness for a no deal Brexit.

The three digital risks are currently being considered by Assistant Director of Informatics on behalf of the Executive Medical Director with a view to reducing the level of risk to 16 or lower following controls being implemented.

- **Sustained Clinical Services (27) -** Inability to deliver sustainable clinical services due to lack of digital transformation.
- **Storage of Paper Records (36) -** Failure to provide adequate storage facilities for paper records then this will impact on the availability of patient records at the point of care. Quality of the paper record may also be reduced
- **Discharge Information (45) -** If patients are discharged from hospital without the necessary discharge information this may have an impact on their care

How do we compare with our peers?

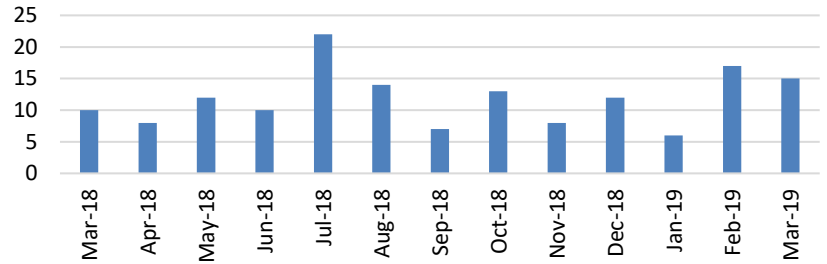
- No comparable data available.

SAFEGUARDING ADULTS

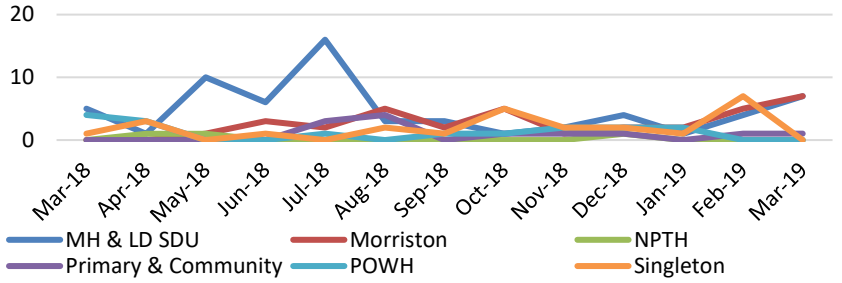
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Local Target	**Period:** March 2019	
		Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Number of Safeguarding Adult referrals relating to Health Board staff/services	Reduce	✗	↑ ●
Measure 2: Number of Safeguarding Adult referrals relating to Health Board staff/services by Service Delivery Unit	Reduce	✗	↑ ●
Measure 3: Themes of Safeguarding Adult reports (Health Board Total)	Monitor	N/A	N/A
Measure 4: Themes of Safeguarding Adult reports by Service Delivery Unit	Monitor	N/A	N/A

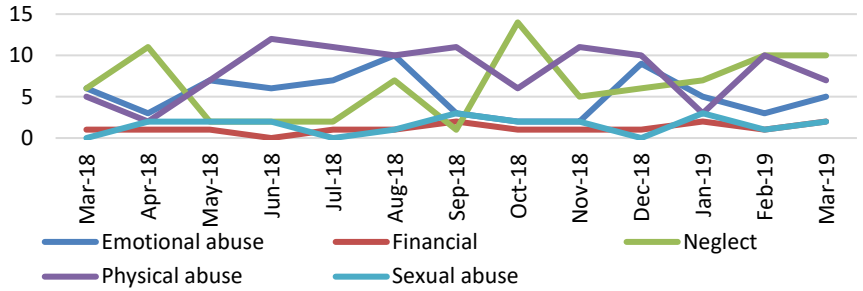
(1) Number of Safeguarding Adult referrals relating to Health Board staff/services (HB Total)



(2) Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit



(3) Themes of Safeguarding Adult reports (HB Total)



(4) Themes of Safeguarding Adult reports (by SDU)

Mar-19	Emotional abuse	Financial	Neglect	Physical abuse	Sexual abuse	Total
MH & LD SDU	4	1		7	1	13
Morriston Hospital SDU		1	7		1	9
NPT Hospital SDU						0
Princess of Wales SDU						0
Singleton Hospital SDU						0
P & CC SDU	1		3			4
Total	5	2	10	7	2	26

Source : Datix System

Measure 1: Number of Safeguarding Adult referrals relating to Health Board staff/ services
Measure 2: Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit
Measure 3: Themes of Safeguarding Adult reports (Health Board Total)
Measure 4: Themes of Safeguarding Adult reports by Service Delivery Unit

How are we doing?

- (1) The number of safeguarding adult at risk referrals relating to Health Board (HB) staff or services continue to vary each month.
- (2) The trend indicates a slight overall increase in the level of referrals in comparison to the previous quarter which most likely reflects higher activity levels within the HB during winter months.
- (3/4) Mental Health & Learning Disabilities Service Delivery Unit (SDU) consistently have the highest number of adult at risk referrals. This is expected due to the complexities and vulnerabilities of their client group, with most referrals relating to allegations of abuse of a patient by another patient. The most common theme across all SDUs is that of physical abuse, with a gradually increasing trend in reported cases of alleged neglect.

What actions are we taking?

- Service Delivery Units report on lessons identified from closed safeguarding cases in their unit performance reports to the Safeguarding Committee, which allows learning from specific cases to be shared across the Health Board. In addition, rotational learning events are to be held quarterly to enable wider dissemination of learning throughout the SDUs with the first event planned for June 2019.
- The themes and trends of adult safeguarding cases across the Health Board are monitored and analysed by the Corporate Safeguarding team. This information is presented to both the Safeguarding Committee and Quality and Safety Committee in the Bi-annual Safeguarding Report

What are the main areas of risk?

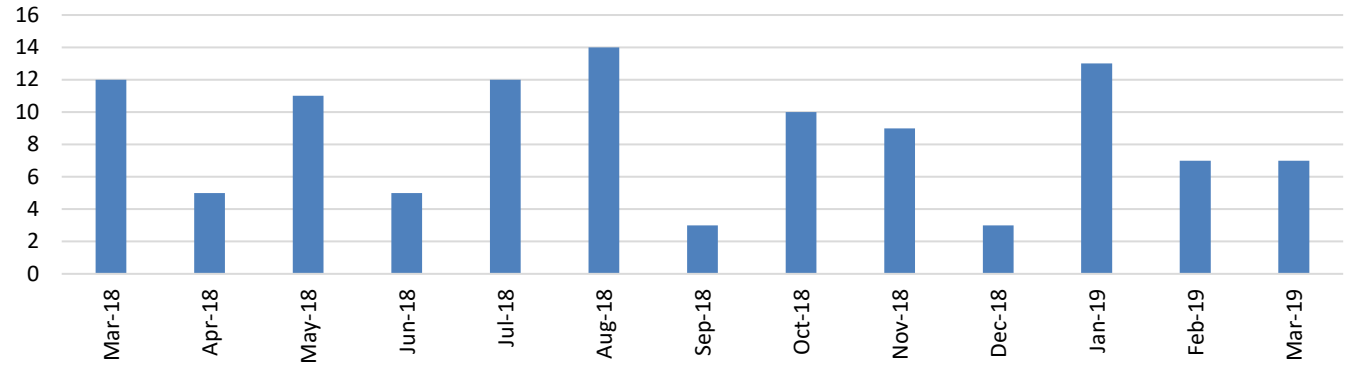
- Achieving legislative requirements of timescales to complete initial enquiries for safeguarding adult referrals – this is recorded within the Corporate Safeguarding Team, and Service Delivery Units are required to report breaches on their performance reports.
- The Health Board is engaging with its Local Authority partners to implement a robust process in order to fulfil its duty to report adults at risk to the Local Authority, with expected implementation in the summer of 2019.

How do we compare with our peers?

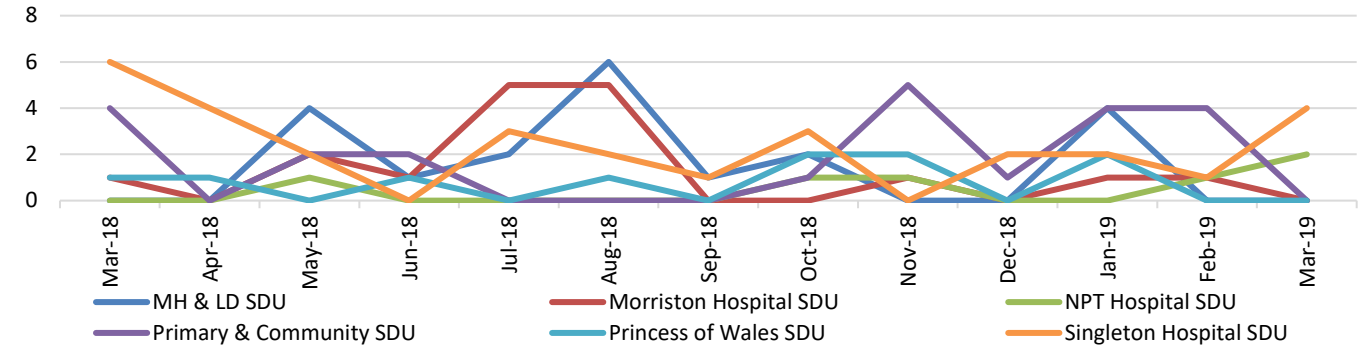
- Peer information is not available for comparison

SAFEGUARDING CHILDREN							
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm		**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support			
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people		**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience			
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience			**Annual Plan Profile**	**WG Target**	**Period:** March 2019 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Number of Safeguarding Children Incidents				Reduce	N/A	✓	↓

(1) Number of Safeguarding Children Incidents



(1) Number of Safe guarding Children Incidents



Source : Datix System

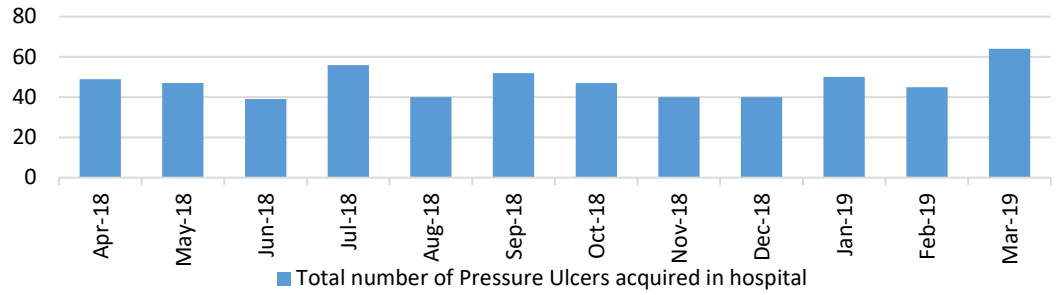
Measure 1: Number of Safeguarding Children Incidents
How are we doing?
• After a peak in October 2018, children's incident reporting has generally reduced, with a spike in January 2019 that may be indicative on general increase in Health Board (HB) activity due to winter pressures. The numbers remain relatively low and so recognising themes and trends are difficult to identify. In terms of the types of incidents reported, the largest proportion are in relation to failure to share information, closely followed by failure to follow guidelines and children nursed on adult wards. It is not known whether all Safeguarding Children incidents are appropriately reported; incidental review indicates there may be discrepancy between actual incidents and those reported. • The Health Board does not capture any Safeguarding Children referrals to Local Authority (LA) Children's Services originating from health and therefore this activity is not visible on the Report Cards. The data is currently obtained by contacting the relevant LA and requesting the information, but Local Authorities do not always collate and report this in a consistent manner.
What actions are we taking?
• The Children's Trigger list was revised in November 2018 and a link has been added on Datix giving guidance for Safeguarding Children Incident Alerts. The list will be revised on an annual basis to ensure its appropriateness in capturing relevant information. • Local audits of the revised Risk Assessment Tool for Children admitted to Adult Ward Environments will take place within the Service Delivery Units (SDU) and these will be reported to Safeguarding Committee. • Safeguarding Children referrals made by HB staff are sent directly to the Local Authority and as such at present, the HB does not have an accurate record of referrals that have been submitted. SDU's currently report on any Safeguarding Children referrals within their quarterly performance reports to the Safeguarding Committee. The Corporate Safeguarding team is currently working with Local Authority partners to establish processes to ensure the HB adequately fulfils its 'duty to report' children and adults at risk of abuse or neglect, and as part of this will incorporate data collection, thus negating the previous proposal for a HB data collection tool on DATIX. Anticipated implementation from autumn 2019. • The Safeguarding Team are planning to undertake an audit in 2019 (in partnership with the DATIX team) to identify whether there is a discrepancy between incidents that are triggered for review and those that should have been triggered but were not; anticipated to be carried out by summer 2019.
What are the main areas of risk?
• There is currently no robust method to capture all Safeguarding Children activity across the HB.
How do we compare with our peers?
• Comparison data from peer organisations not available

PRESSURE ULCERS ACQUIRED IN HOSPITAL

NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

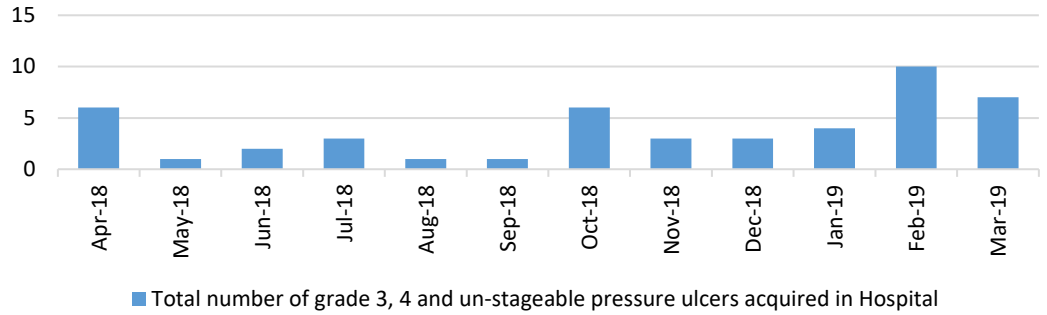
	Local Target	WG Target	**Period:** March 2019 Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: Total Number of pressure ulcers acquired in hospital	Reduce	N/A	✗	↑
Measure 2: Number of grade 3, 4 and un-stageable pressure ulcers acquired in hospital	Reduce	N/A	✓	↓

(1) Total number of Pressure Ulcers acquired in hospital.



Benchmarking

(2) Number of Grade 3, 4 and un-stageable pressure ulcers acquired in hospital



Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of pressure ulcers acquired in hospital

Number of grade 3, 4 and un-stageable pressure ulcers acquired in hospital
How are we doing?
• The "In Hospital" acquired Pressure Ulcers were previously reported as a rate per 100,000 hospital admissions to comply with the requirements of the NHS Wales Delivery Framework. This is no longer required by Welsh Government and the measure is now displayed as the number of pressure ulcers acquired in hospital. • There has been an increase in the rate of pressure ulcer development for in-patients during March 2019. The number of pressure ulcers rose from 45 in February to 64 in March 2019. • Princess of Wales Hospital (POWH) continues to be a hotspot for pressure ulcer development and accounts for 51.6% of all the hospital acquired pressure ulcers developing in March (33 out of 64). • Morriston Hospital has seen a rise in the number of pressure ulcers reported in March, 19 compared to 10 in February. • No pressure ulcers were reported in NPTH or Mental Health during March 2019. • The rate of serious pressure ulcers, that is, Grade 3, 4 and unstageable (US) has decreased from 10 in February to 7 in March 2019. • Five device related pressure ulcers were reported in March 2019, 3 in Morriston Hospital and 2 in POWH.
What actions are we taking?
• The Pressure Ulcer Prevention Strategic Group (PUPSG) continues to meet quarterly with a multi-disciplinary membership and representation from all Service Delivery Unit's (SDU's). • PUPSG continue to work closely with Welsh Risk Pool (WRP) to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan. • The final report of the Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 was presented at PUPSG in February. The report gives strong assurance that the ABMU pressure ulcer investigation and decision making process is robust and reliable. There can be confidence that the causal factors map used by investigators and reviewed by scrutiny panels is a valid tool for ongoing use in identifying themes and trends, and informing work streams. • Following a pilot in Singleton Delivery Unit, WRP designed a quarterly report template for service delivery units to share their learning, casual factor analysis and their work-streams to address the causal factors. Workshops are planned to provide support for each SDU to create their own reports. • Incomplete documentation continues to be a contributory factor. All SDU's have plans in place for pressure ulcer prevention documentation audit. Work is underway with e-learning at Wales to develop an e-learning pressure ulcer prevention education package that can be linked to ESR. Targeted pressure ulcer prevention and recognition education is to be provided for Morriston A&E and NPTH Minor Injury Unit staff. • A concordance policy has been written by Primary Community & Care and the Health Board Lead for co-production and a training package has been developed with the aim of supporting staff to coproduce an acceptable plan of care for pressure ulcer prevention with the patient. This will be submitted to NMB for ratification in May 2019. • A voiced power point presentation has been developed to share learning from a pressure ulcer related Coroner's Inquest case. • Pressure Ulcer Peer Review Scrutiny Panels are held in all Service Delivery Unit's and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
What are the main areas of risk?
• Continued difficulty with maintaining nurse staffing levels on wards, with a significant increase in the number of agency staff during March 2019.
How do we compare with our peers?
• Benchmarking data not available.

PRESSURE ULCERS ACQUIRED IN THE COMMUNITY

NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
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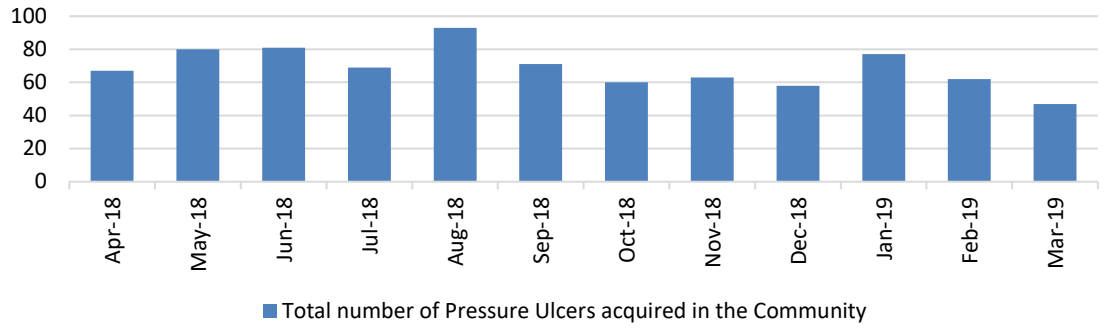
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

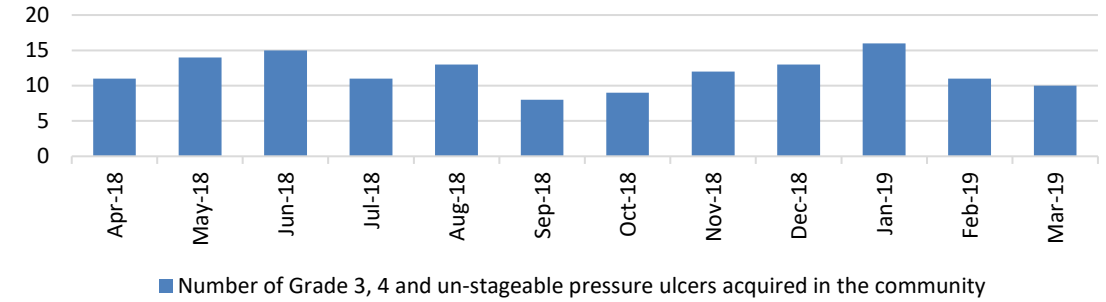
	Annual Plan Profile	**WG Target**	**Period:** March 2019 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Total Number of pressure ulcers acquired in the community.	Reduce	Reduce	✓	↓
Measure 2: Number of grade 3, 4 and un-stageable pressure ulcers acquired in the community.	Reduce	Reduce	✗	↑

(1) Total Number of pressure ulcers acquired in the community.



Benchmarking

(2) Number of grade 3, 4 and unstageable pressure ulcers acquired in the community.



Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of pressure ulcers acquired in the community.
Measure 2: Number of grade 3, 4 and un-stageable pressure ulcers acquired in the community

How are we doing?

- March 2019 saw a significant reduction in pressure ulcers occurring in the community, 47 incidents of pressure ulceration compared to 62 incidents reported in February 2019.
- The reduction in pressure ulcer numbers equates to a 25% decrease in pressure ulcer development in March 2019 compared to February 2019
- Swansea community has seen a 50% reduction, from 20 in February 2019 to 10 pressure ulcers in March 2019.
- There were no device related pressure ulcers reported during March 2019, which is a reduction from 3 reported the previous month.
- There has been a slight decrease in the number of serious pressure ulcers, that is, Grade 3, 4 and unstageable occurring in the community, from 11 in February 2019 to 10 in March 2019.

What actions are we taking?

- The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) continues to meet quarterly. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- PUPSG continue to work closely with Welsh Risk Pool (WRP) to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- The final report of the Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 was presented at PUPSG in February. The report gives strong assurance that the ABMU pressure ulcer investigation and decision making process is robust and reliable. There can be confidence that the causal factors map used by investigators and reviewed by scrutiny panels is a valid tool for ongoing use in identifying themes and trends, and informing work streams.
- Following a pilot in Singleton Delivery Unit, WRP designed a quarterly report template for service delivery units to share their learning, casual factor analysis and their work-streams to address the causal factors. Workshops are planned to provide support for each SDU to create their own report.
- Work is underway with e-learning at Wales to develop an e-learning pressure ulcer prevention education package that can be linked to ESR.
- A concordance policy has been written by Primary Community & Care and the Health Board Lead for co-production and a training package has been developed with the aim of supporting staff to coproduce an acceptable plan of care for pressure ulcer prevention with the patient. This will be submitted to NMB for ratification in May 2019.
- A voiced power point presentation has been developed to share learning from a pressure ulcer related Coroner's Inquest case.
- Using mobilisation has increased the timeliness of home visits when early pressure damage is identified enabling earlier intervention and treatment and avoiding delays in management.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all localities and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
- The community Pressure Ulcer Improvement Group meets quarterly to receive feedback and learning from the local community scrutiny panels.
- Education for pressure ulcer prevention and classification of pressure ulcers remains an ongoing priority. Bespoke sessions are delivered by TVN's to community staff, carer organisations and care homes on a rolling programme.

What are the main areas of risk?

- The Primary Care & Community Services Delivery Unit are supporting large numbers of frail older people at home who are at increased risk of developing pressure damage.

How do we compare with our peers?

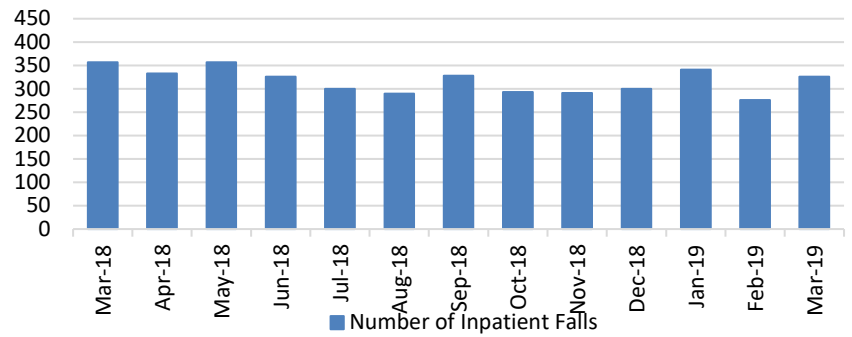
- No benchmark data available.

INPATIENT FALLS

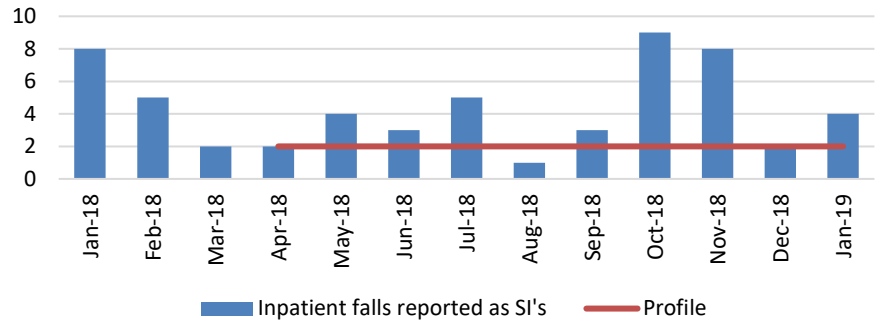
NHS Wales Domain:	**SAFE CARE:** People in Wales are protected from harm and supported to protect themselves from known harm	**Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		

	Annual Plan Profile	WG Target	**Period:** March 2019	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Total Number of Inpatient Falls	N/A	N/A		↓
Measure 2: Number of inpatient falls reported as serious incidents	2	12 Month reduction trend	✓	↑

(1) Total number of Inpatient Falls

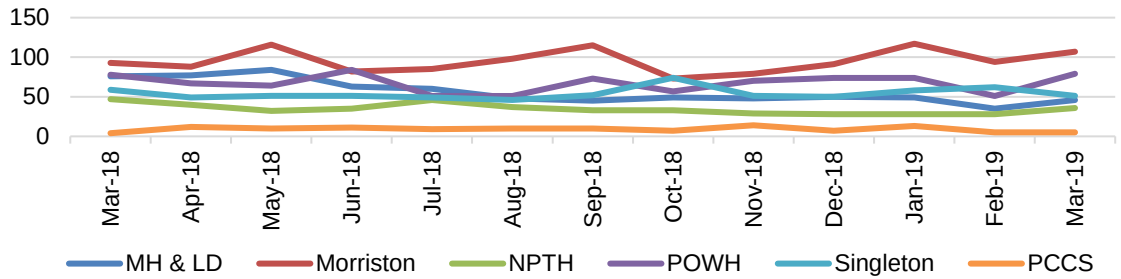


(2) Number of inpatients falls reported as serious incidents



Benchmarking

(1) Number of Inpatient Falls



Source : Incident data from DATIX

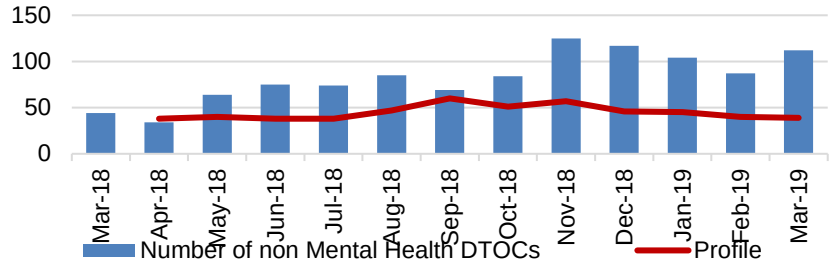
Measure 1: Total Number of Inpatient Falls Measure 2: Number of inpatients falls reported as serious incidents
How are we doing?
• January 2019 shows 341 falls, February reduced to 276 and March has 326 falls overall. Morriston had a further increase in January, which reduced in February to 94, and a slight rise to 107 in March. Singleton has a slight rise in February to 62 and has reduced back down to 51 in March. POW reduced to 62 in February, with a rise to 79 in March. NPT has shown a rise to 36 in March from 28 in January. There are a number of Serious Incident's recorded for the Health Board, 2 in December & 4 in January (awaiting verification from SDU's)
What actions are we taking?
• A Task and finish group has been set up regarding Health Board wide training on Falls and Bone Health Multifactorial Risk Assessment • The Falls Policy, has now been approved by the Health Board, an implementation and training plan is progressing. • A teaching presentation on the new falls policy has been developed and distributed to all leads with each of the Delivery units. • The re-established Strategic Falls Steering group will meet in May 2019 to confirm Terms of Reference.
What are the main areas of risk?
• The Health Board (HB) policy has not yet been implemented, once training has been completed within the Service Delivery Units the policy will be launched across the Health Board. • A project group is being set up to look at the total bed management contract, which will include Hi- Lo beds.
How do we compare with our peers?
• The Health Board (HB) policy includes the recommended guidance from NICE and the recommendations from the 2017 National inpatient Falls Audit, which is in line with the All Wales approach • Training is in progress within each of the Delivery Units once staff are trained the revised policy will be launched.

10.3 Effective Care

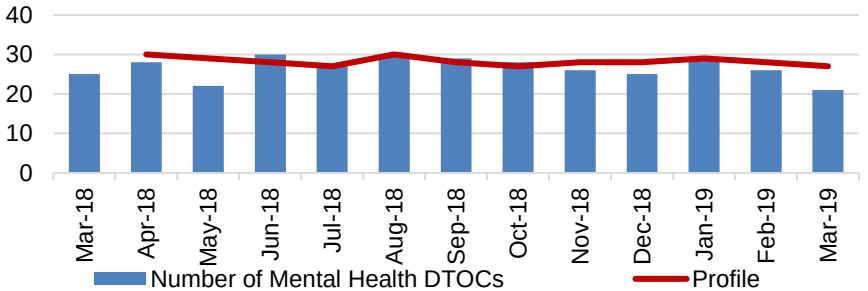
DELAYED TRANSFERS OF CARE (DTOCS)			
NHS Wales Domain:	**EFFECTIVE CARE:** People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that care successful	**NHS Wales Outcome Statement:**	Health care and support are delivered at or as close to my home as possible
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Unscheduled Care & Stroke
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Number of Delayed Transfers of Care for non-mental health specialities (age 75+)	39	N/A	✗	↑
Measure 2: Number of Delayed Transfers of Care for mental health (all ages)	27	N/A	✓	↓
Measure 3: Number of non-mental health Delayed Transfers of care (Rolling 12 months)	N/A	Reduce by 10%	✗	↑
Measure 4: Number of mental health Delayed Transfers of Care (Rolling 12 months)	N/A	Reduce by 5%	✗	↓

(1) Number of Delayed Transfers of Care for non-mental health specialities (age 75+)

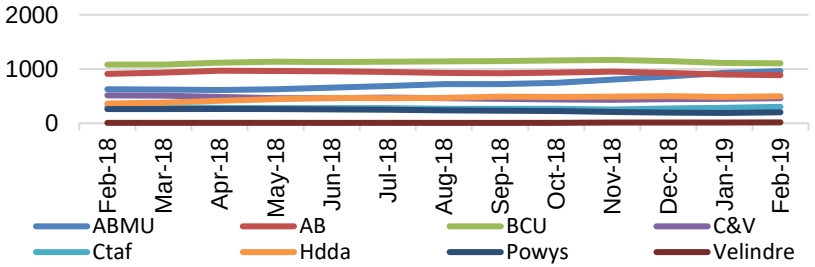


(2) Number of Delayed Transfers of Care for mental health (all ages)

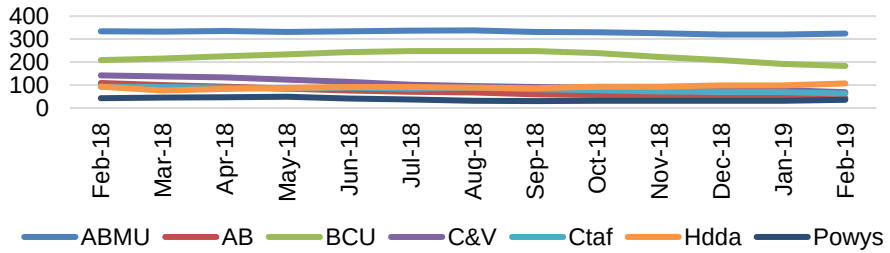


Benchmarking

(2) Number of non-mental health Delayed Transfers of care (Rolling 12 months)



(3) Number of mental health Delayed Transfers of Care (Rolling 12 months)



Source : NHS Delivery Framework, all-Wales performance summary (March 2019)

Measure 1: Number of Delayed Transfers of Care for non-mental health specialities (age 75+)
Measure 2: Number of Delayed Transfers of Care for mental health (all ages)
Measure 3: Number of Delayed Transfers of Care per 10,000 LA population for non-mental health specialities (age 75+)
Measure 4: Number of Delayed Transfers of Care per 10,000 LA population for mental health (all ages)

How are we doing?

- The total number of residents reported as a delayed discharge at a Health Board (HB) site in March 2019 was 133. This was an increase of 18% when compared with the 113 patients reported in February 2019, and an increase of 64(93%) when compared with the 69 delayed transfers of care reported in March 2018.
- Delays in non mental health and learning disability services accounted for the vast majority of our reported delayed discharge numbers equating to 112 or 84%.
- Within the month of March, the main categories contributing to a delayed discharge within our non mental health and LD services were community care/ assessment (37), health care assessment (37), and the selection and availability of a care home (12).
- The number of days associated with these delays were however as follows: Community care/ assessment (2002 days), health care assessment (751 days), selection and availability of a care home (548 days)
- Within mental health, there were 21 delayed discharges in March which equated to 3112 bed days. The main issue contributing to the number of lost bed days was in the category of community assessment/community arrangements.

What actions are we taking?

- Implementing the DToC improvement programme focussing on reducing delayed transfers of care within our HB. This is a clinically led programme and the key aims are to:
  - Standardise the approach taken across all Units to weekly stranded patient meetings
  - Establish centralised senior manager monthly DTOC validation scrutiny meeting and monthly debrief meeting
  - Improve and quicken the assessment process between organisations
  - Improve communication between organisations
  - Implement and develop new pathways of care to support discharge, e.g. ESD service at NPT
- Hospital to Home transformation bid developed to improve system capacity and is awaiting formal feedback from WG. Alternative plans are being progressed to develop discharge capacity in the community during 2019/20 if WG support for the transformation bid is not secured.

What are the main areas of risk?

- Capacity in the care home sector and fragility and capacity of the domiciliary care market in some parts of the Health Board.
- Risks of patient de-conditioning in the frail elderly population if hospital stays are prolonged.
- Workforce capacity including social work capacity.
- Capacity to support ongoing care needs and patient placements out of area.

How do we compare with our peers?

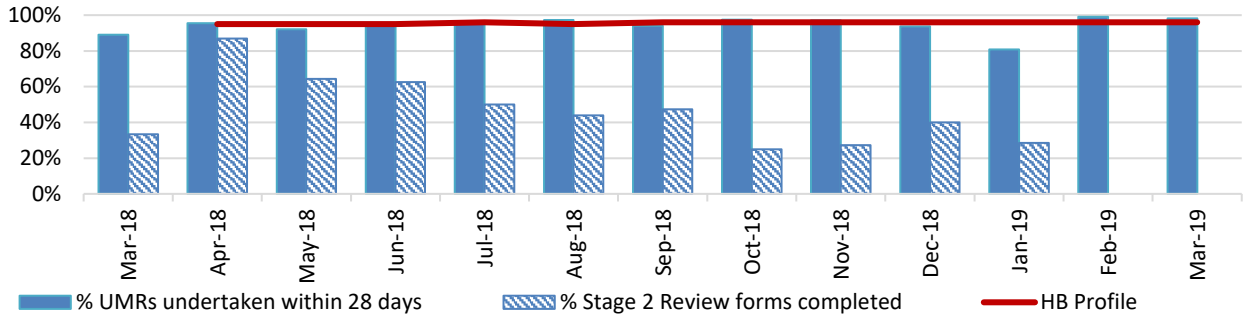
- ABMU HB is seeing an increasing trend in the overall number of delayed transfers of care, whereas the majority of other Health boards are seeing a reducing or stable position.

UNIVERSAL MORTALITY REVIEWS (UMR)

NHS Wales Domain:	**EFFECTIVE CARE:** People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that care successful	**NHS Wales Outcome Statement:**	Interventions to improve my health are based on good quality and timely research and best practice
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Richard Evans, Executive Medical Director		

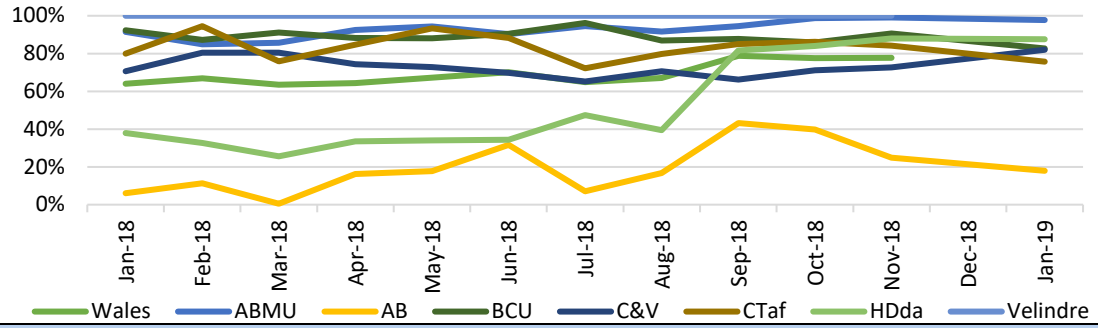
	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: % Universal Mortality Reviews (UMR) undertaken within 28 days of death.	95%	95%	✓	→
Measure 2: % Stage 2 Review forms completed.	N/A	N/A		

(1) % Universal Mortality Reviews (UMR) undertaken within 28 days of death (2) % Stage 2 Review forms completed



Benchmarking

(1) % Universal Mortality Reviews (UMR) undertaken within 28 days of death



Source: NHS Wales Delivery Framework, all-Wales Performance Summary (March 2019)

Measure 1: % Universal Mortality Reviews (UMR) undertaken within 28 days of death.
Measure 2: % Stage 2 Review forms completed.

How are we doing?

- Welsh Government Mortality Review Performance - ABMU achieved 97.7% completion of UMRs within 28 days of death in January 2019.
- The Health Board UMR rate reported in March 2019 was 98%.
- Neath Port Talbot Hospital (NPTH) maintained 100%, Singleton 97.6%, Princess of Wales Hospital (POWH) 98.8% and Morriston 97.8%.
- There were 3 missing UMR forms, 2 in Morriston and 1 in POWH.
- Completion of Stage 2 reviews for January 2019 deaths was at 29%.
- Mental Health and Community data remains unavailable via the eMRA application at present. This is being addressed by Informatics.

What actions are we taking?

- In Medicine at Singleton, all the Stage 2 reviews are discussed at their regular audit meetings.
- Mental Health & Learning Disabilities (MH&LD) report that all inpatient deaths in the Delivery Unit are Stage 1 reviewed at time of death and are allocated by the QI team as necessary to consultants for Stage 2 review. The outcomes are presented initially to the Serious Incident Group and then to the Quality & Safety Committee. Older Persons Mental Health Services also hold quarterly Mortality Review meetings to discuss findings. A modified Stage 1 form introduced in Jan 2018 allows for identification of patients who have a mental health, dementia or learning disability diagnosis across the Health Board.
- The Unit Medical Director (UMD) in POWH is currently revisiting Mortality Reviews on fractured neck of femur patients. From Jan 2019 any deaths occurring with a reason for admission as fractured neck of femur are to be highlighted to the UMD. Responsibility for completion of outstanding Stage 2 reviews has been allocated to a consultant, which has had a positive impact.
- The Morriston Unit are will also in the process of revisiting Mortality Reviews on fractured neck of femur patients.
- The Patient Affairs Office at Morriston has made good progress in recent months in compliance with Stage 1 reviews by following models in use at other Units. This was affected in December by the availability of additional support from the Clinical Audit Department due to other commitments

What are the main areas of risk?

- Timeliness of Stage 2 completion.
- Future implementation (April 2019, initially phased) of the Medical Examiner role is accompanied by risk of increased numbers of ‘Stage 2’ reviews required: the Medical Examiner role will effectively deliver Stage 1 reviews. It is recognised that phased implementation and as yet uncertain recruitment means that the impact will be similarly phased.
- A number of IT issues continue with eMRA.

How do we compare with our peers?

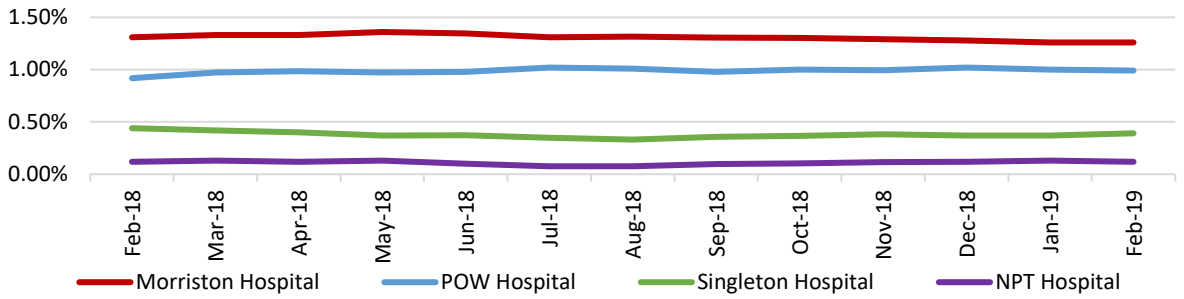
- ABMU remains the top ranking Health Board for the percentage of stage one mortality reviews undertaken within 28 days of death.

CRUDE HOSPITAL MORTALITY RATE

NHS Wales Domain:	**EFFECTIVE CARE:** People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that care successful	**NHS Wales Outcome Statement:**	Interventions to improve my health are based on good quality and timely research and best practice
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Richard Evans, Executive Medical Director		

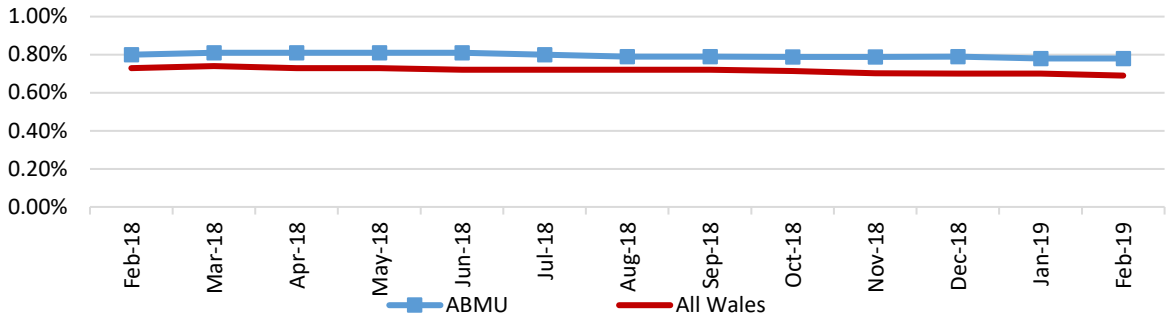
	Annual Plan Profile	**WG Target**	**Period:** February 2019 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Crude hospital mortality rate (less than 75 years of age)	N/A	12 month reduction trend	✗	↑ ●

(1) Crude hospital mortality rate (less than 75 years of age)



Benchmarking

(1) Crude hospital mortality rate (less than 75 years of age)

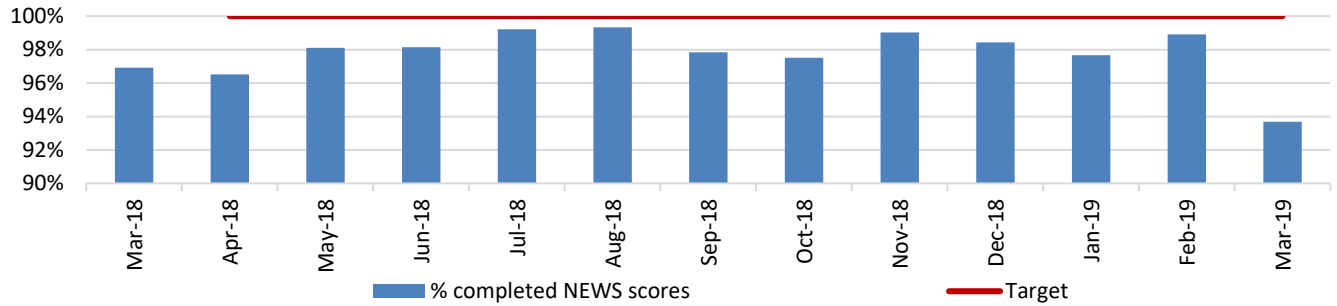


Source: NHS Wales Outcomes Framework, All Wales Performance Summary (March 2019)

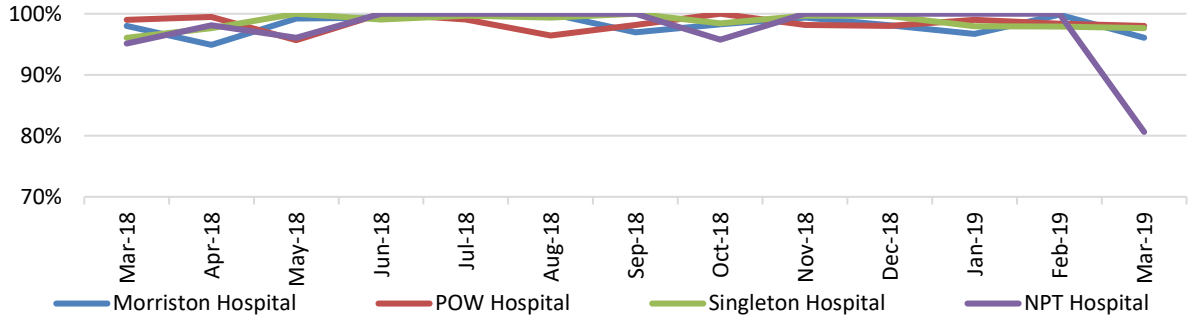
Measure 1: Crude hospital mortality rate (less than 75 years of age)
How are we doing?
• The ABMU Crude Mortality Rate for under 75s in the 12 months to February 2019 was 0.78%, compared with 0.80% for the same period last year. • Site level performance is as follows: (previous year in brackets) Morriston 1.26% (1.31%), Princess of Wales 0.99% (0.92%), Neath Port Talbot 0.11% (0.12%), Singleton 0.39% (0.44%). Site comparison is not possible due to different service models being in place. • There were 114 in-hospital Deaths in this age group in March 2019 and 103 in March 2018: Morriston 63 (58), Princess of Wales Hospital 27 (31), Neath Port Talbot Hospital 1 (2), and Singleton 19 (12). • The number of deaths for Surgical and Elective cases remains consistently low for this age group.
What actions are we taking?
• All Unit Medical Directors have access to the Mortality Dashboard to enable them to review mortality data and mortality review performance and learning. • Reporting and assurance arrangements for mortality review performance and learning will be reviewed by the incoming Executive Medical Director.
What are the main areas of risk?
• There is a risk of harm going undetected resulting in lessons not being learned. Our approach is designed to mitigate this risk and ensure effective monitoring, learning and assurance mechanisms are in place.
How do we compare with our peers?
• ABMU are above the all-Wales Mortality rate for the 12 months to February 19 – 0.78% compared with 0.69%. • ABMU is the best Performing Health Board in respect of UMRs completed within 28 days of the patient's death

NEWS SCORES						
NHS Wales Domain:	**EFFECTIVE CARE:** People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that care successful	**NHS Wales Outcome Statement:**	Interventions to improve my health are based on good quality and timely research and best practice			
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Quality & Safety and Patient Experience: Quality & Safety and Patient Experience			
Executive Lead:	Richard Evans, Executive Medical Director			**Local Target**	**Period:** March 2019 **Current Status** *(against Target):*	**Movement:** *(12 month trend)*
Measure 1: % patients with completed NEWS score and appropriate responses actioned				100%	✗	↓ ●

(1) % patients with completed NEWS score and appropriate responses actioned



(4) % patients with completed NEWS score and appropriate responses actioned (by Service Delivery Unit)



Source: Nursing Care Metrics (March 2019)

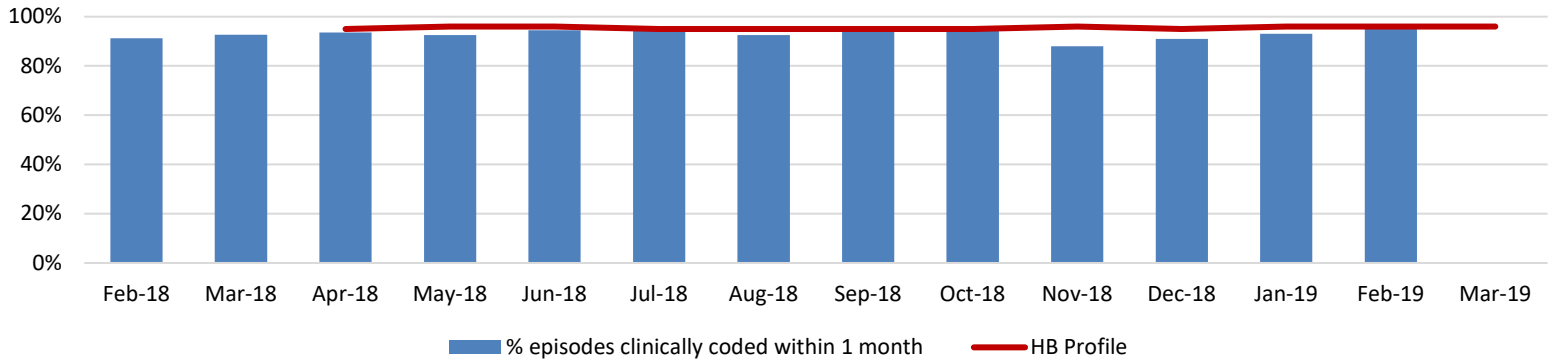
Measure 1: % patients with completed NEWS score and appropriate responses actioned
How are we doing?
• The overall Health Board percentage of patients with a completed NEWS Score in March 2019 was 93.7% compared with 98.9% in February and 96.9% in March 2018. • Performance at Morriston and Neath Port Talbot (NPT) dropped in March. Neath Port Talbot dropped from 100% to 80.6%.
What actions are we taking?
• Delivery Unit Quality & Safety groups continue to regularly review the percentage of patients with a completed NEWS score. • The Recognising Acute Deterioration and Resuscitation (RADAR) Group has received and considered the draft Peer Review Report and have already implemented many of the key recommendations within the report. We will continue to develop an action plan that will focus on identifying a single lead for acute deterioration within the Health Board as recommended within the report. The group has agreed a meaningful metric (Deterioration Dashboard) for monitoring clinical areas response to acute deterioration including; sepsis, AKI, outreach activity, cardiac arrest/2222 calls. The group have also requested regular updates on resuscitation training. • There continues to be no funding for the Sepsis work at Morriston and Singleton Units. Data reporting to Welsh Government has been inconsistent; Singleton were unable to provide data for the first time in January 2019, and this continues. Morriston has reported retrospective data for Sept 18-March 19. The data is limited, compiled from basic analysis of available screen tools, but does meet the dataset request by WG. • The AKI steering group have suggested introducing telephone alerts for patients identified with stage three AKI. This will be reviewed/considered by RADAR group. • A trial of a new NEWS chart has taken place at Singleton and NPT. Early indication show a significant improvement accuracy. Full results will be presented to RADAR group and nation RRAILS steering group, before roll out within the HB. • Replacing all existing defibrillators at Morriston & NPT with newer machines capable of CPR feedback. Singleton to follow later. • No updates received from Unit Medical Directors.
What are the main areas of risk?
• Sepsis forms not currently being entered for Morriston and Singleton – funding ended. • Timeliness of rollout given the operational pressures.
How do we compare with our peers?
• No comparable data available.

CLINICAL CODING

NHS Wales Domain:	**EFFECTIVE CARE:** People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that care successful	**NHS Wales Outcome Statement:**	Interventions to improve my health are based on good quality and timely research and best practice
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Matt John, Interim Chief Information Officer		

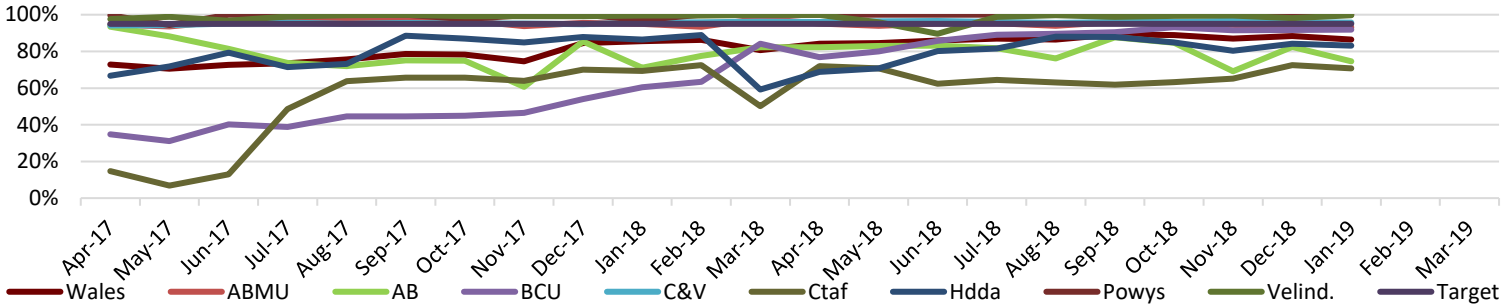
	Annual Plan Profile	WG Target	**Period:** February 2019	
			Current Status *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % episodes clinically coded within one month post episode end date	96%	95%	✓	↓

(1) % episodes clinically coded within one month post episode end date



Benchmarking

(5) % episodes clinically coded within one month post episode end date



Source: NWIS Clinical Coding Extract March 2019

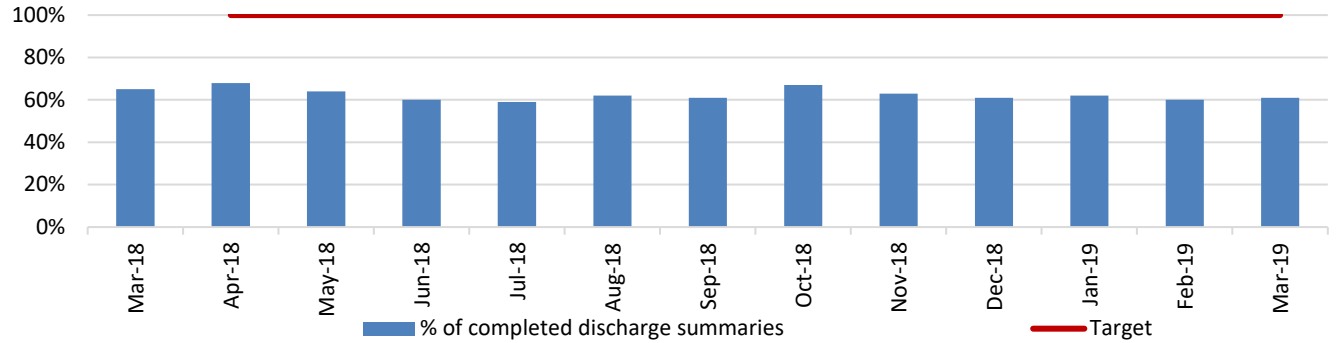
Measure 1: % episodes clinically coded within one month post episode end date
How are we doing?
• The completeness within 30 days for 2018/19 (snapshot positon) was, April 94%, May 93%, June 94%, July 95%, August 92%, September 92%, October 95%, November 88%, December 91%, January 93% and February 95%. • The department has achieved overall cumulative coding completeness for 2018/2019 as follows: April - 99%, May 99%, June 98%, July 97%, August 97%, September 98%, October 98%, 98% for November, December 96% and January 96%. • For February the 95% clinical coding completeness target was reached 'in month' with the additional support of the coding management team and overtime. • The overall cumulative coding completeness for 2018/2019 continues to improve due to the sustained effort of the health records and coding teams to increase completeness.
What actions are we taking?
• Review of roles and responsibilities in the department to ensure that processes are performing at optimum levels. • Continued training of the 6.5 WTE permanent staff which will address the completeness in month once staff are trained and competent. • Overtime undertaken by staff who have completed their training in specific specialties to support the experienced coder's also undertaking overtime to support the overall performance and effectiveness of the clinical coding service. • Detailed audit and improvement plans being proactively managed. • A Swansea Bay UHB capacity and demand analysis being completed to understand the needs of the service in 2019/20 and beyond • Completion of the Welsh Audit Office (WAO) 2018 Clinical Coding Review action plan
What are the main areas of risk?
• Maintaining the productivity levels in 2018/19 whilst the trainee Coders are still training and the contract coders are no longer employed and the availability of the Health Records in a timely manner.
How do we compare with our peers?
• The indicator above is now showing performance against the new target introduced for 2016/17 - 95% complete within 30 days (shown as a snapshot). ABMU is one of the top performing Health Boards. Currently Welsh Government cannot identify the date coded field in the APC extract and therefore the national coding extract is taken 2 weeks after the Health Board position is captured, therefore improving the completion compliance. As a result national reporting of ABMU compliance is higher than that reported internally. ABMU records and monitors the target correctly. NWIS are reviewing the APC extract to address this discrepancy.

DISCHARGE SUMMARIES

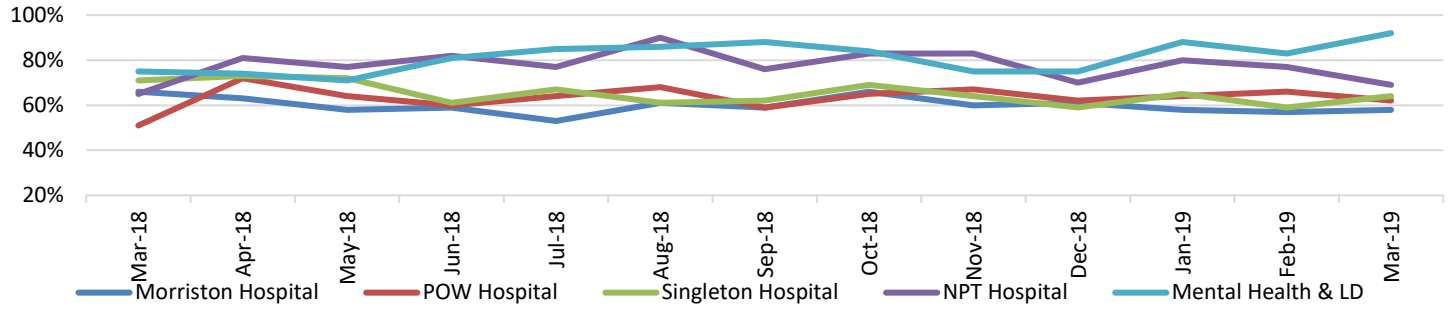
NHS Wales Domain:	**EFFECTIVE CARE:** People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that care successful	**NHS Wales Outcome Statement:**	Interventions to improve my health are based on good quality and timely research and best practice
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Quality & Safety and Patient Experience: Quality and Safety and Patient Experience
Executive Lead:	Richard Evans, Executive Medical Director		

	Annual Plan Profile	**Local Target**	**Period:** March 2019	
			Current Status *(against Target):*	**Movement:** *(12 month trend)*
Measure 1: % of completed discharge summaries	N/A	100%	✕	↓ ●

(1) % of completed discharge summaries



(6) % of completed discharge summaries (by Service Delivery Unit)



Source: ETOC Dashboard

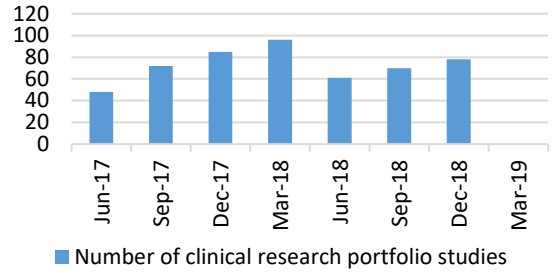
Measure 1: % of completed discharge summaries
How are we doing?
• Performance has been consistent over the last 12 months, with the majority of discharge notifications being completed • The overall Health Board performance in March 2019 was 61%, an improvement of only 1% from the previous month and a fall from the 65% achieved for the same period in 2018. • Performance at Neath Port Talbot has declined over the past two months, dropping from 80% to 69%. • Compliance at Morriston, where most discharges occur, was 58% and has not been higher than 60% since October 2018. • Princess of Wales Hospital (POWH) dropped from 66% to 62%. • At 64%, there was a slight improvement at Singleton from the previous month. • Mental Health and Learning Disabilities improved from 83% to 92%.
What actions are we taking?
• The Executive Medical Director (MD) has asked a Deputy Medical director to oversee a relaunch of the programme of work to improve Electronic Transfer of Notification (ETOC) performance • A plan is to be developed that will provide a trajectory for improvement. • The LMC Chair is involved in discussions regarding the problems caused by incomplete or late ETOCs • Unit Medical Directors (UMDs) are being asked to consider how, and by whom, discharge summaries are completed and to invite members of the clinical teams other than doctors to contribute to them to ensure the highest quality and timely summary gets to the patient's GP. Clinical Nurse Specialists (CNS) are completing eToCs to a high standard in many specialties. • E-Discharge - this is on the Work Programme for Morriston's Clinical Cabinet and Quality & Safety Meetings. It is hoped that the MTeD functionality due to be rolled out from Welsh Clinical Portal will support E-Discharges for Medicine. • The Executive MD and the relevant UMDs met with Trauma & Orthopeadics Leads at Morriston and POWH to emphasise the need to prioritise discharge summaries. • Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician's Associate role could improve communication • The primary measure used in Princess of Wales Hospital is % discharge summaries completed within 24hrs of discharge. There have been notable improvements on individual wards. • MH&LD report that they have identified areas that have not been trained in completing eTOCs and are arranging training. The areas where there is little medical cover to complete will receive training allowing ward managers to complete. The Business and Performance Manager now regularly checks compliance and chases up inpatient areas as required. Oversight of the process and action plan is provided by the UMD and Service Director.
What are the main areas of risk?
• Risk to patient care and the need for readmission. • The General Medical Practitioner Indemnity Scheme, starting 1st April 2019, which will make the health board the defendant in all GP negligence cases, will provide a sharp focus on the quality and quantity of information that is being shared with GP colleagues and their teams.
How do we compare with our peers?
• ABMU is the only health board to publish its performance

RESEARCH

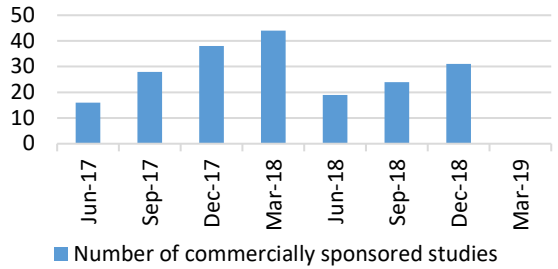
NHS Wales Domain:	**EFFECTIVE CARE:** People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that care successful	**NHS Wales Outcome Statement:**	Interventions to improve my health are based on good quality and timely research and best practice
Health Board Strategic Aim:	Excellent patient outcomes, experience & access	**Health Board Enabling Objective:**	Outstanding research innovation, education and learning
Executive Lead:	Richard Evans, Executive Medical Director		

	Annual Plan Profile	WG Target	**Period:** December 2018	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Number of Health and Care Research Wales clinical research portfolio studies	79	10% Improvement	✗	↓
Number of Health and Care Research Wales commercially sponsored studies.	35	10% Improvement	✗	↓
Number of patients recruited in Health & Care Research Wales clinical research portfolio studies	1,821	5% Improvement	✗	↓
Number of patients recruited in Health & Care Research Wales commercially sponsored studies	316	5% Improvement	✗	↓

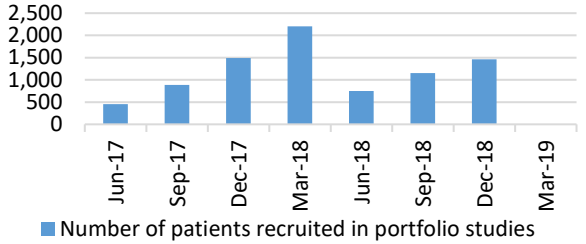
Number of Health and Care Research Wales clinical research portfolio studies



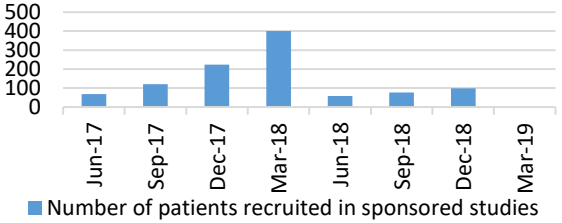
Number of Health and Care Research Wales commercially sponsored studies.



Number of patients recruited in Health & Care Research Wales clinical research portfolio studies



Number of patients recruited in Health & Care Research Wales commercially sponsored studies.



Benchmarking

LHB	Q2 18-19			
	Measure 1	Measure 2	Measure 3	Measure 4
Wales	288	77	10,313	486
ABM	67	22	1,116	59
AB	57	7	970	60
BCU	57	10	736	150
C&V	136	38	3,116	167
Ctaf	44	3	2,156	7
HDda	40	3	548	21
Powys	4	0	18	0
PHW	3	0	1,474	0
Velindre	35	6	161	22
WAST	2	0	18	0

Note: As some studies are operating across multiple HBs, the All Wales figure represents the number of unique studies as opposed to the sum of the HB and Trusts.

Source : NHS Outcomes Framework, All Wales performance summary (March 2019)

Number of Health and Care Research Wales clinical research portfolio studies.
Number of Health and Care Research Wales commercially sponsored studies.
Number of patients recruited in Health and Care Research Wales clinical research portfolio studies.
Number of patients recruited in Health and Care Research Wales commercially sponsored studies.

How are we doing?

- For measures 1 & 3, we have 78 studies open & recruiting and 1,463 patients recruited into portfolio studies – this is 73% and 59% of respective targets achieved. We need to ensure this trend is maintained during the year for the portfolio study targets to be comfortably achieved.
- For measures 2 & 4, relating to number of commercial studies and the number of patients recruited into commercially sponsored studies, we have 31 studies open and recruiting and 99 patients recruited. Therefore, we are at 67% and 24% of target achieved for measures 2 & 4 respectively.
- The impact of Brexit cannot be ignored as we have seen global pharma choosing not to be place studies in the UK due to the potential pending regulatory system differences however we will continue to use our strengths as UK preferred site and centre of excellence status (JCRF) to continue to open new commercial studies and recruit patients accordingly. The enthusiasm and time commitment of local clinicians to work with pharma will be essential to enable an upward trend.
- To note, the Welsh Government metrics for Health & Care Research are in the process of changing and the funding formula is also currently undergoing review and revision.

What actions are we taking?

- Engagement in expressions of interest process led by Health and care Research Wales to identify new portfolio and commercial studies.
- Ensure efficient response times during feasibility and set up to attract Sponsors.
- Effective deployment of research delivery staff to ensure recruitment strategies are maximised.

What are the main areas of risk?

- Impact of UK losing studies in globally competitive environment.
- Slow responses – time for clinicians to respond to expressions of interest and feasibility.
- There is a general decline in R&D activity, especially commercial, in the UK and this may reflect uncertainties around Brexit. One of the few EU institutions to leave the UK immediately was the Medicines and Healthcare products Regulatory Agency (MHRA) which has moved from London to Amsterdam.

How do we compare with our peers?

- For Q2 18-19 data we are second best performing Health Board (HB) for measures 1 & 2 behind C&V.
- Measure 3 is our area for improvement as we are 4th behind C&V, Cwm Taf and PHW for non-commercial recruits (however the high number of recruits in these HBs is likely to be attributed to a particular large scale sample study).
- We are 3rd in Wales for recruiting patients into commercial studies behind C&V and Betsi.

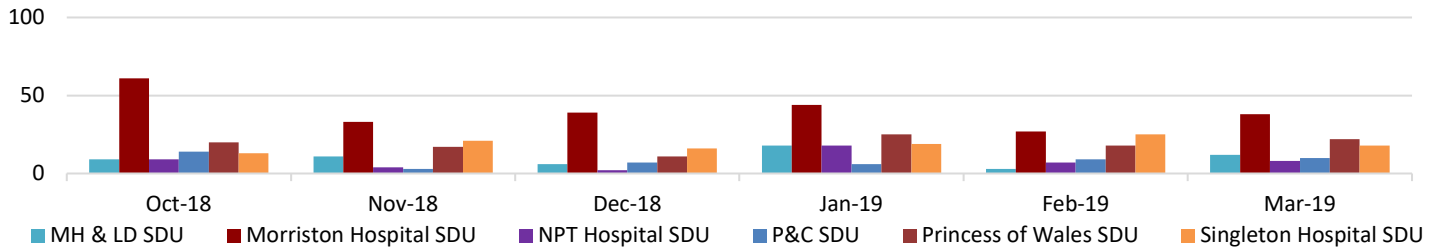
We are not yet in receipt of benchmarking data for Q3.

10.4 Dignified Care

COMPLAINTS			
NHS Wales Domain:	**DIGNIFIED CARE:** People in Wales are treated with dignity and respect and treat others the same	**NHS Wales Outcome Statement:**	My voice is heard and listened to
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		**Period:** March 2019

	Annual Plan Profile	WG Target	Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: Number of new formal complaints received	Reduce	N/A	✗	↑
Measure 2: % of responses sent within 30 working days	80%	80%	✓	↑
Measure 3: % of acknowledgements sent within 2 working days	100%	N/A	✓	→

(1) Number of new formal complaints received



(2) % of responses sent within 30 working days

	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
MH & LD SDU	50%	33%	71%	100%	100%	83%	100%	100%	83%	91%	50%	88%	67%
Morriston Hospital SDU	58%	76%	93%	83%	90%	87%	84%	92%	95%	100%	89%	98%	92%
NPT Hospital SDU	100%	67%	100%	100%	100%	88%	75%	83%	44%	100%	100%	63%	86%
Princess of Wales SDU	60%	74%	75%	90%	64%	90%	88%	83%	100%	82%	70%	83%	94%
P&C SDU	88%	67%	57%	63%	63%	55%	38%	76%	79%	50%	88%	50%	55%
Singleton Hospital SDU	53%	64%	60%	65%	88%	83%	94%	63%	100%	86%	67%	89%	75%
Health Board Total	61%	71%	80%	83%	80%	81%	81%	83%	88%	90%	80%	84%	83%

(3) % of acknowledgements sent within 2 working days

Percentage Acknowledgements Sent ≤ 2 Working Days	2018										2019		
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source : NHS Wales Delivery Framework, all-Wales performance summary (March 2019)

Measure 1: Number of new formal complaints received
Measure 2: % of responses sent within 30 working days
Measure 3: % of acknowledgements sent within 2 working days

How are we doing?

- The Health Board received 92 formal complaints in February 2019, this is a decrease of 7 formal complaints compared to 84 for February 2018.
- The overall Health Board response rate for responding to concerns within 30 working days was 83% for February 2019, which is above the Welsh Government target of 80%.
- The Health Board continues to consistently maintain the 2 day acknowledgement target at 100%.
- Patient Advice Liaison Service (PALS) activity for February 2019, identified 257 contacts of which 1.2% (3) converted to formalised complaints.

What actions are we taking?

- Performance of the 30 day response target is addressed consistently at all Service Delivery Unit (SDU) performance reviews. February performance for the Health Board was 83%
- Service Delivery Unit's (SDU) identify trends and themes from their formal complaints for discussion at each local Quality and Safety meeting and formal reporting through the Health Boards' Assurance and Learning Group where themes, trends and Health Board actions can be identified and shared for learning. A recurring theme in complaints received continues to be communication and delay in receiving appointments. A training programme for communication for all staff grades continues in all SDU's by the Patient Experience Training officer, with further SDU discussions during attendance at Concerns and Redress Group (CRAG)
- Currently there are 41 open Ombudsman investigation cases; Morriston 17, Princess of Wales 7, Singleton 7, Mental Health & Learning Disabilities 2, NPT 1 and ; Primary Care and Community Service 7. Recurring themes from the Ombudsman investigations are discharge process, communication, and poor complaint handling. The Corporate Concerns function has recently embarked on a re-structure. One of the aims of the re structure is to support improvement in the Units and ensure consistency across all of the SDU's in terms of the way the Health Board investigates and responds to complaints. In addition, the Health Board continues to liaise closely with the Ombudsman Improvement Officer and the Community Health Council to discuss on-going investigations. Trends and themes deriving from these interactions will be developed into training and awareness sessions to improve across the Health Board. A new 2019/2020 work plan for Ombudsman referrals has been developed which will be implemented by the newly appointed Ombudsman's Referrals Manager and overseen by the Assistant Head for Concerns Assurance. A key focus on the annual plan will be to demonstrate better learning from the process to help improve future concerns processes.

What are the main areas of risk?

- Improve Quality of Complaint responses while achieving the 30 day response rate target, and decrease the number of complaints referred to and upheld by the Public Service Ombudsman.

How do we compare with our peers?

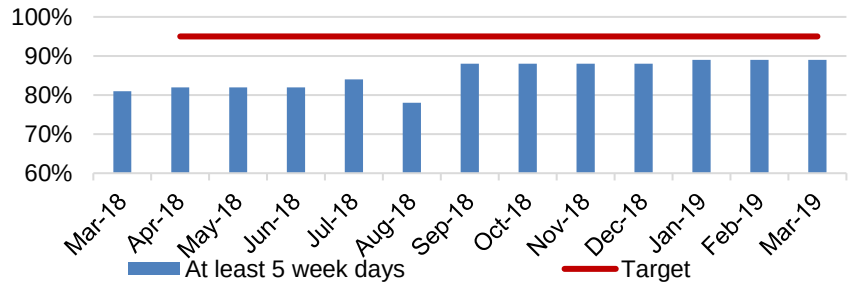
- No monthly all-Wales data to compare.

10.5 Timely Care

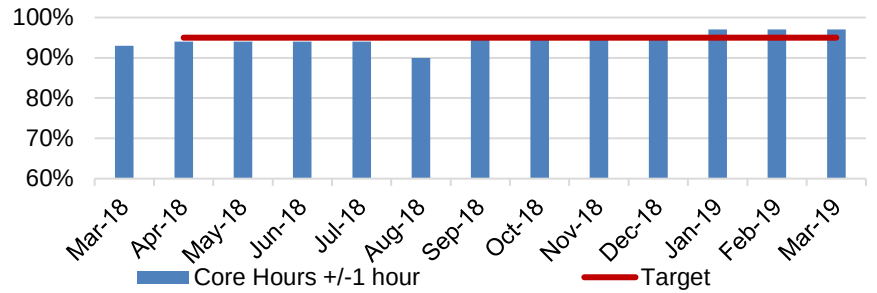
ACCESS TO GENERAL MEDICAL SERVICES (GP ACCESS)			
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	I have easy and timely access to primary care services
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Primary & Community Care
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: % GP practices offering appointments between 17:00 & 18:30 at least 5 week days	95%	95%	✗	↑
Measure 2: % GP practices open during the daily core hours or within 1 hour of daily core hours	95%	95%	✓	↑

(1) % GP practices offering appointments between 17:00 & 18:30 at least 5 week days



(2) % GP practices open during the daily core hours or within 1 hour of daily core hours



Benchmarking

(1) % GP practices offering appointments between 17:00 & 18:30 at least 5 week days

LHB	5 days a week							
	Current	Previous						
	2017	2016		2015		2014		
Wales	84%	⇧	84%	⇧	79%	⇧	79%	
ABM	78%	⇩	79%	⇨	78%	⇧	69%	
AB	97%	⇩	99%	⇧	95%	⇧	93%	
BCU	69%	⇨	69%	⇧	55%	⇧	63%	
C&V	92%	⇨	92%	⇩	94%	⇩	94%	
CTaf	95%	⇩	95%	⇧	93%	⇧	93%	
HDda	80%	⇧	75%	⇧	65%	⇧	65%	
Powys	100%	⇨	100%	⇧	94%	⇧	94%	

(2) % GP practices open during the daily core hours or within 1 hour of daily core hours

LHB	core hours or within 1 hour							
	Current	Previous						
	2017	2016		2015		2014		
Wales	87%	⇧	85%	⇧	82%	⇧	80%	
ABM	90%	⇧	85%	⇧	85%	⇧	73%	
AB	99%	⇩	99%	⇧	93%	⇧	92%	
BCU	78%	⇧	74%	⇧	73%	⇧	73%	
C&V	88%	⇨	88%	⇧	83%	⇧	83%	
CTaf	90%	⇩	90%	⇩	93%	⇩	93%	
HDda	73%	⇩	74%	⇧	65%	⇧	67%	
Powys	100%	⇨	100%	⇨	100%	⇨	100%	

Source : NHS Wales Delivery Framework, all-Wales performance summary (March 2019)

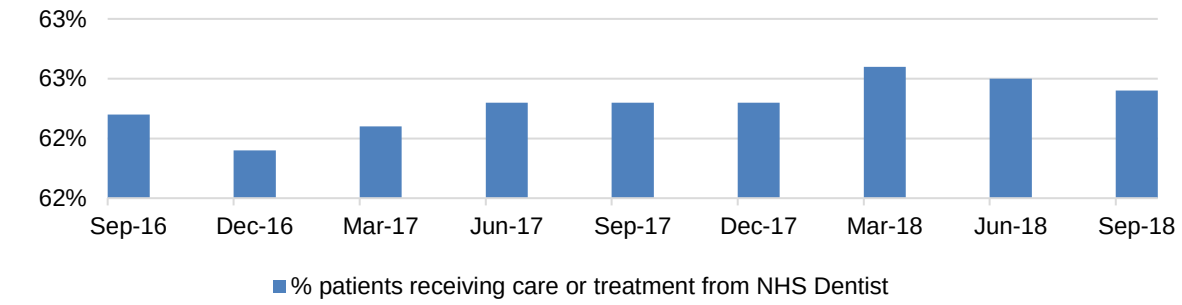
Measure 1: % GP practices offering appointments between 17:00 & 18:30 at least 5 week days Measure 2: % GP practices open during the daily core hours or within 1 hour of daily core hours
How are we doing?
• As at March 2019 58/65 (89%) practices are offering appointments between 17.00 and 18.30 at least 5 nights per week. This is an improved position. 63 out of 65 (97%) practices are now open during daily core hours or within 1 hour of daily core hours. This now meets the Welsh Government target and is an improved position.
What actions are we taking?
• Following the recent announcement by the Minister for Health and Social Care Services, undertake a review to assess the impact on Health Board minimum standards which will be revised during the first six months of this year. • Implement routine monitoring of standards/targets in line with the agreed access action plan. • Through the use of the discretionary framework to merge and monitor sustainability scores provide support to assess assurance of reasonable access to more sustainable General Medical Services, • Formally writing to the practices still not meeting the level 1 standards as agreed with the local medical committee. Discussing access with practices as part of the GMS governance arrangements. • Focus on the introduction of the new model of primary care and promote a range of wellbeing services which will support clusters to discuss access and sustainability as part of their cluster development plans. • Devising and implementing a telephone first self-assessment tool.
What are the main areas of risk?
• Sustainability of general practice will result in poorer access if practices fail or take action to reduce access whilst still being compliant with their contractual requirements. • Sustainability issues attributed to lack of ability to recruit, retain and poor locum availability.
How do we compare with our peers?
• The Access returns were submitted to Welsh Government across Wales in January 2019. • The statistical bulletin will provide an updated all Wales picture to benchmark against. The bulletin was issued on the 27th March 2019 and is currently being analysed.

ACCESS TO GENERAL DENTAL SERVICES (DENTAL ACCESS)

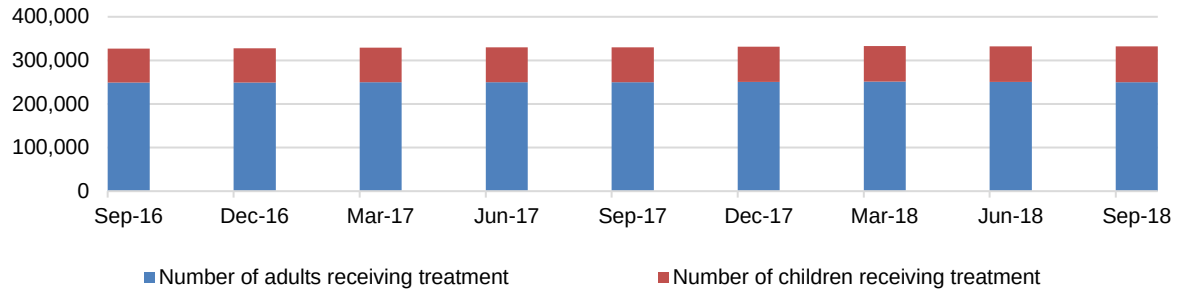
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	I have easy and timely access to primary care services
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Primary & Community Care
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** September 2018 Current Status *(against Target):*	Movement: *(12 month trend)*
Measure 1: % Patients who received care or treatment from an NHS dentist at least once in the most recent 24 months as a % of the population	N/A	Improve	✓	↑ ●

(1) % Patients who received care or treatment from an NHS dentist at least once in the most recent 24 months as a % of the population



Number of Patients receiving NHS treatment



Benchmarking

LHB	Current	Same Period Comparison		
	Sep-18	Sep-17	Sep-16	Sep-15
Wales	55.0%	⇧ 54.9%	⇧ 54.8%	⇧ 54.8%
ABM	62.4%	⇧ 62.3%	⇧ 62.2%	⇩ 62.5%
AB	57.8%	⇧ 57.0%	⇧ 56.7%	⇧ 56.7%
BCU	49.2%	⇩ 49.5%	⇩ 49.8%	⇩ 50.1%
C&V	55.9%	⇩ 56.1%	⇩ 56.0%	⇧ 55.5%
CTaf	60.0%	⇧ 58.8%	⇧ 57.4%	⇧ 57.2%
HDda	45.5%	⇩ 46.0%	⇩ 46.0%	⇧ 45.2%
Powys	56.2%	⇩ 57.0%	⇩ 58.0%	⇩ 60.3%

Source: Stats Wales, Dental Services, NHS Business Services Authority

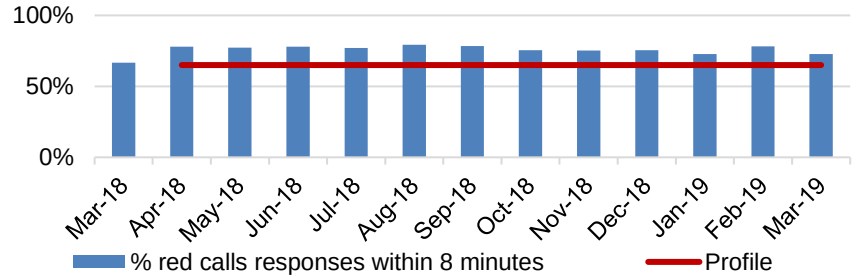
Measure 1: % Patients who received care or treatment from an NHS dentist at least once in the most recent 24 months as a % of the population
How are we doing?
• NHSBSA September 2018 data confirms a steady (+) 0.2% increase in the total number of patients (adults and children) who received NHS dental treatment in ABMU in comparison to 2017 data. Between April and September' 18, 1,996,007 patients were seen under GDS contracts. • Demand on the urgent dental care services continued to remain high throughout 2018: usage of dental OOH increased by +.5 % in Apr.- September 2018 compared to the same period in 2017/18 and +1% in usage of In Hours Urgent Access. • In September 18- 8 dental practices were included on the GDS Reform Programme (10% of practices across the Health Board area including Bridgend) meeting the national target set by Welsh Government.
What actions are we taking?
• Signposting/encouraging patients to use mainstream dental service rather than making unnecessary use of the urgent care services to ensure the latter can focus on those who need it • Providing additional in-hours access sessions through the Educational Supervisors at the Dental Teaching Unit (DTU), maintaining clinical skills and increasing access to NHS dental care. Exploring possibilities to extend services at DTU utilising skills of ES trainers i.e. sedation/complex extractions. • Paediatric GA pathway rolled out in January 2018 to include urgent referrals, anticipated further reduction in GAs provided. Initial review has demonstrated a <46% reduction in the number of GA referrals since the pathway commenced in February 2018. • Successfully supported 5/9 contract reform bids awarded additional WG funds to support skill mix in dental practice (170k). Further roll out of programme due October 2019. • Review of GDS/CDS domiciliary services completed (Dec 2018). New integrated model/service spec being developed for housebound patients to receive timely access to oral health care treatment. • New pathway being developed to ensure Syrian refuges have timely access to routine and urgent care. Service to be in place by June 2019. • From April 2019- 13 practices are included on the GDS reform practice (22%) which is higher than the national expectation of 20% of practices.
What are the main areas of risk?
• Delay in implementation of integrated domiciliary service (Band 7 post currently vacant) • Limited interest from GDPs in Swansea city area to provide Syrian refugee pathway
How do we compare with our peers?
• ABMU continue to have highest access levels to GDS across Wales [62.4%] compared to Welsh average [55%] • ABMU early adopter of national dental e-referral system which will improve quality/processing of GDP referrals/collation of referral data /waiting times/outcomes. SBU HB is 1 of only 2 Health Boards in Wales currently using the new electronic system.

AMBULANCE RESPONSE TIMES AND HANDOVERS

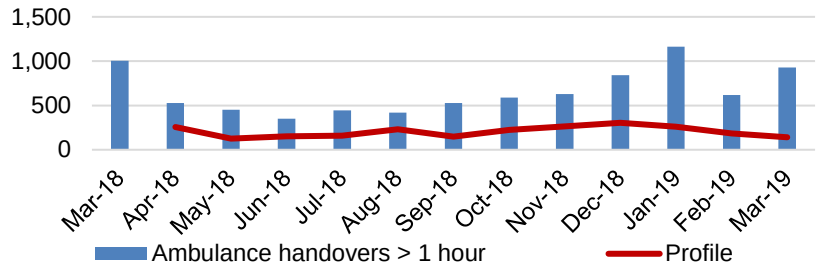
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Unscheduled Care & Stroke
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: % of emergency responses to red calls arriving within (up to and including) 8 minutes	65%	65%	✓	→
Measure 2: Number of patients waiting more than 1 hour for an ambulance handover	139	0	✗	↑

(1) % of emergency responses to red calls arriving within (up to and including) 8 minutes

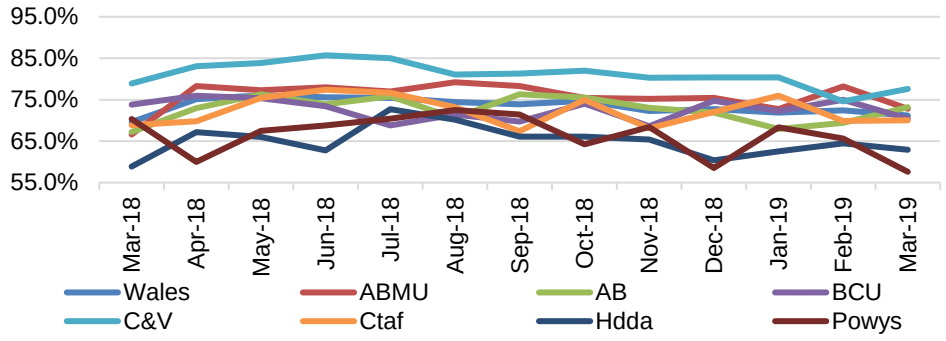


(2) Number of patients waiting more than 1 hour for an ambulance handover

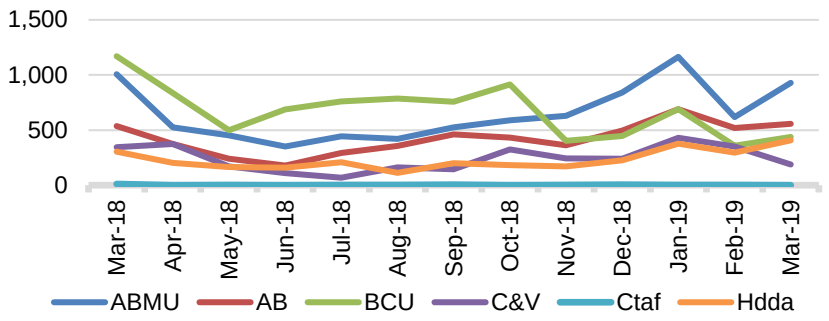


Benchmarking

(1) % of emergency responses to red calls arriving within (up to and including) 8 minutes



(2) Number of patients waiting more than 1 hour for an ambulance handover



Source : StatsWales (data extracted 14.05.2019)

Measure 1: % of emergency responses to red calls arriving within (up to and including) 8 minutes
Measure 2: Number of patients waiting more than 1 hour for an ambulance handover

How are we doing?

- The Health Board's Category A (Red response) was 72.8% in March 2019, which exceeded the National shared target of 65%. When compared with March 2018, performance against this measure improved by 6.2%.
- 1 hour ambulance handover performance remained challenging during Quarter 4. However the number of reported delays reduced from 1159 in January 2019 to 928 in March 2019. When compared with March 2018, the number of >1 hour handover delays also reduced by 73 (7.2%)
- 35 fewer patients were conveyed to our hospital front doors by ambulance in Quarter 4 of 2019 compared with Quarter 4 of 2018.

What actions are we taking?

- A falls response service was commissioned by WAST over the winter months to improve response times for this group of patients who are predominantly elderly and to reduce the number of patients who need to be conveyed to hospital as a result of the intervention of this service. As a result of the success of this service it has been agreed to continue it in 2019.
- Working with WAST to direct patients to appropriate services or pathways, ensuring emergency ambulance capacity is utilised appropriately.
- Implementing the recommendations of the WAST internal audit report on hospital handover that are applicable to Swansea Bay UHB.
- Working with the National Collaborative Commissioning Unit (NCCU) to target a reduction in the longer ambulance handover delays at Morriston which have a disproportionate impact on ambulance lost hours.
- Singleton hospital to continue to support Morriston through the downgraded 999 and treat and transfer protocols to redirect appropriate demand.

What are the main areas of risk?

- Ambulance resourcing to respond to demand within the 8 minute response time.
- Hospital and social care system wide patient flow and discharge constraints which impact upon the Emergency Department's ability to receive timely handover. This can result in increased risk to patients in the community and at hospital if there are prolonged ambulance handover times

How do we compare with our peers?

- The Health Board delivered the 3rd highest Category A response time performance in Wales in March, achieving 72.8%, which was above the All Wales performance of 71.2%.
- The Health Board continues to experience a higher number of delayed handover than the majority of other Health Boards in Wales accounting for 36% of delays in March 2019.

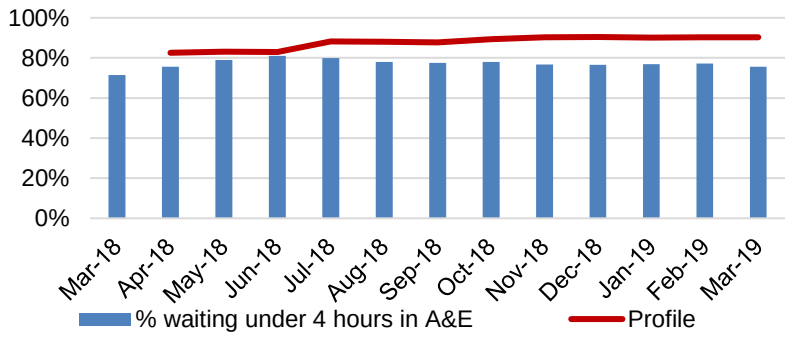
A&E WAITING TIMES

NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Unscheduled Care & Stroke
Executive Lead:	Chris White, Chief Operating Officer		

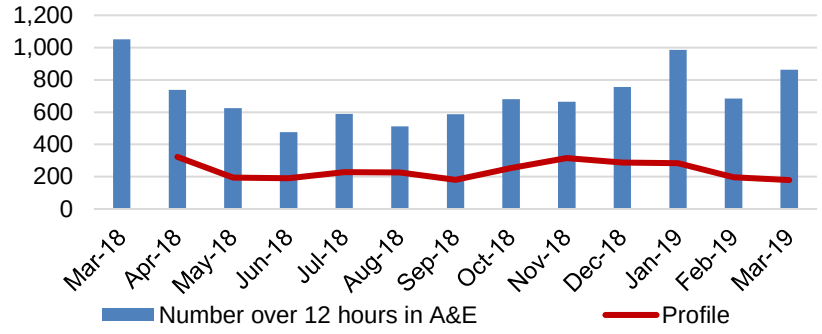
Period: March 2019

	Annual Plan Profile	WG Target	Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: % new patients spending no longer than 4 hours in an Emergency Department	90%	95%	✗	↑ ●
Measure 2: Number of patients spending more than or equal to 12 hours in A&E	179	0	✗	↓ ●

(7) % new patients spending no longer than 4 hours in an Emergency Department

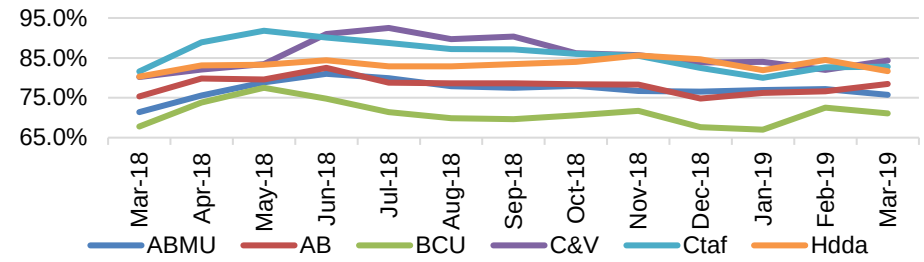


(2) Number of patients spending more than or equal to 12 hours in A&E

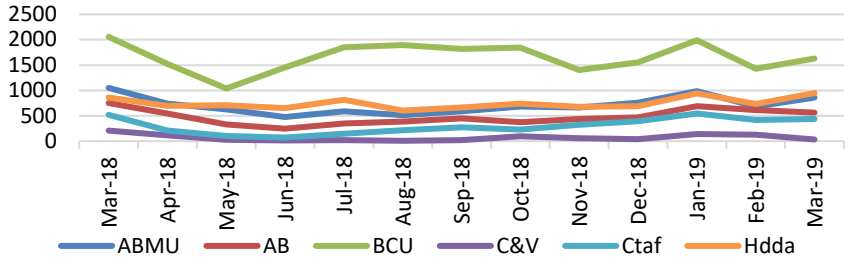


Benchmarking

(1) % new patients spending no longer than 4 hours in an Emergency Department



(2) Number of patients spending more than or equal to 12 hours in A&E



Source : Stats Wales (data extracted 17.04.2019)

Measure 1: % new patients spending no longer than 4 hours in an Emergency Department
Measure 2: Number of patients spending more than or equal to 12 hours in A&E

How are we doing?

- Unscheduled care performance against the 4 hour target in March 2019 was 75.81%, against the all-Wales performance of 78.7%.
- In March 2019, 94.4% of patients were admitted, discharged or transferred from our Emergency Departments within 12 hours. 862 patients stayed longer than 12 hours in our Emergency Departments (ED's) during March 2019, which represents a reduction of 18% (189 patients) when compared with March 2018.
- The overall number of patients attending the Emergency departments and minor injuries units in March 2019 increased by 360 attendances or 2.4% compared with March 2018. March experienced some of the highest daily attendances for the whole of the 2018/19 winter.

What actions are we taking?

- Between April and June 2019 we are:
- Implementing our Unscheduled care improvement plans agreed as part of our annual plan for 2019/20, and embedding the improvement actions from previous quarters.
- Inpatient surge bed capacity is being sustained into April on all of our major hospital sites.
- Evaluating the impact of the winter pressures funding on patient flow and performance.
- Planning for the 3 bank holiday weekends to ensure the Unscheduled care system is as resilient as possible.
- Continuing to recruit to staff vacancies.
- Considering and responding to the Kendall Bluck report recommendations on ED/MIU staffing.
- Focussing on eliminating un-necessary patient delays as part of improving patient flow.
- Implementing the recommendations of the vascular, neck of femur and assessment unit improvement programmes at Morriston hospital.
- Commencing a review of progress against the ambulatory emergency care service recommendations in conjunction with the Delivery Unit at the end of April.

What are the main areas of risk?

- Capacity gaps in Care Homes, Community Resource Teams and capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit'.
- Workforce - with ongoing challenges in general nursing and medical roles in some key specialities and service areas such as the Emergency Department.
- Peaks in demand/patient acuity above predicted levels of activity.
- The impact of infection on available capacity and patient flow.

How do we compare with our peers?

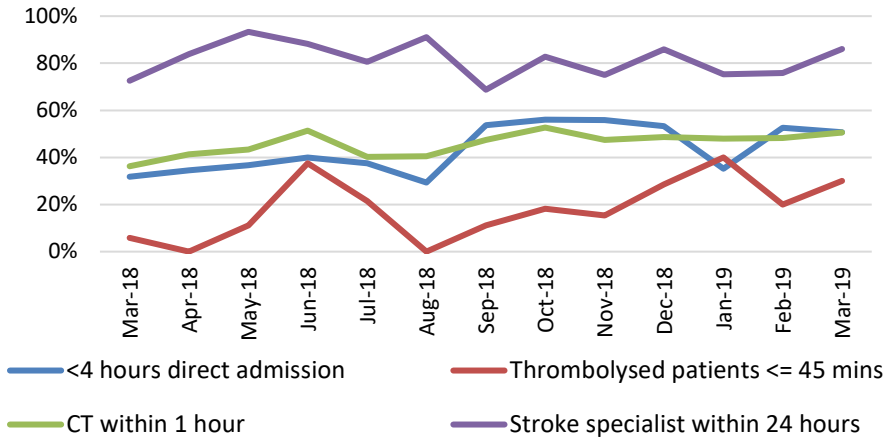
- The Health Board's 4 hour performance was 75.81% in March 2019, which was below the all-Wales 4 hour performance of 78.7% for this period.
- In ABMU Health Board in March 2019, 94.6% of all patients were assessed, treated and transferred from the Emergency Department within 12 hours, which was just below the All Wales position of 95%.

STROKE

NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours	65%	60.2%	✗	↑ ●
Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes	40%	12 ↑ trend	✗	↑ ●
Measure 3: % of patients who receive a CT scan within 1 hour	50%	54.3%	✓	↑ ●
Measure 4: % of patients who are assessed by a stroke specialist consultant physician within 24 hours	85%	84.2%	✓	↓ ●

Acute Stroke Quality Improvement Measures



Benchmarking

Thrombolysis Quality Improvement Measures (Mar-19)	AB	ABM	BCU	C&V	Cwm Taf	Hywel Dda
1a - Percentage of All Strokes Thrombolsyed - H16.3	17.7%	25.3%	14.3%	11.5%	11.8%	13.8%
2b - Percentage of Eligible Patients Thrombolsyed - H16.55	100.0%	100.0%	100.0%	71.4%	100.0%	100.0%
1a - Thrombolysed Patients with Door-to-Needle <= 30 mins	28.6%	0.0%	10.0%	0.0%	12.5%	9.1%
2b - Thrombolysed Patients with Door-to-Needle <= 45 mins	71.4%	20.0%	30.0%	0.0%	37.5%	45.5%
3c - Thrombolysed Patients with Onset to-Needle <= 90 mins	0.0%	0.0%	10.0%	0.0%	0.0%	18.2%
4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score	100.0%	93.3%	100.0%	80.0%	100.0%	100.0%
72 Hour Pathway Quality Improvement Measures (Mar-19)	**AB**	**ABM**	**BCU**	**C&V**	**Cwm Taf**	**Hywel Dda**
1. < 4 Hours Care Performance Indicator	46.8%	50.6%	47.3%	42.3%	45.1%	73.8%
1a - Direct Admission to Acute Stroke Unit - H7.18	52.6%	50.6%	50.0%	53.3%	41.7%	68.5%
1b - Swallow Screening - H14.20	62.7%	83.1%	80.0%	49.0%	78.4%	93.1%
2. < 12 Hours Care Performance Indicator	96.2%	98.7%	97.8%	96.2%	98.0%	100.0%
2a - CT Scan - H6.12	96.2%	98.7%	97.8%	96.2%	98.0%	100.0%
3. < 24 Hours Care Performance Indicator	86.1%	82.3%	76.9%	63.5%	52.9%	89.2%
3a - Assessed by Stroke Consultant - H9.3	96.2%	86.1%	81.3%	73.1%	64.7%	98.5%
3b - Assessed by Stroke Nurse - H8.3	97.5%	97.5%	97.8%	80.8%	88.2%	93.8%
3c - Assessed by One of OT, PT, SALT	88.6%	96.2%	96.7%	86.5%	62.7%	92.3%
4. < 72 Hours Care Performance Indicators	97.5%	97.5%	96.7%	90.4%	94.1%	93.8%
4a - Formal Swallow Assessment - H15.24	100.0%	94.1%	92.0%	81.5%	87.5%	92.6%
4b - OT Assessment - H10.24	98.6%	100.0%	100.0%	93.2%	95.8%	98.1%
4d - SALT Communication Assessment - H12.24	98.6%	98.6%	100.0%	97.7%	95.8%	100.0%
5. < 1 Hour Care Performance Indicator	50.6%	50.6%	40.7%	51.9%	72.5%	84.6%
5a - CT Scan	50.6%	50.6%	40.7%	51.9%	72.5%	84.6%

>= Target | Within 10% below target | More than 10% below taget

Source : All-Wales performance summary (March 2019) & Acute stroke quality improvement measures Delivery Unit report

Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours
Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes
Measure 3: % of patients who receive a CT scan within 1 hour
Measure 4: % of patients who are assessed by a stroke specialist consultant within 24 hours

How are we doing?

- Eligible Patients requiring Thrombolysis has remained positive at 100%, but our door to needle time within 45 minutes remains low. Direct admissions to a stroke unit bed within 4 hours continues to be under target 50.6% which is mainly due to unscheduled care pressures. Assessment by a Consultant has dropped slightly from 93.2% to 86.1%. CT scanning within 12 hours is being maintained within the target (98.7%) – however our access to CT scanning within 1 hour has improved slightly from 47.5% to 50.6% in overall terms is still significantly under target.
- Gaps in overall out of hours medical cover has impacted on our ability to make the desired improvements.

What actions are we taking?

- Weekly multi-disciplinary meetings are held in Morriston and the Clinical leads for the service review individual patient pathways and to identify opportunities for improvement. Actions being progressed in 2019 / 20 include:

Morriston

- The additional medical staffing reported previously has allowed some improvement to service but it cannot be sustained as there are gaps at lower grades which these colleagues have to cover, therefore not allowing them sufficient time to commit to improved stroke performance. The unit makes best endeavours to cover the junior gaps in rota and looks to sustainable recruitment in a difficult to recruit area. This work is led by the Medical Directorate management team.
- Business cases for a Stroke Retrieval team and an Early Supported Discharge team have been included for consideration within the IMTP / IBG for investment.
- A meeting with the Radiology Consultant team and Medical Team is planned to address the access to 1 hour scanning time – with a view to change the current arrangements. Remedial action to be implemented as soon as possible thereafter and ideally by quarter 2.
- Arising from the Delivery Units review of Stroke Thrombolysis – an Action plan has been developed within the Morriston delivery unit and is in place. Cross directorate meetings with the Emergency department leads, Clinical support services leads and Medicine colleagues are taking place to improve various pathways.

ABMU wide

- A Business Case for a “Hyper-acute Stroke Unit” model to be completed by Q3 of 19 / 20.
- A review of TIA service arrangements is planned over the next quarter to address availability/cover arrangements in Neath Port Talbot hospital. Service Directors from NPT and Morriston are leading this work with support from their management and clinical teams – with a view to recommend a way forward by the end of Q2.

What are the main areas of risk?

- Insufficient capacity and workforce resilience to support 7 day working which will ultimately require a strategic change to centralise acute stroke services.
- Not having a dedicated Stroke Consultant out of hours rota
- Unscheduled care pressures and increasing waits for transfers of care affecting stroke care capacity.

How do we compare with our peers?

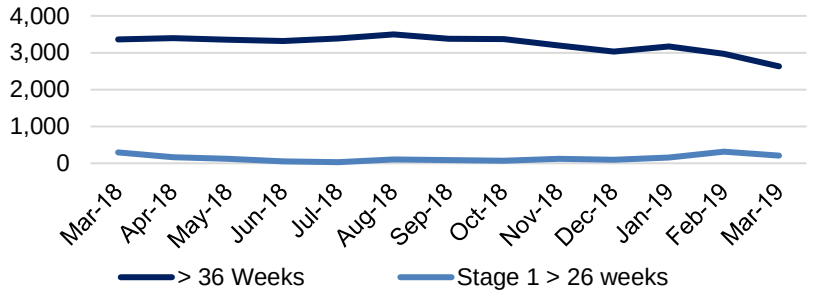
- The Health Board performs well in a number of key performance areas such as Eligible patients being thrombolysed, access to 12 hour CT scanning, access to specialist Nursing/Therapies.
- The Health Board needs to develop dedicated Consultant Stroke out of hours cover and improved ring fenced / dedicated stroke beds in order to deliver further improvements.

REFERRAL TO TREATMENT TIMES (RTT)

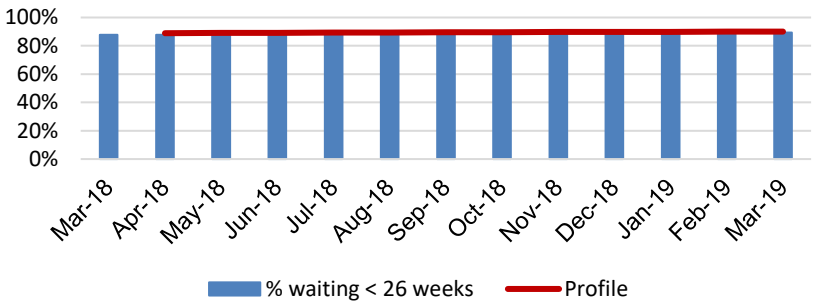
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Planned Care
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: Number of patients waiting more than 36 weeks for referral to treatment (RTT)	2,664	0	✓	↓
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment	0	0	✗	↑
Measure 3: % patients waiting less than 26 weeks for referral to treatment (RTT)	90%	95%	✗	↑

(8) Number of patients waiting more than 36 weeks for referral to treatment, (2) Number of patients waiting more than 26 weeks for first outpatient appointment

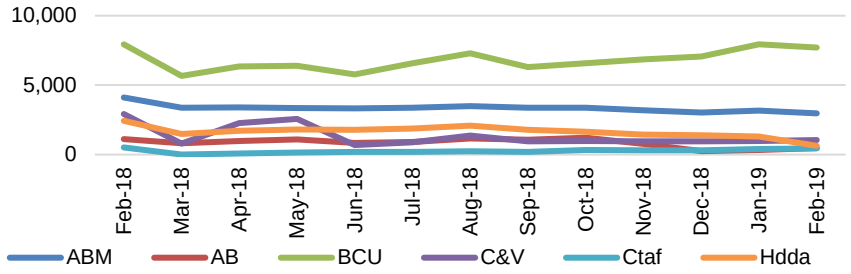


(3) % patients waiting less than 26 weeks for referral to treatment

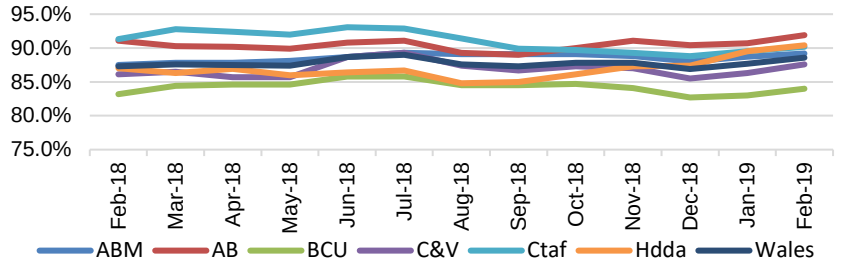


Benchmarking

(1) Number of patients waiting more than 36 weeks for referral to treatment



(3) % patients waiting less than 26 weeks for referral to treatment (RTT)



Source : StatsWales (data extracted 10.05.2019)

Measure 1: Number of patients waiting more than 36 weeks for referral to treatment (RTT)
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment
Measure 3: % patients waiting less than 26 weeks for referral to treatment (RTT)

How are we doing?

- In March 2019 there were 207 patients waiting over 26 weeks for a new outpatient appointment. This was an in-month reduction of 108 compared with February 2019 (315 to 207) and is contained within Oral Maxillo Facial Surgery (OMFS) (68%) and Urology (32%).
- There were 2,630 patients waiting over 36 weeks for treatment in March 2019 compared with 3,363 in March 2018, this is an improvement of 733 and the best position since April 2014. The Health Board achieved and bettered its target of 2,664. There was also an in-month reduction of 339 compared with February 2019. ENT, General Surgery, Plastic Surgery, OMFS and Orthopaedics collectively account for 2,552 of the 2,630 over 36 weeks at March 2019. 98% of the patients waiting over 36 weeks are in the treatment stage of their pathway.
- 1,067 patients are waiting over 52 weeks in March 2019, which is 38% less than in March 2018 and 12% less patients than February 2019.
- The overall Health Board RTT target improved from 87.8% in March 2018 to 89.3% in March 2019.

What actions are we taking?

Following achievement of the 36 week target at the end of March 2019 the focus at the Executive led weekly RTT meetings is now on 2019/20 delivery, with a specific emphasis on maintaining the Quarter 1 profile. A high level summary of these include:-

- Core capacity will continue to be maximised across all specialties.
- Formal contracts have been awarded following an extensive tendering process to enable the outsourcing programme to continue in April
- Where possible, theatre staff are being flexed across sites to close gaps and reduce cancellations of lists through April
- Focussed validation across all specialities to ensure accurate reporting and maximise opportunity consistent with RTT rules
- Lead appointed for the development of a single theatre action plan to address performance and efficiencies with initial focus on improving utilisation for ENT and Orthopaedics at Singleton and NPTH
- Sharing of transferable lessons from the planned care programme work across all specialities at pace to reduce RTT pressures
- Service models for Oral Medicine, Audiology and Nurse Led Gastro as sustainable solutions in plans for 2019/20

What are the main areas of risk?

- Constraints in the case-mix of suitable cases to outsource as the lists become smaller
- Administrative vacancy gaps and sickness impacting on the ability to target robust validation
- Sickness amongst key clinical staff affecting sub-speciality areas and nurse-led clinics
- Staff fatigue to continue to undertake additional clinics and lists
- Theatre nurse staffing pressures affecting cancellations and under-utilised lists
- Demand of cancer and urgent surgical cases utilising planned routine elective capacity and protecting elective bed

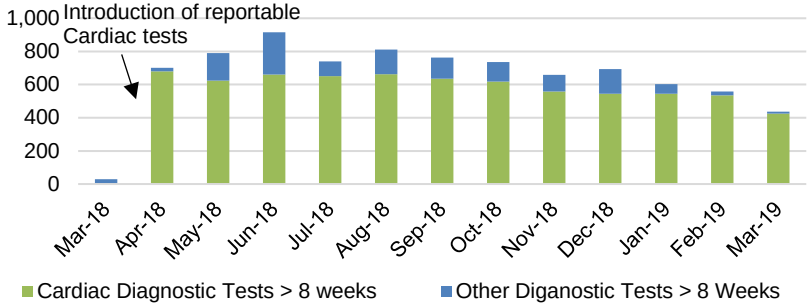
How do we compare with our peers?

- As at the end of February 2019, which is the latest published data available, the Health Board was above the all-Wales position for the percentage of patients waiting less than 26 weeks for referral to treatment (RTT) (89.2% compared with 88.6%) however, was the second worst Health Board in Wales for the number of patients waiting over 36 weeks.

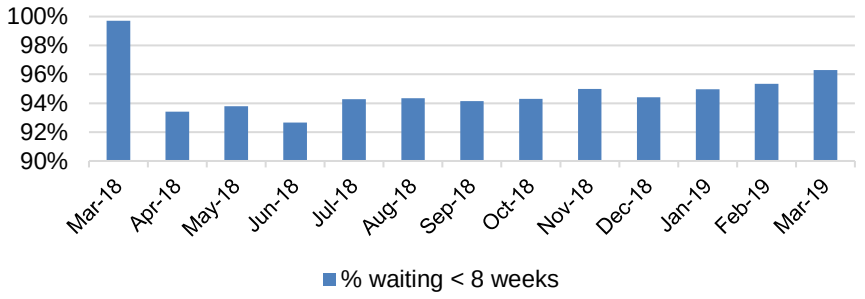
DIAGNOSTIC WAITING TIMES (*EXCLUDING ENDOSCOPY*)			
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Planned Care
Executive Lead:	Chris White, Chief Operating Officer	**Period:** March 2019	

	Annual Plan Profile	WG Target	Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)	450	0	✓	↓ ●
Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)		100%	✗	↓ ●

(1) Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)

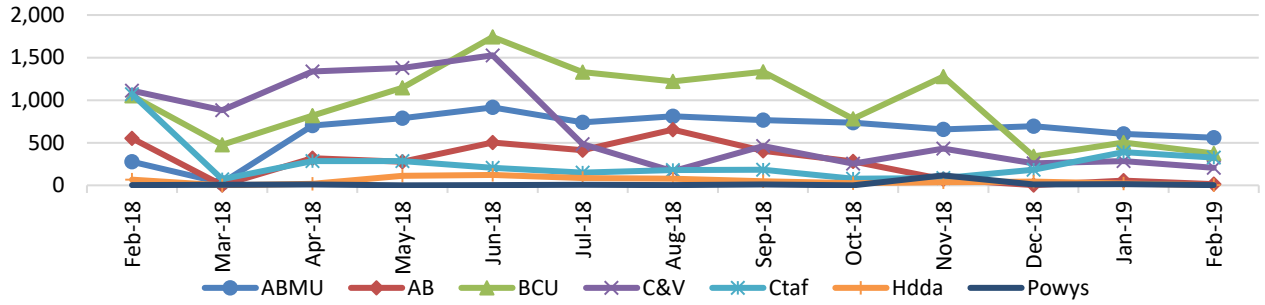


(2) % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)



Benchmarking

(1) Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)



Source : Stats Wales (data extracted 10.05.2019)

Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)
Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)

How are we doing?

- There were 437 patients waiting over 8 weeks for reportable diagnostics as at the end of March 2019, this is a 22% reduction when compared with February 2019 (558 to 437). All of the 437 breaches in March 2019 were for Cardiac Diagnostic Tests:
    - Heart Rhythm Recording= 1
    - Diagnostic Angiography = 3
    - Echo Cardiogram= 8
    - Cardiac Magnetic Resonance Imaging (Cardiac MRI)= 177
    - Cardiac Computed Tomography (Cardiac CT)= 248
- All other diagnostic areas maintained a zero breach position in March 2019.

What actions are we taking?

- Maintain the Nil position for all non-cardiac diagnostics through additional lists and the utilisation of locum support when required to cover unplanned staff absence.
- A refresh of the Cardiac MRI and CT plan is underway which includes a review of the demand & capacity modelling. In addition, a task & finish group has been established which includes representatives from Radiology and the Patient Pathway Team to look at the appropriate management and reporting of the lists for accuracy in line with RTT rules.

What are the main areas of risk?

- Late clinic cancellations due to unforeseen absence of key clinical staff.
- Breakdown of equipment.
- Workforce constraints in key professional groups (nationally and locally).

How do we compare with our peers?

- At the end of February 2019, which is the latest published data available at the time of writing this report, the Health Board was the worst performing Health Board.

ENDOSCOPY

NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
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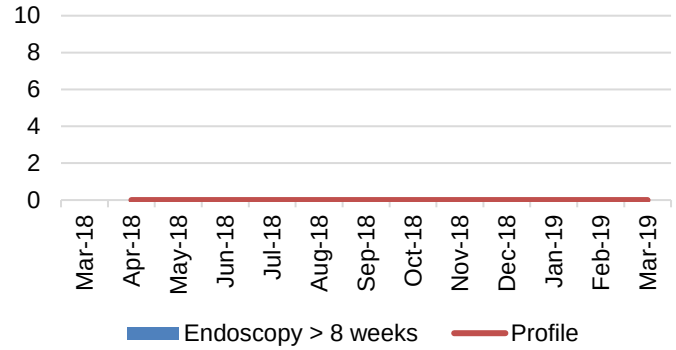
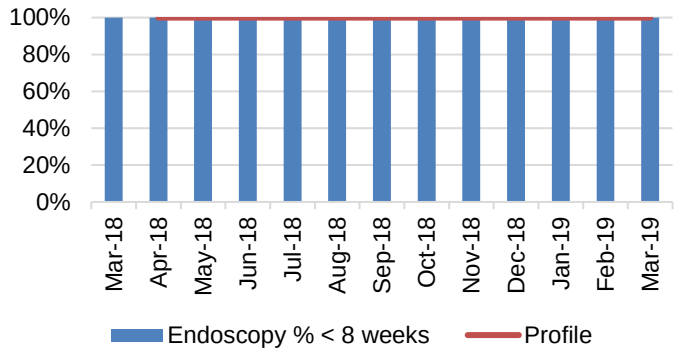
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019 Current Status *(against profile):*	Movement: *(12 month trend)*
Measure 1: Number of patients waiting more than 8 weeks for Endoscopy	0	0	✓	→
Measure 2: % patients waiting less than 8 weeks for Endoscopy	100%	100%	✓	→

(1) Number of patients waiting more than 8 weeks for Endoscopy

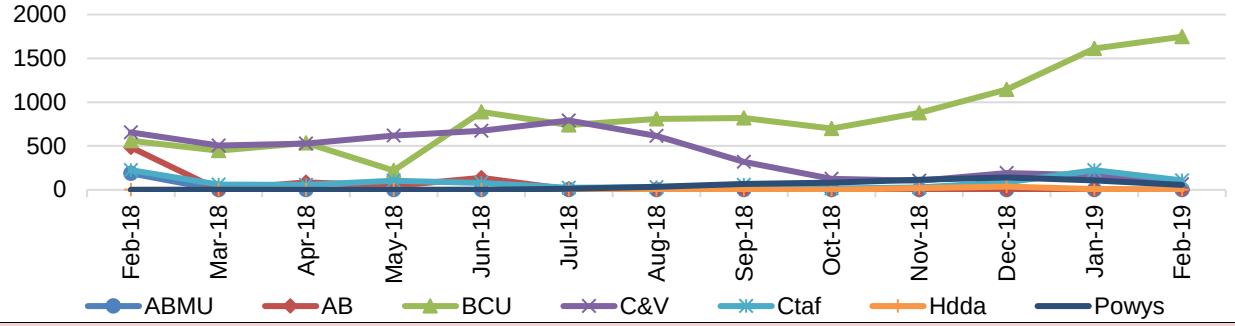


(2) % patients waiting less than 8 weeks for Endoscopy



Benchmarking

(1) Number of patients waiting more than 8 weeks for Endoscopy



Source: NHS Wales Delivery Framework, all-Wales performance summary (April 2019)

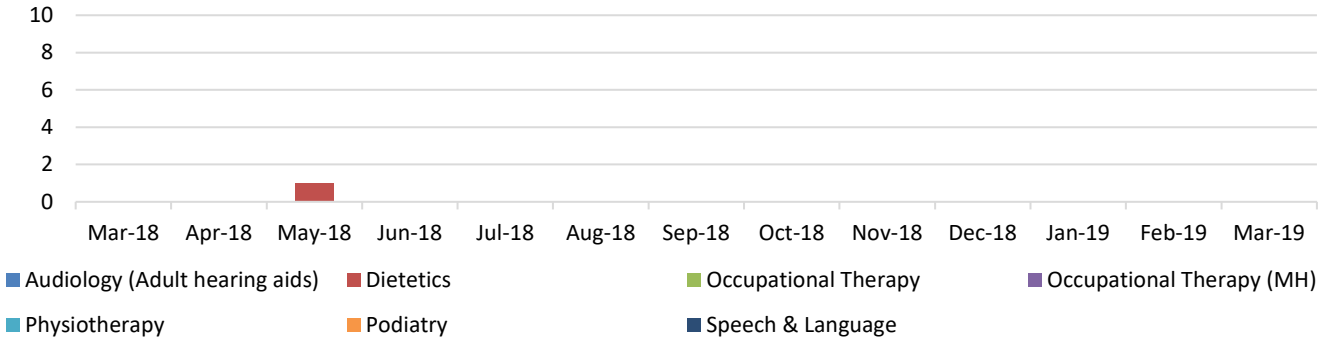
Measure 1: Number of patients waiting more than 8 weeks for Endoscopy Measure 2: % patients waiting less than 8 weeks for Endoscopy
How are we doing?
• ABMU Health Board has achieved zero position for patients waiting over 8 weeks for endoscopy as of the end of March 2019 and we are currently reporting at 6 weeks. • Endoscopy continues to see a significant increase in urgent suspected cancer referrals. The majority of these continue to be in the area of Lower Gastroenterology referrals internally from surgical specialties. • DNA rates continue to remain low at 3%.
What actions are we taking?
• Utilising all available capacity with an average of 30 backfill lists being undertaken per month across 2 sites. Current agreement for funding until the end of May 2019. • Ongoing additional insourcing support confirmed until the end of May 2019 from Medinet to maintain the zero position. • Continued focus on effective triage of referrals • An Endoscopy Capacity and Demand Plan has been submitted for 2019/20 for SBUHB and provides a plan to address current capacity issues and provide assurances that the health board will deliver a maximum waiting time for Endoscopy of 8 weeks. The plan is a combination of a more sustainable approach to achievement of the waiting time targets as well as a continued but decreased short- term capacity solution. The plan combines efficiency gains, increased productivity with increasing workforce to allow the service to move towards a closure of the known gap in capacity and also supports the move towards management of demand in a more robust and effective way. • Surveillance Endoscopic waits in the HB are a risk and immediate action is planned to review how high risk patients are to be managed. This includes a clinical review of the longest waiting surveillance patients by the three clinical leads. • Clear and dedicated leadership for Endoscopy services will be key to drive through the changes required to ensure transformation of Endoscopy services. Within SBUHB we are currently recruiting a Service Improvement Manager to drive Endoscopy transformation and have appointed three Clinical leads (one for each Singleton, Morriston and Neath Port Talbot Endoscopy Units) with the responsibility to develop and facilitate the implementation of the Endoscopy service improvement action plan required as part of the National Programme. • A national approach to service planning to ensure endoscopy services in Wales are in a position to cope with the anticipated increase in referrals from the Bowel Screening Wales programme following implementation of FIT testing is a key recommendation of the WG Report. For SBUHB we are working in collaboration with the Bowel Screening Wales Team to secure funding for an additional funded screening session to commence within Q1 2019/20. In the interim, the team are working with Hywel Dda University Health Board (HDdUHB) to secure additional BSW lists to manage the patients within the waiting time standards. Furthermore, two additional Endoscopists from the HB have expressed an interest in accreditation as Bowel Screening colonoscopists and are being supported through this programme. • A business case has been drafted and will be presented to the SBUHB Investment and Benefits Group in May 2019 which demonstrates the clear need to establish a robust 24/7 GI Bleed Rota model for the patient population of Swansea and Neath. The proposal outlines the steps that need to be put in place, to deliver this.
What are the main areas of risk?
• Routine activity being displaced by cancer, urgent and RTT patients with significant pressures in Gastroenterology and an increase in USC referrals. • Ability to maintain the number of additional sessions undertaken with a very small group of Endoscopists.
How do we compare with our peers?
• ABMU endoscopy performance continues to be good in comparison with the rest of Wales, although performance has improved for some previously underperforming HBs.

THERAPY WAITING TIMES

NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Planned Care
Executive Lead:	Chris White, Chief Operating Officer		

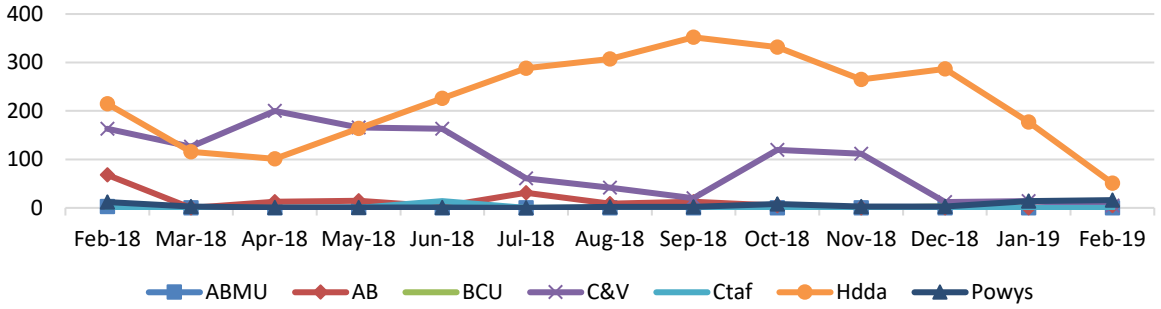
	Annual Plan Profile	WG Target	**Period:** March 2019	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy	0	0	✓	↓ ●

(1) Number of patients waiting more than 14 weeks for a specified Therapy



Benchmarking

(1) Number of patients waiting more than 14 weeks for a specified Therapy



Feb-19	
ABMU	0
AB	5
BCU	0
C&V	5
Ctaf	0
Hdda	51
Powys	16

Source : Stats Wales (data extracted 14.05.2019)

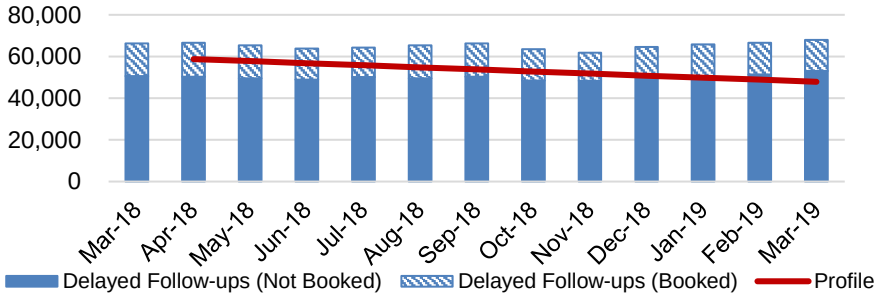
Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy
How are we doing?
• Waiting times targets achieved a nil position at the end of March 2019 across all therapy services and are being sustainably met currently. Walk in Clinics are supporting therapies such as Physiotherapy and Podiatry to manage new demand on the day and telephone services are also available to provide advice and offer intervention as required.
What actions are we taking?
• Teams continue to support each other across the Health Board to manage equity in waiting lists • Proactive waiting list tool implemented which enables services to have an overview to flex staff across the Health Board to address 'hot spots' or an influx of referrals in one area • In house developments continue, redesigning service models to utilise alternative skill mix wherever possible • Ensuring booking is completed well in advance to provide sufficient headroom to re-book should patients cancel in month • Ongoing validation of the waiting lists
What are the main areas of risk?
• Planned maternity leave and inability to backfill with temporary posts • Increasing demand on Walk in Clinics • Vacancies and national shortage of qualified therapists
How do we compare with our peers?
• The Health Board is performing as well as or above our peers

DELAYED FOLLOW-UP APPOINTMENTS

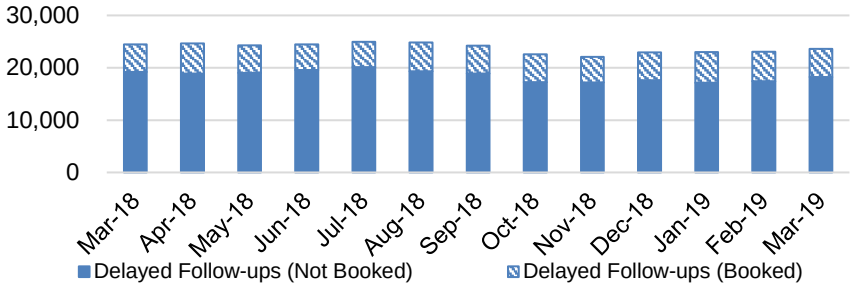
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Planned Care
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for all specialties	47,862	N/A	✗	↑ ●
Measure 2: The number of patients waiting for an outpatient follow-up who are delayed past their agreed target date for planned care specialties (Ophthalmology, ENT, T&O, Dermatology & Urology)	N/A	12 month reduction trend	✗	↓ ●

(1) Number of patients waiting for an outpatient follow- who are delayed past their agreed target date for all specialties

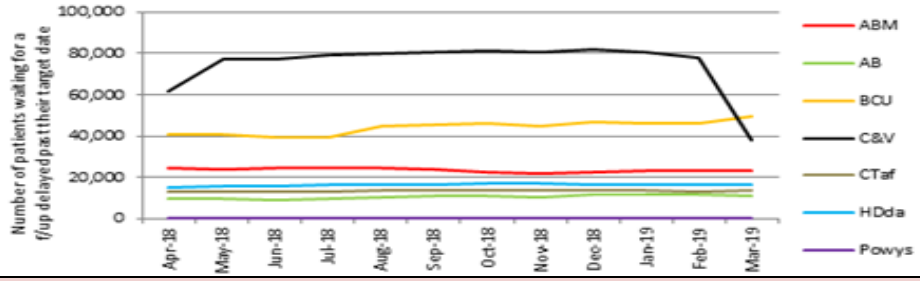


(2) Number of patients waiting for an outpatient follow-up who are delayed past their agreed target date for planned care specialties



Benchmarking

(2) Number of patients waiting for an outpatient follow-up who are delayed past their agreed target date for planned care specialties



Source: NHS Wales Delivery Framework, all-Wales performance summary (April 2019)

Measure 1: The number of patients waiting for an outpatient follow-up who are delayed past their agreed target date for all specialties
Measure 2: The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care specialties (Ophthalmology, ENT, T&O, Dermatology & Urology)

How are we doing?

- The number of patients waiting for a follow up appointment delayed past their target date (booked and non-booked) has increased from 66,271 (March 2018) to 67,908 (March 2019).
- Delayed Follow Up (Not Booked): In-month performance has deteriorated with an increase in the number of not booked patients waiting for a follow up appointment delayed past their target date from 51,380 to 53,125. There has been a further increase in delayed follow up not booked when compared with the same period 12 months ago (50,647 to 53,125).
- Delayed Follow Up (Booked): In-month performance has slightly improved with an increase in the number of booked patients waiting for a follow up appointment delayed past their target date from 15,187 to 14,783. There has been slight improvement in the number of delayed follow ups booked with the same period 12 months ago (15,624 to 14,783).
- In March 2019 the Health Board continues to be above trajectory / IMTP profile.

What actions are we taking?

- At a National level new targets have been introduced for reducing the level of follow ups within Wales and individual Health Boards. Overall numbers will be reduced by 15% and patients waiting over 100% of their target dates by 20% by March 2020. Additional challenges have been allocated to improve reporting figures by September 2019.
- The Outpatient Modernisation Group have a draft Health Board programme of work to address a more focused approach to managing and reducing these overall numbers.
- Additional funding has been released to support medium term validation reviews of the FunB lists – these are being led by the Morriston delivery unit lead.
- The National Outpatient Modernisation Working Group has been refreshed and actively taking forward new measures to address these pressures which are being seen across Wales. Actions include improved coding, clarification of virtual clinic patients, shared learning, and stronger information reporting by specialty – actions arising from this group will be taken forward through the HB's Outpatient Modernisation group during 19 / 20.
- A "Gold Command" group has been established under the joint Chairmanship of Dr Alastair Roeves and Christine Morrell to address concerns within the Ophthalmology Service. The group are finalising recommendations for consideration by the Executive team / Health Board as well as making immediate changes as appropriate and within available funds.

What are the main areas of risk?

- Wales Audit Office review (2015 and 2017) has highlighted that that there is a need for greater clinician engagement in the recording of clinical risks associated with delayed follow up appointments; there are insufficient mechanisms in place to routinely report these clinical risks to the Board; and that issues persist with the management of the FUNB list.
- Need to better prioritise validation activities. Service Delivery Units to provide regular assurance reports to Health Board Quality & Safety Committee and Outpatient Transformation Work stream.

How do we compare with our peers?

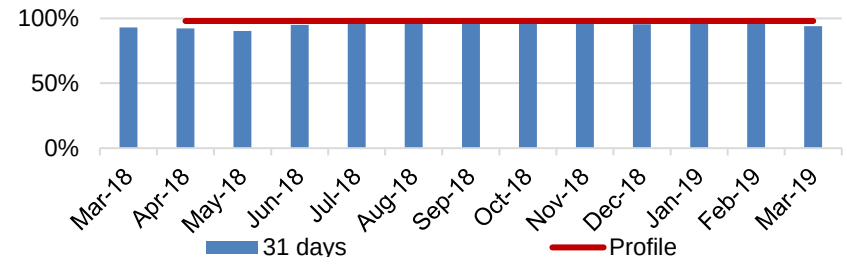
- Most Health Boards have experienced a deteriorating position in the number of patients waiting for an outpatient follow up (booked and not booked) who are delayed past their target date for planned care specialties for period ending March 2019.

CANCER WAITING TIMES

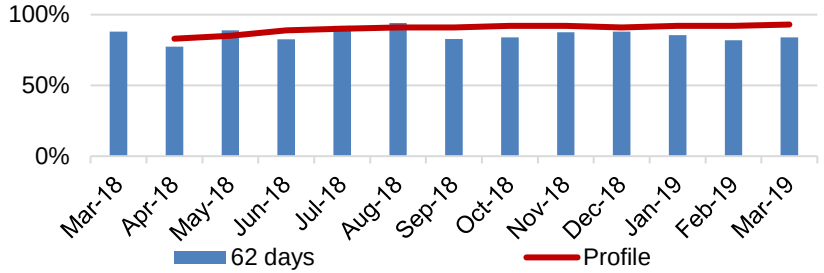
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Cancer
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** March 2019	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: % patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days	98%	98%	✗	↑ ●
Measure 2: % patients newly diagnosed with cancer via the urgent suspected route that started definitive treatment within 62 days	93%	95%	✗	↑ ●

(1) % of patients newly diagnosed with cancer not via the urgent route that started treatment within 31 days

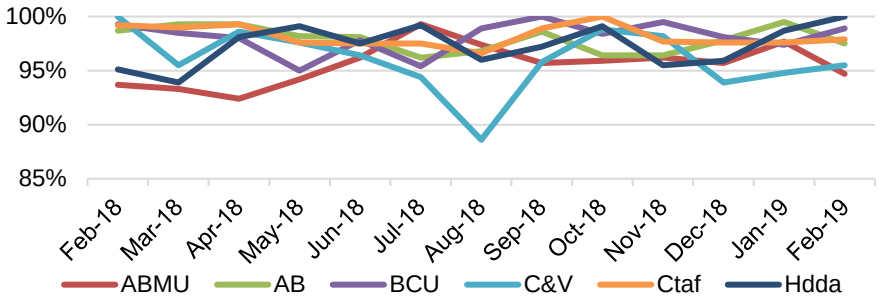


(2) % of patients newly diagnosed with cancer via the urgent suspected route that started treatment within 62 days

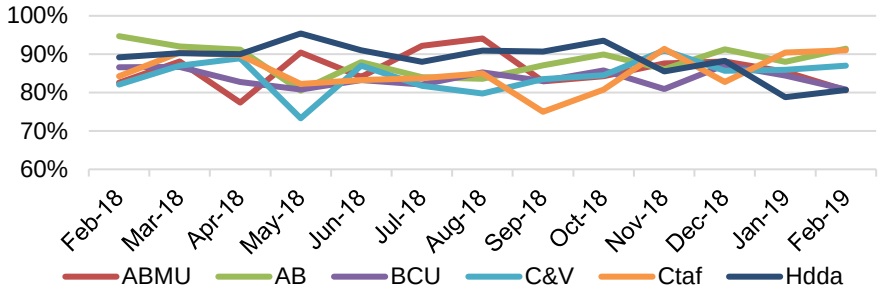


Benchmarking

(1) % of patients newly diagnosed with cancer not via the urgent route that started treatment within 31 days



(2) % of patients newly diagnosed with cancer via the urgent suspected route that started treatment within 62 days



Source : NHS Wales Delivery Framework, all-Wales performance summary (April 2019)

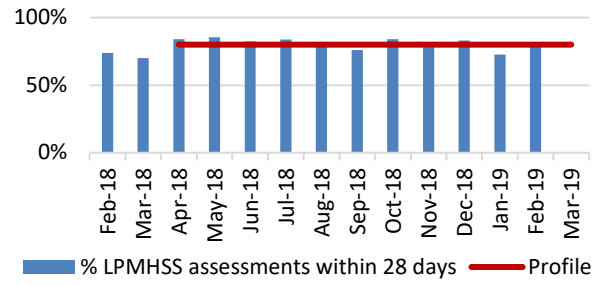
Measure 1: % patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days Measure 2: % patients newly diagnosed with cancer via the urgent suspected route that started definitive treatment within 62 days
How are we doing?
• NUSC performance for March 2019 is 94% (8 breaches). • USC performance for March 2019 is 84% (21 breaches). • USC referrals received by the Health Board remain high. The monthly average during the 13 months March 18 to March 19 is 1932. 1958 referrals were received in March 2019. • Patients waiting over 62 days in backlog has been on an upward trend through March with 66 patients reported in the 31st March PTL.
What actions are we taking?
• The Urology team have backfilled RALP sessions at University Hospital of Wales where possible to reduce waiting times to radical prostate surgery, backfilling Aneurin Bevan UHB sessions. • Patient flow / capacity utilisation is under review during late April/early May within the Chemotherapy Day Unit at Singleton to consider changes to ensure maximum and safe use of available capacity. Findings of the observations will be fed back to the Service during early May. • New Gynae-Oncology Surgeon appointment at Singleton, to commence post May 2019, additional Rapid Access Clinic activity will reduce pathway waits by at least 7 days. • Joint working with Hywel Dda to utilise theatre capacity within Hywel Dda every Friday from mid-May. This will help reduce the long waiting times to surgery for patients within both Health Boards, reducing capacity pressure at Morriston. • Detailed Radiology Demand and Capacity plan including reporting time requirements is being finalised. • New first outpatient OMFS pathway agreed and taken forward with Primary Care with a plan to commence 1st June 2019. • A new Neck Lump Pathway to commence in part at the end of April 2019, with full implementation in July when a new consultant commences in post. It is anticipated the pathway will reduce by 10 days. • AOS/MUO workshop is planned for the 1st July 2019. It is intended this workshop will scope service requirement to improve the pathway for patients with MUO/CUP.
What are the main areas of risk?
• Sickness within Urological Services at Morriston is having a significant impact on waiting times, particularly within the diagnostic phase of the prostate pathway. • Consultants unwilling/reluctant to run additional clinics due to pension implications. • Unscheduled Care pressures, although site management processes aim to minimise impact on cancer cases. • Continued growth in demand and therefore the backlog. • Challenges to appoint to vacant posts and time lag in developing new workforce models. • Growing waiting times in Chemotherapy and radiotherapy –pressures around vacancies / planned maternity leave / changes in NICE guidance. • Ongoing issues with delivery of Breast services, particularly waits to triple assessment (6 weeks to first appointment). • Delays within the Gynaecological pathway both in diagnostic phase (PMB) and surgical capacity. • Pancreatic surgery capacity. • Theatre capacity on the Morriston site due to staffing deficits for long and short-term sickness as well as annual leave.
How do we compare with our peers?
• USC Performance for the quarter ending December 2018 demonstrates ABMU HB had the third best performance of all Welsh Health Boards. Performance so far this quarter has been more challenging however and during February the HB had the lowest % of patients treated within 62 days, although there was 0.1% difference to BCUHB and HDda UHB.

MENTAL HEALTH MEASURES

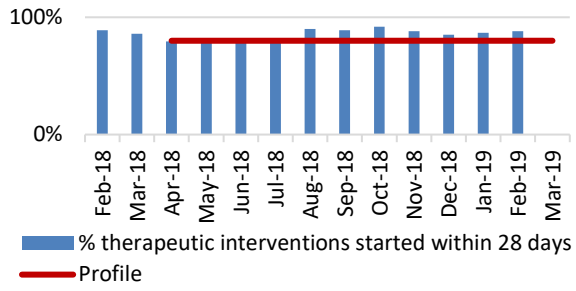
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Mental Health & Learning Disabilities
Executive Lead:	Chris White, Chief Operating Officer		

	Annual Plan Profile	WG Target	**Period:** February 2019 Current Status *(against target):*	Movement: *(12 month trend)*
Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral	80%	80%	✓	↑ ●
Measure 2: % of therapeutic interventions started within 28 days following assessment by LPMHSS	80%	80%	✓	↑ ●
Measure 3: % of Health Board residents in receipt of secondary Mental Health services (all ages) to have a valid Care and Treatment Plan (CTP)	90%	90%	✓	↑ ●
Measure 4: % of qualifying patients (compulsory & informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA	100%	100%	✓	↑ ●

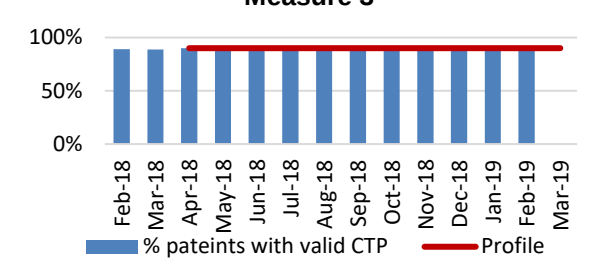
Measure 1



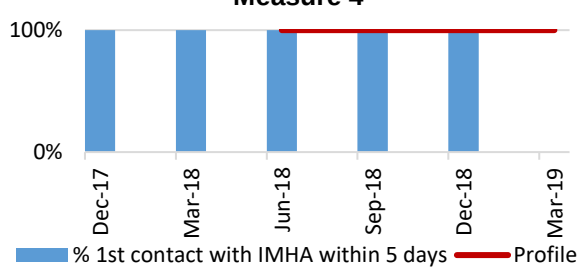
Measure 2



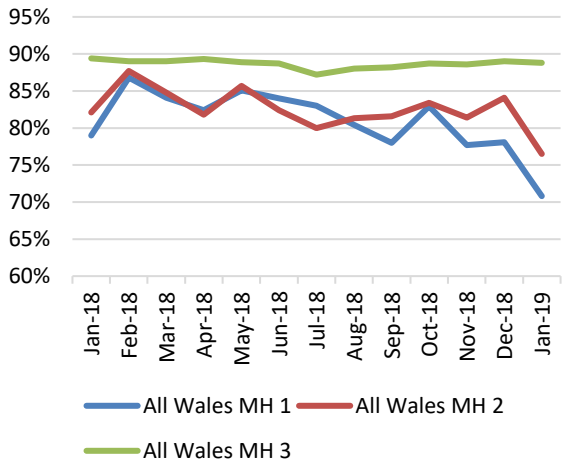
Measure 3



Measure 4



Benchmarking



Source: NHS Wales Delivery Framework, all-Wales performance summary (March 2019)

Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral
Measure 2: % of therapeutic interventions started within 28 days following assessment by LPMHSS
Measure 3: % of Health Board residents in receipt of secondary Mental Health services (all ages) to have a valid Care and Treatment Plan (CTP)
Measure 4: % of qualifying patients (compulsory & informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA

How are we doing?

- Mental Health 1 - ABMU met the target for 8 of the 13 months shown. This data includes CAMHS which is collated by Cwm Taf Health Board. Excluding CAMHS data we met the target for the 13 months. It should be noted that actual waiting time is irrespective of weekends and bank holidays.
- Mental Health 2 - Intervention levels met the target for 11 of the 13 months shown. This data includes CAMHS, which is collated by Cwm Taf HB. If we exclude CAMHS from the analysis we met the target for the 13 months shown. Meeting the target does not tell you how many people are waiting or the length of longest waits, but we manage and monitor the lists locally.
- Mental Health 3 - This data covers Adult, Older People, CAMHS and Learning Disability Services. ABMU met the target from 9 of the 13 months shown. There was a slight dip in June and July but we have sustained compliance since August.

What actions are we taking?

- The LMPHSS has benefited from recent additional Welsh Government resources to help build up the local teams. This will allow the service to help keep pace with additional demand.
- The LPMHSS is in the process of developing a further range of group interventions, in order to offset the demand for therapy.

What are the main areas of risk?

- For assessment and interventions targets, risks relate to potentially increasing demand and the availability of suitably experienced staff.
- One of the actions of the Community Mental Health Team (CMHT) assurance group is to consider the level of demand for secondary mental health services and capacity of care coordinators. Protocols to inform safe and effective discharge from secondary care are being developed to mitigate against the risks of overcapacity.

How do we compare with our peers?

January 2019

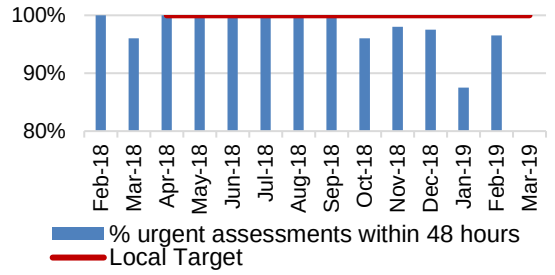
- All-Wales MH1 measure ranged from 44% to 93% including CAMHS 73% ABMU
- All-Wales MH2 measure ranged from 50% to 93% including CAMHS 87% ABMU
- All-Wales MH3 measure ranged from 84% to 95% including CAMHS 91% ABMU

CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

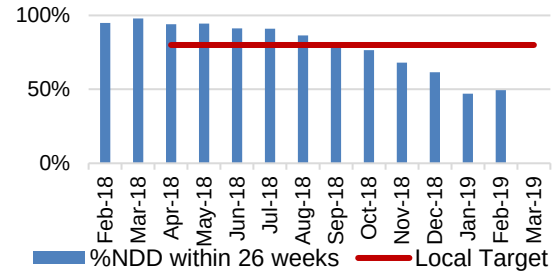
NHS Wales Domain:	**TIMELY CARE:** People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care	**NHS Wales Outcome Statement:**	To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Mental Health & Learning Disabilities
Executive Lead:	Siân Harrop-Griffiths, Director of Strategy		

	Local Target	**Period:** February 2019	
		Current Status *(against target):*	**Movement:** *(12 month trend)*
(1) Crisis - % Urgent Assessment by CAMHS undertaken within 48 Hours from receipt of referral	100%	✗	↓
(2) NDD - % Neurodevelopmental Disorder patients receiving a Diagnostic Assessment within 26 weeks	80%	✗	↓
(3) P-CAMHS - % Routine Assessment by CAMHS undertaken within 28 days from receipt of referral	80%	✗	↓
(4) P-CAMHS - % Therapeutic interventions started within 28 days following assessment by LPMHSS	80%	✓	↑
(5) S-CAMHS - % ABMU residents in receipt of CAMHS to have a valid Care and Treatment Plan	90%	✓	↑
(6) S-CAMHS - % Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral	80%	✓	↑

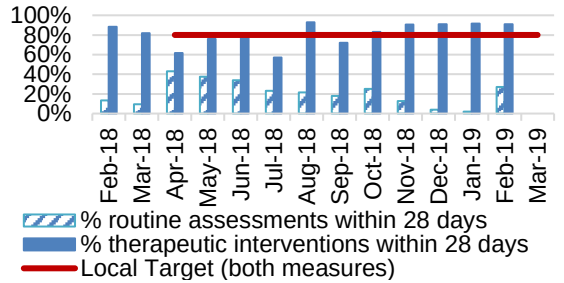
Crisis



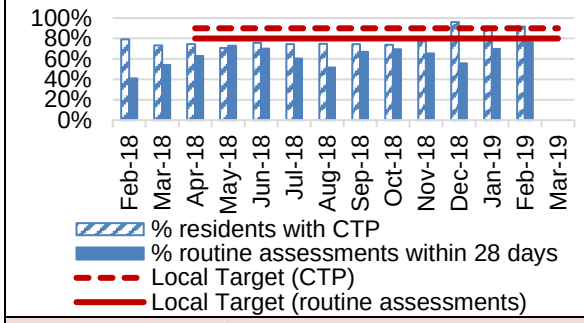
NDD



P-CAMHS



S-CAMHS



Benchmarking (SCAMHS)

Position as at 31/03/19	Bridgend	NPT	Swansea	ABM Overall	C and V	Cwm Taf
Total WL	51	36	63	150	195	133
>4 Weeks	2	4	9	15	123	10
Compliance	96.1%	88.9%	85.7%	90.0%	36.9%	92.5%
Average Weeks	1.2	1.8	1.6	1.5	5.6	1.2

Source: Cwm Taf LHB

(1) Crisis - % Urgent Assessment by CAMHS undertaken within 48 Hours from receipt of referral
(2) NDD - % Neurodevelopmental Disorder patients receiving a Diagnostic Assessment within 26 weeks
(3) P-CAMHS - % Routine Assessment by CAMHS undertaken within 28 days from receipt of referral
(4) P-CAMHS - % Therapeutic interventions started within 28 days following assessment by LPMHSS
(5) S-CAMHS - % ABMU residents in receipt of CAMHS to have a valid Care and Treatment Plan
(6) S-CAMHS - % Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral

How are we doing?

- Measure 1: Crisis - Service now operates 7 days a week, and in Q1 and Q2 of 2018/ 19 100% compliance was consistently achieved. Compliance dipped in Q3 but recovered in February with achievement of 97%. Where 100% has not been achieved this has been because of staff vacancies.
- Measure 2: NDD - Compliance against this measure has deteriorated during Q4 and 50% compliance was reported in February. Until August 2018 compliance against this target had been good, however a dip in performance has been seen following a significant increase in referrals. The increase has been experienced across Wales, due to increased awareness of the service available and unmet demand.
- Measure 3: P-CAMHS – Compliance against the assessment within 28 days has deteriorated since Q2, however the number of patients waiting still remains significantly lower compared to 12 months ago. The longest wait for an assessment in February was 15 weeks. The service remains fragile due to a number of vacancies within a small service, and whilst agency staff are being utilised, the availability of appropriate staff is limited and a continued risk.
- Measure 4: P-CAMHS – Compliance against the 80% target for therapeutic interventions has improved during Q4 and has consistently been achieved since November. • Measure 5: S-CAMHS – Compliance against the Care and Treatment Plan target was achieved.
- Measure 6: S-CAMHS - Compliance against the 80% target in February was at 76%. Performance against this target has been variable over the last 12 months due to staff vacancies, however the position improved in Q4 and the Welsh Government 80% target was achieved across all ABMU areas.

What actions are we taking?

- NDD –The Clinical diagnostic team is now up to full establishment with no outstanding vacancies, vacancy slippage previously being used to fund additional WLI capacity is no longer available. Referral rate has stabilised somewhat but still large month to month fluctuations making future projections difficult to predict. Breach position will continue to decline due to large breach cohorts early in 2019/20 financial year. This situation remains similar across Wales and is being escalated through the All Wales National ND Steering Group and through Swansea Bay UHB Executive team –the Singleton Hospital Delivery Unit are progressing plans to review the demand & capacity of the Service, and the outcomes of that exercise will inform future planning. Accommodation issues remain but being worked through with a tentative summer date for resolution – some efficiency improvements linked with move to suitable accommodation but main improvement is increased governance and decreased risk e.g. transport of notes.
- CAMHS –The variation in performance experienced across both Primary and Secondary CAMHS is consistently related to the number of vacancies across the services, with a number of staff on maternity leave and shortages in suitable staff leading to vacancies having to be re-advertised. During 2018/19 the vacancy underspend was utilised to fund waiting list initiatives to improve the position. CTM UHB also secured additional funds for waiting list initiatives to deliver the targets from Welsh Government. Demand & Capacity modelling results have been shared with the Health Board which shows that there is a marginal shortfall in capacity for SCAMHS. CTM UHB have instructed the NHS Wales Delivery Unit to undertake process mapping work in the first instance in P-CAMHS, one of the objectives will be to identify any gaps in service, so that they can be the focus of funding streams in future. A three year plan for a single integrated PCAMHS and SCAMHS service for SBU HB is being developed with a single office base, a single referral centre to manage all referrals and access to a widened range of services and with clinics in community settings such as GP surgeries and community schools.

What are the main areas of risk?

- The inability to recruit and retain staff is a recurring theme, and the relatively small size of the different specialist teams in CAMHS is a concern that Swansea Bay will continue to address going forward with Cwm Taf Morgannwg via formal commissioning meetings.

How do we compare with our peers?

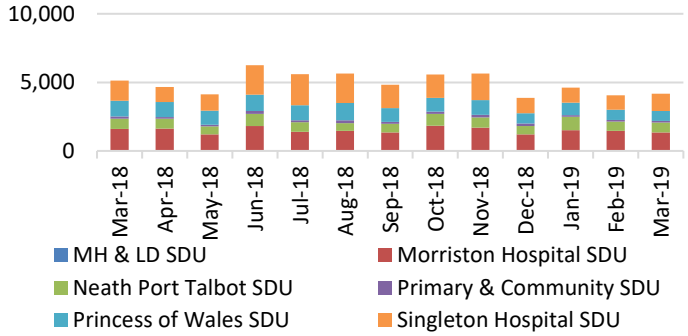
- There is limited data available to undertake peer review across CAMHS. There is some data available against the SCAMHS target which is shown above.

10.6 Individual Care

PATIENT EXPERIENCE			
NHS Wales Domain:	**INDIVIDUAL CARE**: People in Wales are treated as individuals with their own needs and responsibilities	**NHS Wales Outcome Statement:**	I am safe and protected from harm through high quality care, treatment and support
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Enabling Objective:**	Best value outcomes from high quality care: Quality & Safety and Patient Experience
Executive Lead:	Gareth Howells, Director of Nursing & Patient Experience		**Period:** March 2019

	Local Target	WG Target	Current Status *(against target):*	Movement: *(12 month trend)*
Measure 1: Number of friends and family surveys completed	Increase	N/A	✗	↓
Measure 2: % of who would recommend and highly recommend	90%	N/A	✓	→
Measure 3: % of all-Wales surveys scoring 9 or 10 on overall satisfaction	90%	N/A	✗	↓

(1) Number of friends and family surveys completed



Measure 2	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
MH & LD SDU	76%	72%	52%	79%	31%	65%	90%	93%	80%	75%	50%	73%	73%
Morriston Hospital SDU	93%	94%	94%	94%	94%	92%	93%	95%	95%	91%	94%	94%	94%
Neath Port Talbot SDU	99%	99%	98%	99%	99%	98%	98%	98%	99%	99%	98%	98%	99%
Primary & Community SDU	90%	89%	94%	94%	93%	93%	94%	96%	95%	92%	97%	98%	99%
Princess of Wales SDU	94%	95%	95%	96%	96%	95%	95%	94%	95%	95%	96%	94%	92%
Singleton Hospital SDU	95%	94%	94%	97%	96%	97%	97%	96%	95%	96%	92%	95%	86%
HB Total	**95%**	**95%**	**95%**	**96%**	**96%**	**95%**	**96%**	**96%**	**96%**	**94%**	**95%**	**95%**	**95%**

Measure 3	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
MH & LD SDU	0%	-	-	-	-	-	-	-	-	0%	-	-	-
Morriston Hospital SDU	91%	93%	96%	74%	87%	83%	92%	83%	91%	74%	86%	72%	89%
Neath Port Talbot SDU	80%	62%	80%	84%	93%	87%	100%	94%	100%	80%	98%	96%	83%
Primary & Community SDU	93%	92%	97%	-	-	91%	87%	95%	88%	90%	94%	100%	95%
Princess of Wales SDU	79%	87%	82%	86%	77%	63%	88%	83%	96%	84%	92%	84%	79%
Singleton Hospital SDU	79%	85%	86%	90%	84%	95%	79%	88%	83%	90%	88%	70%	88%
HB Total	**84%**	**87%**	**89%**	**85%**	**85%**	**87%**	**89%**	**86%**	**88%**	**82%**	**90%**	**78%**	**89%**

Benchmarking

	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
ABMU Response %	23.3%	19.4%	16.9%	30.1%	26.1%	26.8%	21.8%	22.9%	24.1%	18.0%	17.8%	21.2%	20.7%
ABMU Recommendation %	95.7%	95.1%	95.4%	97.2%	96.5%	96.2%	96.3%	96.5%	96.3%	95.3%	95.9%	95.2%	94.0%
Top Equivalent Organisation Response %	27.7%	17.6%	27.3%	27.0%	19.3%	19.8%	17.0%	18.3%	20.3%	16.4%	18.6%	31.4%	24.3%
Top Equivalent Organisation Recommendation %	93.7%	97.4%	94.2%	92.0%	94.1%	97.1%	92.9%	93.2%	95.5%	95.3%	94.1%	95.7%	95.7%
NHS England Benchmark Response %	22.6%	24.4%	25.1%	24.8%	24.8%	24.6%	24.2%	24.5%	24.2%	21.7%	23.7%	24.2%	24.1%
NHS England Benchmark Recommendation %	95.3%	95.6%	95.8%	95.7%	95.6%	95.5%	95.5%	95.5%	95.5%	95.3%	95.4%	95.5%	95.5%

Source : NHS Wales Delivery Framework, all-Wales performance summary (April 2019)

Measure 1: Number of friends and family surveys completed, Measure 2: % of who would recommend and highly recommend, Measure 3: % of all-Wales surveys scoring 9 or 10 on overall satisfaction

How are we doing?

PLEASE NOTE THIS IS ONE MONTH FRIENDS AND FAMILY UPDATE FOR MARCH

- Health Board Friends & Family patient satisfaction level in March was 95%.
- Neath Port Talbot Hospital (NPTH) completed 727 surveys for March, with a recommended score of 99%.
- Singleton Hospital completed 1,250 surveys for March, with a recommended score of 94%.
- Morriston Hospital completed 1,326 surveys for March, with a recommended score of 94%.
- Princess of Wales Hospital (POWH) completed 726 surveys for March, with a recommended score of 92%.
- Mental Health & Learning Disabilities completed 22 surveys for March, with a recommended score of 73%
- Primary & Community Care completed 112 surveys for March, with a recommended score of 99%

What actions are we taking?

- Removal of the Bridgend area from the SNAP system and reports while rebuilding the new Swansea Bay Snap System.
- Showcased the Patient Story Toolkit to the all-Wales NHS Chairs.
- Attended all-Wales Supplier day, reviewing a once for Wales Patient Feedback System.
- Recruited Media Apprentice to help develop the Patient Story SharePoint site
- Staff undertaken SNAP training
- Patient Feedback Themes, performance results and hotpots are reported in our Quarterly Patient Experience Report. Each Service Delivery Unit receives a quarterly detailed report identifying the themes and develops an action plan for improvement at SDU level. The current report ,which covers October 2019 to February 2019 has the following data:

High scoring areas across the reporting period (all with 100% positive feedback) included:

Pendre, POWH (165 responses) Dyfed Ward, Morriston (47 responses) Ward A, NPTH (132 responses) Diabetics Dept, Singleton Hospital (10 responses)

The 10 lowest scoring areas for the reporting period were:

Dermatology, Singleton Hospital (39%) Ward 20, Singleton Hospital (64%) Breast Care Unit, Singleton Hospital (65%) Fracture Clinic, Princess of Wales Hospital (65%) Corridor 4&5, Singleton Hospital (65%) Lymphoedema, Singleton Hospital (67%) Rheumatology, Princess of Wales Hospital (67%) maxillofacial, Princess of Wales Hospital (67%) Dermatology, Princess of Wales Hospital (69%) Audiology, Morriston Hospital (70%)

The main themes identified in the low scoring areas above were:

Delays in appointments, insufficient information being given to patients and families, food not being of a high standard and car parking on all sites (ongoing issues)

- March has seen the creation of 9 new bespoke patient experience surveys. These bespoke surveys aim is to help the department better understand the needs of their patients. Once completed and analysed a report is sent to the team for them to make any improvements or changes to their services at a local level. We revisit the teams and ask them to share their action plans in light of the patient survey feedback report.

What are the main areas of risk?

- The reduction in the Volume of the Friends and Family Cards may be affected by the vacancies for PALs officers across the Delivery units. The PALS officers are instrumental in driving the completion of the Friends and Family.
- Corporate Patient experience team Staffing levels
- Development of new patient feedback system, with regards to the once for Wales System.
- With the boundary changes, the Princess of Wales will not be feeding into the overall satisfaction scores and may reduce the overarching %. The number of the F&F feedback cards will reduce. A recent test report using November's data without POW revealed that actually the % stayed the same.

How do we compare with our peers?

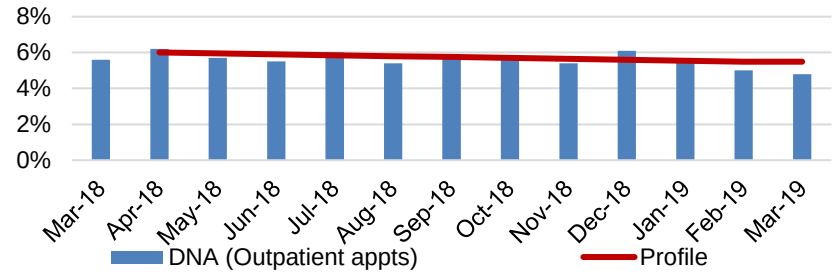
- Monthly/bi monthly data not available on an all Wales basis to compare.

10.7 Our Staff & Resources

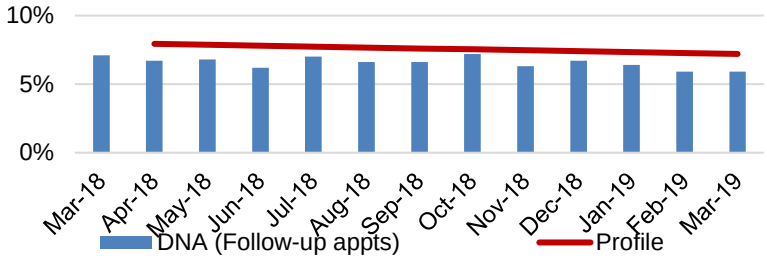
DID NOT ATTEND (DNA) RATES FOR OUTPATIENT APPOINTMENTS			
NHS Wales Domain:	**OUR STAFF AND RESOURCES:** People in Wales can find information about how their NHS is resourced and make careful use of them	**NHS Wales Outcome Statement:**	I work with the NHS to improve the use of resources
Health Board Strategic Aim:	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	**Health Board Enabling Objective:**	Best value outcomes from high quality care: Planned Care
Executive Lead:	Chris White, Chief Operating Officer		

Specialties: *includes General Surgery, Urology, T&O, ENT, Ophthalmology, Oral Surgery, Neurosurgery, Combined Medicine, Dermatology, Rheumatology, Paediatrics and Gynaecology*	**Annual Plan Profile**	**WG Target**	**Period:** March 2019 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: % New Outpatients that Did Not Attend (DNA) For Specific Specialties	5.49%	12 month reduction trend	✓	↓
Measure 2: % Follow-Up Outpatients that Did Not Attend (DNA) For Specific Specialties	7.2%		✓	↓

(1) % New Outpatient that Did Not Attend (DNA) For Specific Specialties

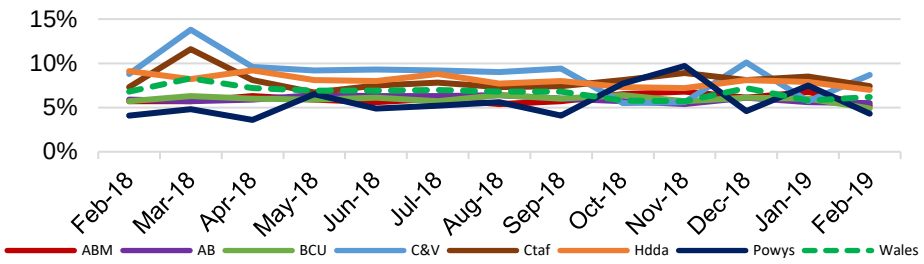


(2) % Follow Up Outpatient that Did Not Attend (DNA) For Specific Specialties

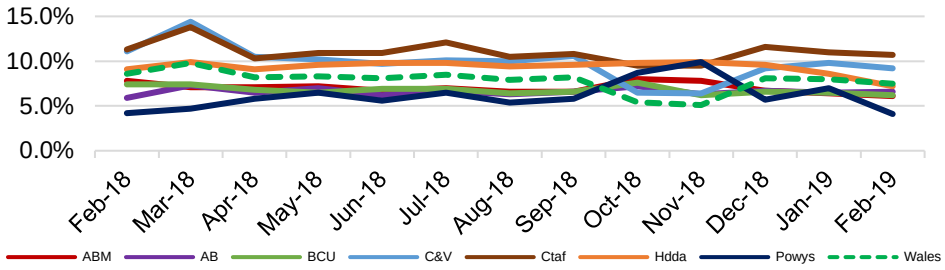


Benchmarking

(1) % New Outpatient that Did Not Attend (DNA) For Specific Specialties



(2) % Follow Up Outpatient that Did Not Attend (DNA) For Specific Specialties



Source : NHS Wales Delivery Framework, all-Wales performance summary (April 2019)

Measure 1: % New Outpatients that Did Not Attend (DNA) For Specific Specialties
Measure 2: % Follow-Up Outpatients that Did Not Attend (DNA) For Specific Specialties

How are we doing?

- New Outpatient DNA: From December 2018 – March 2019 performance has improved from 6.1% to 4.8%.

- Follow-Up DNA: From December 2018 – March 2019 performance has continued to improve from 6.7% to 5.9%.

What actions are we taking?

- Outpatient appointment text reminder service implementation – the Health Board has extended the current contract for a further 12 months – in order to continue the assessment of benefit realisation.
- Development with GP clusters and patients to inform the development of alternative methods of service delivery to support patients in the most appropriate setting including nurse led / advanced practitioner led clinics. Each Delivery Unit has developed a plan to address their DNA position. These plans, overseen by the Outpatient Modernisation Group and led by nominated managerial leads from each delivery unit, have set out objectives to achieve the Annual Plan 2019/20 target of a reduction in the DNA rate of 10%.

Actions to be undertaken by each delivery unit in the next quarter include:

- Monitoring of patient data extract and determine compliance with Health Board DNA policy.
- Clinicians to contact patients who DNA to determine reasons for non-attendance and to inform actions that the Health Board can take to address.
- Explore increased opportunities for partial booking.
- Adhering to best practice guidelines.

What are the main areas of risk?

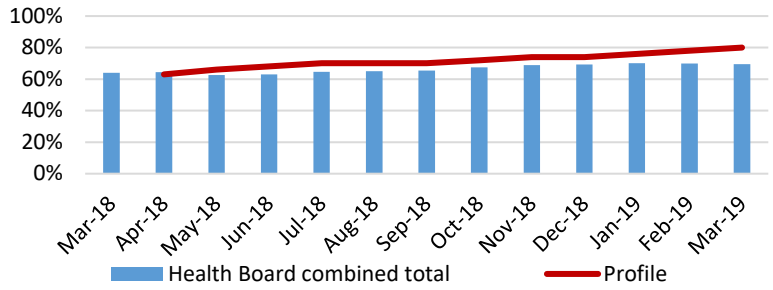
- The Wales Audit Office identified, in a review of ABMU Outpatients in 2015 and 2018, the need to ensure patients receive appointment letters in a timely manner in order to reduce DNAs. The Outpatient Modernisation work stream is continuing to monitor the performance of the Text reminder system and clerical functions to support that work.
- It is important for the Health Board to gain a better understanding of the specialties and clinical conditions which present the most risks of harm to patients who DNA their appointment.
- RTT risk to the Health Board as a result of underutilised capacity for new and follow up appointments with associated financial implications for idle capacity, rearranging appointments and potentially needing to arrange additional waiting list clinics.

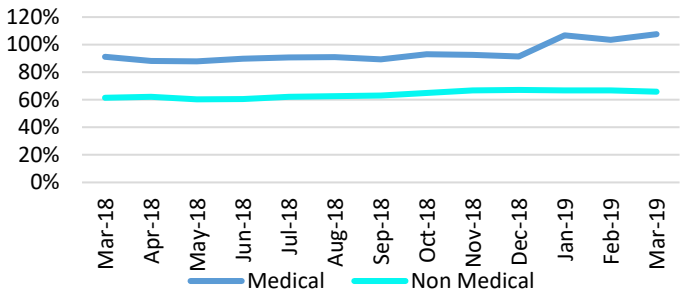
How do we compare with our peers?

- At March 2019, ABMU performance is better than the all-Wales average on New and Follow Up DNA performance.
- New DNA: ABM, has seen improvements against the majority of other Health Boards.
- Follow Up DNA: ABM has seen improvements against the majority of other Health Boards

PERSONAL APPRAISAL AND DEVELOPMENT REVIEW (PADR)							
NHS Wales Domain:	**OUR STAFF AND RESOURCES:** People in Wales can find information about how their NHS is resourced and make careful use of them		**NHS Wales Outcome Statement:**	Quality trained staff who are fully engaged in delivering excellent care and support to me and my family			
Health Board Strategic Aim:	Excellent Staff		**Health Board Enabling Objective:**	Leadership, Culture and Staff Development			
Executive Lead:	Hazel Robinson, Director of Workforce & Organisational Development		**Annual Plan Profile**	**WG Target**	**Period:** March 2019		
					Current Status *(against profile):*	**Movement:** *(12 month trend)*	
Measure 1: % staff (medical & non-medical) undertaking performance appraisals			80%	85%	✗	↑ ●	

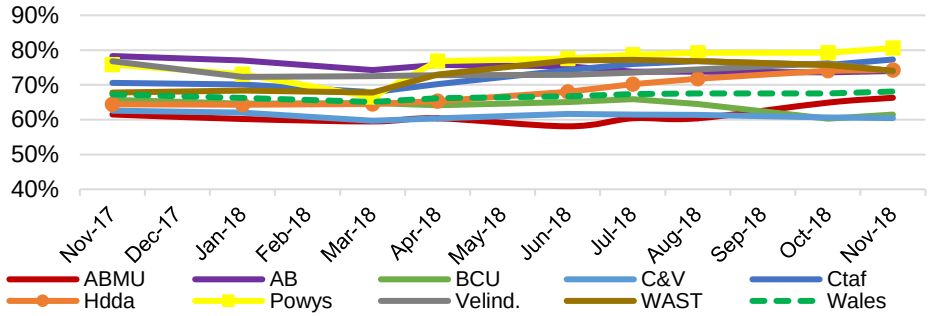
(3) % staff undertaking performance appraisals





Benchmarking

(1) % staff undertaking performance appraisals



Source : Non-Medical: Electronic Staff Record (ESR), Medical : Medical Appraisal and Revalidation System (MARS)/ NHS Wales Delivery Framework, all-Wales performance summary (March 2019)

Measure 1: % staff (medical & non-medical) undertaking performance appraisals

How are we doing?

Medical: Excluding any exemptions (new starters, absences e.g. long term sickness, maternity leave etc.) the appraisal rate for the rolling period to March 19 is 108%. The reason for this percentage is due to doctors undertaking more than 1 appraisal within the 12 month period because they have been late undertaking their annual appraisal; also the number of doctors connected increased - see below.

- Percentages are based on 1369 'connected' doctors: Primary 460, secondary (including 2 x management posts) 909. The number of prescribed doctors has increased since 2017/18, statistics are calculated based on doctors connected as at 1 April, for consistency (numbers may fluctuate slightly throughout the year for starters/leavers). The current number of doctor connect are 1392.
- Since the boundary changes on 1st April 2019 the number of doctors that have a GMC connection to Swansea Bay University Health Board stands at 1086.

Non- Medical:

- Reporting figures demonstrate an increase in PADR compliance - December 2018 69.21% to March 2019 69.49%. This has been an increase in compliance from December 2018 – March 2019 by 0.28%.
- From the 6 Service Delivery Units (SDUs): Mental Health & Learning Disabilities (MHLD) 74.42% a decrease of 3.38% on the last results, Morriston Delivery Unit (MSDU) 68.73% an increase of 0.38%, Neath Port Talbot (NPT) 81.84% a decrease of 2.70%, Primary & Community Care (PCC) 77.95% an increase of 0.41%, Princess of Wales (POW) 65.44% a decrease of 2.36%, Singleton Delivery Unit (SSDU) 70.97% a decrease of 1.50%.

What actions are we taking?

Medical: Maintain current performance levels through continuing engagement with Unit Medical Directors, GP Appraisal Co-ordinators and Medical Appraisal Leads - undertake quarterly exception management process, providing doctors with training and advice.

- Ongoing enhancements to MARS (Medical Appraisal and Revalidation System) continue to improve functionality in line with identified changes/developments
- Ensuring appraisers are kept up to date with changes, training provided at local and regional levels, and quality assurance of appraisals.
- Improving local processes to ensure robust systems are in place to manage annual appraisal.

Non-Medical: There is a continuation of focus on training Managers to complete Values Based PADR/use ESR to improve reporting figures on a request basis with bespoke sessions for teams/units when requested. 29 managers have been trained since January 2019.

- All Delivery Units have been asked to provide a plan to achieve compliance with the 85% target.

What are the main areas of risk?

Medical: • Doctors falling behind on appraisal timescales for revalidation: stress for doctor; diversion of doctor's and management time/resource; potential delayed revalidation; ultimately, consequences for licence to practise if failure to engage.

- Poor quality appraisals - lack of personal/service development and progression; continuation of sub-optimal practices; resistance to change.
- Ensuring new starters and ad hoc doctors are engaged with the annual appraisal process and relevant information received from previous Responsible Officer
- Doctors misunderstanding the requirement of Whole Practice Appraisal (WPA) and not including all elements of work undertaken using their GMC licence within their annual appraisals.

Non-Medical: • Misunderstanding around timings of PADR aligning with increment date.

- Dependence on roll out of Supervisor self-service for PADR Reporting data accuracy, double reporting, use of ESR, accuracy of ESR, IT skills of staff.
- Time to complete PADR's - risk around the quality of PADR versus the target figures.
- Local administrators and locally held data – change of culture and the time scales to do this. NHS pay scales/ increment linked to PADR
- Boundary changes will have had an impact in compliance rates. We will wait out to see the significance of this impact in the coming months.

How do we compare with our peers?

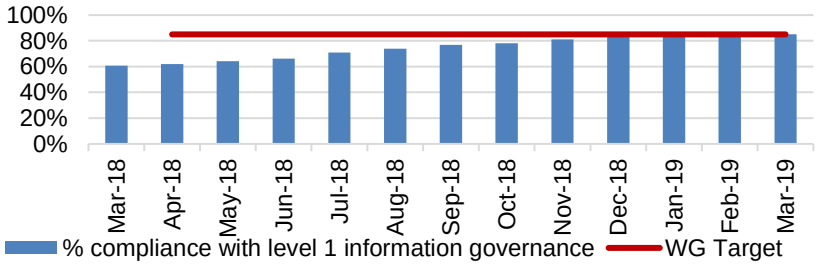
- **Medical:** Awaiting benchmark information for 1st April 2018 to 31st March 2019 from the Revalidation Support Unit (RSU), HEIW
- **Non-Medical:** There have been slight variations in performance of ABMU in line with other Health Boards across Wales throughout the later months of 2018.

MANDATORY AND STATUTORY TRAINING

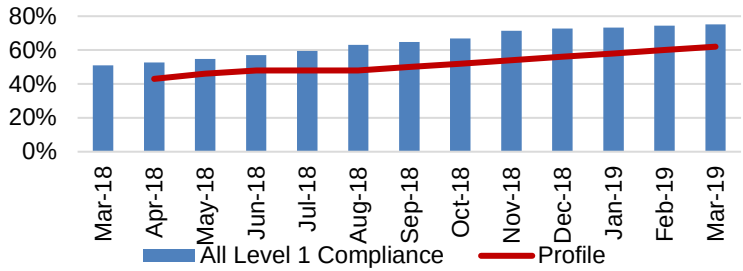
NHS Wales Domain:	**OUR STAFF AND RESOURCES:** People in Wales can find information about how their NHS is resourced and make careful use of them	**NHS Wales Outcome Statement:**	Quality trained staff who are fully engaged in delivering excellent care and support to me and my family
Health Board Strategic Aim:	Excellent Staff	**Health Board Enabling Objective:**	Leadership, Culture and Staff Development
Executive Lead:	Hazel Robinson, Director of Workforce & Organisational Development		

	Annual Plan Profile	WG Target	**Period:** March 2019	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: % compliance for the completed level 1 Information Governance (Wales) training element of the Core Skills and Training Framework	N/A	85%	✓	↑ ●
Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework	62%	85%	✓	↑ ●

(1) % compliance for the completed level 1 Information Governance (Wales) training element of the Core Skills and Training Framework

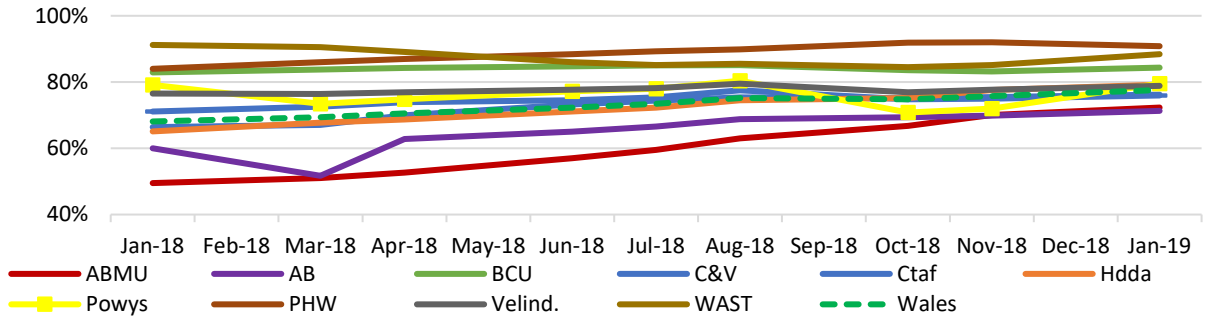


(2) % compliance for all completed Level 1 competencies within the Core Skills and Training Framework



Benchmarking

(2) % compliance for all completed Level 1 competencies within the Core Skills and Training Framework



Source : NHS WALES Delivery Framework, all-Wales performance summary (March 2019)

Measure 1: % compliance for the completed level 1 Information Governance (Wales) training element of the Core Skills and Training Framework
Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework

How are we doing?

Information Governance

- The Current Compliance for IG Level 1 training is 85%, an increase by 23% since March 2018. This is a result of continued IG training delivery and IG compliance monitoring by a dedicated IG Training Lead and awareness raising via the Information Governance Board Leads, bulletins, IG intranet pages, continued support with e-learning sessions, train the trainer sessions and open access/departmental face to face sessions held across the Health Board. Proactive targeting of non-compliant staff has continued to take place via monthly checks on all staff, complemented by mailshot to all non-compliant staff. A supplementary ESR user guide specific for accessing IG e-learning has been continually distributed.

All Level 1 Competencies

- The current level of compliance for Mandatory and Statutory stands at 75.22%. This is an improvement on the last reported compliance level of 72.81% in December 2018, by 2.41%. This is an equivalent of 6,000 compliances being completed. A continuation of proactive targeting of non-compliant staff has worked since October 2018 to ensure the compliance level has risen. The support that the health board lead for ESR & M&S compliance has provided, through e-learning workshops and over the phone trouble shooting has been attributable to the percentage increase.

What actions are we taking?

- Information Governance Continue to send compliance lists for IG Training compliance to directorates and service delivery units.
- Continue to report IG training compliance formally to the Information Governance Board and to Audit Committee, as well as include it in the annual public facing SIRO Report.
- Finalise the production of an IG training video as an alternative to e-learning or face to face sessions.
- All Level 1 Competencies Investigate Inter Authority Transfer Process to ensure records transfer with employees.
- Update outstanding individual records from Action Point.
- Use additional resources such as apprentices to reduce the backlog on Action Point.
- Continue to deliver e-learning workshops across the Health Board.
- Investigate where compliance in higher level training mitigates the need for level 1 training and implement automatic sign off of competencies.
- Level 2 training updates level 1 automatically on all Mandatory Training subjects.

What are the main areas of risk?

All level 1 Competencies ESR self-service and supervisor self-service roll out and usage.

- IT infrastructures.
- Potential changes to pay progression and increments.
- Lack of resources (highlighted at Audit Committee).
- Lack of computer literacy amongst staff
- Time and access to computers for community based staff
- Retire & Returning employees recruited via Direct Hire processes require manual update of training records if available
- Face to Face recording Level 1 Competencies can take considerable time to manually update and indicate a misinterpretation of compliance

How do we compare with our peers?

All Level 1 Competencies

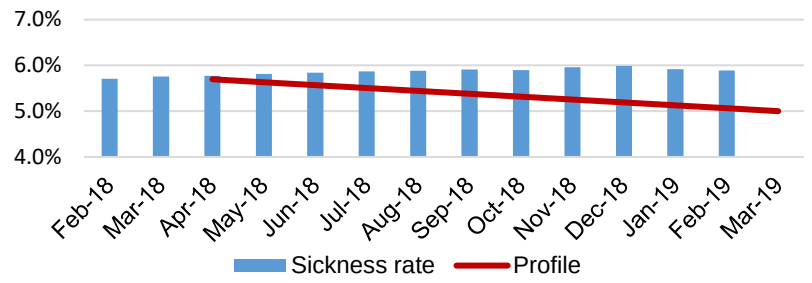
- ABMU have showed consistent improvement over the 12 month period reflected. ABMU show the compliance for the 10 core skills Mandatory Training Framework is matching other Health boards.

SICKNESS ABSENCE

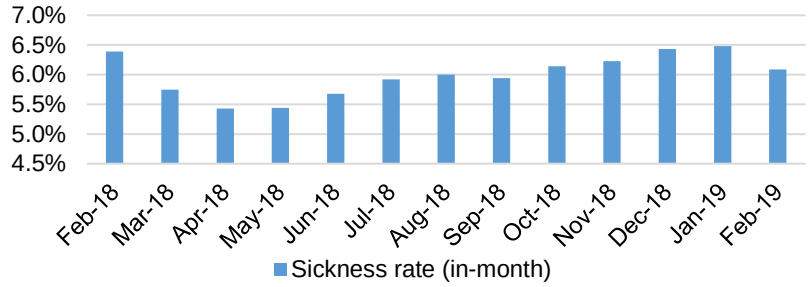
NHS Wales Domain:	**OUR STAFF AND RESOURCES:** People in Wales can find information about how their NHS is resourced and make careful use of them	**NHS Wales Outcome Statement:**	Quality trained staff who are fully engaged in delivering excellent care and support to me and my family
Health Board Strategic Aim:	Excellent Staff	**Health Board Enabling Objective:**	Workforce Efficiency
Executive Lead:	Hazel Robinson, Director of Workforce & Organisational Development		

	Annual Plan Profile	WG Target	**Period:** February 2019 Current Status *(against target):*	Movement: *(12 month trend)*
Measure 1: % workforce sickness absence (Rolling 12 months)	5%	12 Month Reduction Trend	✗	↑ ●
Measure 2: % workforce sickness absence (In-month)	N/A	12 Month Reduction Trend	✗	↑ ●

(3) % workforce sickness absence (Rolling 12 months)

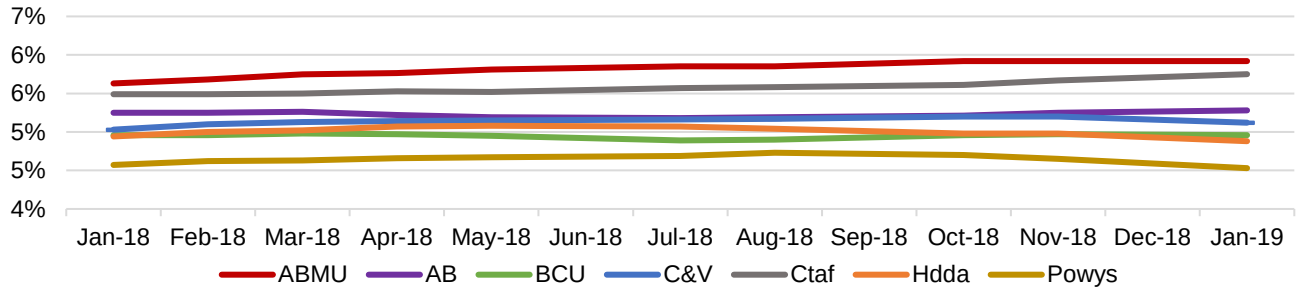


(4) % workforce sickness absence (In-Month)



Benchmarking

(1) % workforce sickness absence (Rolling 12 months)



Source : NHS Wales Delivery Framework, all-Wales performance summary (April 2019)

Measure 1: % workforce sickness absence (Rolling 12 months)
Measure 2: % workforce sickness absence (In-month)

How are we doing?

Rolling 12 month performance:

- Mar 17 - Feb 18 = 5.69%
- Feb 18 - Jan 19 = 5.92%
- Mar 18 - Feb 19 = 5.89%

In Month performance:

- Jan 19 = 6.48%
- Feb 19 = 6.09% (was 6.47% in Feb 18)

- The 12-month rolling performance to end of February 19 has continued to follow the improvement we achieved in January and currently stands at 5.89% (down 0.03% on January 19). Our in month performance in February 19 also improved and was 6.09%, an improvement of 0.39% on the previous month.
- Short-term absence reduced by 0.58% between February 2018 and February 2019. With an increase of 620 short-term cases, and a decrease of 2,247 FTE hours, between February 2018 and February 2019. Demonstrating early intervention techniques adopted from our best practice case study are seeing a quicker return to work date.
- Long-term absence in February 19 stands at 4.50%, which is down 0.08% on January 2019. February's long-term absence performance has seen three out of five-delivery units improve their long-term position, with Singleton delivery unit's long-term position decreasing by 0.5% since December 2018.
- Our highest reason for absence continues to be stress related absence, which remained static compared to the previous month.

What actions are we taking?

- Outputs of best practice case study, conducted in three areas of good sickness performance, are being incorporated into each DU's attendance action plans.
- Development of a pilot within Morriston facilities department has commenced, implementing best practice from the above case study.
- Training sessions for managers regarding the new all-Wales Managing Attendance policy have been extended until August 2019.
- OH Improvement Plan completed with targets for reductions in waiting times approved by Exec Board. Plans to develop a more multidisciplinary approach during 2019.
- Delivering Invest to Save 'Rapid Access - Staff Wellbeing Advice and Support Service' enabling early intervention for Musculoskeletal (MSk) and Mental Health, ideally within 5 days (90 referrals monthly) and expediting to MSk diagnostics and surgery when required. This model accepted as Bevan Exemplar 18/19.
- Currently implementing digital dictation software for clinicians to reduce waits for OH reports to be sent to managers. Evaluation to be completed July 19.
- 300+ Staff Wellbeing Champions now trained to support their teams health and wellbeing and signpost to HB support services, promoting a prevention/early intervention approach.
- Deliver 'menopause wellbeing workshops' across four main sites during 2019 to support the new all Wales policy implementation.

What are the main areas of risk?

- Failure to maintain continued focus on sickness absence performance may lead to levels increasing.
- Singular focus on sickness management without measured attention on supporting staff attendance through health and wellbeing interventions congruent with our organisational values.
- Direct effect on costs in terms of bank, agency and overtime.
- Increasing levels of sick absence increases pressure on those staff who remain at work.
- Levels of service change likely to affect health and wellbeing with most likely impact on mental health and stress related sickness.

How do we compare with our peers?

- The latest 12 month cumulative differential between ABMU and the all-Wales performance is 0.64%.

11. NHS WALES SELF ASSESSMENT TEMPLATES

11.1 Accessible Communication and Information

NHS Organisation	Swansea Bay University Health Board
Date of Report	April 2019
Report Prepared By	Alison Clarke Sian Jones

The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children.

Reporting Schedule: Progress against the organisation's action plan for the current operational year is to be reported bi-annually. This form is to be submitted on 31 October and 30 April.

Complete form to be returned to: **hss.performance@gov.wales**

Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss? The Health Board uses the reporting template to provide the focus for positive action and also highlight the current gaps for our service users and stakeholders with sensory loss. This is reviewed at each meeting and forms the action plan. Our Sensory Loss Standards Group comprises representation from NHS clinical and managerial staff, voluntary organisations and patient representatives. In light of the Bridgend Boundary Change it has been agreed that the Health Board's Sensory Loss Accessibility Group will merge with the Disability Reference Group to form the Swansea Bay University Accessibility Reference Group (ARG). The first meeting is arranged for 26th April 2019.	

Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:

Needs Assessments	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
All public & patient areas should be assessed to identify the needs of people with sensory loss	Members of the Sensory Loss Standards Group have reviewed the audit tool and have identified a small team from within the group, comprising both Service users and staff members to undertake the audit to check progress against the standards. Engagement from Primary care has resulted in the primary care audit being undertaken in the Beacon Centre, Swansea January 2019. Key members of the Sensory Loss Working Group, including patient representatives were in attendance. Actions following the audit to be reviewed by the GP practice, with support from the primary care team. This was reported in the Q&S Forum. An audit of Singleton Hospital Ophthalmology Department will be undertaken. Planning and preparation for this is to commence in 2019. Collaboration with the Dementia Training Team has resulted in sharing of information and	Ability to expand and implement the audit in new clinical areas, cooperation and participation of teams is essential in clinical areas. Disproportionate focus of audits undertaken in secondary care settings Engagement from Estates department. Capacity of staff and time required to undertake the audit.	Engagement with primary care settings to undertake the audit. Review of the current audit tool in collaboration with service users, third sector and Health Board staff to assess ease of use. Primary Care Estates manager to be invited to engage with audit in primary care facilities. Support provided from members of the Sensory Loss group and involvement of new members of the group further to the Bridgend Boundary Change.

	learning in relation to hospital signage and coloured toilet seats. Environmental audits have taken place and the results shared with the Sensory Loss Group. Disability Reference Group (DRG) conducted access visit to Neath Port Talbot Hospital.	Inconsistent attendance at the group meetings due to Dementia related workload. Corrective actions to improve accessibility taking place.	Request annual update from Dementia team. Recommendations made to improve accessibility. Neath Port Talbot Hospital considering implementation.
All public information produced by organisation should be assessed for accessibility prior to publication.	ABMU Disability Reference Group reviewed all terminology for signage at Morriston Hospital as well as agreeing pictograms to be used alongside descriptors, resulting in new signage being put in place in Phase 1B. ABMU Disability Reference Group developed guidance for Health Board on signage – distributed to Capital & Estates department for implementation Feedback from patient experience team reported on; Improved signage in certain areas of the hospital. Inconsistent approach to the provision of accessible publications. Standards for production of information for the public developed by ABMU Disability	Cost of production of the materials required to improve signage. Lack of understanding by staff of the statutory obligation to provide information in accessible formats. Awareness raising with staff across large complex organisation and implementation.	Larger font required for hospital signage – signs replaced Produce intranet article on the need to provide accessible information. Review information relating to the booking of interpreters. Report at Q&S forum and share across all delivery Units.

	Reference Group and signed off by Health Board. Accessible information will be placed onto the health board website for Morriston, providing visual and written guides on the sites. Work is ongoing, other sites to be added this year.	Ability to roll out to other sites.	Use of digital technologies.

Standards of Service Delivery	**Key Actions Achieved during 2018-19**	**Risks to Delivery**	**Corrective Actions**
Health Prevention (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include:			
➢ Raising staff awareness	During ante natal and the birth visit the Healthy Child Wales programme (HCSP) assesses all the medical and social needs of both parents including sensory loss. A Care plan is developed to ensure clients have access to interpreters/sign language. Staff have had training in delivering the HCWP. Staff awareness raising takes place at professional meetings and skills training sessions.	Availability of interpreters.	Use of external providers for economies of scale and easy access
➢ Ensuring all public information is accessible for people with Sensory loss	Staff use texting as well as other forms of communication to ensure clients understand information and interventions provided. Information leaflets provided by Public Health Wales are given to	If interpreters or access to Ipads are not available. No braille information is currently available re: Fluenz or Height, Weight and Vision Screening	Staff ensure resources are available by planning and booking interpreters for planned appointments. Awaiting response from Public Health Wales.

	all parents/carers of eligible children re: Fluenz programme. Top 10 excerpt from AQS currently being produced and will include easy read, audio and BSL versions.	programmes, or the Child Measurement Programme.	
➢ Accessible appointment systems	Home visits by the Health Visitor allow for two way communication of appointments. Ongoing appointments are discussed and acceptable ways for clients negotiated to ensure they have an understanding of appointments. ABMU is part of a National Task & Finish Group for school entry hearing screening.	If interpreter not available. If information cannot be produced in an appropriate accessible format.	Staff ensure resources are available by planning and booking interpreters' sign language staff for planned appointments. Support sought from Third sector partners where information is available in an accessible format. Access to the Editorial Advisory Group to provide advice ensuring information leaflets are available and meet the standards.
➢ Communication models	Health Board staff work in collaboration with Specialist teachers/classroom assistants in Units and support School Nurses as necessary if the parents or pupil has a sensory loss issue. Texting appointment details and alerts.	No teacher available.	Re-arrange school visit.
Primary and Community Care. Priority areas include:			
➢ Raising staff awareness	Sensory Loss Awareness training, has been identified to be of high importance. Discussion is underway to facilitate the provision of electronic and direct learning and increase awareness	Lack of understanding by staff of the statutory obligation to meet the standards for sensory Loss.	E-learning module, intranet article, engagement with third sector to showcase at HB conferences, open days etc.

	for frontline staff. There is the ambition that 'sensory loss champions' could be identified to support staff or service users when required. Podiatry & Orthotic staff are aware of interpreter service, central resource e-mail address and central telephone line and signpost patients with sensory loss accordingly. Staff in the Orthoptic Dept have completed the on line sensory loss training. All Maesteg Hospital A&C staff have undertaken the e-learning module on sensory loss. All Chronic Pain & MCAS Staff are informed of interpreter services and how to access these. Audiology staff have regular 'deaf awareness' training, and interpreter services are used routinely The pilot of a BSL video to support reception staff meet and greet deaf people is being developed by the NHS Centre for Equality and Human Rights and will be evaluated for its effectiveness at 6 and 12 month. The video will be made available to the Health Board.	Video unavailable Health Board not being able to access the resource via YouTube. Inability for a rep to attend the forum.	Contact project lead for update. Advise of a different platform that will be required in order for staff to be able to access.

	The Primary Care Quality & Safety Group have invited a representative of the Sensory Loss Group to participate in the meeting, to support raising of the standards and improving awareness of Sensory loss in Primary Care.		Acquire meeting dates ahead of time so that appropriate representation can be sought.
➢ Accessible appointment systems	Evidence provided of services offering communication via telephone, text and e-mail for appointments i.e. Audiology patients are able to communicate via text, email and telephone. Speech & Language Therapy offer appointments by telephone and post only. There is no access to text messaging. Podiatry and Orthotics do not currently use text service, however the option to communicate by text is being explored. Chronic Pain service uses phone, text and e-mail. MCAS uses phone and e-mail. Text is available from October 2018. Braille is available to people who request it. Letters are produced by RNIB and cost recharged back to us. Information is on Intranet under language/communication support.	Inconsistency of approaches across HB. Competing priorities for services.	Share good practice between services. Ensure staff and managers aware of statutory obligation.

	Patients attending the Bridgend Eye Unit/Orthoptic Dept are able to access the booking office by e-mail. Development/Education session with Martin Griffiths from Hearing Loss Wales on the Accessible Healthcare report – access to GP Services was undertaken for the sensory Loss accessibility group.		
➢ Communication models	Services have access to British Sign Language Interpreters to support service users. Evidence across a number of services of having developed and implemented communication for appointments via telephone, text and e-mail but this remains inconsistent across the organisation. Braille available (see comment above). MCAS will be using text service from October 2018. **Loop systems** are available in: Audiology Clinics and Cwmavon Health Centre. Speech & Language Therapy has access to interpreters and employs a generic e-mail account.	Availability of interpreters. No loop systems currently available in Community Clinic sites; Dyfed Road hub and Speech & Language Therapy. Funding for new system and	Staff ensure resources are available by planning and booking interpreters for scheduled appointments Raise awareness of this in annual plan and risk assessment.

	Loop systems in Podiatry and Orthotics are available including hospital sites and Port Talbot Resource Centre. Chronic Pain & MCAS are mostly community based and a portable hearing loop system is available for use. Maesteg Hospital has a hearing loop. Bridgend Eye Unit/Orthoptic Dept has a portable hearing loop at the reception desk and another available for use in the clinic rooms. Hearing Loop has been hired in from external organisation for future ARG meetings. Ophthalmology/Orthoptic department at Singleton have purchased 2 portable hearing loops. One is located in the Eye Care Liaison Officer's room and another available for use in any clinic room. All staff have been made aware that these loops are available.	maintenance/replacement of old equipment. Infrequent usage of the service can result in staff being unfamiliar with the equipment. Access to Hearing loop system Staff training and awareness and implementation of the system.	e-learning training package to support sensory loss awareness across the workforce. Obtain hearing loop system. Portable hearing loop departmental protocol and training.
Implementation of the Accessible Information Standard	The Sensory Loss Accessibility Working Group supports and facilitates the raising of awareness and engagement of services in Primary Care to be informed of the Accessible Information Standard.	Capacity to undertake the audit.	Audit of clinical areas against the standards.

Secondary Care. Priority areas include:			
➢ Raising staff awareness ➢ Communication models ➢ Accessible appointment systems	Informatics Senior Managers received sensory loss training from Deafblind Cymru, and Royal National Institute of Blind People (RNIB) The Lymphoedema clinic is now employing Oracle to book interpreters, in particular for patients who have suffered head and neck cancer. The service is currently piloting the text messaging service to remind patients of appointments. Patient appointments can be issued via letter or if required more bespoke methods have been used to issue appointments in person. Interpreter services are booked in advance of the appointment. Patients are also provided with leaflets and video applications about lymphoedema, and lymphoedema management & treatment to enhance the different ways information is provided to patients, other than verbally from clinicians. ACCESSIBLE APPOINTMENT LETTERS: The Health Board is continuing to work with service users with visual impairment to develop a method to receive large print outpatient appointment	Ability to provide training to all staff groups. Ability to refresh staff awareness of sensory loss. Some patients may not have an e-mail address so would be unable to participate in the pilot.	Consider that e-learning training in sensory loss is made mandatory. Active support and involvement of the IM&T department has been secured and the pilot will be evaluated to inform future action. Meeting in March 2019 – to discuss large print letter – IM&T representative to attend ARG meeting

	letters. The appointment letter will be put into PDF format and then e-mailed to the patient. Work continues on this pilot with regular feedback at Sensory Loss group meeting. The IM&T department is awaiting suggestions from our deaf colleagues as to the content of the letter to make it user friendly and encourage sign up.	Availability of feedback to inform the project, until this has been received it is not possible to commence the pilot.	in April 2019 Contact service users for feedback and guidance.
	ACCESSIBLE CONSULTATIONS: ABMU carried out a successful Face Time trial using iPads to provide real-time signing for deaf people whose first language is British Sign Language and who are receiving care in hospital. The Face Time trial was developed as part of ABMU's wider mobilisation project, which involves using new technology to improve contact between the health board, staff and patients. When it is made more widely available it will not replace face to face interpretation but will instead be an extension of the existing service. This opportunity has been extended to a pilot within Neath Port Talbot Outpatient Department.	Access to the appropriate technology and awareness of the service across all hospital sites and clinical areas. The innovative practice is not requested or actively pursued. Staff turn-over may result in the knowledge of the technology and service being forgotten.	The use of Social Media, Internet and Intranet to communicate this alternative approach and its success placing patient experience at the centre of the evaluation. Refresh the awareness raising of this innovative practice to the Delivery Units.
	HEARING LOOPS: A mapping exercise of the availability of	Bridgend Boundary Change	Review in light of Bridgend boundary Change.

	hearing loops across the Health Board has been undertaken.		
	ENGAGEMENT: ABMU continues to engage with a range of stakeholders this includes local representatives from disability access groups, RNIB Cymru and local RNIB groups, British Deaf Association, Bridgend and Swansea Deaf Clubs, Wales Council for the Deaf, Deaf Blind Cymru and Action on Hearing Loss Cymru. The ongoing engagement takes place through ABMU's Sensory Loss Standards Group, Disability Reference Group, Deaf Focus Group and Stakeholder reference Group.	Ability to sustain raising awareness and maintaining awareness of the standards and best practice.	Organise awareness raising events and increase use of social media in collaboration with our third sector partners, service users and community groups to raise and sustain awareness to achieve further improvement.
	Outpatient departments access British Sign Language Interpreters via Oracle to support service users.	Having the information that a patient requires an interpreter.	Ensure referral has required information to inform the decision about Sensory loss requirements. Capture information on the PAS.
	British Sign Language interpreters are integral to the success of the Sensory Loss Working Group and are commissioned to provide a service at the meeting.	Availability of interpreters.	Book interpreters service well in advance of meeting. Review contract with WITS further to engagement with local Deaf Focus Group.
	A service provided by the Volunteer service for adult hearing aid users has been developed and implemented in partnership with Action on	Availability of Volunteers or changes to the Volunteers service in the health board.	Engagement with the Lead for Volunteers in ABMU HB to ensure a sustainable service.

	Hearing Loss. A nationally agreed pathway for battery provision and ongoing hearing aid maintenance, including self-management, battery management and volunteer peer support is now being run out of Singleton hospital.		
Implementation of the Accessible Information Standard	The Sensory Loss Accessibility Working Group supports and facilitates the raising of awareness and engagement of services in Secondary Care to be informed of the Accessible Information Standard.	Capacity to undertake the audit.	Audit of clinical areas against the standards.

Standards of Service Delivery	**Key Actions Achieved during 2018-19**	**Risks to Delivery**	**Corrective Actions**
Emergency & Unscheduled Care. Priority areas include:			
➢ Raising staff awareness ➢ Communication models	IN-HOURS/OUT OF HOURS: Wales Council for Deaf People shares information with the Health Board in relation to accessing interpreters in an emergency situation.	Out of Hours Service support may not always be as comprehensive as in-hours.	Raise awareness of other models to improve communication in times of emergency including the WAST app.
Concerns & Feedback (CF). Areas include:			
➢ Highlighting current models of CF in place which would support individuals with sensory loss to raise	Texting, braille version information on how to raise a concern. Easy read leaflets on how to raise a concern and information on Putting Things Right for concerns. Audio version	Complacency with models familiar with and lack of modernisation and use of digital technologies to improve communications in this area.	Horizon scan and access up to date information on new systems and devices employed to improve services in this field.

a concern or provide feedback	on how to raise a concern. Using suitable font for corresponding with complainants with visual issues. A British Sign Language video version of the patient complaints information leaflet is available on the ABMU HB website for BSL users to access to support in raising a concern. Let's Talk, one of ABMU's feedback mechanisms, includes a text message and email service to notify the HB of issues / provide the HB with positive and negative feedback on its services. Bridgend Boundary Change will impact on group membership for the Sensory Loss Accessibility Working Group. Review group and membership and invite new members to the ARG.	Poor information and limited reporting of data on Sensory loss complaints via Datix. Reduced awareness of number of complaints and themes. Loss of experienced staff with appropriate knowledge and skills in this field.	Through improved data collection and reporting in Patient Experience and Datix review themes and trends relating to sensory loss and produce action plan. Recruit new members prior to April 2019. Invite to the ARG.
➢ Highlight any CFs received in sensory loss and actions taken	Difficulty reading appointment letter, font size increased to improve accessibility of information.	Staff not always aware of patients' sensory loss when booking patient.	E-mail project to continue.

Patient Experience*	**Key Actions Achieved during 2018-19**	**Risks to Delivery**	**Corrective Actions**

Mechanisms are in place to seek and understand the patient's experience of accessible communication and information	The All Wales survey is used to seek and understand the patient experience of accessible communication and information. Representatives from BDA Wales, Action on Hearing Loss Cymru, Deaf Blind Cymru and RNIB Cymru comprise the membership of ABMU's Sensory Loss Group. Service users experience is shared at the meeting to inform gaps and areas for improvement. The BDA and RNIB are also represented on ABMU's Disability Reference Group. People with sensory loss are actively engaged in department audits relating to the Sensory Loss standards and their experiences communicated to staff. Sensory Loss Training has been provided for staff in the Informatics Department to support future work/developments relating to making appointment letters more accessible to people with sensory loss. Training provided by third sector organisations. The sensory group facilitates the opportunity to receive service user feedback; Issues highlighted by a patient with hearing difficulties was lack of	Poor performance on RTTs, increased DNA rates, poor patient experience, patient does not receive the care required. Limited staff awareness.	Any concerns are identified and logged on Datix. 'You said – We Did' forms are also completed and reported in Quality and Safety forums in each Unit. Provide e-mail access for appointments to patients with sensory loss, continue engagement with IM&T.

	communication methods within Primary and Secondary Care. Patients are required to respond to hospital appointment letters via telephone as no e-mail address is provided. The service user then has to visit the hospital to make any changes to the appointment. There are ongoing issues with obtaining a portable hearing loop in some parts of the HB. Patient praised the superb efforts of a GP who made changes to facilitate patients' use of services; the patient put the GP forward for an ABMU award for exceptional service. Service user feedback has indicated that the HB should be cognisant of other professionals such as Lip speakers and Palantypists . A Speech-to-Text Reporter was in attendance at the last meeting. A service user has highlighted that the HB should recognise carers with a sensory loss and that support should also be provided to people with sensory loss who may be attending an appointment in the capacity of a carer or as the parent of a child.	Availability of funding and access to training. Failure to communicate health information. Patient may DNA or vital information may not be understood by carer.	Health Board is working to ensure that hearing loops are available and that staff are trained to use them. Intranet articles to raise profile of different conditions. Investigate opportunities to employ new technologies. Developing links with regional carers associations as most carers associations have newsletters etc. and might insert an information item.

	Dyfed Road GP Surgery, Neath has implemented an electronic scrolling sign that details the patient's name, the doctor/nurse they are to see and the appropriate room number. The customer care and interaction provided by reception staff at NPT, Morriston and Singleton Hospitals has been praised by patients who had a hearing and visual loss. However there is also feedback relating to attitude of professionals and the need for education of the workforce to better manage people with sensory loss.		
	Key Themes		**Corrective Actions**
The key themes to emerge from patient experience feedback (both positive and negative)	Awareness training for staff on sensory loss		Provide different awareness training options for staff, face to face training, e-learning, drop-ins.
	Access to hearing loops		Complete hearing loop mapping report, present at Q&S and raise awareness at Unit level
	There is a continued requirement to provide information in a more accessible format e.g. large, bold print, with appropriate contrast.		IT Department is piloting large print appointment letters. This would be an interim measure until a national solution is implemented.
	Departments should provide more accessible information and a variety of ways in which the service can be contacted, particularly e-mail and text messaging.		Advised to include other communication options in appointment letters.

	Problems with lighting and flooring in POWH Eye Clinic raised at Disability Reference Group.	DRG agrees use of capital monies allocated to improve access to our facilities – Lighting and flooring replaced
	Problems with flooring in corridors at POWH identified by DRG	Flooring replaced with advice from DRG representatives
	Lack of blue badge spaces adjacent to Children's Centre at POWH identified by DRG	Work underway to redesignate spaces to increase number of blue badge spaces Work was undertaken which showed that many of the spaces had been counted incorrectly and there are many more spaces than initially thought.
	Lack of drop curbs identified on route from bus stop to POWH entrance	Being addressed using capital allocation
	Patients/visitors would like the Volunteer service to be able to support them more with accessing areas of the hospital and information.	Digitalisation training and access to ipads for volunteers.
* **Patient experience mechanism and themes to be documented in this return applies specifically to patients with sensory loss who have accessible communication and information needs**. There is a requirement in the NHS Delivery Framework for NHS organisations to provide an update on patient experience for all patients (not just for those with accessible communication or information needs). This is to be reported on a separate proforma entitled 'Evidence of how organisations are responding to patient feedback to improve services' and links to the NHS Framework for Assuring Service User Feedback.		

11.2 Advancing Equality and Good Relations

NHS Organisation	Abertawe Bro Morgannwg University Health Board
Date of Report	25 March 2019
Report Prepared By	Joanne Abbot-Davies, Jane Williams, Nicola Johnson

The Public Sector Equality Duty seeks to ensure that equality is properly considered within the organisation & influences decision making at all levels. To meet the requirements of the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 Health Boards & NHS Trusts must consider how they can positively contribute to a fairer society through advancing equality & good relations in their day-to-day activities. The equality duty ensures that equality considerations are built into the design of policies & the delivery of services and that they are kept under review. This will achieve better outcomes for all.

Reporting Schedule: Progress against the organisation's plan is to be reported bi-annually. 31 October and 30 April.

Does the organisation have a Strategic Equality Plan (SEP) in place, setting out how tackling inequality and barriers to access improves the health outcomes and experience of patients, their families and carers? Does the SEP include equality objectives to meet the general duty covering the following protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race (including ethnic or national origin, colour or nationality), religion or belief (including lack of belief), marriage and civil partnership, sex, sexual orientation?	**Yes** **Yes**

Update on the actions implemented during the current <u>operational year</u> to advance equality & good relations in the health board's day to day activities

	Key Actions Planned	**Risks to Delivery & Corrective Actions**	**What was achieved**
Planning & Performance Management			
IMTPs clearly demonstrate how the NHS organisation meets the duties associated with equality & human rights and the arrangements for equality impact assessment.	Ensure we meet the commitment within our Annual Plan to assess the equality impact of proposed service change.	Risk: Equality Impact Assessment (EIA) may not be an integral part of the service change processes. Action: Training and coaching provided to key service managers. The Health Board identified that we have a skills and capacity gap to impact assess complex service change. We secured an external expert on secondment from Welsh Government to support the Service Remodelling Workstream and Strategic Planning (equality impact	Equality impact assessment has been integrated into the work of the Service Remodelling Workstream. EIA used to inform the Board decision on Tranche 1 of the schemes and also phase 1 EIAs completed for Tranche 2 schemes. The external expert has developed a library of information to be used in future EIAs. Links to the new Quality Impact Assessment process that

		assessment of our new Clinical Services Plan and Annual Plan). Ongoing arrangements have been agreed including the appointment of a temporary Integrated Impact Assessment manager (Job Description currently being banded). The JD includes supporting EIA at an earlier stage of our corporate planning processes.	the Service Remodelling Workstream has also put in place. EIA completed for the Clinical Services Plan which was approved by Board in January (also covered our Annual Plan which is the year 1 implementation plan). Agreement to appoint a temporary Integrated Impact Assessment Manager in place. Job description drafted and with HR for banding so that recruitment can proceed.
Steps have been taken, where possible, to align equality impact & health needs assessments to ensure they take account of the 'protected characteristics' & utilise specific data sets & engagement activity.	Develop an Area Plan for Western Bay & establish monitoring against actions.	The equality impact assessment for the Western Bay Population Assessment 2017 identified that there is greater insight into the care and support needs of some people with protected characteristics than others. Further research is needed to address the data gaps.	Lessons learnt workshop held on preparation of Population Assessment & Area Plan – info collated to support future improvement work. Plan developed to refresh Population Assessment and Area Plan on new Western Bay footprint (West Glamorgan) after Bridgend Boundary change
IMTPs set out how equality impact assessment is embedded into service change plans & informed by the findings from engagement & consultation and other evidence.	Continue to undertake equality impact assessments on proposed service changes and use the results of our assessments to inform decision making.	Risk: Board may not take decisions in light of impacts on protected groups. Risk: Service Delivery Units may not understand the need or importance of carrying out EIAs. Risk: Individuals across Health Board may not have the experience, training or skills to develop EIAs.	Refresher training was provided for service delivery units undertaking equality impact assessment in late 2017 with ongoing support available. Deficits in skills led to secondment of EqIA specialist to support Health Board in developing EqIAs and providing central information resource. Equality impact assessment

		Further EIA training is also being planned for the Planning Team and key managers in Delivery Units. The IMTP will be Equality Impact Assessed in tandem with our Organisational Strategy and Clinical Services Plan.	training was delivered on 22.02.2018 as part of the Board development session.. The external specialist has developed a library of information that can be used in future EIAs. EIAs are developed for all service changes. Where engagement is undertaken an initial EIA is prepared at the start of the process and amended at the end to reflect comments made through the engagement. Our HB business case paperwork is being refreshed as part of the Transformation Programme and this will include the requirements to undertake EIA at this early stage of planning.
Service plans include clear measurable objectives for reducing health inequalities & are aligned to the equality priorities set out in the Strategic Equality Plan.	Engage with the public and partners to develop a strategic framework for mental health The Annual Plan 2018/19 sets out our approach and priorities for reducing health inequalities.	Risk: Lack of availability of time / skills to support co-designed and co-produced engagement process across Health Board and Local Authorities. All of the actions in the Annual Plan to be tracked through quarterly reporting to the Board.	Engagement undertaken to inform the Health Board and Local Authorities' Strategic Framework for Adult Mental Health. 105 people gave their experiences face-to-face and another 170 through questionnaires. Quarter 3 report on the delivery of the Annual Plan has been approved by the Board.

	Key Actions Planned	**Risks to Delivery & Corrective Actions**	**What was achieved**
Governance			

The Health Board/NHS Trust receives assurance that processes are in place to identify Equality impact, undertake engagement and that mitigating actions are clearly set out. Committee or Sub-committees confirm that equality impact assessments inform decision making.	Review the reporting arrangements to provide assurance on equality.		Reporting arrangements clarified as part of the overall review of the Board Sub Committee structure. The Service Remodelling Workstream has EqIA as a standing item on the agenda and ensures they are completed for all service changes within the programme. All proformas on proposed service change for CHC include a section on EqIA
The Health Board/NHS Trust ensures that equality considerations are included in the procurement, commissioning and contracting of services.	Deliver equality training to the Procurement Team.	Two training sessions were held in the Procurement offices at an agreed time and date to overcome the risk of low numbers of staff being released for training.	All members of the Procurement Team attended equality and human rights training delivered by the NHS Centre for Equality and Human Rights.
Quality and safety			
Each service change programme/plan as a minimum includes: equality implications, including positive and negative impacts on patients, public and staff and mitigating actions to reduce any anticipated negative impact.	Ensure we meet the commitment within our Annual Plan 2017/18 to assess the equality impact of proposed service changes.	Risk: EqIA not seen as integral part of planning service change. Training and coaching provided to key service managers. The Health Board identified that we have a skills and capacity gap to impact assess complex service change. We secured an external specialist on secondment from Welsh Government. Ongoing arrangements have been agreed including the appointment of a temporary Integrated Impact Assessment manager (JD currently being banded). The JD includes	Equality impact assessment has been integrated into the work of the Service Remodelling Workstream and engagements on service changes. It is also integrated with our strategic planning processes.

		supporting EIA at an earlier stage of our corporate planning processes.	
Equality is clearly linked to quality initiatives and are informed by the needs assessment findings, the risk register, and the challenges and improvement priorities set out in the Annual Quality Statement.	Engage with the public and partners to transform services by improving efficiency, addressing PJ paralysis and so reducing the number of beds required in DGHs and OPMHS.	Risk that public and partners do not understand benefits to quality and reduction of risks through new pattern of services.	Engagement held in early 2018-19 outlining a new pattern of services. EqIA completed as part of this process and amended in light of engagement findings A Quality Impact Assessment process has also been used to assess our complex service changes this year and to develop our financial plan for 2019/20 as part of the Annual Planning process. The Integrated Impact Assessment Manager will be responsible for overseeing and promoting both processes.
Workforce			
There is evidence that employment information informs policy decision making and workforce planning.	Aim to increase the diversity of the workforce	ESR self-service should improve the disclosure rate of protected characteristics for staff. The self-service facility enables staff to update their own details.	We promoted NHS careers / apprenticeships at diversity events, including Swansea Bay Job Centre and Welsh Refugee Council's first ever BAME event held in Swansea YMCA on 13.02.2019. Our Vocational Training staff talked to BAME people who took away the Apprenticeship or Vocational Training leaflet so they can discuss it in more detail with their work coaches.

			We launched Project SEARCH with Bridgend College and Elite Supported Employment Agency on 13.09.2018. This has enabled nine young people with additional learning needs and disabilities to secure a supported internship at the Princess of Wales Hospital. The interns completed their first 10 week placement which has been a positive experience. The departments involved are supporting the interns to apply for vacancies. Elite Training Agency is also supporting interns to look for alternative vacancies in the wider local community.
Numbers of staff who have completed mandatory equality and human rights training 'Treat Me Fairly' (TMF)			12,586

Completed form to be returned to: hss.performance@gov.wales

Relevant Strategies and Guidance

- Equality and Human Rights Commission Wales (EHRC) https://www.equalityhumanrights.com/en/commission-wales
- Making Fair Financial Decisions: Guidance for Decision-makers - Equality and Human Rights Commission
- EHRC's "Is Wales Fairer?" 2015
- Welsh Government Equality Objectives 2016
- Organisations Revised Strategic Equality Plans 2016 - 20
- EIA Practice Hub – NHS CEHR/WLGA 2015 – http://www.eiapractice.wales.nhs.uk/home
- The Essential Guide to the Public Sector Equality Duty: An Overview for Public Authorities in Wales (EHRC)

11.3 Dementia Training

Reporting Template: As outlined in the 'Good Work - dementia learning and development framework' all staff who work for NHS Wales need to have a solid

Reporting Schedule	31st March 2019
Health Board/Trust	*ABMU HB*
Date of Report	*31st March 2019*
Completed By	Nicola Derrick and Andrea Rose
Contact Number	01656 753909
E-mail	Nicola.Derrick@wales.nhs.uk

awareness of dementia and the issues that surround it, to ensure that their approach supports people with dementia and carers to live well. This reporting template monitors the percentage of employed staff who have completed dementia training at an informed level and the actions being implemented to ensure the appropriate staff groups receive dementia training at a skilled and influencer level. Data is to be sourced from the Electronic Staff Record (ESR).
Target**:** For 2018-19, 85% of staff who come into contact with the public will have completed the appropriate level of dementia/education training.
Reporting Schedule: Dementia training is to be reported bi-annually. This form is to be submitted on 21 October (for data collected at 30 September) and 21 April (for data collected at 31 March).
Form to be returned to: hss.performance@gov.wales

Data at:	**Target**	**Total number of staff on ESR**	**Total number of staff on ESR who have completed dementia training at an informed level**	**Percentage of staff who have completed dementia training at an informed level**	**Update on issues impacting delivery**
30 September 2018	**85%**	*16317*	*12138*	75.7%	Cancellation of 20 sessions between September 2017 to September 2018 due to insufficient nominations and non-attendance of staff on the day of the event leaving insufficient numbers to run the event effectively. Long Term and Short Term sickness has also effected training offered
31 March 2019	**85%**	16202	13265	81.8%	Two members of the DCCT have transferred to Cwm Taf from April 1st 2019

What actions have been implemented to identify staff groups who require dementia training at a skilled and/or influencer level*? What has been put in place to deliver and record training for these groups?

Skilled Level – DCT3-Dementia Care Training Level 3 = 533 staff have completed DCT3 recorded on ESR Influencer Level – Plans to develop an Influencer Training Package for 2019, will look to enlist the assistance of Corporate Learning and Development ensure the training is pitched at the correct level of education for this group of staff

*Further information on the staff groups that are required to complete dementia training at a skilled and/or influencer level and the training topics to be covered are available in 'Good Work - dementia learning and development framework'. https://socialcare.wales/resources/good-work-dementia-learning-and-development-framework

11.4 Implementation of the Welsh Language actions as defined in 'More Than Just Words'

NHS Organisation	**Swansea Bay University Health Board (SBUHB)**
Date of Report	**April 2019**
Report Prepared By	**Carol Harry, Welsh Language Officer**

Each Health Board and Trust is expected to put in place actions to deliver the strategic framework for Welsh language services in health, social services and social care: 'More Than Just Words'. This has been developed to meet the care needs of Welsh speakers, their families or carers. Actions to deliver the framework are to cover both primary and secondary care sectors.
Reporting Schedule: Progress against actions to deliver 'More Than Just Words' is to be reported bi-annually. This form is to be submitted on 31 October and 30 April.

Update on the actions to deliver the More than Just Words Strategic Framework

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
Population Needs Assessment The organisation has identified the Welsh language needs of its population and has used it to plan services.	**Yes**	Population Assessment for the Western Bay1 region, was launched in April 2017 to be repeated in 2021 allowing Western Bay partners to incorporate new information and to ensure progress is monitored effectively. In 2018 Welsh Government announced the decision to change the Health Board Boundary layout2. Abertawe Bro Morgannwg University Health Board (ABMUHB) became the new Swansea Bay University	None identified for this reporting period.	Not applicable for this reporting period.

1 http://www.westernbaypopulationassessment.org/en/home/
2 http://www.wales.nhs.uk/sitesplus/863/page/97259

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		Health Board (SBUHB) from 1 April 2019 with a geographical footprint covering the areas of Neath Port Talbot and Swansea. As result of the boundary change the population assessment has been revised to reflect the new West Glamorgan area and priorities aligned through the new Regional Partnership Board. We continue to use population assessments to inform how services assess the needs of Welsh speakers and this data is underpinning our strategy for service development. Our grant contracts with the third sector continue to require bodies to set out their approach to bilingual service provision	An Equality Impact Assessment was undertaken as part of the Bridgend Transition Programme which considered the impact in relation to Welsh Language. No adverse impact was identified.	

Welsh Language Skills The organisation has identified the Welsh language skill levels of its workforce and is using this information to plan services.	**No**	639 staff have identified themselves on the Electronic Staff Record (ESR) system as having some level of Welsh language skills. Completion of this via ESR is not mandatory but staff with the relevant access rights are being encouraged to complete it. Staff can register their Welsh language skills via ESR but at present it is not possible for every staff member to do so as not all staff	Some staff do not have the confidence to use their Welsh language skills with patients. Some staff simply say they do not wish to use their Welsh Language skills and for this reason have chosen not to display the logo denoting that they have bilingual skills on their uniforms.	We continue to encourage staff to input their language skills into ESR and sites have manually collected this data as a backup. Lunchtime sessions have been held at one of our sites to encourage staff to chat in Welsh that helps to refresh their skills and increase confidence levels. We are encouraging other

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		have access to an ABMU computer. To address this it is now possible for staff to access ESR via their own Tablets/mobile phones. As not all staff will naturally do so we are having to collect data at local level.	36 staff completed the Welsh Language learning course.	sites to hold similar sessions. In tandem with the free-on-line Welsh courses consideration is being given to joint working with neighbouring health boards to pool Welsh Language tuition resources.
Where there are gaps in Welsh language skills the organisation has ensured that vacancies are advertised as 'Welsh language essential'.	**No**	The ABMU Bilingual Skills Strategy requires managers to undertake an assessment of Welsh Language skills to seek to increase the number of 'Welsh Language essential' vacancies. The Managers Recruiting Criteria Pack is currently being updated.	It remains difficult to recruit English-speaking candidates to particular specialisms.	We promote the free app 'Gofalu trwy'r Gymraeg' on our bilingual social media channels and on our Intranet and website. We are promoting the free-on line Welsh Language course including the new Croeso; 'Sector Iechyd Cymraeg Gwaith' on line course, to encourage existing staff to improve/refresh their Welsh Language skills.
How many members of staff have undertaken a course to learn Welsh or to increase their confidence to speak Welsh during this operational year?				Analysis:- Enrolled on Welsh language Course:- 536 Completed the Course:- 36 Not Started the course:- 278

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	Risk to Delivery	Corrective Actions
				Currently Undertaking the Course:- 222 Staff that have enrolled on the new Croeso; 'Sector Iechyd Cymraeg Gwaith' on line Course.;- 14 have enrolled on the new Welsh language Course Completed the Course:- 0 Not Started the course:- 3 Currently Undertaking the Course:- 11
Patient Preference and Experience The organisation has processes in place to record when an Active Offer has been made and ensure that the language preference of patients is noted across primary and secondary care.	**No**	Our patient letter templates provide for dual language (i.e. both English and Welsh). By the end of 2018, we achieved 100 % in terms of patient letters being sent bilingually. A bilingual appointment reminder service via SMS text is in place across all of the main ABMU specialities. The default first text message received is Bi-Lingual, and from that point forward the patient may specify whether they wish to receive further texts in Welsh or English on an opt in basis.	There is currently no single method of capturing an individual's language preference in a way that populates preference across all information systems. Also the solution for language preference may be different from system to system. WPAS (our main patient information system) does not currently have the functionality to	Our ability to comply with the Welsh Language Standards and the 'More than just words' Framework is reliant on the ability of the NHS Wales Informatics Service (NWIS) to provide this function. We have written to NWIS to raise this issue.

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		The 'Myrddin' patient information system has a field to record patient language preference; we currently have 752 patients logged as having indicated their preferred language as being Welsh. Our outpatient self- check-in system at Morriston Hospital offers patients a choice of whether to transact in Welsh or English. 1,760 patients have registered their attendance in Welsh. The language preferences of all inpatients is collected on admission via the Unified Assessment Form.	capture language preference and produce specific correspondence based on this preference. NWIS need to manage this issue at a national level, to determine whether it should be included within the Electronic Master Patient Index which would then populate all integrated systems with the relevant information in a consistent way	
The organisation has methods in place to communicate to staff the importance of making an Active Offer.	**Yes**	The language preferences of all inpatients is collected on admission via the Unified Assessment Form.		Welsh language section of the intranet and website to be reviewed**.**
The organisation is mainstreaming experience of Welsh language services as part of the information received/ feedback from patients.	**Yes**	All patient satisfaction surveys are produced bilingually. The All Wales Survey has a Welsh Language Question: 'Were you able to speak Welsh to staff if needed to?' Out of the 3,313 All Wales Surveys completed for the time period :-	Due to the low number of staff with Welsh language skills whilst we endeavour to provide a service in Welsh where appropriate – if this is not practical (or indeed clinically safe) we explain this to the service user.	We have recruited an Apprentice Welsh Language Translator.

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		2,059 Answered – Not applicable (as they spoke another language) 551 completed the Welsh question 354 answered – Always 59 Answered – Sometimes 70 answered – Never 68 answered – Usually All 'Friends and Family' reports are produced bilingually and are placed on ward/department notice boards All patient condition information leaflets are produced bilingually. All complaints received in Welsh receive a Welsh language response within the target set. All Health Board staff have access to learn Welsh via the Work Welsh Welcome online course. Staff are encouraged to learn everyday phrases that they can use in conversation with the patient, as often a word of comfort is all that is needed.	We have one substantive Welsh Language Translator role and utilise the services of external translation providers when demand for in house translation exceeds internal capacity. There is a risk that relying on external providers could impact on the turnaround times for completing translation work.	We are seeking to appoint a second in-house Welsh language translator.

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
How many patients have been asked their language preference and have had this preference noted on their records?				We have 752 patients that have registered their language preference as Welsh

Commissioned and Contracted Services The organisation ensures that Welsh language considerations are included in the commissioning and contracting of services including primary care services	**Yes**	The Local Framework for the appointment of Contractors and Consultants ensures this and includes the following as a standard:- *The Employer has a Welsh Language Scheme which sets out its various commitments in terms of bilingualism. A copy of the Scheme can be accessed via the website at www.abm.wales.nhs.uk To assist the Employer in delivering upon these important commitments it is important that the Contractor ensures that any materials/signage on display to the public will be bilingual and meet the requirements of the Scheme in terms of their size, layout, format, quality and prominence. In addition, where there is likely to be a direct interface with the public (either by telephone, email, letters or face to face contact), the relevant provisions of the Employer's Welsh Language Scheme must be observed. Advice regarding compliance can be*	All contractors and consultants appointed will have to comply with this requirement.	Welsh language section of the intranet and website to be reviewed**.**

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		obtained via the Employer's Welsh Language Officer on 01639 683351.		

Sharing Best Practice Best practice in providing Welsh language services is shared with all relevant staff in the organisation and the organisation also shares best practice with other health boards and trusts.	**Yes**	Speech and Language Therapists within our Mental Health & Learning Disabilities Delivery Unit use the 'Iaith Gwaith' quote mark on clinical correspondence and reports to help highlight that they are able to deliver a bilingual service. This initiative is being rolled-out across Therapy services across ABMUHB. In collaboration with 'Coleg Cymraeg Cenedlaethol', 'Coleg Gwyr' and Swansea University ABMUHB has been represented at Careers festivals and sessions such as 'Nursing through the medium of Welsh' and 'Midwifery Training and the Welsh language'. We also work with local schools and colleges to promote the importance of the use of Welsh language in the workplace and the importance of recruiting bilingual staff who are able to provide services through the medium of Welsh. We continue to communicate bilingually in terms of our hospital	As an organisation we have previously encountered difficulties in recruiting suitably qualified and experienced translators.	We promote the free app 'Gofalu trwy'r Gymraeg' on our bilingual social media and on our Intra/internet

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		based information screens, our website, patient information leaflets and posters as well as through social media channels. We are continuing to increase the level of Welsh medium reading material in in-patient and outpatient areas. We have held awareness sessions on Welsh language issues for GPs and practice managers and continue to work with them to increase the number of referrals setting out patient language needs. We have redeveloped and updated our staff handbook which has a section on the importance of Welsh language awareness. We continue to promote the free-online Welsh language course available to all staff. Including the new Croeso; 'Sector Iechyd Cymraeg Gwaith' on line course. We have recruited a Welsh language Translation apprentice, and the Health Board will also be recruiting a second qualified in house Welsh language translator.		

11.5 Improving the Health and Well-being of Homeless and Vulnerable Groups

NHS Organisation	ABMU Health Board
Date of Report	March 15th 2019
Report Prepared by	Tony Kluge, Cluster Development Manager (5 Clusters) Debra Morgan, ABMU HB Planning and Partnerships Support Manager Tel: 01792 601825/ 01792 601876

Health Boards are expected to have in place assessments and plans to identify and target the health & well-being needs of homeless & vulnerable groups of all ages in the local area. **Vulnerable groups are people identified as: homeless, asylum seekers & refugees, gypsies & travellers, substance misusers, EU migrants who are homeless or living in circumstances of insecurity.**
Reporting Schedule: Progress against the Health Board's action plan is to be reported bi-annually. This form is to be submitted on 31 October and 30 April to cover the period April 2018 to March 2019.
Completed form to be returned to: hss.performance@gov.wales

	Key Actions Achieved April to September 2018	**Key Actions Achieved** October 2018 to March 2019	**Risks to Delivery**	**Corrective Actions**
1. Leadership The Health Board demonstrates leadership driving improved health outcomes for homeless and vulnerable groups.	A multi agency approach has been adopted across ABMU linked to key geographical areas in implementing the standards set out in the Welsh Government's 'Standards for Improving the Health and Wellbeing of Homeless People and Specific Vulnerable Groups'. The Health and Housing Group is currently planning a Western Bay Housing Symposium to be held on October 5th which will focus on exploring merging	The Bridgend Boundary Change takes effect from April 1st. As of this date Bridgend will be incorporated into Cwm Taf Health Board and ABMU will be renamed Swansea Bay University Health Board. Following this move there is a need to discuss a reorganisation of HHAVGAP looking at developing closer links between Swansea And Neath Port Talbot to work together to consider the needs of Swansea Bay	• Lack of multi agency involvement/partnership working • Communication systems fragmented/not joined up • Lack of governance and mechanisms to ensure that issues raised are flagged and discussed at appropriate forums	• The need to develop and strengthen the work and profile of HHAVGAP across Swansea and Neath Port Talbot has been flagged and discussed by the Health and Housing Strategy Group. It needs to be further discussed following the Boundary Change implementation on April 1st.

	Key Actions Achieved April to September 2018	**Key Actions Achieved** October 2018 to March 2019	**Risks to Delivery**	**Corrective Actions**
	issues for health and social care, funding available for health, housing and social care via the Integrated Care Fund and improving support available for rough sleepers. This symposium will build further on the Vulnerability Workshop held in December 2017	University Health Board's Vulnerable groups collectively and devise a joint action plan.		
2. Joint Working The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders to improve health of vulnerable groups and contribute to the prevention of homelessness.	The HHAVGAP Group continues to meet quarterly in Swansea. Meetings took place on June 13th and September 12th during this reporting period. Updates and discussions have taken place at these meetings related to the development of the homelessness strategy and action plan for Swansea. Local Authorities have been consulting with partners including health regarding the development of their Homelessness Strategy Consultation. The HHAVGAP Group have received regular updates from Swansea Council regarding the strategy and have inputted into the consultation and action	HHAVGAP Group meetings have continued to take place on December 12th and March 20th during this reporting period. HHAVGAP membership includes diverse representation from Swansea Council, ABMU HB, CHC, SCVS, and the Third Sector. Other organisations attend on a rolling programme to update on schemes and projects on a regular basis eg: Women's Aid, Welsh Refugee Council. The varied membership and the collaborative approach to supporting vulnerable groups is a key strength of the group.	• Increasing demand on services • Lack of funding/resource • Lack of multi agency involvement • Systems not 'joined up' projects/initiatives/ • Support mechanisms fragmented	• Membership of the HHAVGAP steering group continues to develop and expand as additional third sector organisations and other interested parties attend and join the group as appropriate. • Innovative use of Cluster Funds/ ICF funds and other funding streams to support Vulnerable Groups locally continues to prove effective. • Events/workshops/co production opportunities to continue to be held as appropriate.

	Key Actions Achieved April to September 2018	Key Actions Achieved October 2018 to March 2019	Risks to Delivery	Corrective Actions
	plan development. Swansea Council have produced the draft documents and the consultation is taking place from 3rd to 30th September. Drop in sessions regarding the consultation took place on September 19th and September 24th. Swansea's plan will go to cabinet on November 15th and be in place by the end of the year. NPT County Borough Council held a consultation event to review the NPT draft Homelessness Plan on September 14th. Feedback was given to the HHAVGAP Group by the Community Health Council group on June 13th following the publication of the report: *Views and Experiences of People who are Homeless/Vulnerably Housed.* This report was also shared with the Health and Housing Strategy Group who are formulating a response. The report flagged the role of the Homelessness Nurse in Swansea as a positive	Continued discussions have taken place regarding action planning for 2019-2020. A multi agency mental health event took place organised and hosted by the HHAVGAP Group, that focussed on the mental health needs of vulnerable groups. The HHAVGAP group identified the need to focus on this area owing to recurring issues linked to vulnerable groups with complex needs including mental health routinely discussed at HHAVGAP Steering Group meetings. The main aim of the event was to ensure the voices of vulnerable groups and professionals supporting them are heard. This was felt to be particularly important when services are being planned and developed. The event was attended by 29 staff from across different statutory and third sector organisations		• Training opportunities to raise awareness of specific Vulnerable Groups to continue to be offered as appropriate to members of HHAVGAP, GP Practices and other organisations. • Resources developed by HHAVGAP to continue to be shared with partners when relevant and appropriate to need.

	Key Actions Achieved April to September 2018	Key Actions Achieved October 2018 to March 2019	Risks to Delivery	Corrective Actions
	initiative. It was also mentioned that there may be a possibility of extending this role to 7 days a week for Swansea as the Local Authority were investigating funding streams to facilitate this. It was also noted that the service provided for the homeless in Swansea was not currently replicated in Neath Port Talbot and Bridgend. Some respondents living in Neath Port Talbot and Bridgend had travelled to Swansea to see the Homelessness Nurse and access support. Megan Stephens from the Domestic Abuse Hub delivered an overview of the Key 3 Project. Domestic Abuse is a PSB Priority. It can lead to mental health issues including depression. The aim of the project is to ensure that existing services are effectively used and the dots are joined regarding existing support. It was also reported that 'Ask and Act' Training is being rolled out across health.	including ABMU HB, Swansea Council, Crisis, Gwalia, the Wallich, the African Community Centre, Dignity Street Foundation, Barod, EYST, Housing Options and FHA Wales. A draft Event report has been produced to be signed off at the HHAVGAP meeting on March 20th and will be shared with senior staff from the Local Authority, Health Board and all attendees to ensure that the comments, recurring themes and messages can be highlighted when planning services and support for mental health and vulnerable groups moving forward. Some of these issues included identifying key factors in relation to barriers, gaps and solutions to accessing services that can be taken forward.		

	Key Actions Achieved April to September 2018	**Key Actions Achieved** October 2018 to March 2019	**Risks to Delivery**	**Corrective Actions**
	The Women's Refuge Service in the Penderi Network continues to develop. Feedback is actively being sought from Service Users and Key organisations like Women's Aid in the Coming months to determine what is working well and how this Primary Care Service could be further improved. The Penderi Cluster Network Commissioned SCVS to undertake a CYP Consultation on mental health during 2017/18. This report was shared with HHAVGAP in June 2018. Avenues for future exploration have been proposed. Swansea Council and the Health Board have requested data to inform their wellbeing plans. Recommendations will be factored into the Penderi Cluster Plan going forward. Links have been developed with the Gypsy and Traveller Liaison Officer	Suggested solutions included a more joined up approach, stronger governance and the need for a drop in appointments system 'on demand' allowing a more flexible approach. This flexibility is needed to allow vulnerable people to access services without rigid appointments. An issue was raised at HHAVGAP regarding improving DNA rates for Gypsy Traveller Children at hospital outpatient departments. Links have been made with paediatrics at Morriston Hospital and the Gypsy Traveller Liaison Officer to facilitate this. The text message service was discussed as a way of communicating with traveller families. Working links have now been established with Secondary Care. Women's Aid have delivered positive feedback on the SWAN		

	Key Actions Achieved April to September 2018	Key Actions Achieved October 2018 to March 2019	Risks to Delivery	Corrective Actions
	based at Swansea Council who has given an overview of the work that she does. Links have been forged with the Business Support Manager based at the Cwmtawe Cluster Network where both Official and Unofficial sites in Swansea are based. Moves have been made to look at effective support of vulnerable patients within the secure estate at key transition points. Links have been made with the prison health team and the Head of Reoffending. The Head of Reoffending attended HHAVGAP on September 12th and discussed an initiative being introduced for prison officers to work alongside Housing Associations. Links have been made between the HMP Swansea and Housing Options and meetings are taking place with the Homelessness Nurse, Housing Options and the Prison Health Team to consider effective	project that supports female Sex Workers in Swansea. Between August and December 53 women have signed up to the project which is due to end on March 2020. A high proportion of the women involved in the project are substance misusers. The Homelessness Nurse and a Sexual Health Nurse are involved in the scheme and outcomes are proving positive. An update on IRIS Training was delivered at HHAVGAP which aims to improve the general practice response to domestic violence and abuse. The Health Board are awaiting the outcome of funding applications (due at the end of March), which if successful will result in roll out of this training in General Practices across the Health Board. Links have also been made with the Welsh		

	Key Actions Achieved April to September 2018	Key Actions Achieved October 2018 to March 2019	Risks to Delivery	Corrective Actions
	support for vulnerable men at key transition points ie: release. A link has also been made with the Welsh Refugee Council who will be attending the December meeting to outline work they are undertaking to support destitute asylum seekers. Cruse will also attend the December meeting to focus on trauma and services that they are able to offer vulnerable people to support good mental health. The HHAVGAP Group is planning a mental health event that is scheduled for November 1st. Links have been made with Housing and the Mental Health team to outline the current position regarding supporting mental health and plans moving forward. The aim of the session is to ensure that any issues/concerns are	Refugee Council . A presentation was delivered regarding the issue of asylum seekers who have no recourse to public funds. Awareness raising sessions have taken place regarding what this means for asylum seekers and what support is available. A meeting has taken place with Public Health Wales who are currently doing a case study on good practice regarding HHAVGAP in Swansea with a view to strengthening HHAVGAP Forums and joined up working in Health Boards across Wales.		

	Key Actions Achieved April to September 2018	Key Actions Achieved October 2018 to March 2019	Risks to Delivery	Corrective Actions
	flagged regarding mental health and vulnerable groups to ensure the needs of vulnerable groups are included in any planning of services/strategy moving forward.			
3. Health Intelligence The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders and demonstrates an understanding of the profile and health needs of homeless people & vulnerable groups in their area.	-Health intelligence is continually strengthened by the contributions made to the HHAVGAP Steering Group. This information is continually fed to the appropriate senior manager to ensure any operational issues can be addressed effectively. Currently the need for Access Cards that can be used by Vulnerable Groups has been flagged. This would be valuable to use across the ABMU footprint. There are plans to pilot this with the Penderi and City Networks as part of the Asylum Seeker Support Project. These cards can also be piloted with homeless groups and gypsy travellers via HHAVGAP.	Information and case studies continue to be shared at the HHAVGAP steering Group. This information is fed to the appropriate senior manager to flag and address operational issues raised at the HHAVGAP forum. Following discussion, Access Cards are to be discussed at the March 20th meeting. Issues have been flagged with Mental Health regarding improving communication and knowing who to access/speak to regarding support for vulnerable people within the community. GP Cluster networks are continuing to develop	• Lack of resources/accurate and timely information and data • Lack of multi agency/partnership involvement • Systems and processes disjointed	• Continued expansion of membership adds to the intelligence provided to the HHAVGAP partnership • Feedback from Cluster Profiles/Cluster Development plans help to inform possible projects/innovative solutions to improve services and access arrangements for Vulnerable Groups • Training to continue to be offered as appropriate to partner organisations to increase awareness of the needs of Vulnerable Groups

	Key Actions Achieved April to September 2018	**Key Actions Achieved** October 2018 to March 2019	**Risks to Delivery**	**Corrective Actions**
	Information has been circulated to members of the HHAVGAP group on cultural awareness training. It is hoped that this information can inform future Protected Learning Time Sessions for GPs and front line staff and other key organisations. GP Cluster Networks continue to develop initiatives based on the population and wellbeing profiles of their networks and issues identified in Cluster profiles eg: Asylum Seeker Support/English for Health/Mental Health initiatives	initiatives based on population and wellbeing profiles linked to vulnerable groups eg: Mental health, complex needs, health literacy etc and are working with the Third Sector to meet the needs of patients and further develop social prescribing initiatives. The Penderi Cluster has commissioned feedback on Health Literacy/Communication improvement across the Cluster. The Cluster are awaiting the recommendations with a view to improving health outcomes/understanding for all patients. Feedback has also been actively sought on the Women's Refuge Service offered within the Penderi Cluster. Recommendations will be acted on with a view to improving the service offered.		
4. Access to Healthcare	Key Actions noted for October 2017-March 2018	Case studies and concerns continue to be	• Increase in demand	• Health Service for Homeless and

	Key Actions Achieved April to September 2018	**Key Actions Achieved** October 2018 to March 2019	**Risks to Delivery**	**Corrective Actions**
Homeless and vulnerable groups have equitable access to a full range of health and specialist services.	have continued during April 2018-September 2018. Case Studies continue to be presented at HHAVGAP meetings as a 'reality check' to determine where services are performing well and where improvements could be made. Any issues are fed back as appropriate. The HHAVGAP Group in Swansea has developed posters to promote language line. These posters have been shared with GP Practices across the City. As part of the English for Health Project Access Information is being developed for Speakers of Other Languages. EYST has received funding from the Integrated Care Fund to extend the Asylum Seeker Support Model to the Penderi Cluster Network in addition to the work being undertaken in the City Network.	raised as a 'reality check'to note where positive practice is being undertaken, where services are performing well and where improvements can be made. Case Studies are a standard agenda item at HHAVGAP meetings. Access leaflets have been produced by EYST in a variety of different languages and have been shared with the Cluster Networks as appropriate. A report is expected on the project undertaken by EYST to support asylum seekers accessing Primary Care in the City and Penderi networks. The outreach mental health nurse supporting vulnerable groups retired in November 2018. Two part time nurses have been recruited to fill this post as a full time equivalent. and will work alongside the	• Access to interpretation and translation services • Issues raised are not prioritised/ undertaken owing to work/ delivery pressures • Lack of funding to sustain and develop vital targeted support	Vulnerable Groups is delivered out of Orchard Street Clinic and Access Point. The service is offered on a flexible and outreach basis to suit the needs of the individual. • Homelessness and Mental Health Outreach Nurses to support Vulnerable Groups are in place in Swansea to ensure key vulnerable groups receive appropriate healthcare services • The health access team continue to provide open access drop in for asylum seekers on Mondays and Fridays. The interventions are varied according to need.

	Key Actions Achieved April to September 2018	**Key Actions Achieved** October 2018 to March 2019	**Risks to Delivery**	**Corrective Actions**
	Ther Penderi Cluster Network also piloted a successful short term English for Health Project in May and June supporting Asylum Seekers with health related 'English' to help when accessing health services	Homelessness Nurse. They will begin in April and June 2019. The Health Access Team Coordinator has been involved in an advisory capacity with the PHW research undertaken by Swansea University looking at asylum seeker and refugee access to Health Care. This research should be made available in the coming months. The Health Access Team works closely with local support services. Clients are informed of the support available to them during health assessments and are provided with maps and directions of the relevant services. All information is reinforced via an interpreter when necessary.		
5. Homeless & Vulnerable Groups' Health Action Plan (HaVGHAP)	The Local HHAVGAP Action Plan is in place and continues to be reviewed regularly by the HHAVGAP Group in Swansea. The	The current action plan was reviewed in December 2018 and will be revisited at the March 20th meeting. The plan	• Systems/processes not joined up • Lack of partnership/multi agency working	• Western Bay Housing Symposium to be held on October 5th will help inform best practice and

	Key Actions Achieved April to September 2018	Key Actions Achieved October 2018 to March 2019	Risks to Delivery	Corrective Actions
The Health Board leads the development, implementation & monitoring of the HaVGHAP (as an element of the Single Integrated Plan & regional commissioning strategies) in partnership with the Local Authority, service users, third sector & other stakeholders.	current action plan was reviewed at the meetings held on June 13th and September 12th. It is a living document that changes following each meeting according to actions and current initiatives.	continues to be a 'living' document that changes according to actions undertaken and completed and current priorities		discussions going forward. • Mental Health Event to be held on November 1st will inform mental health partnership discussions with specific reference to Vulnerable Groups. • Publication of Local Authority Homelessness Strategy will also further inform the Action Plan and developments moving forward

Please ensure that the update you provide considers all vulnerable groups. For gypsy and travellers, when providing an update, please consider the outcome measures as detailed in 'Travelling for Better Health' (this will ensure that a separate update is not commissioned).

- Travelling for Better Health is available at: http://gov.wales/docs/dhss/publications/150730measuresen.pdf EIA Practice Hub – NHS CEHR/WLGA 2015 – http://www.eiapractice.wales.nhs.uk/home
- The Essential Guide to the Public Sector Equality Duty: An Overview for Public Authorities in Wales (EHRC)

12. LIST OF ABBREVIATIONS

ABMU HB	Abertawe Bro Morgannwg University Health Board
ACS	Acute Coronary Syndrome
AOS	Acute Oncology Service

JCRF	Joint Clinical Research Facility
LA	Local Authority
M&S training	Mandatory and Statutory training

CAMHS	Child and Adolescent Mental Health
CBC	County Borough Council
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CRT	Community Resource Team
CT	Computerised Tomography
CTM UHB	Cwm Taf Morgannwg University Health Board
DEXA	Dual Energy X-Ray Absorptiometry
DNA	Did Not Attend
DU	Delivery Unit
ECHO	Emergency Care and Hospital Operations
ED	Emergency Department
ESD	Early Supported Discharge
ESR	Electronic Staff Record
eTOC	Electronic Transfer of Care
EU	European Union
FTE	Full Time Equivalent
FUNB	Follow Up Not Booked
GA	General Anaesthetic
GMC	General Medical Council
GMS	General Medical Services
HB	Health Board
HCA	Healthcare acquired
HCSW	Healthcare Support Worker
HYM	Hafan Y Mor
IBG	Investments and Benefits Group
ICOP	Integrated Care of Older People
IMTP	Integrated Medium term Plan
IPC	Infection Prevention and Control
IV	Intravenous
RCA	Root Cause Analysis
RDC	Rapid Diagnostic Centre
RMO	Resident Medical Officer
RRAILS	Rapid Response to Acute Illness Learning Set
RRP	Recruitment Retention Premium

MIU	Minor Injuries Unit
MMR	Measles, Mumps and Rubella
MSK	Musculoskeletal
NDD	Neurodevelopmental disorder
NEWS	National Early Warning Score
NICE	National Institute of Clinical Excellence
NMB	Nursing Midwifery Board
NPTH	Neath Port Talbot Hospital
NUSC	Non Urgent Suspected Cancer
NWIS	NHS Wales Informatics Service
OD	Organisational Development
ODTC	Ophthalmology Diagnostics Treatment Centre
OH	Occupational Health
OPAS	Older Persons Assessment Service
OT	Occupational Therapy
PA	Physician Associate
PALS	Patient Advisory Liaison Service
P-CAMHS	Primary Child and Adolescent Mental Health
PCCS	Primary Care and Community Services
PDSA	Plan, Do, Study, Act
PEAS	Patient Experience and Advice Service
PHW	Public Health Wales
PKB	Patient Knows Best
PMB	Post-Menopausal Bleeding
POVA	Protection of Vulnerable Adults
POWH	Princess of Wales Hospital
PROMS	Patient Reported Outcome Measures
PTS	Patient Transport Service
Q&S	Quality and Safety
R&S	Recovery and Sustainability

RTT	Referral to Treatment Time
SAFER	Senior review, All patients, Flow, Early discharge, Review
SARC	Sexual Abuse Referral Centre
SBAR	Situation, Background, Analysis, Recommendations
SBU HB	Swansea Bay University Health Board
S-CAMHS	Specialist Child and Adolescent Mental Health
SDU	Service Delivery Unit
SI	Serious Incidents
SLA	Service Level Agreement
SLT	Speech and Language Therapy
SMART	Specific, Measurable, Agreed upon, Realistic, Time-based
SOC	Strategic Outline Case
StSP	Spot The Sick Patient
SACT	Systematic Anti-Cancer Therapy
TAVI	Transcatheter aortic valve implantation
UDA	Unit of Dental Activity
UMR	Universal Mortality Review
USC	Urgent Suspected Cancer
WAST	Welsh Ambulance Service Trust
WFI	Welsh Fertility Institute
WG	Welsh Government
WHSSC	Welsh Heath Specialised Services Committee
WLI	Waiting List Initiative
W&OD	Workforce and Organisational Development
WPAS	Welsh Patient Administration System