ABM University Health Board	
27th April 2018 **Performance and Finance Committee** **Agenda item: 2d**	
Subject	*Integrated Performance Report*
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Approved by	Siân Harrop-Griffiths, Director of Strategy
Presented by	Siân Harrop-Griffiths, Director of Strategy Executive Leads

1.0 Situation

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 2017/18 National Delivery Framework within the overall context of the delivering the Health Board's Corporate Objectives.

2.0 Background

The National Delivery Framework for 2017/18 sets out 19 outcome statements and 105 performance measures under 7 domains, against which the performance of the Health Board is measured. The Health Board does not receive a report card for each of these indicators, but receives report cards based on the key measures as agreed by the Board. This system has been in place since September 2014 and the report cards have developed over this period to include new metrics as the Board requires. All of the report cards can be found in Appendix 1 of this report.

The five non-financial Targeted Intervention Priority performance measures are drawn out in more detail in this report. These are: -

- Unscheduled care
- Stroke
- Planned care
- Cancer
- Healthcare acquired infections

Whilst these slot in to different Corporate Objectives, they are presented at the front of this report to give the Board focus on the key targets before going on to report on other performance measures.

The sixth Targeted Intervention Priority of finance is covered in a separate report.

3.0 Assessment

Appendix 1 of this report provides detailed performance against all national and local measures. At a summary level, the tables below sets out the current performance assessment for the totality of the 2017/18 NHS Delivery Framework and local measures included in this report by the Health Board's Corporate Objectives.

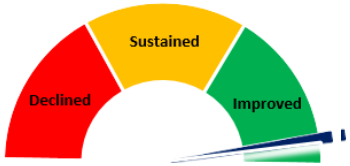
Corporate Objective	Number of measures in the reporting period that have been:	
	Achieved ✓	Not Achieved X
Promoting and Enabling Healthier Communities	9	8
Delivering Excellent Patient Outcomes, Experience and Access	19	36
Demonstrating Value and Sustainability	2	1
Securing a Fully Engaged and Skilled Workforce	4	2
Embedding Effective Governance and Partnerships	2	6
Total	**36**	**53**

The below summary shows the overall trend for the national and local measures under each Corporate Objective.

Promoting and enabling healthier communities

Delivering Excellent Patient Outcomes, Experience and Access

Demonstrating Value and Sustainability



Securing a Fully Engaged and Skilled Workforce

Embedding Effective Governance and Partnerships

Targeted Intervention Priority Measures Summary- Health Board Level

			Quarter 1			Quarter 2			Quarter 3			Quarter 4			Welsh Government Target
			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	
Unscheduled Care	4 hour A&E waits	Actual	79.16%	82.00%	83.10%	83.15%	82.24%	84.13%	79.12%	75.81%	73.41%	76.06%			95.00%
		Profile	*81%*	*85%*	*85%*	*85%*	*86%*	*86%*	*88%*	*87%*	*87%*	*85%*	*88%*	*90%*	
	12 hour A&E waits	Actual	418	377	369	296	294	347	706	875	871	924			0
		Profile	*550*	*480*	*400*	*350*	*320*	*320*	*330*	*350*	*410*	*400*	*370*	*300*	
	1 hour ambulance handover	Actual	332	244	295	206	295	289	617	752	904	1030			0
		Profile	*430*	*335*	*240*	*180*	*120*	*120*	*130*	*160*	*220*	*210*	*160*	*100*	
	Red calls responses within 8 minutes	Actual	83%	80%	81%	76%	79%	82%	73%	73%	69%	66%			65%
		Profile	*72%*	*73%*	*74%*	*75%*	*76%*	*76%*	*76%*	*74%*	*74%*	*75%*	*76%*	*76%*	
Stroke	4 hour bundle	Actual	39.56%	58.16%	50.00%	57.35%	50.00%	49.49%	41.30%	34.78%	26.14%	31.17%			The most recent SSNAP UK National quarterly average
		Profile	*47%*	*55%*	*60%*	*69%*	*72%*	*72%*	*72%*	*66%*	*63%*	*66%*	*69%*	*72%*	
	12 hour bundle	Actual	90.11%	89.80%	90.18%	88.24%	92.05%	91.92%	96.74%	93.48%	95.45%	93.51%			
		Profile	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	
	24 hour bundle	Actual	61.54%	79.59%	78.57%	80.88%	84.09%	83.84%	89.13%	73.91%	89.77%	93.51%			
		Profile	*75%*	*75%*	*75%*	*75%*	*75%*	*75%*	*75%*	*75%*	*75%*	*75%*	*75%*	*75%*	
	72 hour bundle	Actual	94.51%	97.96%	95.54%	97.06%	94.32%	97.98%	96.74%	95.65%	94.32%	94.81%			
		Profile	*97%*	*97%*	*97%*	*97%*	*97%*	*97%*	*97%*	*97%*	*97%*	*97%*	*97%*	*97%*	
Planned care	Outpatients waiting more than 26 weeks	Actual	1,061	1,395	1,029	1,134	1,599	1,567	1,438	1,524	1,679	1,111			0
		Profile								1,678	2,493	1,969	896	551	
	Treatment waits over 36 weeks	Actual	3,997	4,155	3,966	4,388	4,642	4,284	4,463	4,561	4,716	4,609			0
		Profile								4,298	4,402	4,093	3,928	3,530	
	Treatment waits over 52 weeks	Actual	1,362	1,445	1,520	1,570	1,630	1,648	1,692	1,829	1,931	1,877			0
		Profile													
	Diagnostic waits over 8 weeks	Actual	411	519	484	533	651	455	349	361	576	473			0
		Profile	0	0	0	0	0	0	0	0	0	0	0	0	
Cancer	NUSC patients starting treatment in 31 days	Actual	95%	94%	93%	97%	96%	98%	95%	99%	94%	90%			98%
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	
	USC patients starting treatment in 62 days	Actual	87%	74%	73%	77%	80%	79%	85%	89%	82%	76%			95%
		Profile	*88%*	*88%*	*89%*	*90%*	*90%*	*90%*	*90%*	*89%*	*89%*	*88%*	*89%*	*90%*	
Healthcare Acquired Infections	Rate of *S.aureus* Bacteramias per 100,000 population	Actual	32.18	42.27	32.18	42.27	24.47	34.48	28.92	39.08	57.84	31.14			Less than or equal to 20 cases per 100,000 population
		Profile	*41.00*	*40.00*	*39.00*	*38.33*	*37.67*	*37.00*	*35.83*	*34.67*	*33.50*	*32.33*	*31.17*	*30.00*	
	Rate of *C.difficile* per 100,000 population	Actual	57.47	42.27	71.26	44.49	57.84	48.27	51.17	68.96	28.92	48.94			Less than or equal to 26 cases per 100,000 population
		Profile	*40.00*	*39.00*	*38.00*	*37.00*	*36.00*	*35.00*	*34.00*	*33.00*	*32.00*	*31.30*	*30.70*	*30.00*	

**RAG status derived from performance against trajectory*

Overview

The following summarises the key success in January 2018, along with the priorities, risks and threats to achievement of the quality, access and workforce standards

Successes	Priorities
• ABMU continues to be the best performing Health Board for completion of Universal Mortality Reviews within 28 days. Only Velindre Trust performed better but they have very few in-hospital deaths. • Performance against the Welsh Government target to gain assurance on the Serious Incident reports within 60 working days, remains consistently above the 80% target since April 2017. All submitted closure forms received assurance by Welsh Government in January 2018 evidencing continued improvement in the quality of forms submitted. • The Health Board is consistently maintaining the 2 day acknowledgement target at 100% for formal complaints.	• Learning from Breaking the Cycle to inform 2018/19 Winter plans. • Delivery of RTT year-end projections through maximising internal and external capacity. • Additional staff awareness sessions in February 2018 on implementation of the SAFER flow bundles. • Sustainability of general practice to ensure equitable access to services and reduction of potential knock on effect on Emergency Departments. • Cancer performance continues to struggle in comparison with other Health Boards but ABMU has the highest volumes of cancer patients treated per month. Priority will be to focus on reducing backlog and achieving year end trajectories.
Opportunities	**Risks & Threats**
• New approach to investigating and learning from Never Events to be rolled out to Princess of Wales Hospital following successful pilot in Morriston Hospital. • Morriston DU to commence a pilot improvement programme relating to peripheral catheters and urinary catheters in February 2018 in order to reduce the occurrence healthcare infections. • Ongoing planning in terms of working towards the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from national Stroke Implementation Group to fund a dedicated project manager to support this work • Using non recurrent additional winter pressures monies to strengthen the non-injury falls pathway to support a reduction in conveyance to hospital.	• Health Board is currently an outlier in relation to the number of Never Events particularly for Orthopaedics. • Winter pressures and cancellations of elective procedures due to lack of beds is making the year-end RTT target even more challenging. Focus for Q3 will be to maximise internal and external capacity as much as possible in order to deliver the year-end trajectory as agreed by Welsh Government. • January 2018 saw a 38% increase in ambulance red calls (life threatening calls), a 14 % reduction in amber calls and a 2% reduction in green (lower acuity calls) The number of patients conveyed to ED requiring a red call response was the second highest experienced in the last 2 years. The increase in complexity of patients and overall demand will place significant pressure on Emergency Departments.

4.0 Recommendations

The Board is asked to:

- Note current Health Board performance against key measures and targets and the actions being taken to improve performance.

Appendix 1- Summary of performance against national and local measures

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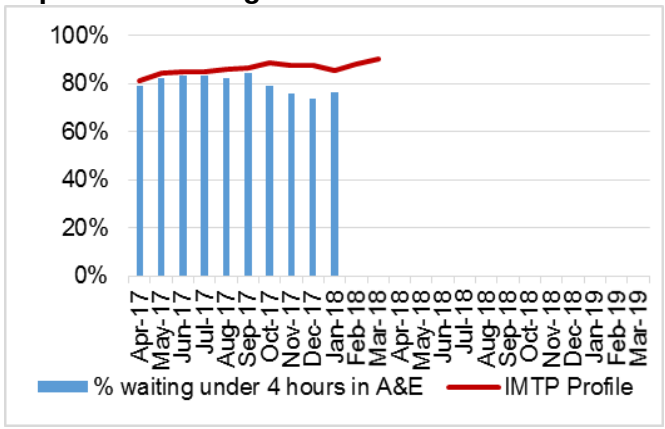
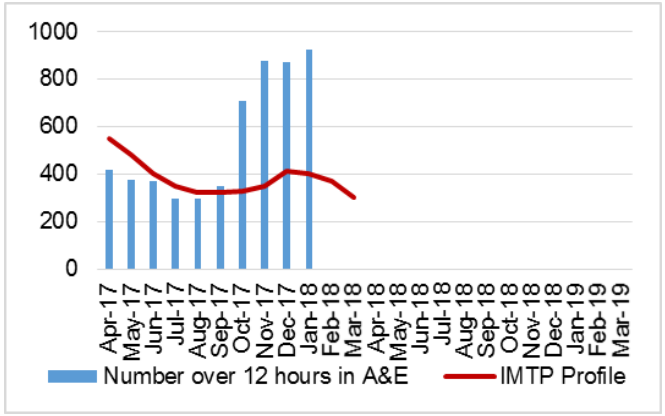
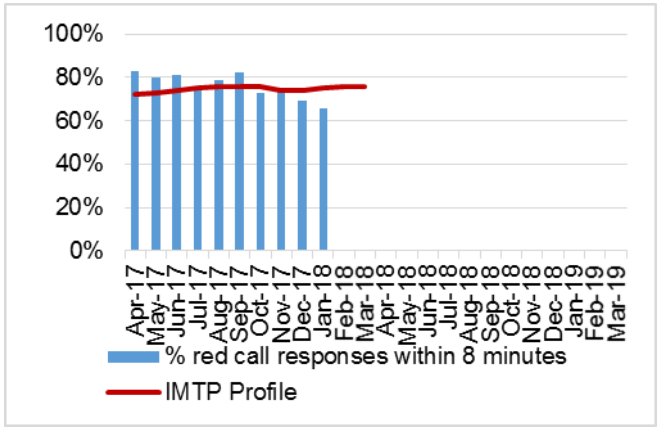
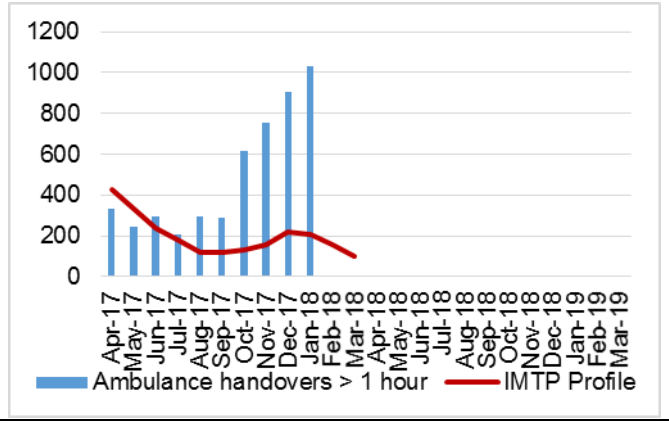
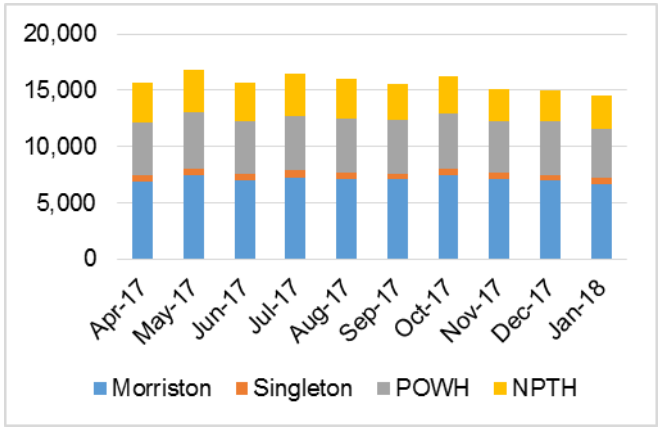
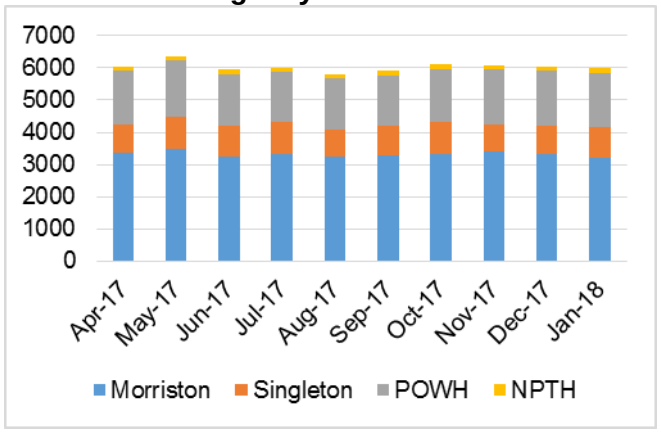
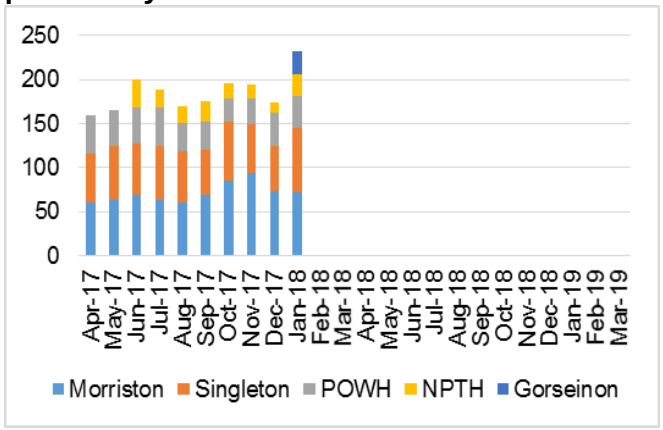
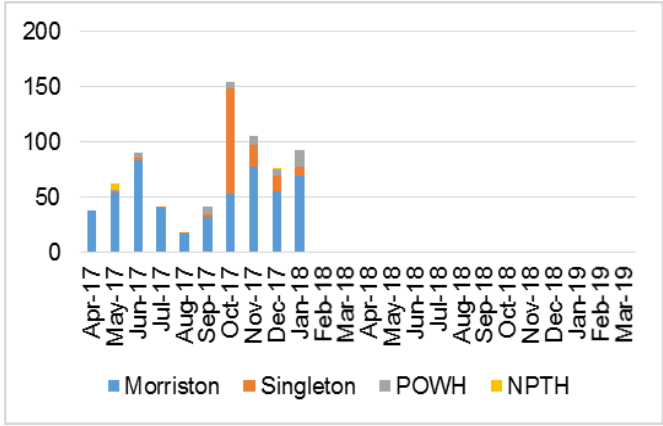
1. TARGETED INTERVENTION PRIORITIES

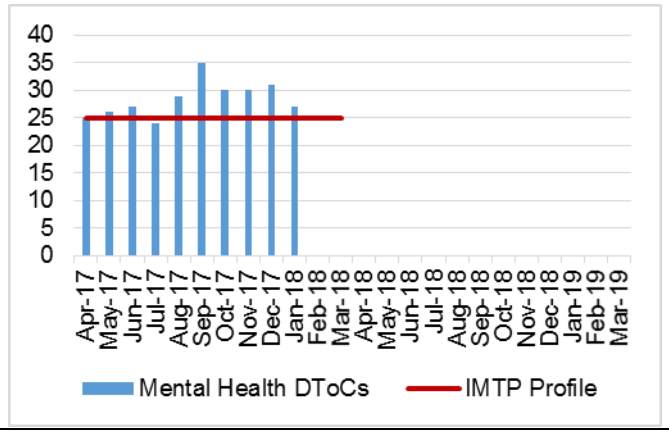
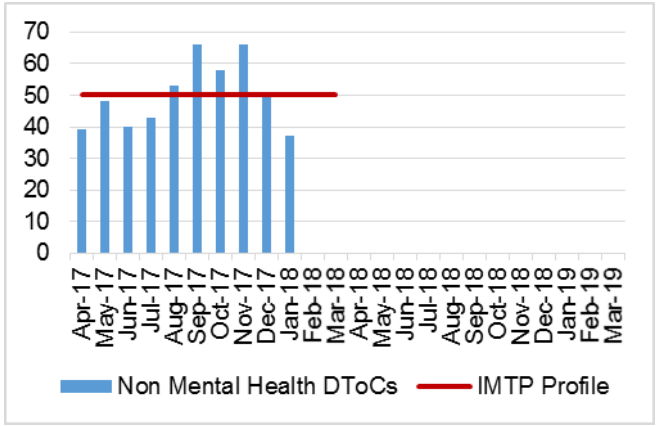
1.1 Unscheduled Care (WG Measures 73-76)

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 achievement of the 4 hour performance measure continues to be a challenge and in January 2018, the Health Board was below the internal profile of 85%. Singleton and Neath Port Talbot Hospitals continue to achieve the national target of 95% but Morriston and Princess of Wales are below profile achieving 66.08% and 73.42% in January 2018.	**% patients waiting under 4 hours in A&E** 	• Undertake mini breaking the cycle actions during March in Morriston Hospital. • Commence the phased roll out of the electronic ward dashboard in March– this will reduce duplication/ release staff time. • Extension of front door frailty service in Singleton Hospital up to the end of March 2018 delivering comprehensive geriatric assessment to patients within SAU.
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	Performance against the 12 hour A&E measure also continues to be a challenge especially through the Winter period. In January 2018, the Health Board had 924 12 hour breaches of which 625 were attributed to Morriston Hospital; 297 to Princess of Wales and 1 in both Singleton and Neath Port Talbot Hospitals.	**Number of patients waiting over 12 hours in A&E** 	As above. Please note that upon sign off all relevant charts in sections 1.1 to 1.5 of the report will be populated with the 2018/19 agreed trajectory

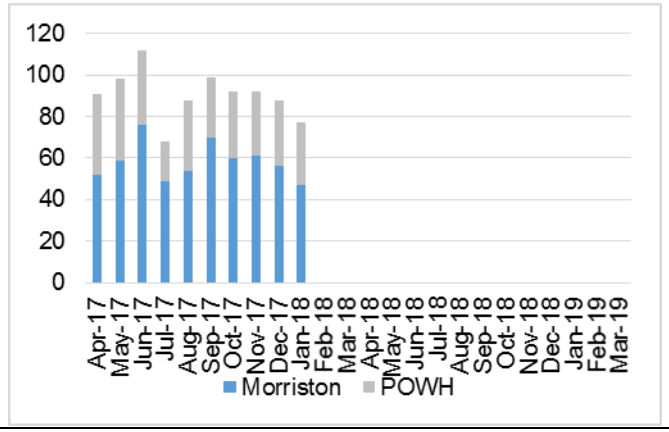
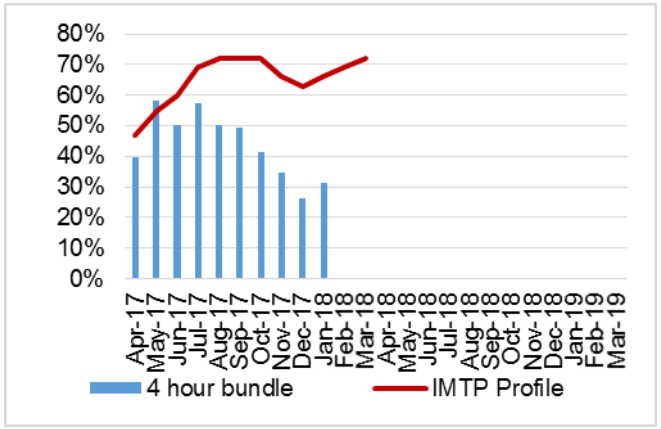
Description	Current Performance	Trend	Actions planned for next period
Ambulance responses The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Ambulance response times are consistently above the national target of 65% but feel short of the 75% internal profile in January 2018 with an achievement of 66%. The number and proportion of red call conveyances continues to increase, with WAST data suggesting that ABMU HB has the highest number and proportion of red calls in Wales for the population served.	**Percentage of red call responses within 8 minutes** 	• Pilot agreed with Welsh Ambulance Service Trust (WAST) to see Mental Health patients in Community and not ED. • Implementation of Afan Valley community paramedic pilot involving WAST and 3 District Nursing teams with the aim of improving communication and implementation of direct referral pathways (e.g. blocked catheters). • Meeting between WAST and ABMU Executives to review ambulance demand data and explore further opportunities to jointly strengthen pathways, workforce and service models.
Ambulance handovers The number of ambulance handovers over one hour	The number of ambulance handovers to local hospitals taking over 1 hour continue to be significantly over profile which is a reflection of the pressures being felt in A&E departments and the subsequent challenge of the 4 and 12 hour A&E targets. In January 2018, Morriston Hospital saw a 7% increase compared with January 2017 (609 to 653). Princess of Wales Hospital (POWH) saw a 77% increase (173 to 306) and Singleton Hospital saw a 73% increase (41 to 71).	**Number of ambulance handovers over one hour** 	• In Morriston Hospital - additional Nursing within ED to support additional escalation overnight (reduce handover delays) and additional Advanced Nurse Practitioner (ANP)/ Emergency Nurse Practitioner (ENP) to further support minors flow • Continue use of WAST Hospital Ambulance Liaison Officers (HALO) in order to reduce 1 hour ambulance delays.

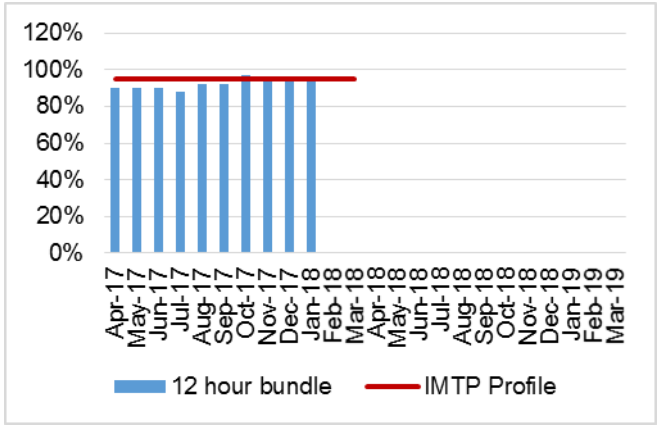
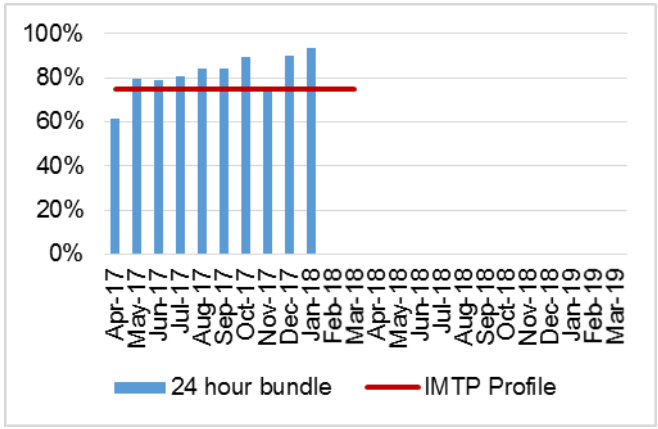
Description	Current Performance	Trend	Actions planned for next period
A&E Attendances The number of attendances at emergency departments in the Health Board	In January 2018, there were at total of 14,505 A&E attendances across the Health Board which is 48 more than January 2017: • Morriston Hospital: 2% increase in attendances • Singleton Hospital Minor Injury Unit (MIU): 10% increase in attendances • Princess of Wales Hospital: 1% reduction in attendances • Neath Port Talbot Hospital MIU: 3% reduction on attendances	**Number of A&E attendances** 	• Increase joint working with WAST/111 to improve unscheduled care system- Work with WAST/111 increase publicity with non-NHS partners (to increase 111 use and divert from ED) • Enhance Community Pharmacy services • Launch Telephone First model and standards for ABMU practices (to increase GMS capacity to meet demand). • Improve access to Oral Health services by increasing capacity in high need areas
Emergency Admissions The number of emergency admissions across the Health Board by site	In January 2018, there were at total of 6,081 emergency admissions across the Health Board which is 143 less than January 2017: • Morriston Hospital: 4% reduction in admissions • Singleton Hospital: 1% increase in admissions • Princess of Wales Hospital: 4% reduction in admissions • Neath Port Talbot Hospital: 17% increase in admissions (from 145 to 169)	**Number of emergency admissions** 	• Increased focus within the unscheduled care improvement programme on delivering increased levels of activity through ambulatory and day of surgery models of care, which will contribute to reduced length of stay. • Introduce on-call OOH community pharmacy for palliative care (to reduce emergency admissions)

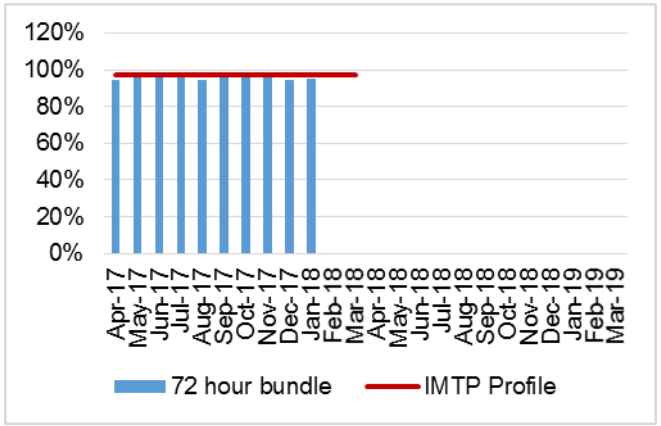
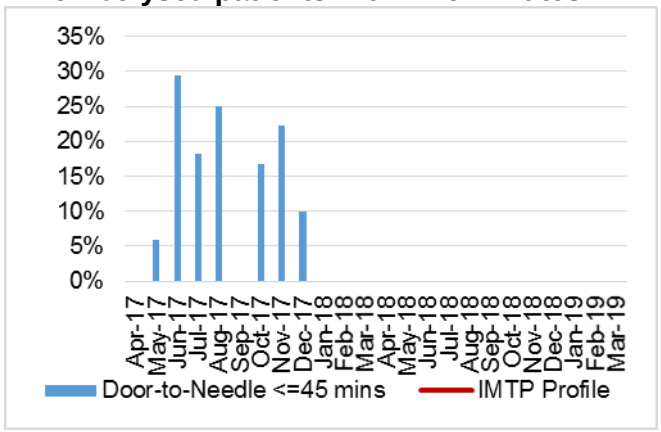
Description	Current Performance	Trend	Actions planned for next period
Medically Fit The number of patients waiting at each site in the Health Board that are deemed discharge/ medically fit	In January 2018, there were 233 patients who were deemed medically/ discharge fit but were still occupying a bed in one of the Health Board's Hospitals. This is a 34% increase when compared with January 2017.	**The number of discharge/ medically fit patients by site**  *****Standardised collection of data from Gorseinon Hospital only commenced in January 2018*	• Weekend opening of Discharge Lounge and Discharge Lounge Liaison role in Morriston Hospital to ensure optimised use of lounge before 10:30am and 12 midday • In POWH redesign process for Medically and Discharge Fit information and patients to reduce delays • Implement revised process for prioritising blood results for discharges on day of discharge.
Elective procedures cancelled due to lack of beds The number of elective procedure cancelled across the hospital where the main cancellation reasons was	In January 2018, there was a significant improvement in the number of elective procedures cancelled due to lack of beds when compared with January 2017. Across the Health Board 87 procedures were cancelled in January 2018 compared with 210 in 2017 (59% reduction). Morriston saw the largest proportion of procedures cancelled but had 64% less cancelation than last winter.	**Total number of elective procedures cancelled due to lack of beds** 	• Improved escalation process in Morriston Hospital- introduce revised escalation process to reduce ward delays and early release of bed space for admissions. • Continue to implement additional arrangements to mitigate impact of unscheduled care pressures on elective capacity.

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 January 2018 were slightly higher than the internal profile of 25 but were the lowest number since August 2017. In January 2018, the number of delays were proportioned equally across the three localities.	**Number of Mental Health DToCs** 	• Tonna Hospital- Provision of 10 beds to care for patients awaiting care packages. Will provide an extra 400 bed days 21st February to 31st March.
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board - Non Mental Health (age 75+)	In January 2018, the number of non mental health delayed transfers of care saw the best position since February 2017 and were notably below the internal profile. Swansea Locality continues to account for the largest proportion of delays (70%), followed by NPT with 19% and Bridgend with 11%.	**Number of Non Mental Health DToCs** 	• Pilot Accelerated Placement team- A Social Worker, a Discharge Liaison Nurse and a manager working together to identify all patients waiting for Dom care/RH care, and pro-actively moving patients to commissioned re-ablement /nursing home beds. • Define and maximise use of Discharge to Assess at Home (to increase patient flow)

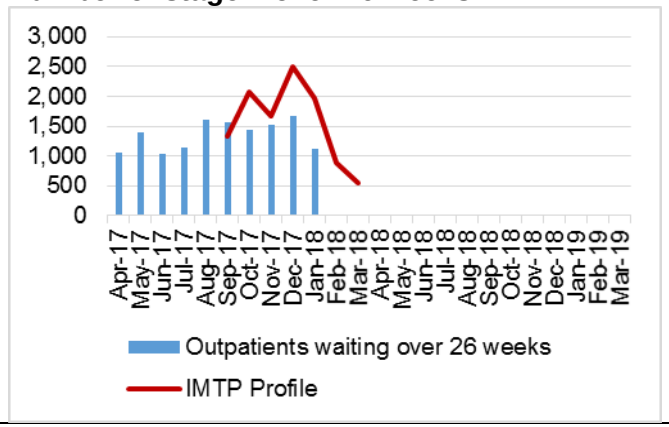
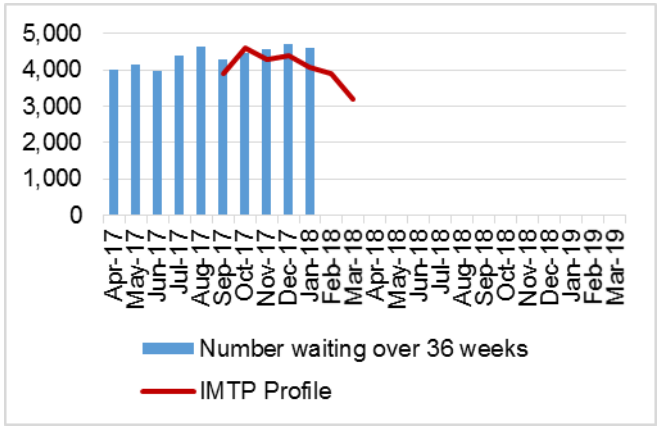
1.2 Acute Stroke Care (WG Measures 69-72)

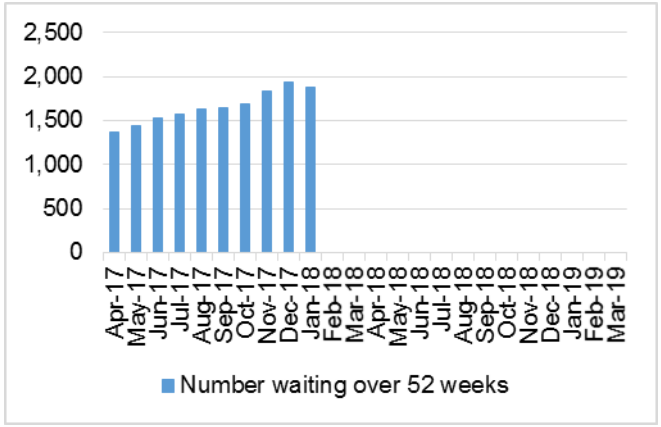
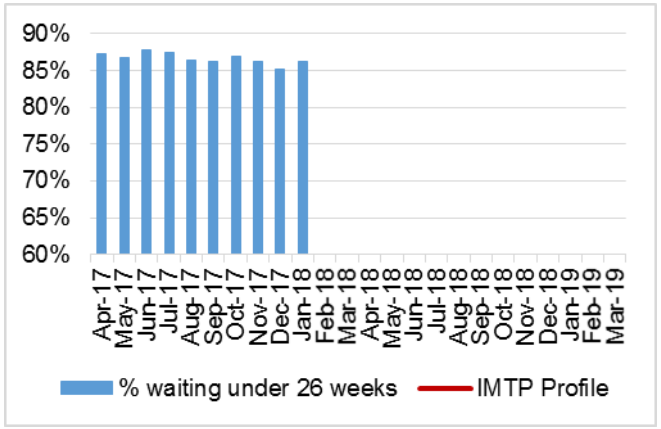
Description	Current Performance	Trend	Actions planned for next period
Stroke Admissions The total number of stroke admissions into the Health Board	In January 2018, there were 77 confirmed stroke admissions across the Health Board; 47 in Morriston and 30 in Princess of Wales. This is slightly lower than the 98 admissions in January 2018.	**Total number of stroke admissions** 	• Training sessions for out of hours nurse practitioners planned in February to improve the identification and assessment of stroke patients.
Stroke 4 hour bundle	In January 2018 only 24 out of the 77 patients had a direct admission to an acute stroke Unit within 4 hours. This appears to be a challenge across Wales as in January 2018 performance ranged from 23.3% to 63.9%. ABMU achieved 32.4%. Aneurin Bevan are the only Health Board in Wales to have a Hyper Acute Stroke Unit (HASU) and achieved 35.5% in January.	**Percentage compliance with stroke 4 hour care bundle** 	• Ongoing planning in terms of working towards the “Hyper-Acute Stroke Unit” model. Non recurrent funding secured from national funding to fund a dedicated project manager to support this work. • Training new cohort of medical doctors on stroke pathway, SAFER flow, board rounds to improve flow. • Business case developed for support to implement 3 month trial of an electronic system to capture and map patients as they move through the stroke pathway

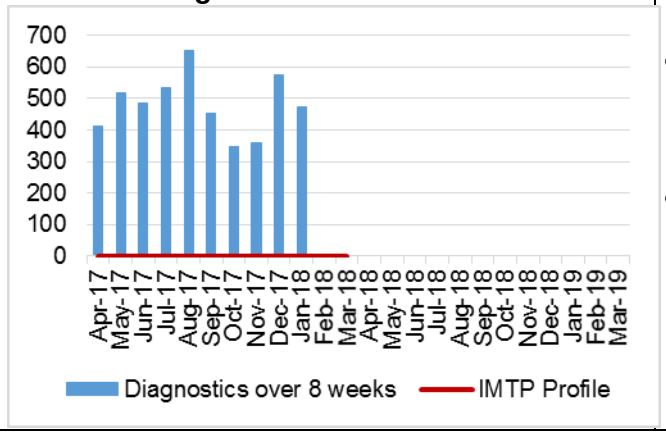
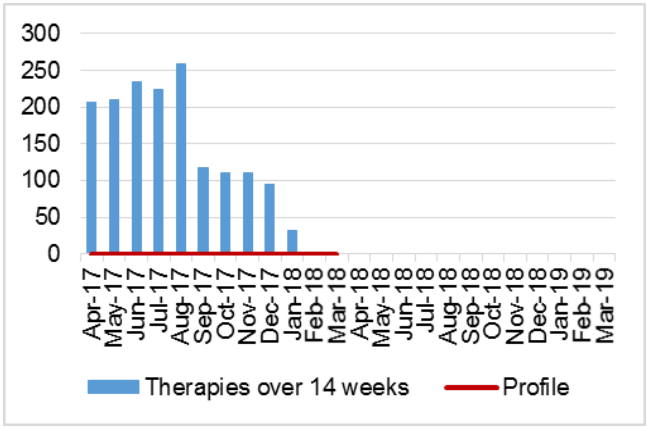
Description	Current Performance	Trend	Actions planned for next period
Stroke 12 hour bundle	In January 2018, ABMU achieved 93.2% which was short of the internal profile of 95% and the SSNAP national average of 94.3%.	**Percentage compliance with stroke 12 hour care bundle** 	• Process mapping undertaken on the stroke pathway with the support of 1000 Lives - further work required to review 12 hour access pathway and supported need for additional medical registrar cover to improve timeliness of assessment. Recruitment to additional post continues.
Stroke 24 hour bundle	In January 2018, ABMU achieved 93.2% which exceeded the internal profile of 75% and the SSNAP national average of 82.9%.	**Percentage compliance with stroke 24 hour care bundle** 	• As above.

Description	Current Performance	Trend	Actions planned for next period
Stroke 72 hour bundle	In January 2018, ABMU achieved 94.81% which is marginally below the internal profile of 97%. ABMU has consistently achieved above 94% for this bundle in 2017/18.	**Percentage compliance with stroke 72 hour care bundle** 	• Review of stroke pathway with the support of the Delivery Unit - to identify potential for targeted improvement.
Thrombolysed Patients with Door-to-Needle <= 45 mins	In January 2018, 90% of eligible patients were thrombolysed but none of the 10 eligible patients were thrombolysed within the 45 minutes (door to needle) standard.	**Thrombolysed patients within 45 minutes** 	• As above.

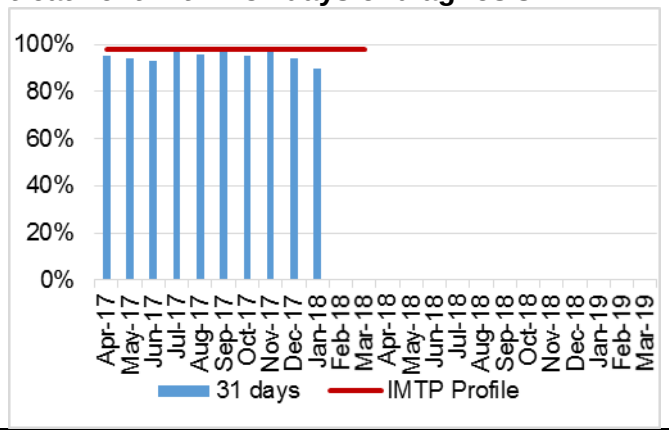
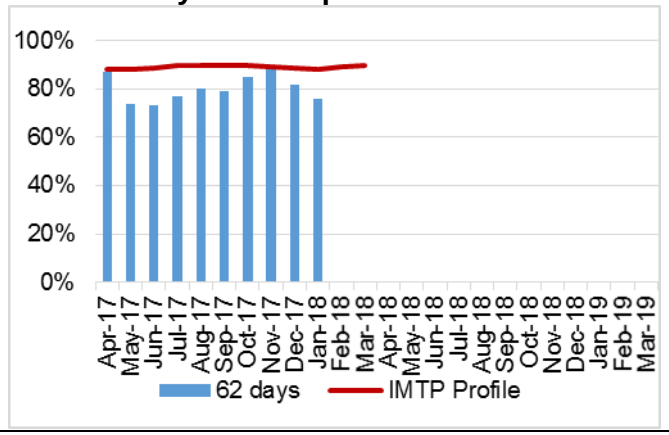
1.3 Planned Care (WG Measures 65-67)

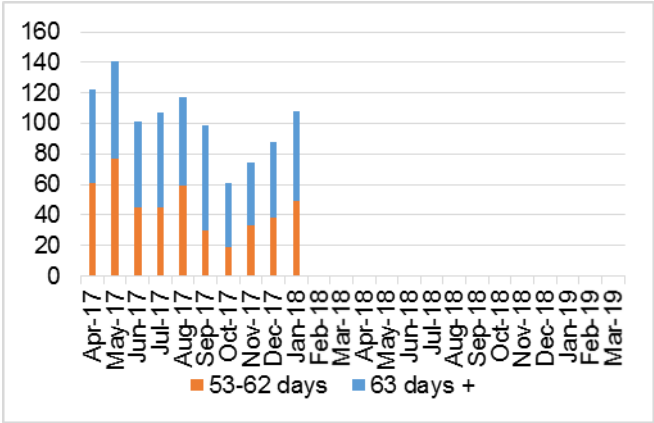
Description	Current Performance	Trend	Actions planned for next period
Outpatient waiting times The number of patients waiting more than 26 weeks for an outpatient appointment (stage 1)	The number of patients waiting over 26 weeks for a first outpatient appointment continues to reduce in line with the internal trajectory. In January there were 1,111 patients waiting over 26 weeks compared with 921 in January 2017. OMFS account for 54% of the breaches, followed by Ophthalmology with 19%.	**Number of stage 1 over 26 weeks** 	• Core capacity being maximised and additional clinics being secured across a range of specialties to deliver Nil outpatient breaches over 26 weeks at year-end with the exception of OMFS (300 forecast).
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 for the Health Board. In January 2018 there were 391 more patients waiting over 36 weeks compared with January 2017. 90% of patients are waiting in the treatment stage of the pathway and Orthopaedics accounts for 45% of the breaches, followed by General Surgery with 15%.	**Number of patients waiting longer than 36 weeks** 	• Insourcing tender exercise concluded & contracts awarded. Working with awarded companies to put additional lists in place for a range of specialties across Singleton, Morriston and Princess of Wales. • Outsourcing continuing to be maximised and additional capacity sourced where available. • Tender for Referral to Treatment (RTT) system validation concluded and contract awarded. Set up work being concluded and validation due to commence.

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.	**Number of patients waiting longer than 52 weeks** 	• The actions relating to > 52 week patients are the same as 36 week patients. • The All Wales Delivery Unit is currently undertaking a "long waiting " patients review which is nearing completion. The Health Board will fully engage in the actions required from this review to reduce long waiting volumes and times
Total waiting times Percentage of patients waiting less than 26 weeks from referral to treatment	Throughout 2017/18 the overall percentage of patients waiting less than 26 weeks from referral to treatment has been consistently around 86%.	**Percentage of patient waiting less than 26 weeks** 	• Plans as outlined in previous tables.

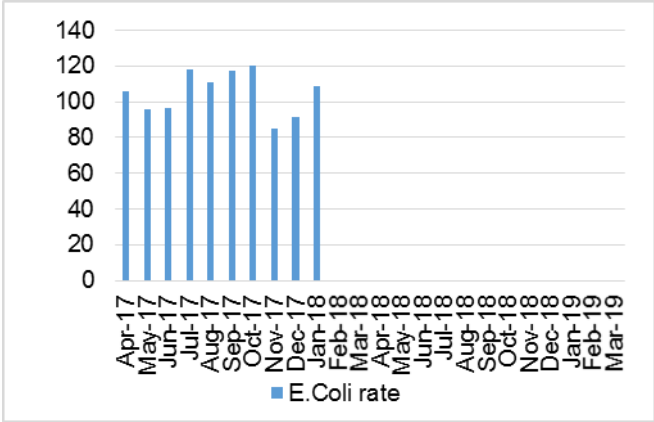
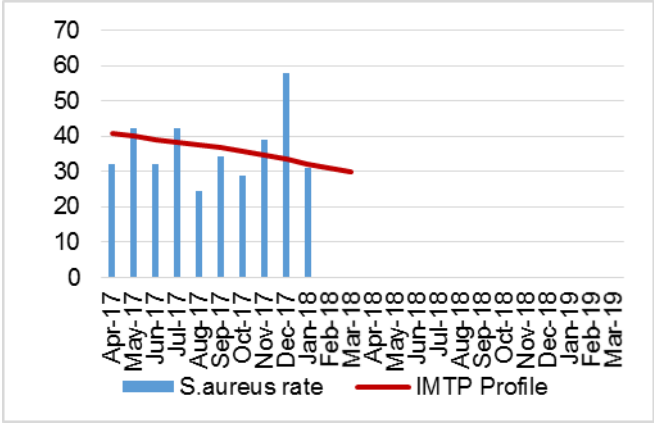
Description	Current Performance	Trend	Actions planned for next period
Diagnostics waiting times The number of patients waiting more than 8 weeks for specified diagnostics	In January 2018, there were 473 patients waiting over 8 weeks for specified diagnostics compared with 491 in January 2017. Endoscopy continues to be the pressure area for diagnostics with 377 breaches in January 2018. The remaining 96 breaches were in Cystoscopy (62), Fluoroscopy (5), Vascular Technology (29). Improvement projected to 278 in February.	**Number of patients waiting longer than 8 weeks for diagnostics** 	• Remedial actions in place for Fluoroscopy and Vascular Technology. • Additional lists secured for Cystoscopy will be cleared through the appointment of a locum Urology Consultant. • Endoscopy will be cleared through additional lists, maximising backfill arrangements and utilising the capacity of the insourcing company.
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. In January 2018 there were 32 patients waiting over 14 weeks compared with 396 in January 2017. The breakdown of breaches in January 2018 are: • Dietetics: 8 • Occupational therapy: 2 • Speech and Language Therapy: 22	**Number of patients waiting longer than 14 weeks for therapies** 	• All patients being managed into early appointment slots to provide headroom for re-booking any late cancellations. Plans to deliver Nil at year-end with no risks being highlighted.

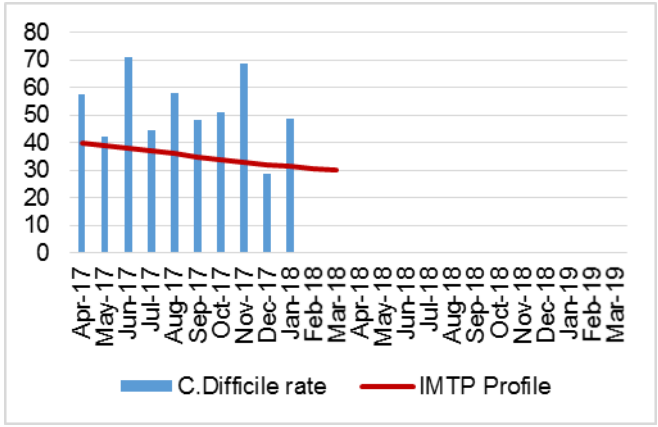
1.4 Cancer (WG Measures 77 and 78)

Description	Current Performance	Trend	Actions planned for next period
NUSC waiting times- Percentage of patients newly diagnosed with cancer, not via urgent route that started definitive treatment within 31 days of diagnosis	In January 2018 the percentage of patients starting treatment within 31 days was 91%. There were 16 breaches in total across the Health Board: • Breast: 10 • Gynaecological: 1 • Upper GI: 2 • Urological: 3	**Percentage of NUSC patients starting treatment within 31 days of diagnosis** 	• Review of surgical capacity/need for additional consultant surgeons for Gynaecology to be progressed. • Progress Macmillan funded Quality Improvement Manager vacancy. The post holder will play a key role in leading and delivering the Cancer Services Improvement Programme across ABMU Health Board.
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	In January 2018 the percentage of patients starting treatment within 62 days was 79%. There were 24 breaches in total across the Health Board: • Breast: 11 • Gynaecological: 3 • Haematological: 1 • Lower GI: 5 • Sarcoma: 1 • Urological: 3	**Percentage of USC patients starting treatment within 62 days of receipt of referral** 	• Bimonthly support and challenge meetings between MDT Lead, Service Managers, Cancer Clinical Lead and Lead Service Director. • Change to Job Plans of Radiologists in February to reduce waits to one stop breast clinics at Singleton. • Pilot of surgical direct to test model for gastroenterology patients. Pilot is going well, full results expected end of March with analysis by end of April 2018

<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 January backlog by tumour site:
<table>
<tr><th>Tumour Site</th><th>53 - 62 days</th><th>63 ></th></tr>
<tr><td>Breast</td><td>13</td><td>6</td></tr>
<tr><td>Gynaecological</td><td>7</td><td>9</td></tr>
<tr><td>Haematological</td><td>2</td><td>5</td></tr>
<tr><td>Head and Neck</td><td>5</td><td>4</td></tr>
<tr><td>Lower GI</td><td>3</td><td>2</td></tr>
<tr><td>Lung</td><td>2</td><td>7</td></tr>
<tr><td>Other</td><td>0</td><td>1</td></tr>
<tr><td>Skin</td><td>2</td><td>0</td></tr>
<tr><td>Upper GI</td><td>4</td><td>2</td></tr>
<tr><td>Urological</td><td>11</td><td>23</td></tr>
<tr><td>Grand Total</td><td>49</td><td>59</td></tr>
</table></td>
<td>Number of patients with a wait status of more than 53 days
 
</td>
<td>• Improvement seen during February.
• Validation of breach pathways undertaken.
• Following a review of tracking capacity at Morriston 2 trackers appointed to substantive posts at Morriston to ensure continued robust tracking and patient pull through pathways.</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 January the percentage of patients seen within 14 days to first appointment/assessment ranged between 29% and 45%.</td>
<td>The number of patients waiting for a first outpatient appointment (by total days waiting)- January 2018
<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>4</td><td>36</td><td>69</td><td>33</td><td>142</td></tr>
<tr><td>Gynaecological</td><td>1</td><td>14</td><td>1</td><td>0</td><td>16</td></tr>
<tr><td>Haematological</td><td>1</td><td>3</td><td>0</td><td>0</td><td>4</td></tr>
<tr><td>Head and Neck</td><td>12</td><td>14</td><td>2</td><td>0</td><td>28</td></tr>
<tr><td>Lower GI</td><td>21</td><td>35</td><td>0</td><td>0</td><td>56</td></tr>
<tr><td>Lung</td><td>5</td><td>4</td><td>0</td><td>0</td><td>9</td></tr>
<tr><td>Other</td><td>14</td><td>6</td><td>3</td><td>1</td><td>24</td></tr>
<tr><td>Skin</td><td>31</td><td>29</td><td>5</td><td>0</td><td>36</td></tr>
<tr><td>Upper GI</td><td>5</td><td>5</td><td>1</td><td>0</td><td>11</td></tr>
<tr><td>Urological</td><td>4</td><td>8</td><td>7</td><td>27</td><td>46</td></tr>
<tr><td>Total</td><td>98</td><td>154</td><td>88</td><td>61</td><td>401</td></tr>
</table></td>
<td>• Cancer Improvement Team undertaking Demand & Capacity for USC first outpatient waits. Model in place for gastroenterology, breast and gynaecology PMB pathway. To be released to the service via the Cancer Dashboard early April 2018.</td>
</tr>
</table>

1.5 Healthcare Acquired Infections (WG Measures 23 and 24)

Description	Current Performance	Trend	Actions planned for next period
E.coli bacteraemia- Rate of laboratory confirmed *E.coli* bacteraemias cases per 100,000 population	Over the first 10 months of 2017/18, the Health Board average was 47 cases per month. The total number of cases between April and January 2018 was 466. By the end of January, the Health Board was 114 cases above the expected cumulative number of cases for 2017/18.	***E.coli* bacteraemias cases per 100,000 population** 	• Plan, Do, Study, Act (PDSA) methodology pilots on: the prevalence of peripheral vascular catheters and urinary catheters; STOP campaign (the initial requirement for an indwelling device and review of whether it is still required) incorporated within Board Rounds. • Ward-based training on the importance of hydration for prevention of Urinary Tract Infections (UTIs). • Revision of blood culture collection protocol.
S.aureus bacteraemias- Rate of laboratory confirmed *S.aureus* bacteraemias (MRSA & MSSA) cases per 100,000 population	For the months between April and January 2017/18, the Health Board average decreased to 16 cases per month. The total number of cases between April and January 2018 was 162. By the end of January, the Health Board had exceeded the maximum total number of cases to achieve the annual infection reduction expectation by 57 cases.	***S.aureus* bacteraemias cases per 100,000 population** 	• PDSA methodology pilots as above, and revision of blood culture collection protocol. • Audit of compliance with MRSA Clinical Risk Assessment (CRA) on admission, to improve compliance and ensure appropriate action taken based on outcome of the CRA. • Change in *Staph. aureus* decolonisation protocol to improve compliance with application and resulting in an improved decolonisation.

Description	Current Performance	Trend	Actions planned for next period
C.difficile- Rate of laboratory confirmed C.difficile cases per 100,000 population	Over the first 10 months of 2017/18, the Health Board average was 24 cases per month. **Due to technical problems, the PHW published data is incorrect and will be amended in the May report.** The correct total number of cases between April 2017 and January 2018 was 238. By the end of January, the Health Board was 120 cases above the expected cumulative number of cases for 2017/18.	***C.difficile* cases per 100,000 population** 	• Implement a restricted Antimicrobial policy. • Expressions of interest invitation for 6 Health Care Acquired Infection/ Antimicrobial Resistance Quality Improvement Clinical Leads, who will have dedicated sessions and clear objectives. • Increase percentage of patients isolated within 2 hours' onset of unexplained diarrhoea. • Increased Delivery Unit compliance with ensuring all single and multi-bedded source rooms are emptied temporarily to enable deep cleaning and high level decontamination following identification and isolation of *C. difficile.*

2. SUMMARY OF PERFORMANCE AGAINST WELSH GOVERNMENT PERFORMANCE MEASURES

A high level summary of each of the measures by Corporate Objective can be found in the following table. The detail of each of the measures which constitute the tables can be found in section 1 for the Targeted Intervention Priorities and section 3 for all other local and national measures.

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Corporate Objective 1: Promoting and Enabling Healthier Communities					
Staying Healthy	1	Percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks pregnancy	*WG developing data flows*		
Staying Healthy	Local measure	Percentage of children up to date in schedule at 4th birthday	✗	↑ ●	No
Staying Healthy	2	Percentage of children who receive 3 doses of the '5 in 1' vaccine by age 1	✓	↓ ●	No
Staying Healthy	3	Percentage of children who received 2 doses of the MMR vaccine by age 5	✗	↑ ●	No
Staying Healthy	4	Percentage of children who are 10 days old within the reporting period who have accesses the 10-14 days health visitor contact component of the Healthy Child Wales Programme	✗	↓ ●	No
Staying Healthy	5	Uptake of the influenza vaccination among: • 65 years old and over • Under 65s in risk groups • Pregnant women • Health care workers	✗ ✗ ✗ ✓	↑ ● ↑ ● ↓ ● ↑ ●	Yes *(page 36)*
Staying Healthy	6	The rate of emergency hospital admissions for basket 8 chronic conditions per 100,000 of the health board population	✓	↓ ●	No
Staying Healthy	7	The rate of emergency hospital multiple readmissions (with a year for basket 8 chronic conditions per 100,000 of the health board population	✓	↓ ●	No
Staying Healthy	8	The percentage of adult smokers who make a quit attempt via smoking cessation services	✗	↑ ●	Yes *(page 38)*
Staying Healthy	9	The percentage of those smokers who are validated as quit at 4 weeks	✓	↑ ●	Yes *(page 38)*
Safe Care	15	Rate of hospital admissions with any mention of intentional self-harm for children and young people per 1,000 population	✗	↑ ●	No
Dignified Care	66	Percentage of people with dementia in Wales age 65 years or over who are diagnosed (registered on a GP QOF register)	✓	↑ ●	No

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Individual Care	87	Rate of calls to the mental health helpline CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population	✓	↑ ●	No
Individual Care	88	Rate of calls to the Welsh dementia helpline by Welsh residents per 100,000 of the population (age 40+)	✓	↑ ●	No
Individual Care	89	rate of calls to the DAN 24/7 helpline by Welsh residents per 100,000 of the population	✓	↑ ●	No
Corporate Objective 2- Delivering Excellent Patient Outcomes, Experience and Access					
Staying Healthy	10	Percentage of people (age 16+) who found it difficult to make a convenient appointment with a GP	✗	↓ ●	No
Safe Care	16	Amenable mortality per 100,000 of the European standardised population	✗	↑ ●	No
Safe Care	19	The number of preventable hospital acquired thromboses	✓	↓ ●	No
Safe Care	20	Total antibacterial items per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)	✓	↑ ●	*No*
Safe Care	22	The rate of laboratory confirmed *E.Coli* bacteraemias cases per 100,000 population	✗	↑ ●	Yes *(page 42)*
Safe Care	23	The rate of laboratory confirmed *S.aueus* bacteraemias (MRSA & MSSA) cases per 100,000 population	✗	↑ ●	Yes *(page 44)*
Safe Care	24	The rate of laboratory confirmed *C.difficile* cases per 100,000 population	✗	↓ ●	Yes *(page 46)*
Safe Care	Local measure	% compliance with Hand Hygiene Audits	✓	↓ ●	Yes *(page 48)*
Safe Care	25	Non steroid anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)	✓	↓ ●	*No*
Safe Care	31	Number of patients with grade 1,2,3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions	✓	↓ ●	Yes *(page 50)*
Safe Care	32	Number of patients with grade 3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions	✗	↑ ●	Yes *(page 50)*

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Safe Care	Local measure	Number of patients with grade 1,2,3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in the community	✓	↓ ●	Yes *(page 52)*
Safe Care	Local measure	Number of patients with grade 3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in the community	✓	↓ ●	Yes *(page 52)*
Safe Care	Local measure	Total number of inpatient falls	✓	↓ ●	Yes *(page 54)*
Effective Care	37	Delayed transfer of care delivery per 10,000 LHB population-mental health (all ages)	✗	↑ ●	Yes *(page 56)*
Effective Care	38	Delayed transfer of care delivery per 10,000 LHB population- non mental health (age 75+)	✗	↑ ●	Yes *(page 56)*
Effective Care	39	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	✗	↓ ●	Yes *(page 58)*
Effective Care	40	Crude hospital mortality rate (74 years of age or less)	✗	→ ●	Yes *(page 60)*
Effective Care	43	Percentage of episodes clinically coded within one reporting month post episode month end date	✓	↑ ●	Yes *(page 62)*
Effective Care	44	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	✓	↑ ●	No
Safe Care	Local measure	Percentage of completed discharge summaries	✓	↑ ●	Yes *(page 64)*
Effective Care	45	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	*WG establishing data flows*		
Dignified Care	50	The average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	✗	↓ ●	No
Dignified Care	51	Percentage of patients who had their procedures postponed on more than one occasion for non clinical reasons with less than 8 days notice and are subsequently carried out within 14 calendar days or at the patient's earliest convenience	✓	↑ ●	Yes *(page 66)*
Dignified Care	52	Number of patients agreed 75 and over with an AEC (Anticholinergic Effect on Condition) of 3 or more for items on active repeat, as a percentage of all patients aged 75	*WG establishing data flows*		

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
		years and over			
Dignified Care	56	Percentage 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	✗	↓ ●	No
Dignified Care	57	Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital	✓	↑ ●	No
Timely Care	60	Percentage of GP practices open during daily core hours or within 1 hour of daily core hours	✓	↑ ●	Yes *(page 68)*
Timely Care	61	Percentage of GP practices offering daily appointments between 17:00 and 18:30 hours	✗	↓ ●	Yes *(page 68)*
Timely Care	62	Percentage of urgent calls for health boards that only have GP Out of Hours that were logged and the patient started their definitive clinical assessment within 20 minutes of the initial call being answered	*WG awaiting data from 111*		
Timely Care	63	Percentage of patients that were priorities as very urgent for health boards that only have GP Our of Hours and seen (either in the primary care centre or via a home visit) within 60 minutes following their clinical assessment or face to face triage (in the case of 'walk in' patients)	*WG awaiting data from 111*		
Timely Care	64	Percentage of the health board population regularly accessing NHS primary dental care	✗	↓ ●	No
Timely Care	65	Percentage of patients waiting less than 26 weeks for treatment	✗	↓ ●	Yes *(page 70)*
Timely Care	66	The number of patients waiting more than 36 weeks for treatment	✗	↑ ●	Yes *(page 70)*
Timely Care	67	The number of patients waiting more than 8 weeks for a specified diagnostic *(Excluding Endoscopy)*	✗	↑ ●	Yes *(page 72)*
		The number of patients waiting more than 8 weeks for Endoscopy	✗	↓ ●	Yes *(page 74)*
Timely Care	68	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their target date	✗	↑ ●	Yes *(page 76)*

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Timely Care	69	Percentage of patients who are diagnosed with stroke who have a direct admission to an acute stroke unit within 4 hours	✗	↑ ●	Yes *(page 78)*
Timely Care	70	Percentage of patients who are diagnosed with stroke who are thrombolysed within 45 minutes (door to needle)	✗	↓ ●	No
Timely Care	71	Percentage of patients who are diagnosed with stroke who receive a CT scan within 12 hours	✓	↑ ●	Yes *(page 78)*
Timely Care	72	Percentage of patients who are diagnosed with stroke who have been assessed by a stroke consultant within 24 hours	✗	↑ ●	Yes *(page 78)*
Timely Care	73	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	✓	↑ ●	Yes *(page 80)*
Timely Care	74	Number of ambulance handovers over one hour	✗	↑ ●	Yes *(page 80)*
Timely Care	75	Percentage 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	✗	↓ ●	Yes *(page 82)*
Timely Care	76	Number of patients who spend 12 hours or more in all major and minor care facilities from arrival until admission, transfer or discharge	✗	↑ ●	Yes *(page 82)*
Timely Care	77	Percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within 31 days of diagnosis	✗	↑ ●	Yes *(page 84)*
Timely Care	78	Percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within 62 days of receipt of referral	✗	↓ ●	Yes *(page 84)*
Timely Care	79	Percentage of survival within 30 days of emergency admission for a hip fracture	✓	↑ ●	No
Timely Care	80	Percentage of mental health assessments undertaken within 28 days from the date of receipt of referral	✗	↓ ●	Yes *(page 86)*
Timely Care	81	Percentage of therapeutic interventions started within 28 days following an assessment LPMHSS	✗	↑ ●	Yes *(page 86)*
Individual Care	90	Percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	✗	↓ ●	Yes *(page 86)*

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Individual Care	91	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	✔	→ ●	Yes *(page 86)*
Individual Care	92	Percentage of hospitals within a health board which have arrangements in place to ensure advocacy is available for all qualifying patients	✔	→ ●	Yes *(page 86)*
Timely Care	Local measure	Percentage of Urgent Assessment by the Child and Adolescent Mental Health Services (CAMHS) undertaken within 48 Hours from receipt of referral	✖	↑ ●	Yes *(page 88)*
Timely Care	Local measure	Percentage of routine Assessment by CAMHS undertaken within 28 days from receipt of referral	✖	↑ ●	Yes *(page 88)*
Timely Care	Local measure	Percentage of patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks	✖	↑ ●	Yes *(page 88)*
Timely Care	Local measure	Percentage of therapeutic interventions started within 28 days following assessment by LPMHSS	✖	↓ ●	Yes *(page 88)*
Timely Care	Local measure	Percentage of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)	✖	↓ ●	Yes *(page 88)*
Our staff & resources	96	Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product plus biosimilar	*WG establishing data flows*		
Our staff & resources	96	Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product plus biosimilar	-	-	No
Our staff & resources	98	Caesarean section rate	✖	↑ ●	No
Corporate Objective 3- Demonstrating Value and Sustainability					
Our staff & resources	93	Rate of patients who did not attend a GP appointment	*WG establishing data flows*		
Our staff & resources	94	Percentage of patients who did not attend a new outpatient appointment	✔	↓ ●	Yes *(page 91)*
Our staff & resources	95	Percentage of patients who did not attend a follow-up outpatient appointment	✔	↓ ●	Yes *(page 91)*

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce					
Dignified Care	59	Percentage of GP practice teams that have completed mental health training in dementia care or other training as outlined under the Directed Enhanced Services for mental illness	✗	↓ ●	No
Our Staff & Resources	100	Percentage of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months	✗	↑ ●	Yes (page 94)
Our Staff & Resources	101	Percentage of staff who are undertaking a performance appraisal who agree it helps them improve how they do their job	✓	↑ ●	No
Our Staff & Resources	102	Overall staff engagement score- scale score method	✓	↑ ●	No
Our Staff & Resources	103	Percentage compliance for each completed Level 1 competency with the Core Skills and Training Framework by organisation	-	-	No
Our Staff & Resources	104	Percentage of sickness absence rate of staff	✓	↓ ●	Yes (page 96)
Our Staff & Resources	105	Percentage of staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	✓	↑ ●	No
Corporate Objective 5 - Embedding Effective Governance and Partnerships					
Safe Care	26	Number of Patient Safety Solutions Wales Alerts that were not assured within the agreed timescale	-	-	No
Safe Care	27	Number of Patient Safety solution Wales Notices that were not assured within the agree timescale	-	-	No
Safe Care	28	Percentage of serious incidents assured within the agreed timescales	✗	↑ ●	Yes (page 101)
Safe Care	29	Number of never events	✗	↑ ●	Yes (page 101)
Effective Care	46	Number of Health and Care Research Wales clinical research portfolio studies	✗	↓ ●	No
Effective Care	47	Number of Health and Care research Wales commercially sponsored studies	✗	↑ ●	No

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Effective Care	48	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	✗	↓ ●	No
Effective Care	49	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	✗	↑ ●	No
Dignified Care	Local measure	Number of new formal complaints received	-	↑ ●	Yes (page 103)
Dignified Care	54	Percentage of concerns that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the concern was first received by the organisation	✓	↑ ●	Yes (page 103)
Dignified Care	Local measure	Percentage of acknowledgements sent within 2 working days	✓	→ ●	Yes (page 103)

The performance measures included in this narrative report are the Targeted Intervention Priorities and the performance measures that currently do not have a dedicated report card. Work continues to be undertaken to develop more report cards and revise existing cards to ensure that the Health Board's reporting framework is fully aligned to the 2017/18 NHS Delivery Framework and the Annual Plan 2017/18.

Annual measures in particular do not lend themselves to having a dedicated report card and so these will be integrated into existing report cards where appropriate. The use of dedicated report cards for all national measures will give the Board greater understanding of current performance and actions planned to improve (or sustain) performance during 2017/18.

3. NHS DELIVERY FRAMEWORK/ KEY LOCAL MEASURES BY CORPORATE OBJECTIVE

3.1 Promoting and Enabling Healthier Communities

The table starting on page 4 above sets out the assessed performance of the key metrics under this Corporate Objective. Due to the varied reporting frequencies for these measures the reporting periods are mixed within this section but do reflect the most up to date information available. The majority of measures are reported quarterly with quarter 3 for 2017/18 being the latest data available.

The detailed performance report cards provide further background analysis to this performance assessment and cards are in included within this section of the report starting on page 36.

Further detail is provided on the following measures in the absence of dedicated report cards where new data has become available since the last performance report to the Board in January 2018:

Health Visitor contact for children who are ten days old (WG measure 4)

The Healthy Child Wales Programme (HCWP) sets the strategic direction for Health Boards in Wales for the delivery of early intervention health services that are designed to ensure that children achieve optimum health. The programme was implemented across all Health Boards from 1st October 2016. The programme sets out planned contacts children and their families can expect from the Health Boards from maternity service handover to the first years of schooling. These universal contacts cover three areas of intervention:

- Screening
- Immunisation
- Monitoring and supporting child development

One of the measures in the HCWP which is included in the NHS Wales Delivery Framework, is the percentage of children who are 10 days old within the reporting period who have accessed the 10-14 days health visitor contact component. The latest published data for April- September 2017 (quarter 2) shows that ABMU achieved 60.7% which is lower than the all-Wales position of 81.0%. ABMU is the worst performing Health Board in quarter 2.

There have been a number of issues that have impacted on the data during the first quarters of 2017/18 which are directly attributable to the low compliance:

- Practitioners are reporting that the contacts have been completed and the forms have been submitted to the child health departments but a relatively high number of forms have failed to be delivered. As a result, alternative methods of delivery such as email are currently being explored.
- There was an issue with the some of the notifications not being populated after birth on the maternity system but this has now been addressed by the Head of Maternity services with a new Standard Operating Protocol in place.
- Practitioners are reporting that the relevant forms are being submitted however an audit is being undertaken against the births and the Child Health data to identify if there are any practitioners are not submitting the forms. In addition, the outcome of the audit will be shared with NWIS as internal data

suggests that the Health Board's compliance is higher than the all-Wales published data.

Emergency hospital admissions and re-admissions (WG measures 6-7)

The 8 basket procedures included in the measure are:

- Respiratory
- Cardiovascular
- Neurological
- Musculoskeletal
- Diabetes
- CVA
- Atrial Fibrillation
- Alzheimer's

The rationale behind this measure is that emergency admissions for chronic conditions will improve through the availability and quality of comprehensive services for integrated chronic conditions management resulting in a smooth and efficient patient pathway.

In November 2017 the rate of emergency admissions and readmissions (for basket of 8 chronic conditions) improved compared with November 2016. The Health Board is above the all-Wales average for both measures. The below tables show how ABMU compares with the other Health Boards in Wales and historical activity trends

Rate of emergency hospital admissions for basket of 8 chronic conditions per 100,000 population

LHB	Current	Same Period Comparison		
	Nov-17	Nov-16	Nov-15	Apr-11
Wales	1,111	↑ 1,215	↑ 1,179	↑ 1,244
ABM	1,278	↑ 1,295	↓ 1,198	↑ 1,372
AB	1,229	↑ 1,312	↑ 1,303	↑ 1,319
BCU	984	↑ 1,144	↑ 1,181	↑ 1,204
C&V	1,020	↑ 1,107	↑ 1,030	↑ 1,141
CTaf	1,439	↑ 1,668	↑ 1,569	↑ 1,560
HDda	1,173	↑ 1,293	↑ 1,256	↑ 1,346

Rate of emergency hospital readmissions for basket of 8 chronic conditions per 100,000 population

LHB	Current	Same Period Comparison		
	Nov-17	Nov-16	Nov-15	Apr-11
Wales	229	↑ 251	↑ 244	↑ 269
ABM	263	↑ 266	↓ 252	↑ 297
AB	248	↑ 273	↑ 258	↑ 305
BCU	217	↑ 248	↑ 261	↑ 260
C&V	202	↓ 198	↓ 192	↑ 228
CTaf	310	↑ 388	↑ 353	↑ 361
HDda	225	↑ 249	↑ 244	↑ 267

Calls to helplines (WG measures 87-89)

These measures focus on three helplines available to Welsh residents which include the C.A.L.L. helpline; the DAN 24/7 helpline and Wales Dementia helpline. The Community Advice and Listening Line (C.A.L.L.) service offers emotional support and information/literature on Mental Health and related matters to people in Wales. The Wales Dementia helpline offers emotional support to anyone, of any age who is caring for someone with Dementia as well another family members of friends plus it

supports those who have been diagnosed with Dementia. DAN 24/7 is a telephone drugs helpline providing a single point of contact for anyone in Wales wanting further information or help relating to drugs or alcohol.

The latest data available is quarter three 2017/18 which shows that there has been a significant increase in the uptake for the C.A.L.L. helpline but a reduction in uptake for the other two helplines when compared with quarter three 2016/17. For the uptake rates of the DAN 24/7 helpline, ABMU is below the all-Wales uptake rate (25.9 compared with 38.9). This is a similar position for the uptake rate for the Wales Dementia helpline as ABMU is below the all-Wales rate (5.1 compared with 9.1).

Even though the uptake rate for C.A.L.L. has significantly improved from 71.9 in quarter three 2016/17 to 122.1 2017/18, ABMU has the second lowest uptake rate in Wales and is significantly below the all-Wales average of 177.9. The Health Board actively promotes the C.A.L.L. helpline through the use of leaflets and call cards which are made available in community sites and wards. Care co-ordinators also advise people they come into contact with about the helpline. In addition, as the helpline is for all people with any mental wellbeing concerns not just severe mental health difficulties, the helpline is featured in our Choose Well materials.

Further detail on current performance and proposed actions going forward can be found for the following measures via dedicated report cards:

- Influenza immunisation (WG measure 5)
- Smoking Cessation (WG measures 8 and 9)

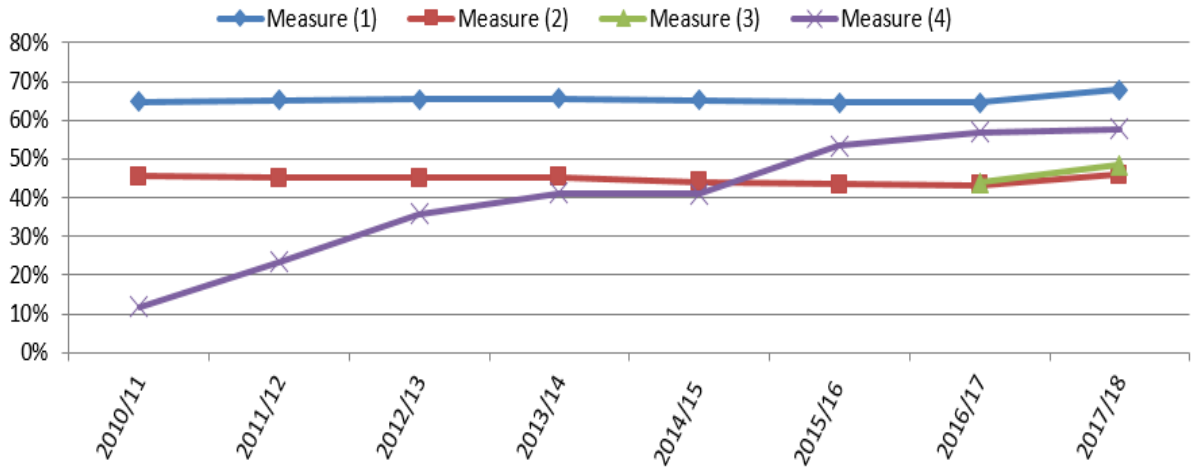
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

% 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.

Corporate Objective : Promoting & Enabling Healthier Communities			Executive Lead : Sandra Husbands	
Period : Feb 2018	**IMTP Profile Target : (1) 75%, (2) 55%, (46%), (4) 60%**	**WG Target : (1) 75%, (2) 55%**	**Current Status :** ✖	**Movement :** ⇧ ● **Improving**

Current Trend: 2010/11 - 2017/18

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



** Data up to 13th February 2018*

Benchmarking

% uptake of the Seasonal Flu Vaccine

** All Data up to 13th February 2018*

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

% 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 13th Feb 2018 (IVOR):

- Measure 1. Uptake is higher (68.0%) compared with the same time last season (64.8%) with an additional 4,035 vaccinations given. Uptake by cluster ranges from 63.1% (Upper Valleys) to 73.6% (Bridgend East). Practice uptake ranges from 57.7% to 84.1%. 11 practices have achieved the national target.
- Measure 2. Uptake is higher 46.3% compared with the same time last season (43.5%). Cluster uptake ranges from 39.3% (Bridgend West) to 51.8% (Afan). Wide variance in uptake by practice from 28.4% to 76.8%. 12 practices have achieved the 55% target, four practices have achieved 55% uptake for the 9 chronic conditions.
- Measure 3. Uptake is higher 48.8% compared with the same time last season 44%. Cluster uptake ranges between 33.3% (Bridgend West) and 57.8% (Afan). Practice uptake ranges from 21.6% to 91.8%. There is currently no national target - ABMU has achieved the IMTP profile target of 46%.
- Measure 4. 58.3% of frontline staff have received the flu vaccine and 9,453 staff have been vaccinated as 21/2/18 making this the Health Board's most successful staff campaign to date.

What actions are we taking?

- Weekly email comprising of IVOR data, influenza surveillance and campaign information circulated to practice managers and senior colleagues
- Health Board primary care team continue to follow up and offer Public Health Team support to lower performing practices
- Vaccine uptake discussed at cluster leads and cluster meetings
- Dissemination of national Public Health Wales VPDP Beat flu campaign communications including FAQ to help support NHS Wales organisations and clinicians
- Weekly communications via the Health Board's intranet and weekly update e-mails to Senior Managers to encourage staff to have the vaccine.
- Weekly open vaccination clinics are held across the 4 main hospital sites. Additional resource for mobile vaccinators was made available between September 2017 and January 2018

What are the main areas of risk?

- The Health Board may not meet the Welsh Government Tier 1 target of 60% of frontline staff being vaccinated. It has become apparent that different reporting methods that may not comply with Welsh Government guidelines may be being used by some Health Boards. If this is the case, then ABMU may be disadvantaged for using the official guidance and it is estimated that we may have actually vaccinated 63% of frontline staff.

How do we compare with our peers?

- For patients aged 65 years and older uptake is comparable to other Health Boards although slightly less than the Welsh average of 68.7%. ABMU is ranked 4th.
- ABMU is ranked 6th for patients 6 months to 64 years at risk and is below the Welsh average of 48.2%
- ABMU is ranked 6th for vaccine uptake for 2 and 3 year old and is below the Welsh average of 50%.
- Currently ABMU is 3rd out of the large Health Board's in Wales, however, it is estimated we may be second if data collection reflected the perceived discrepancies in data collection.

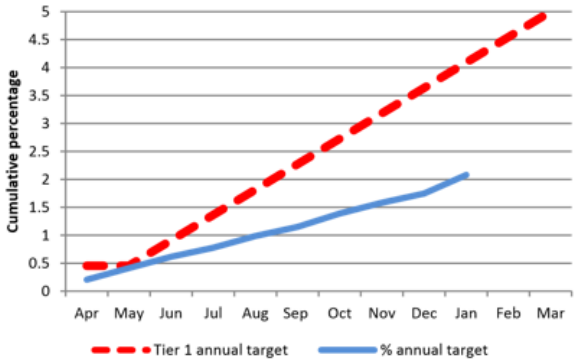
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

Measure 1: % Welsh resident smokers make a quit attempt via Smoking Cessation Services (numerator = set a quit date each month; denominator derived from ABMU smoking population)
Measure 2: % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks (people previously setting a quit date and now quit)

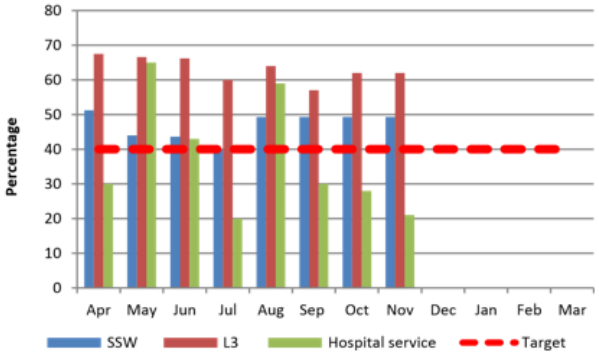
Corporate Objective : Promoting & Enabling Healthier Communities			Executive Lead : Sandra Husbands	
Period : Jan 2018	IMTP Profile Target : (1) 5% (2) 40%	WG Target : (1) 5% (2) 40%	Current Status :	Movement : Impr

Current Trend: 2017-2018 (monthly)

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



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



Benchmarking

(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

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

<u>Measure 1:</u> % Welsh resident smokers make a quit attempt via Smoking Cessation Services (numerator = set a quit date each month; denominator derived from ABMU smoking population)
<u>Measure 2:</u> % Welsh resident smokers who are CO validated as successfully quitting at 4 weeks (people previously setting a quit date and now quit)

How are we doing?

- To achieve the 5% smoking cessation target approximately 4,600 smokers need to be treated in ABMU stop smoking services per year, with an average of 383 smokers treated per month. ABMU has treated 1,909 smokers (monthly activity data) against the cumulative monthly target of 3,825, achieving to January 2018 2.1% of the overall 5% target (expected trajectory performance by January 2018 is 4%).
- Level 3 community pharmacy cessation services and Stop Smoking Wales have consistently achieved over the 40% target, for smokers that have a Carbon monoxide validated reading as quit at 4 weeks. The hospital service however has varied and recent performance is below the 40% target
- The most recent data from the National Survey for Wales 2016/17 estimates that 21% of ABMU ABMU's population (aged 16+) smoke. This is higher than the Wales average of 19%. Smoking prevalence in ABMU's constituent counties are Bridgend 20.0%, Swansea 20.0% and NPT 24.6%.

What actions are we taking?

- ABMU Cessation Services Steering group established. First meeting held January 2018.
- Phase 3 of the national integrated cessation system in progress. Review of ABMU cessation services to be undertaken as part of national integration agenda and against minimum service standards being developed on an all-Wales basis.
- ABMU cessation services have supported the development of Help Me Quit resources, supportive materials and standardised quit book; training and development network for cessation advisors established. Network event held and survey monkey conducted to inform network action plan
- All 84 pharmacies commissioned are now accredited. 100 Community Pharmacies commissioned from April 2018 to deliver the level 3 smoking cessation service. Plan in place to address performance, service development and quality improvement; paper taken to primary care forum February 2018.
- Work commenced with NWIS and Health Board IT to improve the recording of smoking status on patient clinical systems and electronic referral mechanism to the hospital service.
- Telephone support pilot with SSW underway in ABMU. Service is now able to see clients who have quit smoking within 2 weeks. This will help with supporting clients discharged from Hospital and who have quit recently before joining the service.
- Maternal smoking priority as part of WG National improvement programme. National monthly meetings held looking at system wide improvements across Health Boards. ABMU maternal smoking working group established. Work progressing to understand the needs of pregnant smokers and improve attrition in cessation services. Cessation pathway in development
- Broader work to create supportive smoke free environments being scoped.

What are the main areas of risk?

- New cessation brand 'Help me quit' introduced in 2018. Possible confusion for smokers and service referrers during transition period of current cessation services to the new brand
- Difficulty in achieving 4 week CO validated quit for in-patient smokers affecting performance target
- Focus currently on cessation services and driving the demand to services, without addressing the broader supportive environments and wider determinants agenda. This work being scoped for progression in 2018/19
- The demand for ABMU cessation services from smokers does not produce the required number of treated smokers.
- Commissioned pharmacies are now accredited, but not necessarily actively delivering the service. Service to be extended to all ABMU pharmacies in line with national funding. Community pharmacies may not have the desire and/or capacity to deliver the Level 3 service to expected levels. Capacity of primary care Delivery Unit staff to support the expansion of level 3
- The projected numbers of pharmacies do not deliver the required number of treated smokers

How do we compare with our peers?

- The latest published data available from Welsh Government shows that during Q1-2 2017/18 ABMU was above the all-Wales position for the percentage of resident smokers who are CO validated as successfully quitting at 4 weeks; but below the all-Wales position for the percentage of resident smokers making a quit attempt via smoking cessation services.

3.2 Delivering Excellent Patient Outcomes, Experience and Access

The table which starts on page 4 above sets out the assessed performance of the key metrics under this Corporate Objective. For the majority of cases this data relates to January 2018. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 42.

Further detail is provided on the following measures in the absence of dedicated report cards where new data has become available since the last performance report to the Board in January 2018:

Prescribing (WG measures 20 and 25)

ABMU has made significant progress in the last year to reduce overall antibacterial prescribing. This includes a reduction in overall prescribing for Quarter 3 2017/18 vs Quarter 3 2016/17 of 3% across ABMU.

Key activities to build on this in 2017/8 are as follows:

- Support for Global and National Initiatives; World Antibiotic Awareness Week and European Antimicrobial Awareness Day.
- Community pharmacy engagement
- Review of antibiotic prescribing guidelines

Non-steroidal anti-inflammatory drugs (NSAIDs) Average Daily Quantity (ADQ) per 1000 STAR PUs has been a National prescribing indicator since 2012-13 (before which it was NSAIDs ADQ per 1000 PUs), and over this time ABMU has shown a continual and consistent reduction in use. Quarter 3 2017/18 saw a reduction in NSAID average daily quantity from 1,635 in 2016/17 to 1,541 in 2017/18.

2017/18 has seen the introduction of a new indicator focusing on NSAIDs and chronic kidney disease (CKD) where practices are encouraged to regularly review the ongoing need for an NSAID in patients with CKD. Comparing quarter 1 to quarter 3 2017/18 ABMU has seen a 1.48% reduction in patients on the CKD register who have received a repeat prescription for a NSAID within the last 3 months, and a 1.53% reduction in patients who are not on the CKD register but have an EGFR of 59ml/min - <15ml/min and have received a repeat prescription for a NSAID within the last 3 months.

NSAIDs are also included in the Primary Care Medicines Management team work plan to prompt team members to encourage practices to avoid or reduce the use of NSAIDs where possible, and use the most cost effective preparations first line (ibuprofen and naproxen). NSAID prescribing is also highlighted at the practice annual prescribing visits, and forms part of the current prescribing management scheme where practices are encouraged to reduce the use of pain medicines through prudent prescribing, and use the lowest effective dose of NSAIDs to minimise side effects. Some practices are reviewing this area as one of their annual prescribing actions linked with the Quality and Outcomes Framework (QOF).

Further detail on current performance and proposed actions going forward can be found for the following measures via dedicated report cards:

- Infection Control (WG Measure 22 to 24)
- Pressure Ulcers (Local Measure)
- Inpatient Falls (Local Measure)
- Mortality (WG Measures 39, 40 and 79)
- Delayed Transfers of Care (DTOCs) (WG Measures 37 and 38)
- Clinical Coding (WG Measures 43)
- Discharge Summaries (Local Measure)
- Postponed Operations (WG Measures 51)
- Primary Care Access (WG Measures 60, 61 and 64)
- Planned Care (WG Measures 65 to 67)
- Delayed Follow-ups (WG Measure 68)
- Stroke (WG Measures 69 to 72)
- Unscheduled Care (WG Measures 73 to 76)
- Cancer (WG Measures 77 and 78)
- Mental Health (WG Measures 80 to 92)
- Child and Adolescent Mental Health (CAMHS) (Local Measures)

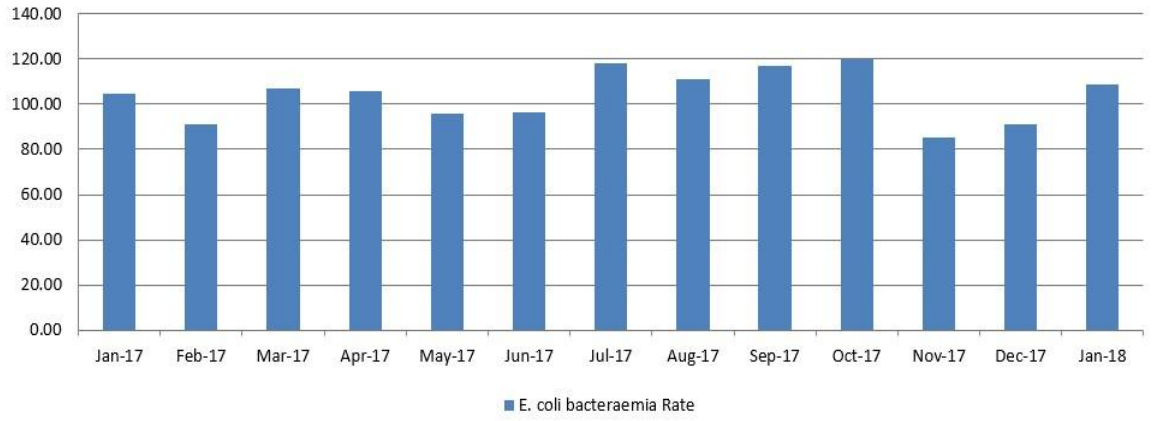
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Angela Hopkins**	
Period : Jan 2018	**IMTP Profile Target :**	**WG Target : Reduce**	**Current Status :** ✖	**Movement :** ⇧ ● **Worsening**

Current Trend: Jan 17 - Jan 18

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



Benchmarking

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

LHB	Apr 17 - Jan 18	Cumulative Number Against Mar 18 Reduction Expectation
Wales	85.52	+502
ABM	105.02	+173
AB	79.64	+95
BCU	78.34	+70
C&V	69.87	+45
Ctaf	94.43	+71
Hdda	119.37	+171

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected reduction by Mar 18

Source : Public Health Wales, C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (Feb 2018)

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population

How are we doing?

- Over the first 10 months of 2017/18, the Health Board average was 47 cases per month. The total number of cases between April and January 2018 was 466.
- By the end of January, the Health Board was 114 cases above the expected cumulative number of cases for 2017/18.
- 49 cases of Escherichia coli (E. coli) bacteraemia were identified in January; 18 inpatients and 31 non-inpatients.
- Localised surveillance of all cases has identified that 68% of all cases are community-acquired infection. The distribution of hospital acquired cases is as follows: Morriston – 41%, Singleton – 27%, Princess of Wales – 19%, Neath Port Talbot – 12%.
- There has been a 21% increase in the number of cases of E. coli bacteraemia identified within the Health Board between April and January 2018, compared with the same 10-month period in 2016/17.

What actions are we taking?

- There has been no national surveillance programme specific to E. coli bacteraemia in the past. This is a year where the Health Board will be establishing baseline data, whilst additionally it is required to achieve a reduction.
- Delivery Units will be expected to include in their annual plans how they will progress the number of staff who have been ANTT competence assessed – for 2018/19 financial year.
- A training package specific to E. coli and associated bacteraemia has been developed as a "bolt-on" to Standard Infection Control Precautions training - first presentation delivered by 22 January 2018. Delivery of ongoing training has been affected by the high incidence of influenza seen across ABMU in January 2018. To be rolled out by 31 March 2018.
- Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters – ongoing into Q4, 2017/18.
- Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters – to launch January 2018.

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.

How do we compare with our peers?

- ABMU has the second highest cumulative incidence of E. coli bacteraemia in comparison with the other major Welsh Health Boards. There has been an approximate 6% increase in cases across NHS Wales in the first 10 months of 2017/18, compared with the same period in 2016/17.
- Ten months into the reduction expectation period, one of the 6 major Health Boards is on trajectory to meet the reduction expectation (Cardiff and Vale). 4 Health Boards can no longer the 2017/18 reduction expectation (Abertawe Bro Morgannwg UHB, Aneurin Bevan UHB, Betsi Cadwaladr UHB and Hywel Dda UHB).

SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM				
Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Angela Hopkins**	
Period : Jan 2018	**IMTP Profile Target : 32.3**	**WG Target : Reduce**	**Current Status :** ✓	**Movement :** ↓ **Improving**

Current Trend: Jan 17 - Jan 18

(1) Number of cases of S. aureus bacteraemia per 100,000 of the population.

Benchmarking

(1) Number of cases of S. aureus bacteraemia per 100,000 of the population.

Source : Public Health Wales, C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (Feb 18)

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population

How are we doing?

- For the months between April and January 2017/18, the Health Board average decreased to 16 cases per month. The total number of cases between April and January 2018 was 162. By the end of January, the Health Board had exceeded the maximum total number of cases to achieve the annual infection reduction expectation by 57 cases.
- In January, the Health Board had 14 cases of Staph. aureus (SA) bacteraemia (9 inpatient cases; 5 non-inpatient cases). Local surveillance identified that 6 of the 14 cases were community acquired infections. Morriston accounted for 75% of the hospital acquired cases. Cases were unrelated.
- There has been a 9% increase in the number of cases of Staph. aureus bacteraemia identified within the Health Board between April and January 2018, compared with the same 10-month period in 2016/17.
- Localised surveillance of all cases has identified that 51% of all cases are community-acquired infection.

What actions are we taking?

- Delivery Units will be expected to include in their annual plans how they will progress the number of staff who have been ANTT competence assessed – for 2018/19 financial year.
- Identify wards with the highest incidence of hospital acquired Staph. aureus bacteraemia and undertake direct observation of practice assessments to identify key practices which would benefit from PDSA-style improvement initiatives - by 28 February 2018.
- Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters – ongoing into Q4, 2017/18.
- Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters – to launch February 2018.

What are the main areas of risk?

- An increasing proportion of MSSA bacteraemia is community acquired, with many patient related contributory factors, such as recreational infecting 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?

- ABMU continues to have the highest cumulative incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards. There has been a 13% increase in cases across NHS Wales in the first 10 months of 2017/18, compared with the same period in 2016/17.
- None of the 6 major health boards can now achieve the 2017/18 reduction expectation.

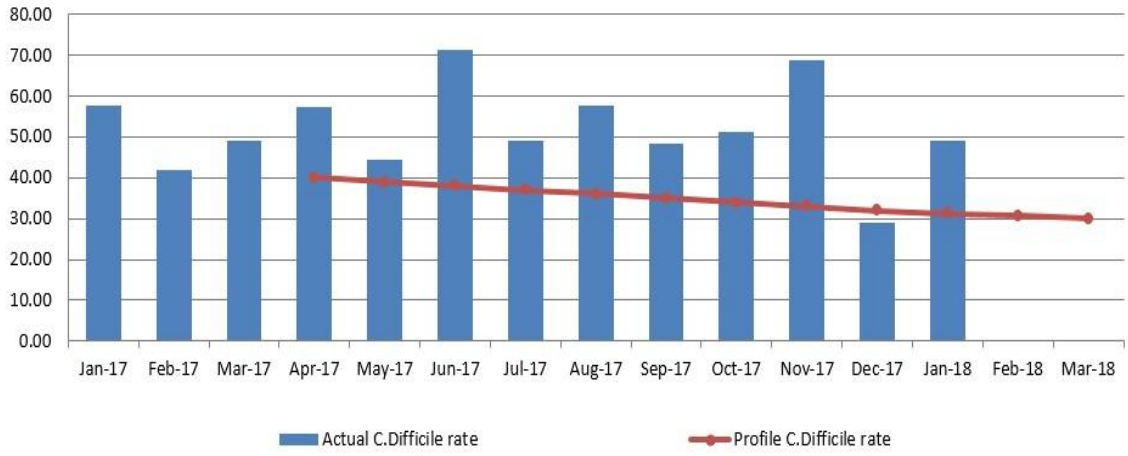
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of C. *Difficile* per 100,000 of the population

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Angela Hopkins**	
Period : Jan 2018	**IMTP Profile Target : 33.0**	**WG Target : Reduce**	**Current Status :**	**Movement : Imp**

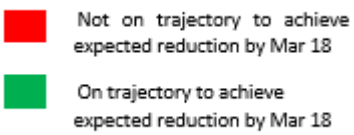
Current Trend: Jan 17 - Jan 18

(1) Number of C.d*ifficile cases* per 100,000 of the population.



Benchmarking

(1) Number of cases of C Difficile per 100,000 of the population.



Source : Public Health Wales, C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (Feb 2018)

Measure 1: Rate of C Difficile cases per 100,000 of the population

How are we doing?

- Over the first 10 months of 2017/18, the Health Board average was 23 cases per month. The total number of cases between April and January 2018 was 230. By the end of January, the Health Board was 94 cases above the expected cumulative number of cases for 2017/18.
- 22 cases of C. difficile infection were identified in ABMU in January 2018. There were 17 cases from inpatient locations; 5 cases from non inpatient locations. Local surveillance identified that 16 of the 22 cases in January were hospital acquired infections.
- Localised surveillance of all cases has identified that 79% of all cases are identified as being hospital-acquired infection (occurring more than 48 hours after admission), however, antimicrobial prescribing in Primary Care potentially contributes to an indeterminate proportion of these cases.
- The distribution of hospital acquired cases from April 2017 to January 2018 is as follows: Morriston – 43%, Princess of Wales – 31%, Singleton – 18%, Primary Care & Community – 4%, Neath Port Talbot – 4%.
- There had been a 23% increase in the number of cases of Clostridium difficile infection identified within the Health Board between April and January 2018, compared with the same 10-month period in 2016/17. The rate of increase April – November 2018 was 46%.

What actions are we taking?

- More restrictive antimicrobial guidelines are being amended currently, in preparation for implementation by 31st March 2018.
- Before the restrictive guidelines can be implemented, the additional resource and costs involved with monitoring gentamicin levels will need to be identified and agreed – by 28 February 2018.
- Safe system of work protocol in relation to UVC completed. Updated training programme, based on new safe system, has been developed. The revised safe system of work and associated training have been sent to HSE before training commences. Re-introduction of UVC anticipated by end February 2018.
- The Medical Director has agreed funding for identified clinical leads for Infection Prevention and Antimicrobial Stewardship in the acute Delivery Units. Expressions of interest will be invited in February 2018.

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 pre-emptive beds; 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.
- Worsening position impacts on public confidence.

How do we compare with our peers?

- ABMU has a significantly higher cumulative incidence of C. difficile infection (51.83/100,000) in comparison with all other major Welsh Health Boards. Hywel Dda has the second highest incidence, at 41.34. More significantly, Cardiff & Vale UHB has an incidence of 25.56, which is a rate more than half the rate in ABMU.
- There has been an 11% increase in cases across NHS Wales in the first 10 months of 2017/18, compared with the same period in 2016/17.
- One of the 6 major Health Boards is on trajectory to meet the reduction expectation (Cardiff and Vale). 4 health boards can no longer the 2017/18 reduction expectation (Abertawe Bro Morgannwg UHB, Aneurin Bevan UHB, Betsi Cadwaladr UHB and Hywel Dda UHB).

SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

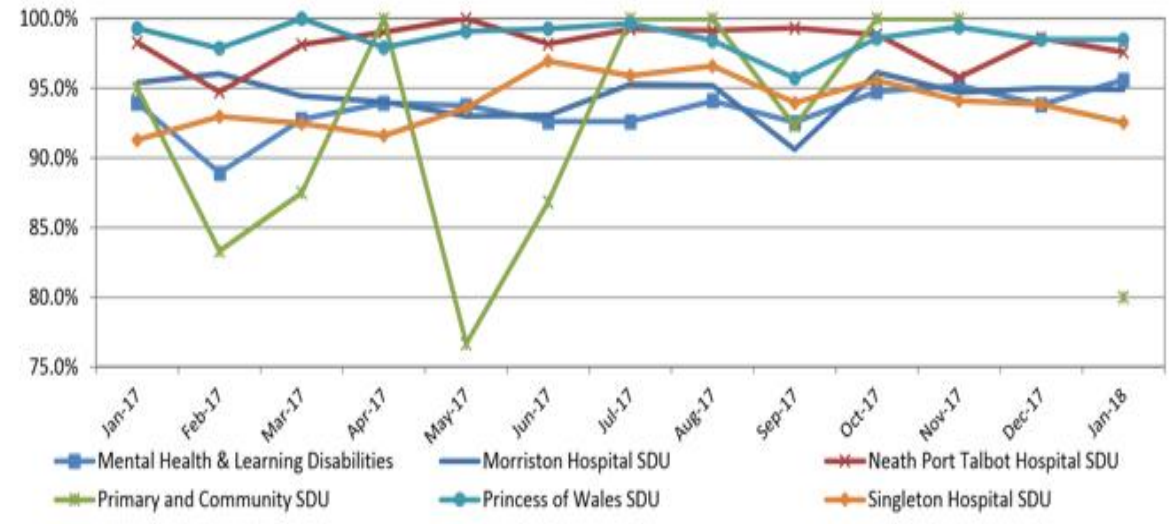
Measure 1: % compliance with Hand Hygiene Audits

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Sandra Husbands	
Period: Jan 2018	**IMTP Profile Target :** 95%	**WG Target :** N/A	**Current Status :** ✓	**Movement :** Worsening

Current Trend: Nov 16- Nov 17

(1) % compliance with Hand Hygiene Audits

Benchmarking



Source : ABMU Care Matrix

Measure 1: % compliance with Hand Hygiene Audits

How are we doing?

- Compliance with hand hygiene (HH) for January 2018 decreased to 95.26%.
- For January 2018, 79 wards/units (54%) reported compliance ≥95%.
- 17 wards/departments (12%) reported compliance ≥90% ≤94%; 9 wards/units (6%) reported compliance ≤89%.
- 41 wards/departments had not uploaded the results of their audits undertaken in January 2018.
- All Service Delivery Unit (SDU) reported compliance ≥90% ≤94% in January 2018.
- 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?

- ABMU Infection Prevention & Control (IPC) team has agreed with two neighbouring Health Board IPC teams to undertake further peer reviews of hand hygiene compliance.
- The updated Hand Hygiene Training programme is being delivered since the end of January.

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?

- Data not available.

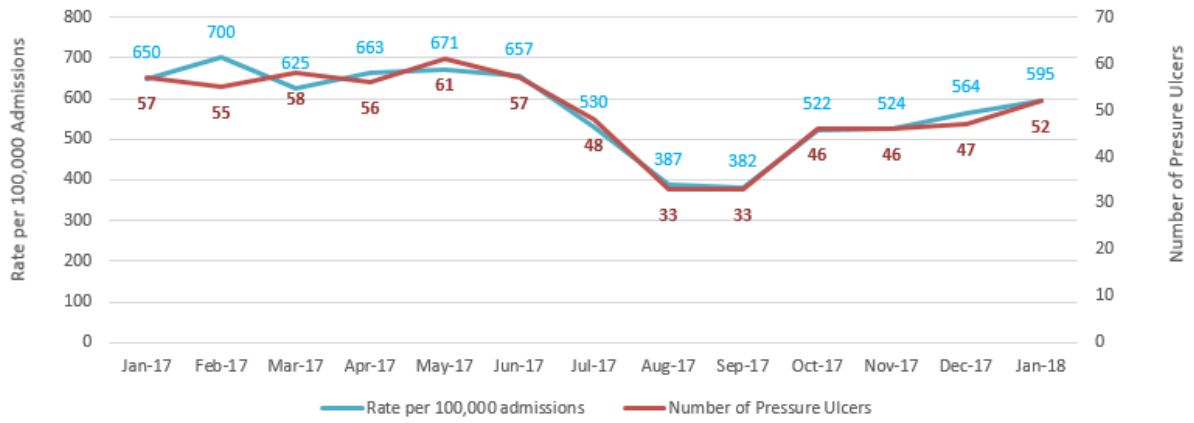
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: **Total Number of pressure ulcers acquired in hospital per 100,000 hospital admissions.**
Measure 2: **Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions.**

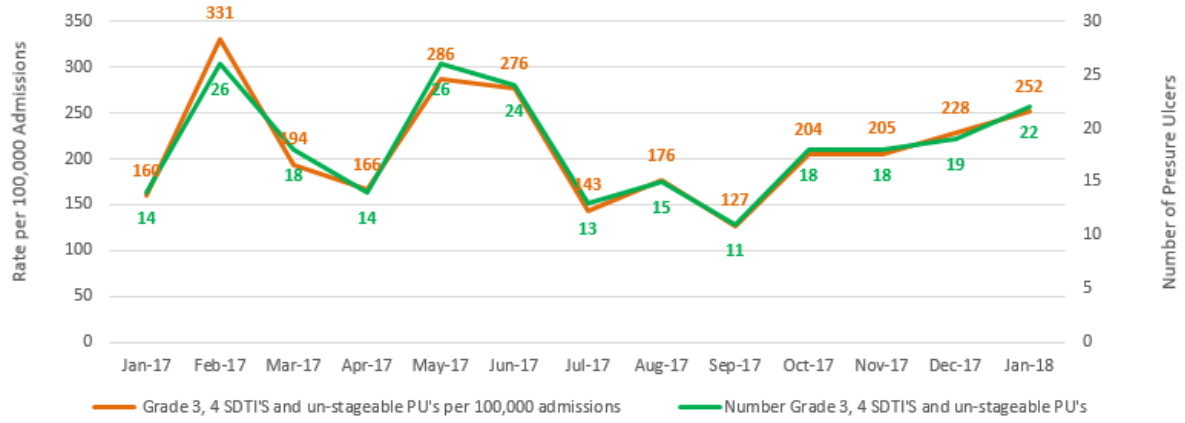
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Jan 2018	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Impr

Current Trend: Jan 17 - Jan 18

(1) Total Pressure Ulcers acquired in hospital



(2) Grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital



Benchmarking

Welsh Government benchmarking data is not yet available.
It is expected at some point during 2017/18

Source : PRESSURE ULCERS FROM DATIX and ADMISSIONS FROM MYRDDIN

Measure 1: Total Number of pressure ulcers acquired in hospital per 100,000 hospital admissions.
Measure 2: Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions.

How are we doing?

- The "In Hospital" acquired Pressure Ulcers are reported as a rate per 100,000 hospital admissions to comply with the requirements of the 2017/18 NHS Wales Delivery Framework. The number of pressure ulcer incidents is also included to enable comparison with the reported measure of per 100,000 admissions.
- There has been an increase in the rate of pressure ulcer development for inpatients during January 2018. The rate per 100,000 admissions has increased from 564 in December to 595 in January 2018. This reflects an increase of 5 pressure ulcer incidents, from 47 in December 2017 to 52 in January 2018.
- The Princess of Wales Hospital remains the hot spot for pressure ulcer development with 42% of all in-patient pressure ulcers developing at the site.
- The rate of Grade 3+ pressure ulcers has increased from 228 per 100,000 admissions in December, to 252 per 100,000 admissions in January.
- Of the 22 Grade 3+ pressure ulcer incidents reported in December, 8 were classified as deep damage.
- Again, no Grade 4 pressure ulcers were reported.

What actions are we taking?

- A review of Serious Incident pressure ulcers occurring between April 2017 and January 2018 has been carried out to identify themes for causal and contributory factors for pressure ulcer development. The findings from the serious incident review will contribute to the development of the Strategic Quality Improvement Plan (SQuIP) for preventing pressure ulcers.
- The Pressure Ulcer Prevention Strategic Group (PUPSG) is due to meet in March 2018 and the draft SQuIP will be presented at the March PUPSG meeting.
- A pilot workshop for developing the skills of pressure ulcer peer review scrutiny panel members was held in February. Feedback from the workshop will be analysed and a plan for scrutiny panel education developed. Roll out of the education across ABMU will be implemented in early April 2018.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all SDU's and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
- The Princess of Wales Hospital remains the hot spot for pressure ulcer development in January 2018. This is being closely monitored by the Unit Nurse Director.
- Datix scrutiny was conducted for January 2018 data, duplicate entries were identified and the data rectified to ensure Health Board reporting accuracy.
- The Policy for the Prevention and Management of Pressure Ulcers has been revised and is out for comment. Once comments have been incorporated the policy will be submitted to NMB in March 2018 for approval and ratification.

What are the main areas of risk?

- Winter pressures on the ambulance service and occupancy of in-patient areas increase the challenge for staff in preventing pressure ulcers. Morriston Hospital has seen a direct correlation with increased USC pressures and pressure ulcer development. Both from the perspective of ward staff's ability to manage the acuity and numbers of extra patients on the wards and because of long waits for ambulances at home and in ambulances at A&E.

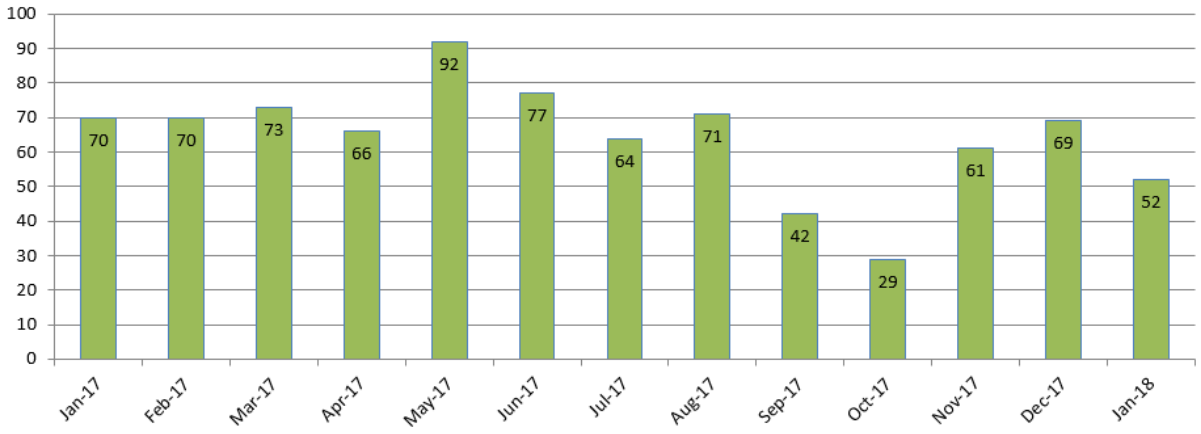
How do we compare with our peers?

NOTE: the total rate per 100,000 admissions may increase despite total incidents decreasing based on the monthly admissions per 100,000 measure.

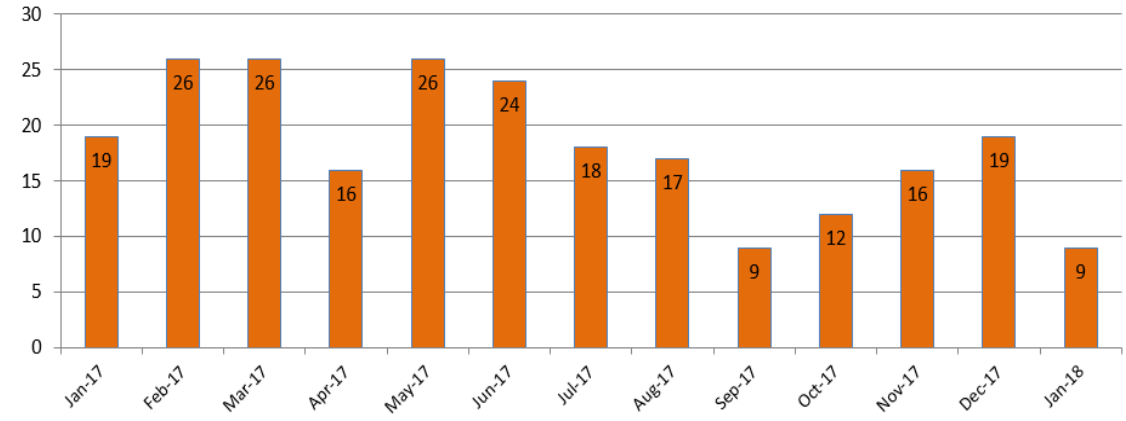
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM				
Measure 1: Total Number of pressure ulcers developed in the community. **Measure 2:** Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers developed in the community.				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Jan 2018	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Improving

Current Trend: Jan 17 - Jan 18

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



(2) Number of grade 3, 4 suspected deep tissue injury and unstageable pressure ulcers developed in the community.



Benchmarking

Welsh Government benchmarking data is not yet available.
It is expected at some point during 2017/18

Source : PRESSURE ULCERS FROM DATIX

<u>Measure 1:</u> Total Number of pressure ulcers developed in the community.
<u>Measure 2:</u> Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers developed in the community.

How are we doing?

- During January 2018, 52 incidents of pressure ulceration were reported, this is a decrease compared to the 69 incidents reported in December 2017.
- Of the pressure ulcers reported in December, 83% recorded superficial damage.
- There has been a significant decrease in the Grade 3+ pressure ulcers reported, from 19 in December 2017 to 9 in January 2018.
- Of the Grade 3+ pressure ulcers reported in January, 4 met the criteria for Serious Incident reporting.
- One Grade 4 pressure ulcer was reported.

What actions are we taking?

- A review of Serious Incident pressure ulcers occurring between April 2017 and January 2018 has been carried out to identify themes for causal and contributory factors for pressure ulcer development. The findings from the serious incident review will contribute to the development of the Strategic Quality Improvement Plan (SQuIP) for preventing pressure ulcers.
- The Pressure Ulcer Prevention Strategic Group (PUPSG) is due to meet in March 2018 and the draft SQuIP will be presented at the March PUPSG meeting.
- A pilot workshop for developing the skills of pressure ulcer peer review scrutiny panel members was held in February. Feedback from the workshop will be analysed and a plan for rolling out scrutiny panel education across ABMU will be designed, with implementation to start in early April 2018.
- Monthly Quality Improvement Pressure Ulcer meetings, chaired by the Head of Community Nursing provide assurance for effective pressure ulcer prevention and investigation of incidents. The learning from the panel is shared through the Pressure Ulcer Prevention Strategic Group and disseminated to locality staff.
- Peer review scrutiny panels are held in Swansea, Bridgend and NPT localities, the frequency has been increased to weekly to proactively manage the risks identified. This will increase the number of pressure ulcer incidents scrutinised and enhance local accountability. The learning from each local panel is shared at the Unit Quality Improvement meeting.
- 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.
- The Governance team continue work to improve the validity of the Datix incident data to reduce errors and duplicate reports.
- The Policy for the Prevention and Management of Pressure Ulcers has been revised and is out for comment. Once comments have been incorporated the policy will be submitted to NMB in March for ratification.

What are the main areas of risk?

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

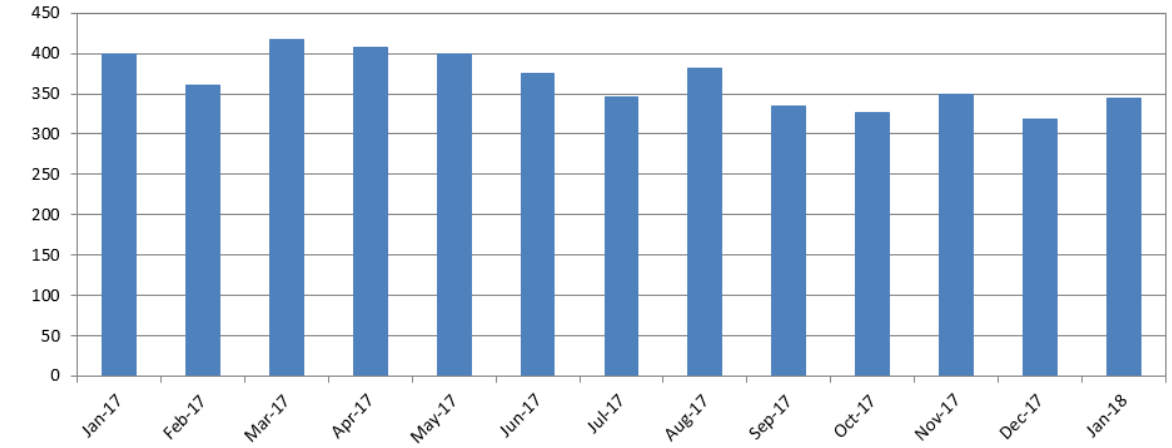
How do we compare with our peers?

No benchmark data available.

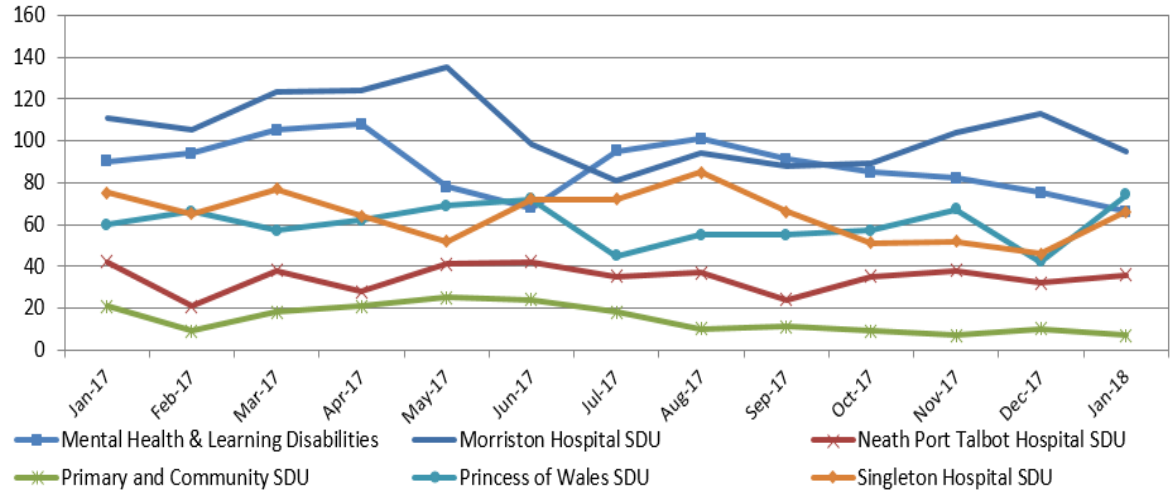
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM				
Measure 1: Total Number of Inpatient Falls				
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead : Angela Hopkins**	
Period : Jan 2018	**IMTP Profile Target : Reduce**	**WG Target : Reduce**	**Current Status : N/A**	**Movement : Improving**

Current Trend: Jan 17- Jan 18

(1) Number of Inpatient Falls



(1) Number of Inpatient Falls



Benchmarking

Welsh Government benchmarking data is not yet available.
It is expected at some point during 2017/18

Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of Inpatient Falls

How are we doing?

- The number of Falls reported via Datix shows an increase in January 2018 to 334 from 318 in December 2017.
- In comparison with December 2017 the data for January 2018 the following Units reported a decrease in all falls recorded via Datix - Mental Health & Learning Disabilities, Primary and Community SDU and Morriston DU. The following units have reported an increase in all falls recorded via Datix - Singleton SDU (from 46 to 66), Princess of wales SDU (from 42 to 74) and NPTH (from 32 to 36).
- Princess of wales SDU saw the largest increase (from 42 to 74) with none reported as majors.
- NPT SDU have reported 2 major falls with harm both fractured femurs
- Whilst there was in month movement the 12 month movement continues to show an overall reduction

What actions are we taking?

The Falls Prevention Management Group (FPMG) continues to meet monthly actions from the meetings have included:

- The Falls policy has now been reviewed, this was scheduled to be approved by the NMB in February but the meeting was cancelled; the policy will now go to members for approval outside the meeting and be taken forward for ratification to the Quality and Safety Forum in March 2018 with implementation scheduled for end of March 2018. Baseline audits on the implementation of the new falls policy and associated documentation will be undertaken by the corporate nursing team in May 2018.
- All Service Delivery Units (SDU's) have Falls Scrutiny panels, Primary and Community panels all agreed outcomes from the scrutiny panel will be presented to the FPMG to enable shared learning.
- The FPMG will provide assurance that a training needs analysis has been completed, training package sent to members of FPMG for implementation from March 2018.
- Base line audit and review of all equipment relating to falls management was discussed at the February 2018 FPMG. The Health Board have purchased via Charitable Funds 60 high low beds with roll out planned in March 2018. Further work will be scheduled for April 2018 to review other equipment needs.
- Chair of FPMG has requested from Health Board manual handling lead an outline of the asset register to ensure accurate Health Board picture by March 2018.
- Further work will be scheduled in April 2018 to review overall equipment needs.
- FPMG membership will be reviewed in February 2018 (and monthly) going forward to establish if the group would benefit from more senior clinical representation. Work continues with the Datix user group to configure the system to collate and report accurately falls with harm versus falls without harm. Each SDU now collates this information monthly and reports into the FPMG group.

What are the main areas of risk?

- The current process on Datix uses the NICE definitions of “falls with harm” in order to produce accurate data to distinguish “slips, trips without harm” from falls with harm. All Service Delivery Units are now able to quantify their falls with or without harm. This ensures a consistent validated figure will be available.

How do we compare with our peers?

- Action plan has been developed as a result of National inpatient falls audit the results and action plan are on the agenda for the March 2018 FPMG meeting.

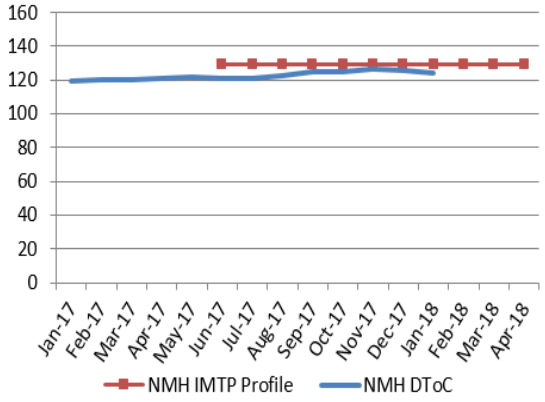
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

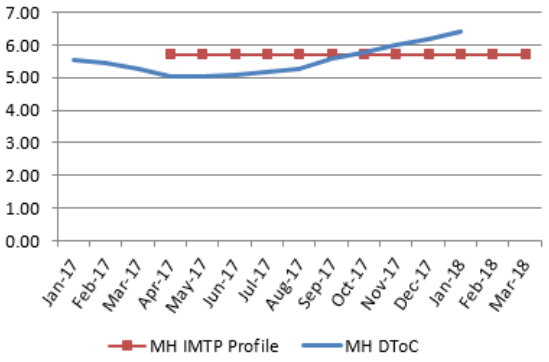
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period: Jan 2018	IMTP Profile Target : (1) 5.7 (2) 129.1	WG Target : Improve	Current Status :	Movement : W

Current Trend: Jan 17- Jan 18

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



Measure 2: Number of Delayed Transfers of Care (DTOCs) per 10,000 LA population for mental health (all ages)



Benchmarking

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

LHB	Current	Same Period Comparison		
	Jan-18	Jan-17	Jan-16	Jan-15
Wales	142.7	↑ 157.9	↑ 163.5	↑ 143.2
ABM	120.7	↓ 119.6	↓ 106.0	↓ 49.3
AB	179.9	↓ 163.7	↑ 194.6	↑ 195.9
BCU	159.6	↑ 206.5	↑ 182.5	↓ 137.6
C&V	150.2	↑ 196.9	↑ 282.5	↑ 243.8
CTaf	126.0	↑ 160.1	↓ 118.0	↑ 163.9
HDda	79.9	↓ 61.3	↓ 56.3	↓ 68.3
Powys	185.3	↑ 197.8	↑ 229.8	↑ 216.1

Measure 2: Number of Delayed Transfers of Care (DTOCs) per 10,000 LA population for mental health (all ages)

LHB	Current	Same Period Comparison		
	Jan-18	Jan-17	Jan-16	Jan-15
Wales	3.2	↑ 3.7	↑ 3.7	↑ 4.1
ABM	6.2	↓ 5.5	↓ 5.4	↓ 5.3
AB	1.8	↓ 1.6	↑ 1.9	↑ 3.0
BCU	2.8	↑ 3.0	↓ 2.6	↓ 2.6
C&V	2.5	↑ 5.7	↑ 5.0	↑ 5.2
CTaf	2.8	↑ 3.5	↑ 3.6	↑ 4.6
HDda	2.8	↑ 4.1	↑ 3.9	↑ 3.5
Powys	3.2	↓ 2.0	↑ 5.3	↑ 7.4

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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

How are we doing?

- The total number of patients classified as a delayed transfer in December 2017 was 86. This was a reduction in the 98 delayed transfers of care reported in November 2017, although an increase when compared with the 79 reported in December 2016.
- The overall bed days associated with delayed transfers of care in December however was at the highest reported levels, with the majority of this increase experienced in mental health services, due to limited availability of care placements in the community.
- The main reasons contributing towards a delayed discharge include Community Care assessment, Healthcare Assessment, and the availability of a care home placement.

What actions are we taking?

- Implementation of good practice recommendations on effective discharge planning, with a particular focus on earlier and consistent communication with patients and families on the quality and safety benefits of earlier discharge.
- Joint work with Local Authorities (LA's) regarding options to support the provision of sustainable capacity in the community.
- Regular communication and escalation of delays with all heads of service regarding patients requiring local authority support for discharge. The Health Board is utilising a proportion of its non-recurrent additional winter pressures funding to support additional capacity in the community to support discharge to assess models of care.
- The Care Home strategy has been launched to stimulate and support the sector, and providers have engaged in the process, although recruitment of registered general and mental health nurses remains challenging.
- Additional staff awareness sessions in February on implementation of the SAFER flow bundles aimed at improving patient flow and reducing risk to patients.

What are the main areas of risk?

- Capacity in the care home and fragility 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.
- Complex assessment processes in hospital.
- Workforce including social work capacity.
- Effective Implementation of patient choice policy and the discharge policy.

How do we compare with our peers?

- Delayed transfers of care continue to be a challenge for many Health Boards across Wales.

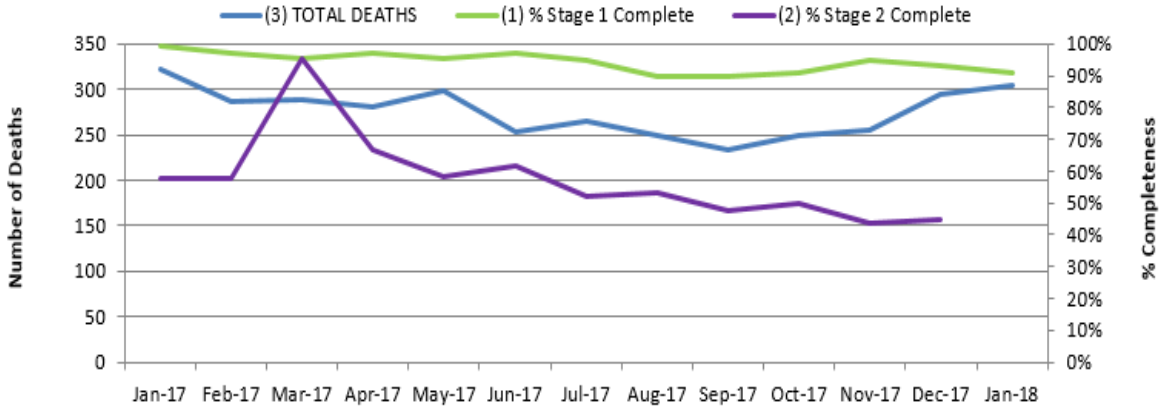
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % Universal Mortality Reviews (UMR) undertaken within 28 days of death.
Measure 2: % Stage 2 Review forms completed.
Measure 3: Number of Hospital Deaths of persons over the age of 16 *(Excluding Emergency Department)*

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Jan 2018	**IMTP Profile Target : (1) 96%**	**WG Target : (1) 95%**	**Current Status :** ✖	**Movement :** ↓ ● **Wo**

Current Trend: Jan 17- Jan 18

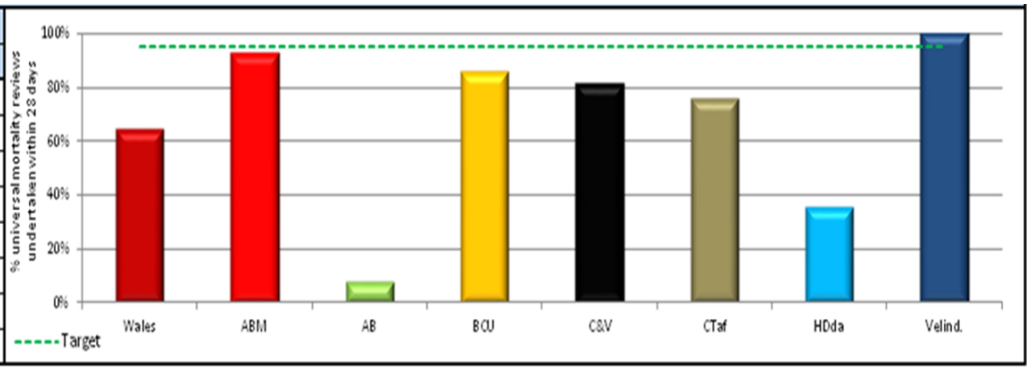
(1) % Universal Mortality Reviews (UMR) undertaken within 28 days of death,
(2) % Stage 2 Review forms completed,
(3) Number of Hospital Deaths of persons over the age of 16 *(Excluding Emergency Department)*



Benchmarking

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

LHB	Current Dec-17
Wales	64.0%
ABM	92.5%
AB	7.6%
BCU	85.4%
C&V	81.4%
CTaf	75.3%
HDda	34.9%
Velind.	100.0%



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

Measure 1: % Universal Mortality Reviews (UMR) undertaken within 28 days of death.
Measure 2: % Stage 2 Review forms completed.
Measure 3: Number of Hospital Deaths of persons over the age of 16 *(Excluding Emergency Department)*

How are we doing?

- Welsh Government Mortality Review Performance - ABMU continues to be the best performing Health Board achieving 90.4% completion of UMRs within 28 days of death in October. Only Velindre Trust performed better but they have very few in-hospital deaths. The Wales compliance was 66.5% in October.
- The Health Board UMR rate in December was 92% compared with 94% in November. Singleton achieved 100%. POW achieved 97%, Morriston 86% and NPT 57% (4/7). There were 24 missing UMR forms; 3 each in POWH and NPT and 18 in Morriston.
- 19 deaths triggered a Stage 2 review in December compared with 21 in November.
- Completion of Stage 2 reviews within 8 weeks (October deaths) was 50%, a slight increase from the previous month (47%). There are 72 outstanding Stage 2 reviews from April - October 2017.
- Mental Health and Community data are unavailable via the eMRA application at present. This is being addressed by Informatics.
- Thematic reviews - These are being worked through by the UMDs. Infections remains the most frequent theme.

What actions are we taking?

- Morriston DU has revised its process of death certification to improve the quality and timeliness of certification and to ensure that a UMR is completed every time. The proposal has been agreed by the Morriston Clinical Cabinet and is expected to be implemented shortly.
- The Oncology Clinical Director, and one of the other Oncology Consultants, are working through the small backlog of Oncology Stage 2 reviews.
- In Medicine at Singleton, all the Stage 2 reviews are discussed at their regular audit meetings.
- The MH&LD Delivery Unit is participating in the 3-part National pilot of the implementation of mortality reviews for people with mental health issues and learning disabilities. It is being piloted in the NPT Locality from January 2018.
- A new mortality reporting process has been developed based on the mortality dashboard. One of the Delivery Units presents their feedback and lessons learned at each Clinical Outcomes Group (COG) meeting and onwards to the next Quality & Safety Committee as part of the DU's report
- A proposal to ensure that as many Stage 2 mortality reviews as possible as completed promptly following the patient's death to maximise learning was agreed at the Quality & Safety Committee in December and is now being implemented

What are the main areas of risk?

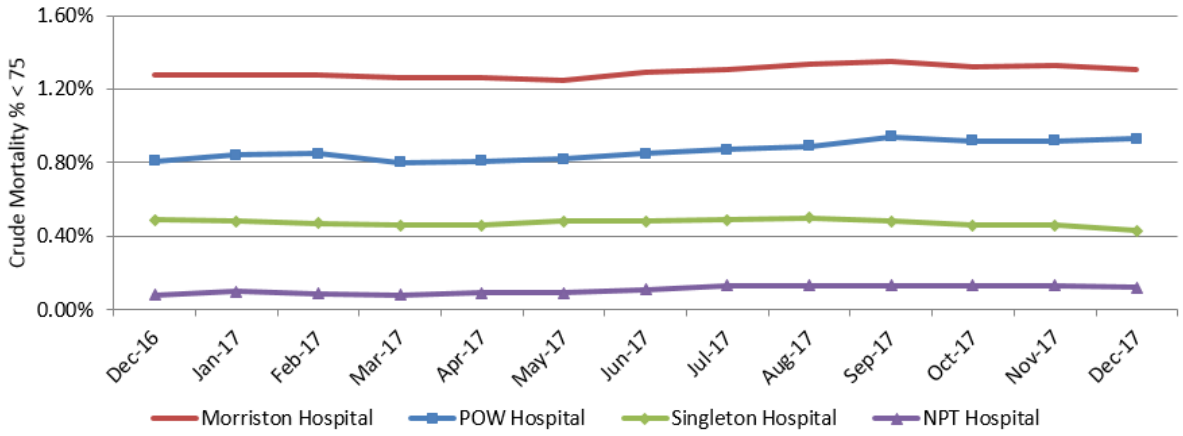
- Timeliness of Stage 2 completion. This is being addressed by a differential approach to backlog cases and current cases to ensure that in future the focus is on current learning.

How do we compare with our peers?

- ABMU is the top ranking Health Board for the percentage of mortality reviews undertaken within 28 days of death in December 2017 and was above the all-Wales position (90.4% compared with 66.5%).

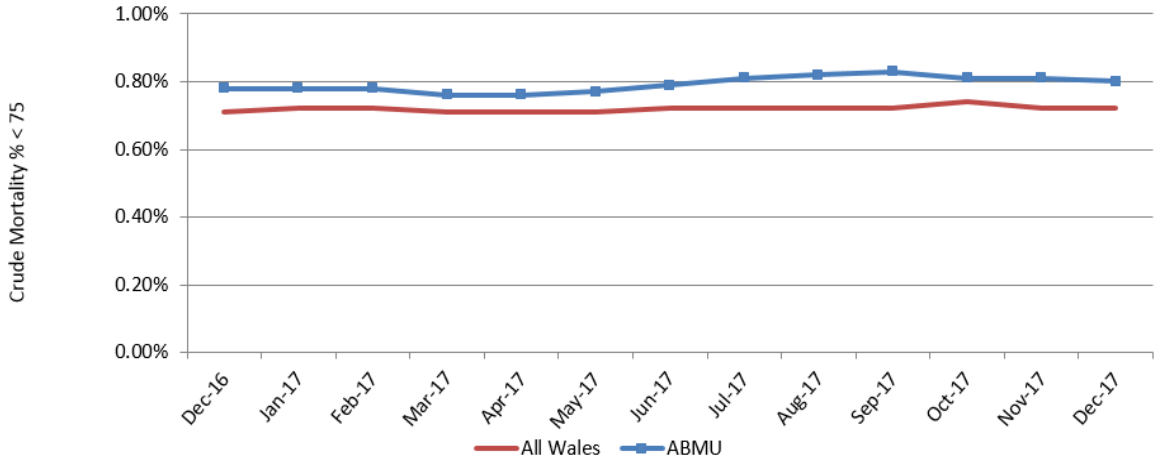
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE				
Measure 1: Crude hospital mortality rate (less than 75 years of age)				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Hamish Laing**	
Period : Dec 2017	**IMTP Profile Target :**	**WG Target : 12 month reduction trend**	**Current Status :** ✖	**Movement :** ⇨ ● **Stable**
Current Trend: Dec 17- Dec 17				

(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 (FEBRUARY 2018)

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 December 2017 was 0.80%, compared with 0.78% for the same period last year
- Site level performance is as follows: (previous year in brackets) Morriston 1.31% (1.28%), Princess of Wales 0.93% (0.81%), Neath Port Talbot 0.12% (0.08%), Singleton 0.43% (0.49%). Site comparison is not possible due to different service models being in place.
- There were 114 in-hospital Deaths in this age group in January 2018 the same as January 2017: Morriston 54 (55), PWH 35 (41), NPTH 1 (3), Singleton 25 (13). Whereas the number of deaths at Singleton Hospital in this category appear high when compared to the same period last year, all deaths have undergone a stage 1 review with only one requiring a stage 2 review.
- The number of deaths for Surgical and Elective cases remains consistently low for this age group.

What actions are we taking?

- A mortality report is considered by Clinical Outcomes Group (COG), chaired by the Executive Medical Director.
- Each Service Delivery Unit (SDU) continues to receive Mortality Reports enabling them to monitor mortality in the Unit, and to allow each Unit Medical Director to feedback learning from the mortality review process and review of fluctuations in their mortality data, to the Clinical Outcomes Group (COG). Delivery Units are requested to present to COG in rotation at the meeting. Singleton Hospital will present at March's COG.
- The Units are expected to continue to review Mortality data via the Mortality Dashboard. Information and analysis for Universal Mortality Reviews, Stage 2 mortality reviews and thematic mortality reviews undertaken by Unit Medical Director Process continues to be available on a daily basis via the Mortality dashboard
- Thematic, Stage 3 reviews of completed Stage 2 mortality reviews up to the end of January demonstrated that in the majority of cases nothing untoward was noted. Infections are still the most frequent theme, usually pneumonia in elderly patients
- A proposal to ensure that as many Stage 2 mortality reviews as possible are completed promptly following the patient's death to maximise learning was presented to the Q&SC in December and agreed. Unit Medical Directors will be asked to ensure that outstanding Stage 2 reviews for deaths prior to January 2017 that have not been referred to the Coroner, or did not have a Datix entry, are completed by 31st March 2018.

What are the main areas of risk?

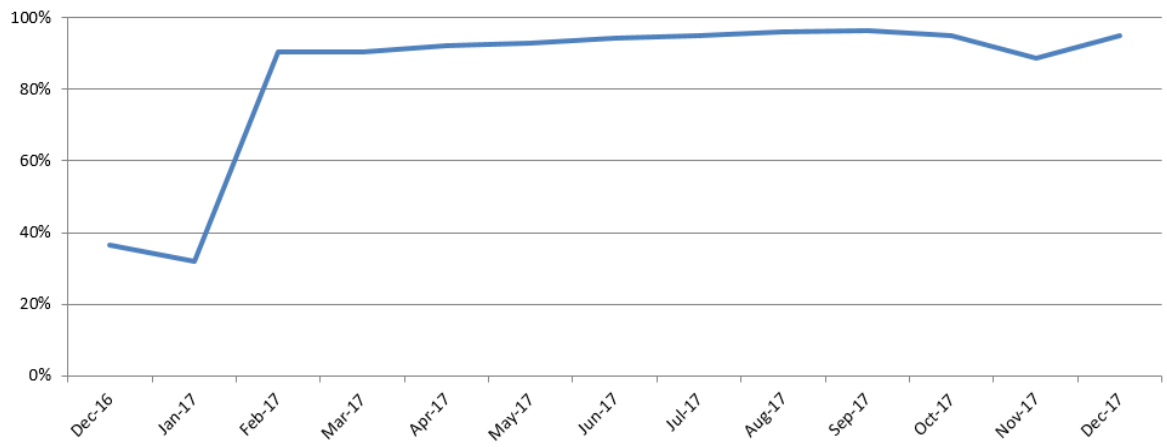
- There is a risk of harm going undetected resulting in lessons not being learned. Our approach is designed to mitigate this risk and ensure effective monitoring, learning and assurance mechanisms are in place.

How do we compare with our peers?

- ABMU are above the all-Wales Mortality rate for the 12 months to December 17 – 0.80% compared with 0.72%.
- ABMU is the best Performing Health Board in respect of UMRs completed within 28 days of the patients death (94%). All-Wales compliance was (72%)

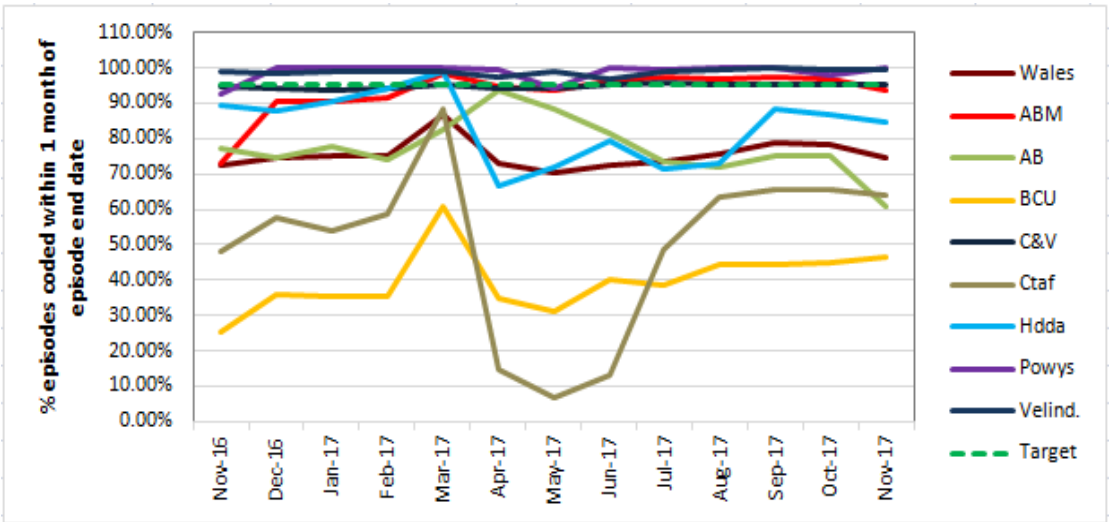
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE				
Measure 1: % episodes clinically coded within one month post episode end date				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead: Hamish Laing**	
Period : Dec 2017	**IMTP Profile Target :**	**WG Target : 95%**	**Current Status :** ✓	**Movement :** ⇧ ● **In**
Current Trend: Dec 16- Dec 17				

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



Benchmarking

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



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

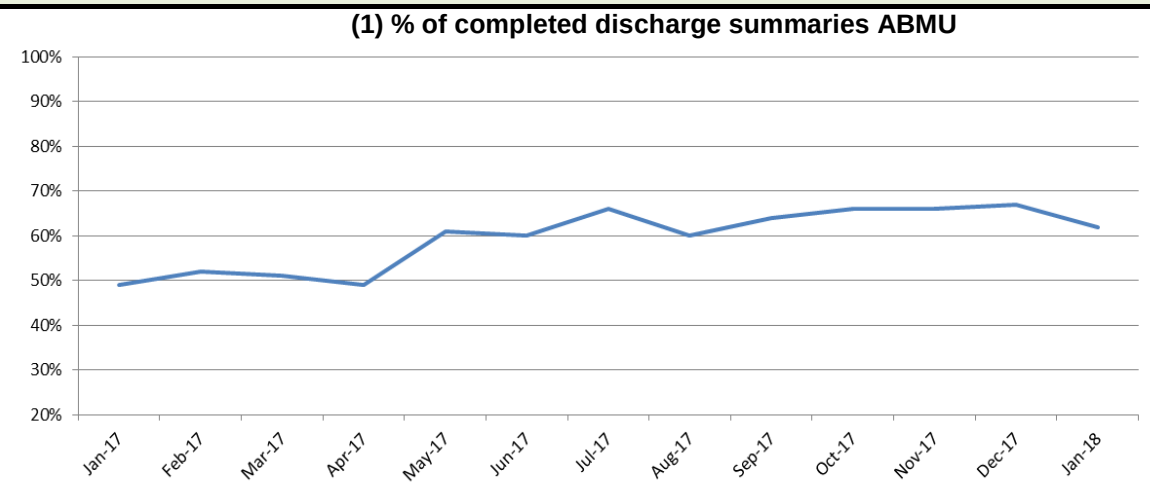
Measure 1: % episodes clinically coded within one month post episode end date
How are we doing?
• The department has achieved overall Coding completeness for 2017/2018 as follows: April - 99.35%, May - 99.16%, June - 98.99%, July - 99.26%, August - 98.71%, September - 98.35%, and October is 99%, November 97%. This performance has been achieved as a result of considerable changes in working practices and integration with the Health Records Department • The completeness within 30 days for December was 95%. This is an improvement on the November reported position, however staffing levels in the department remains a challenge • The NWIS national audit team carried out coding accuracy audits across all four main acute hospital sites during 2017. The Health Board has now received the full audit report and findings. The percentage compliance for the Health Board has improved from 90.2% to 93% in accuracy. ABMU compares favourably with peers and is the highest ranked acute Health Board. The accuracy rate will provide assurance of the quality of the coding completed during the period, particularly as during this time there has also been a considerable improvement in efficiency and coding completeness target. The findings and recommendations will be incorporated into the Clinical Coding audit and development plans for 2018/19.
What actions are we taking?
• From November 2017 the central Informatics Clinical Coding has taken on responsibility for Clinical Coding in Mental Health, this will address compliance issues previously reported. • The all-Wales benchmarking data has been updated to include up to August 2017 and demonstrates a significant improvement for ABMU from the previous positon of 40% compliance in August 2016. The ABMU position will improve further in 2018. • Continued training of the 6.5 WTE permanent staff which will address the completeness in month once staff are trained and competent - end of 2018. • Experienced coders are undertaking overtime to support the overall performance and effectiveness of the clinical coding service.
What are the main areas of risk?
• Maintaining the productivity levels in 2017/18 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 1 month (shown as a snapshot). ABMU is the top performing Health Board that provides acute service with October 2017 over 96%.

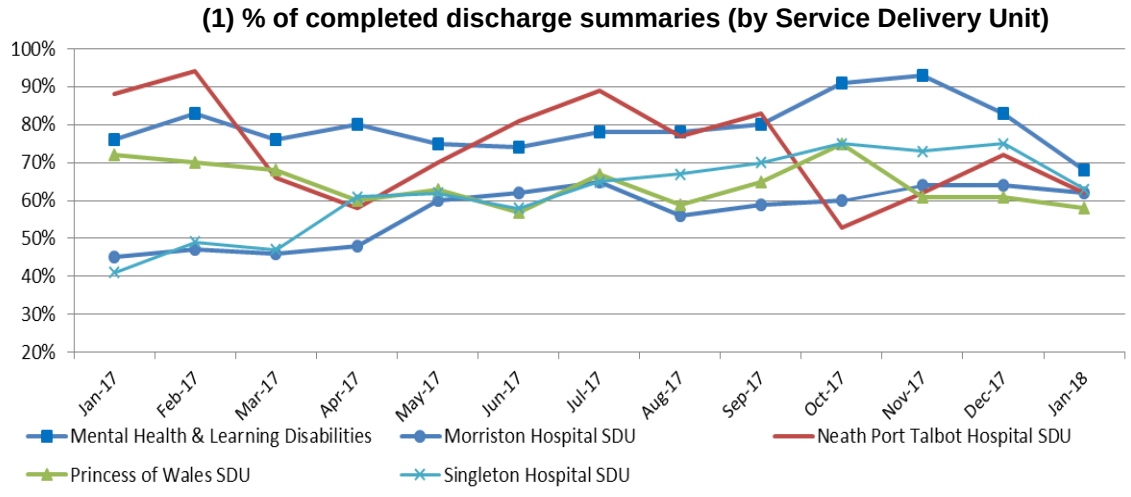
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % of completed discharge summaries

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Jan 2018	**IMTP Profile Target :** Improve	**WG Target :** 100%	**Current Status :** N/A	**Movement :** Improving

Current Trend: Jan 17- Jan 18





Benchmarking

Welsh Government benchmarking data is not yet available. It is expected at some point during 2017/18

Source : ETOC Dashboard

Measure 1: % of completed discharge summaries

How are we doing?

- Performance in this quality priority has improved continuously since December 2016 (67% compared with 50%).
- There continues to be performance variance between Service Delivery Units (61%-83%).
- This month the performance has improved in 2 out of 5 Delivery Units, remained static in 2 out of 5 and decreased in one Unit.
- Mental Health & Learning Disabilities was the best performer achieving 83%, despite a reduction in performance compared with November.

What actions are we taking?

- The Executive Medical Director (MD) has asked Unit Medical Directors (UMDs) 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.
- The Executive MD and the relevant UMDs will be meeting with T&O Leads at Morriston and POWH to emphasise the need to prioritise discharge summaries.
- Morriston's 6 month Discharge Improvement Programme has now ended. It has achieved a steady improvement during this period but has remained the same for the past two months. Performance is being closely monitored by Service Managers to sustain the improvement. Where services are struggling due to gaps in doctors' rotas, other approaches to completing the eToC are being explored (Nurse Practitioners/ Physicians' Associates). The Morriston UMD is working with IT and Informatics to explore the possibility of sending automated emails to individual consultants if an eToC has not been completed within 48hrs. The UMD is having targeted discussions with T&O and Burns & Plastics teams to support them to improve performance
- Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician' Associate role could improve communication.
- Sickness absence amongst the Medical team at NPTH has impacted on completion of eToCs. Discharge summary performance is monitored and discussed at monthly Medical Consultant meetings.
- The primary measure being used in POWH is % discharge summaries completed within 24hrs of discharge. There have been notable improvements on individual wards.

What are the main areas of risk?

- Risk to patient care and the need for readmission.

How do we compare with our peers?

- ABMU is the only Health Board to publish its performance

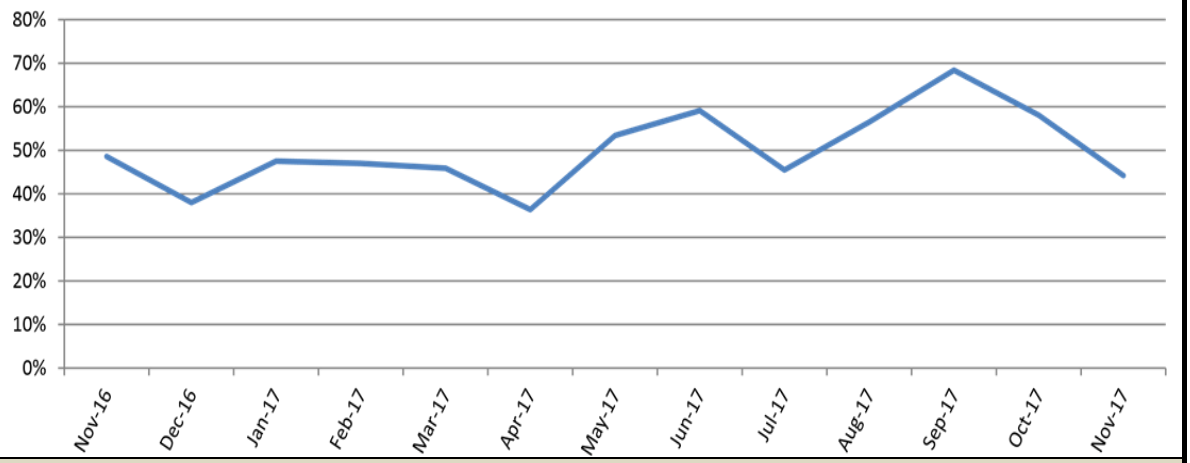
DIGNIFIED CARE - PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

Measure 1: % of patients who had their procedure postponed > 1 occasion & then had their procedure within 14 days or at the patient's earliest convenience.

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead: Chris White	
Period : Nov 2017	IMTP Profile Target : Improve	WG Target : Improve	Current Status : ✓	Movement : ⇧ Imp

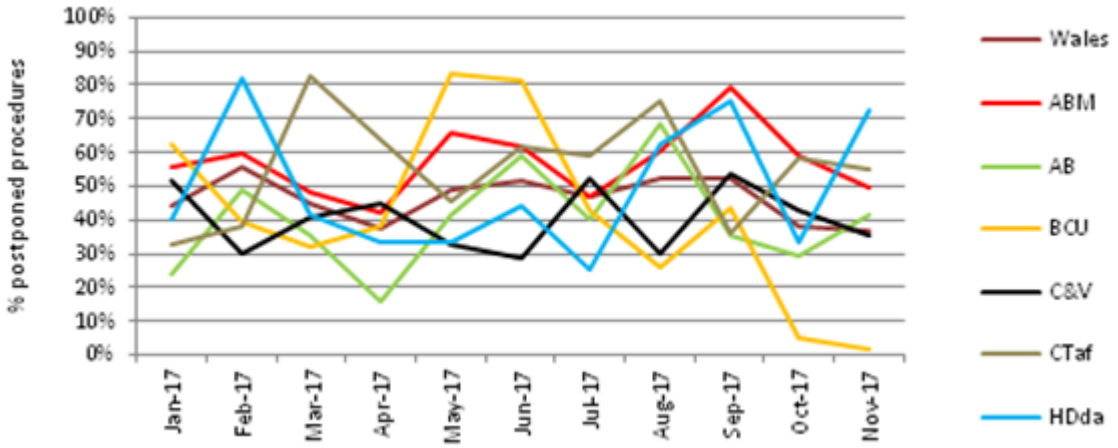
Current Trend: Nov 16- Nov 17

(1) % of patients who had their procedure postponed > 1 occasion & then had their procedure within 14 days or at the patient's earliest convenience.



Benchmarking

(1) % of patients who had their procedure postponed > 1 occasion & then had their procedure within 14 days or at the patient's earliest convenience.



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

Measure 1: % of patients who had their procedure postponed > 1 occasion & then had their procedure within 14 days or at the patient's earliest convenience.

How are we doing?

- Percentages continue to fluctuate month on month due to the relatively small numbers involved.
- It is important to note that the data only represents those patients who have had their procedure within 14 days of their last postponed appointment and does not capture those patients who have chosen to have their procedure undertaken at their earliest convenience as Myrddin is currently unable to record this. 14 days does not constitute a reasonable offer under the Referral to Treatment (RTT) rules.
- Out of the 77 patients in November 2017 who had their procedure postponed on more than one occasion, 34 had their procedure carried out within the proceeding 14 days.

What actions are we taking?

- Escalate the development work required within the Myrddin Patient Administration System (PAS) to enable the health board to appropriately record and measure whether the appointment offered to undertake the procedure is at the patients earliest convenience, with the aim to have this functionality in place by March 2018.

What are the main areas of risk?

- Urgent and Urgent Suspected Cancer demand taking priority over booking of routine cases.

How do we compare with our peers?

- As at the end of November 2017, which is the latest published data available at the time of writing this report, ABMU performance was above the all-Wales position of 36.9% and the third best performing Health Board.

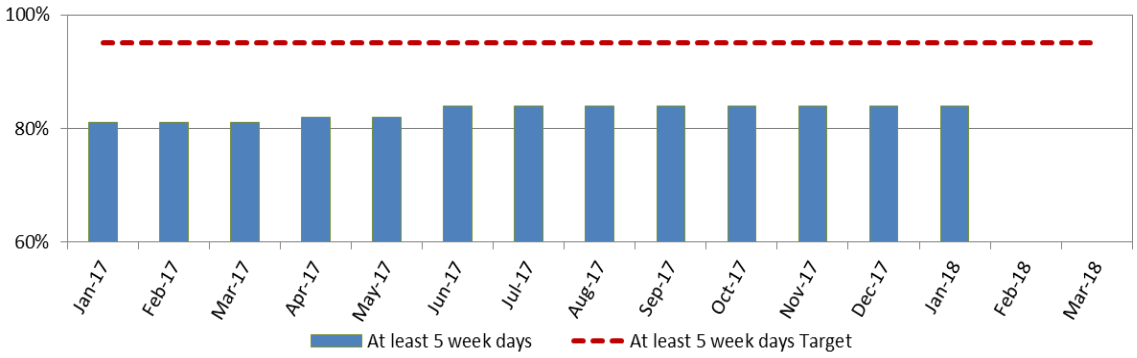
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

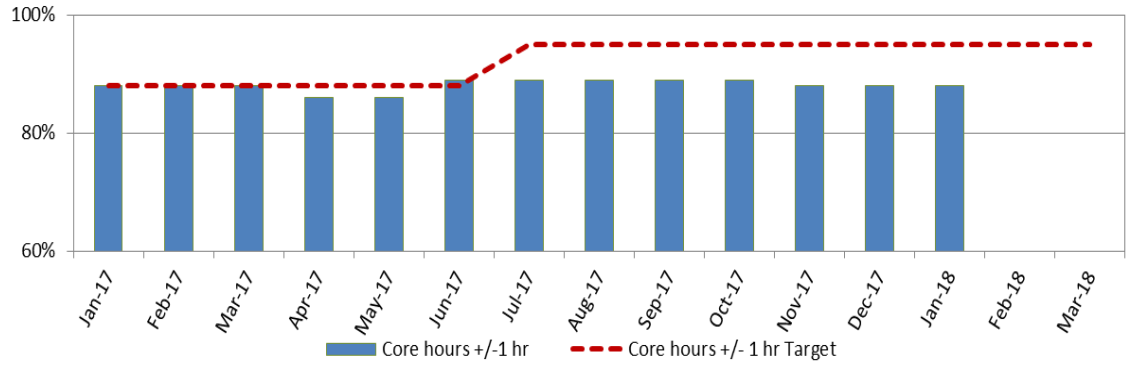
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Jan 2018	**IMTP Profile Target :** (1) 95% (2) 95%	**WG Target :** (1) 95% (2) 95%	**Current Status:**	**Movement :** Imp

Current Trend: Jan 17- Jan 18

(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

LHB	5 days a week				core hours or within 1 hour			
	Current	Previous			Current	Previous		
	2016	2015	2014	2013	2016	2015	2014	2013
Wales	84%	↑ 79%	↑ 79%	↑ 76%	85%	↑ 82%	↑ 80%	↑ 76%
ABM	79%	↑ 78%	↑ 69%	↑ 61%	85%	→ 85%	↑ 73%	↑ 72%
AB	99%	↑ 95%	↑ 93%	↑ 93%	99%	↑ 93%	↑ 92%	↑ 87%
BCU	69%	↑ 55%	↑ 63%	↑ 63%	74%	↑ 73%	↑ 73%	↑ 70%
C&V	92%	↓ 94%	↓ 94%	↓ 93%	88%	↑ 83%	↑ 83%	↑ 76%
CTaf	95%	↑ 93%	↑ 93%	↑ 94%	90%	↓ 93%	↓ 93%	↓ 92%
HDda	75%	↑ 65%	↑ 65%	↑ 54%	74%	↑ 65%	↑ 67%	↑ 57%
Powys	100%	↑ 94%	↑ 94%	→ 100%	100%	→ 100%	→ 100%	→ 100%

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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 January 2018, 56 out of 68 (82%) practices are offering appointments between 17.00 and 18.30 at least 5 nights per week.
- 63 out of 68 (93%) practices are now open during daily core hours or within 1 hour of daily core hours. This is an improvement over January 2018 of 88%.

What actions are we taking?

- The Unit's access and sustainability forum continues to meet with the aim of driving forward improved and sustainable primary care general medical services, the meeting frequency has been increased to bi-monthly.
- The practice support / primary care team has worked with 18 practices who are experiencing sustainability issues.
- Three sets of practices have been supported through a discretionary framework to merge thereby ensuring ongoing access to more sustainable General Medical Services. The framework is being updated for ongoing use in a fourth merger planning for which has commenced.
- The primary care team has completed a desk top analysis of current access arrangements by practice and written to all practices who are not meeting the level 1 standards as agreed with the local medical committee.
- A refreshed submission has been made to Welsh Government on access arrangements and the results are currently being analysed.
- Discussion have commenced with the LMC on the revision of the current access standards.
- Access data has been utilised to score practices under the GMS governance arrangements and will form part of the visiting programme.
- Clusters are being supported to discuss access and sustainability as part of their cluster development plans. Pro- active work has taken place to support clusters to expand multi-disciplinary teams in accordance with the emerging model of primary care for Wales.
- 25% of practices are utilising some form of telephone triage – the telephone first model has been finalised and self-assessment work will take place next year aligning to the national survey results. The telephone first model is being formally launched on 27th February 2018.

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 have been submitted to Welsh Government across Wales in January 2018. The statistical bulletin will then provide an updated all-Wales picture to benchmark against.

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON

CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

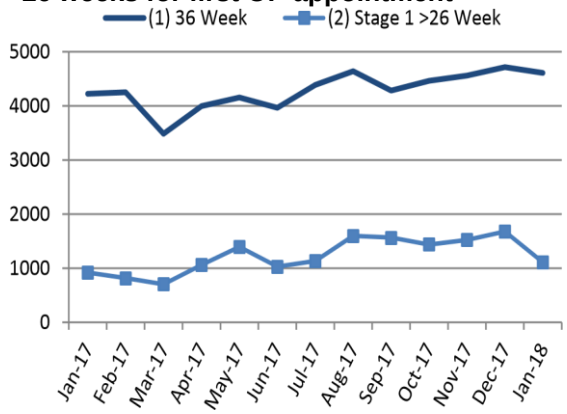
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment

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

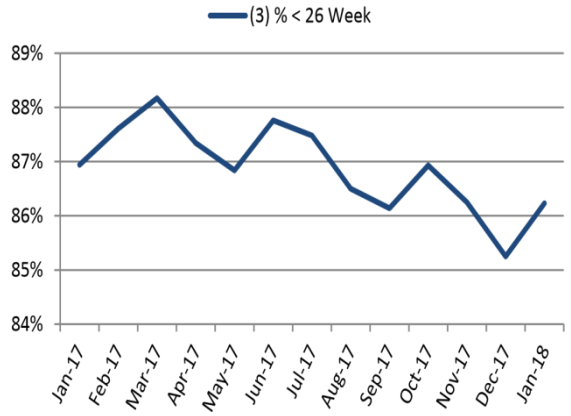
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Jan 2018	IMTP Profile Target :	WG Target : (1) 0 (2) 0 (3) 95%	Current Status :	Movement : Wo

Current Trend: Jan 17- Jan 18

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

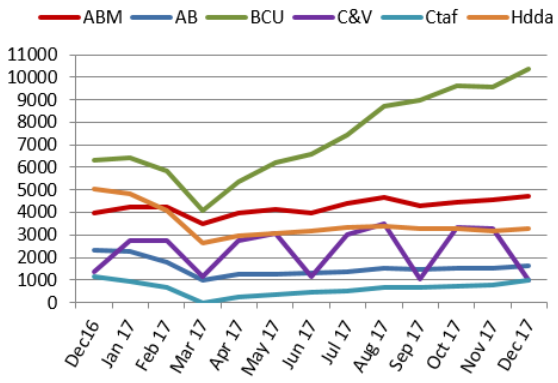


(3) % patients waiting less than 26 weeks for referral to treatment (RTT)

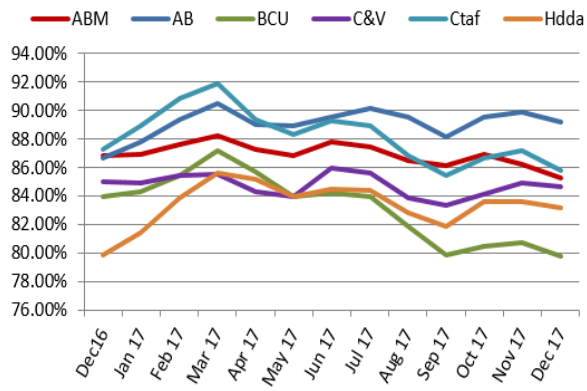


Benchmarking

(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 : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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 January 2018 there are 1,111 patients waiting over 26 weeks for a new outpatient appointment. This was an in-month reduction of 568 compared with December 2017 (1,679 to 1,111) and is largely contained within Gastroenterology, Oral/ Maxillo Facial (OMF) and Ophthalmology.
- There are 4,609 patients waiting over 36 weeks for treatment in January 2018 compared with 4,223 in January 2017, this is a deterioration of 386. However there was an in-month reduction of 107 compared with December 2017. ENT, General Surgery, Ophthalmology, Oral/ Maxillo Facial (OMF) and Orthopaedics collectively account for 4,204 of the over 36 weeks at January 2018 with 87% of the patients waiting over 36 weeks all in the treatment stage of their pathway.
- 1,877 patients are waiting over 52 weeks in January 2018 which is 44% more patients than in January 2017 but 3% less patients than December 2017.
- The overall Health Board RTT target saw an improvement in January 2018 from 85.25% to 86.23%.

What actions are we taking?

- Welsh Government confirmed an allocation to the Health Board of £10.07m out of the £50m made available to reduce waiting times across Wales. This included £8.672m for quarters 3 and 4 RTT delivery to achieve a year-end position of no more than 2,640 patients waiting over 36 weeks.
- Each Unit submitted a quarter 3/4 RTT profile plan to support the delivery of the year-end target and were asked to consider both internal and external solutions however the aggregate of the plans did not deliver the 2,640. The current forecast is 3,191.
- Financial clawback from Welsh Government for non-delivery of this target, based on the 3,191 position, has been estimated at around £4.8m, decreasing with incremental improvement on this position. A range of actions are therefore being implemented to reduce the 3,191 to below 3,000. These include:-
- Further insourcing capacity, in addition to the level of insourcing already included within the 3,191 position, for Urology, General Surgery and Vascular cases at Morriston Hospital for patients requiring a protected bed.
- Further benefit from clinical face to face validation in March (predicated on agreed additional surgical slots in April and May). This will require an agreed resource package for Q1 to enable this.
- Further benefit from Referral to Treatment (RTT) system validation. A contract has been awarded to an external company through a formal procurement process and work has commenced through to the end of March 2018.
- Weekly combined Unit meetings are in place, led by the Chief Operating Officer, to scrutinise and add further challenge to the plans to both increase the range of solutions and confirm delivery of the plans already identified.
- Work is ongoing, supported by the Welsh Government Delivery Unit (DU) to manage ‘treat in turn’ of the waiting list where this is seen as the biggest opportunity.

What are the main areas of risk?

- Lack of theatre & staff availability to provide extra capacity for evening and weekend clinics/lists.
- Administrative vacancy gaps and sickness impacting on ability to target robust validation.
- Staff fatigue to continue to run additional clinics and lists.
- Demand of cancer and urgent surgical cases utilising planned routine elective capacity and protecting elective bed capacity.
- Inability of private providers to deliver planned outsourcing and insourcing volumes.
- The current planned care trajectories assume no impact on planned care performance of bed reconfiguration within the Health Board (i.e. the planned length of stay reductions and alternative care models deliver a zero net bed impact).

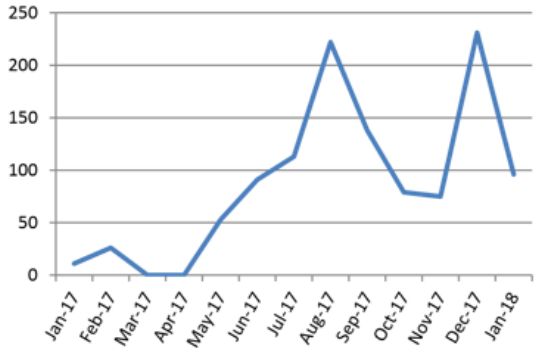
How do we compare with our peers?

- As at the end of December 2017, which is the latest published data available, ABMU was above the all-Wales position for the percentage of patients waiting less than 26 weeks for referral to treatment (RTT) (85.3% compared with 84.6%) however, was the second worst Health Board in Wales for the number of patients waiting over 36 weeks.

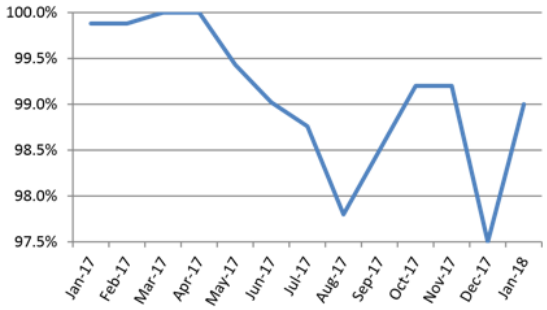
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE				
Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy) **Measure 2:** % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Jan 2018	IMTP Profile Target : (1) 0 (2) 100%	WG Target : (1) 0 (2) 100%	Current Status :	Movement : W

Current Trend: Jan 17- Jan 18

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

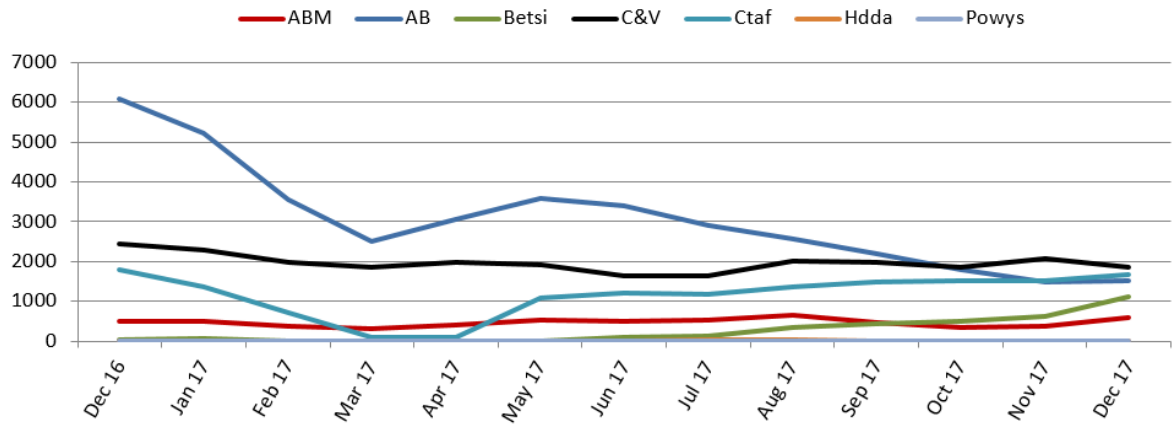


(2) % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy & Cardiac)



Benchmarking

(1) Number of patients waiting less than 8 weeks for specific diagnostics (including Endoscopy & Cardiac)



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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 96 patients waiting over 8 weeks for reportable diagnostics as at the end of January 2018.
- 29 breaches were in Vascular Technology in Morriston, 62 breaches were in Cystoscopy and 5 breaches were in Fluoroscopy in Princess of Wales Hospital.
- All of the other diagnostic areas maintained a zero breach position in January 2018.

What actions are we taking?

- Cystoscopy at Princess of Wales (POW) - additional capacity has been secured through the appointment of a Locum Urology Consultant who is focussing on the routine work, allowing the substantive Consultants to concentrate on the urgent and non-urgent suspected cancer work. The position will improve in February and is on target to clear to a Nil position at the end of March in line with the Health Boards agreed end of year target.
- The breaches in Vascular Technology and Fluoroscopy were as a result of unplanned absence and the Service Delivery Units have confirmed that the position will clear to Nil at the end of February and be sustained through March.

What are the main areas of risk?

- Routine activity being displaced by urgent and cancer patients. This is a particular risk for the Urology diagnostic procedures at Princess of Wales Unit due to the fragility of their service.
- Late clinic cancellations due to unforeseen absence of key clinical staff.
- Breakdown of equipment.
- Workforce constraints in key professional groups (nationally and locally).

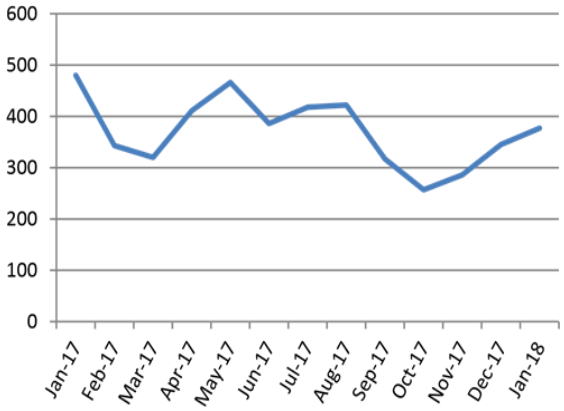
How do we compare with our peers?

- At the end of December 2017, which is the latest published data available at the time of writing this report, ABMU was the second best performing Health Board excluding Powys.

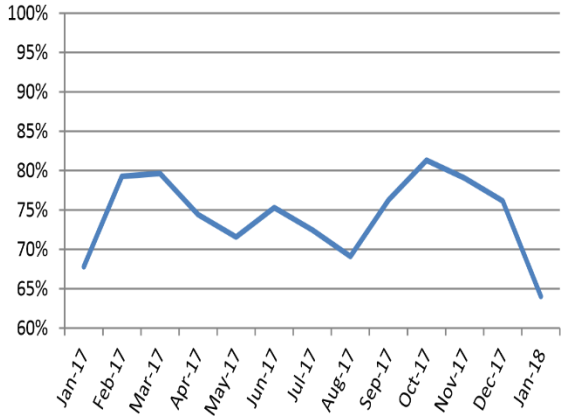
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE				
Measure 1: Number of patients waiting more than 8 weeks for Endoscopy **Measure 2:** % patients waiting less than 8 weeks for Endoscopy				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Chris White**	
Period: Jan 2018	**IMTP Profile Target :** (1) 0 (2) 100%	**WG Target :** (1) 0 (2) 100%	**Current Status :** ✖	**Movement :** Improving

Current Trend: Jan 17- Jan 18

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

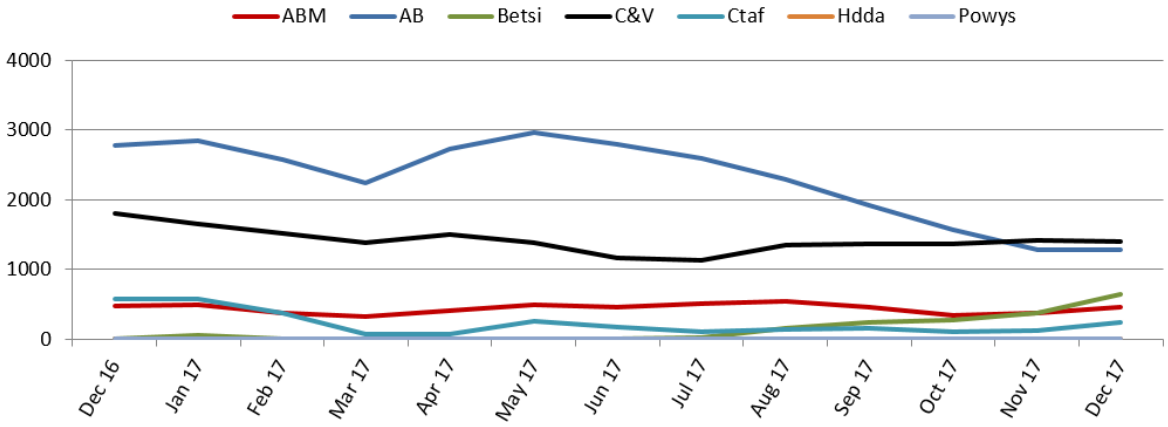


(2) % patients waiting less than 8 weeks for Endoscopy



Benchmarking

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



Source : NHS STATS WALES FEBRUARY 2018

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 had 377 patients waiting over 8 weeks for endoscopy as at the end of January 2018.
- 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 end of March 2018.
- Working closely with colleagues in the Delivery Unit to review demand and capacity plans and ongoing review weekly to ensure that capacity is being maximised on all sites.
- Administrative validation has begun on the whole cohort of patients up to end of March.
- Development of alternative diagnostic pathway in partnership with Radiology (CT colongraphy) is still ongoing.
- Continued focus on effective triage of referrals.
- Partnership working with Hywel Dda underway. Currently benchmarking points per list and early discussions are underway to see if clinical cross cover for staffed sessions in ABMU can be facilitated. Support from Hywel Dda for Q4 17/18 has been secured as from March 2018. Mr Dias will be undertaking x4 sessions throughout March in Morriston.
- Singleton Endoscopy Unit refurbishment is underway and planned for completion in March 2018. The Unit will then be JAG compliant.

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 Health Boards where ABMU has seen static improvement.

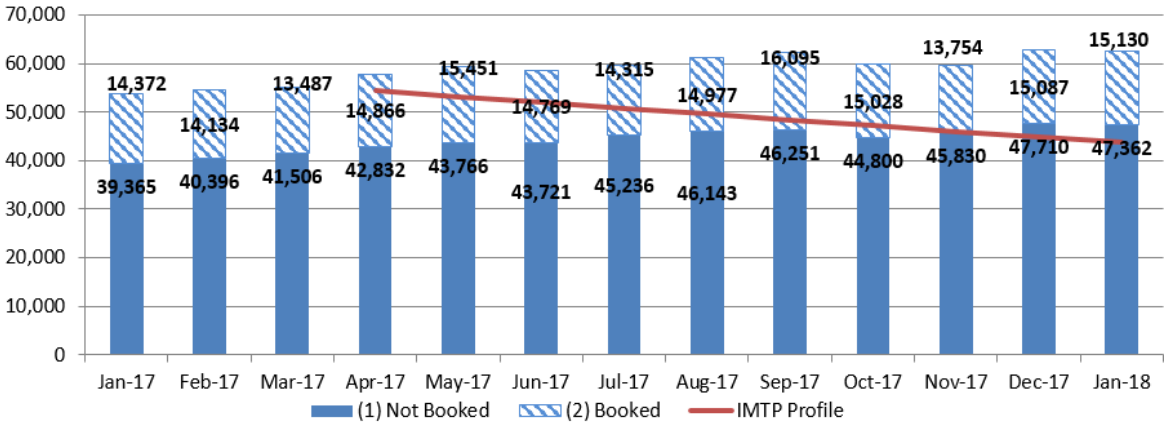
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: **Total number of not booked patients waiting for a follow up appointment delayed past their target date**
Measure 2: **Total number of booked patients waiting for a follow up appointment delayed past their target date**
Measure 3: **Patients waiting for a follow up appointment delayed past their target date (Booked & Not Booked)**

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Jan 2018	IMTP Profile Target : 43,670	WG Target : Reduction	Current Status :	Movement : Wo

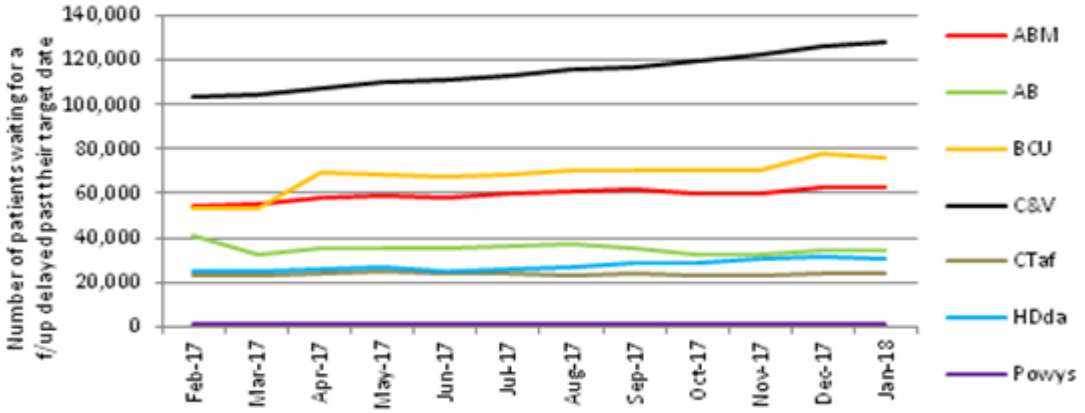
Current Trend: Jan 17- Jan 18

(1) Number of not booked patients waiting for a follow up appointment delayed past their target date,
(2) Number of booked patients waiting for a follow up appointment delayed past their target date



Benchmarking

(3) Patients waiting for a follow up appointment delayed past their target date (Booked & Not Booked)



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

Measure 1: Total number of not booked patients waiting for a follow up appointment delayed past their target date
Measure 2: Total number of booked patients waiting for a follow up appointment delayed past their target date
Measure 3: Patients waiting for a follow up appointment delayed past their target date (Booked & Not Booked)

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 53,737 (Jan 2017) to 62,492 (Jan 2018).
- Delayed Follow Up (Not Booked):In-month performance has slightly improved with a decrease in the number of not booked patients waiting for a follow up appointment delayed past their target date from 47,710 to 47,362. There are 20% more delayed follow up not booked with the same period 12 months ago (39,365 to 47,362).
- Delayed Follow Up (Booked): In-month performance has slightly deteriorated with an increase in the number of booked patients waiting for a follow up appointment delayed past their target date from 15,087 to 15,130. There are 5.5% more delayed follow ups booked with the same period 12 months ago (14,372 to 15,130).
- In January 2018 the Health Board is 18,822 higher than the IMTP profile.

What actions are we taking?

- Each Delivery Unit has been requested to develop a plan to address their Delayed Follow Up Not Booked / Delayed Follow Up Booked position. These plans are overseen by the Outpatient Improvement Group which in turn reports to the Planned Care Board. The plans need to explicitly indicate the expected impact towards the delivery of the IMTP profile target; and provide assurance that those highest risk patients are being addressed and ensure that patients are not being harmed. It is expected that there will be a focus on: Clinical Review of Delayed Follow Up Not Booked to ensure that the clinical risks of patients is understood and actions taken to ensure patients do not come to harm; Explore opportunities for patient initiated follow ups appointments / See On Symptom approach; Consultant and nurse led virtual clinics; Increased utilisation of technology for the provision of non face to face appointments.
- The Wales Audit Office (WAO) has undertaken a follow-up audit to the 2015 review of follow-up outpatient appointments. Focus was given to assurance, scrutiny and reporting mechanisms; clinical risks on longest waiting patients; underlying issues for follow up backlog. A report has been received from the WAO highlighting 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. The recommendations of the report are being addressed through the Outpatient Improvement Group with Delivery Units requested to submit 2018/19 action plans by 6th April 2018.
- A Follow Up Not Booked 'Deep Dive' is being undertaken at the Finance and Performance Committee meeting to be held on the 23rd February 2018 with the aim to explore recent performance and the actions being undertaken to improve the Health Board position.

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. To be addressed through Outpatient Improvement Group and Delivery Unit 2018/19 plans due by 6th April 2018.
- Need to better prioritise validation activities. Service Delivery Units to provide regular assurance reports to Health Board Quality & Safety Committee and Outpatient Transformation Workstream.

How do we compare with our peers?

- From January to January 2018: ABMU, BC, C&V, CT, HD and Powys positions have deteriorated; AB position has improved.

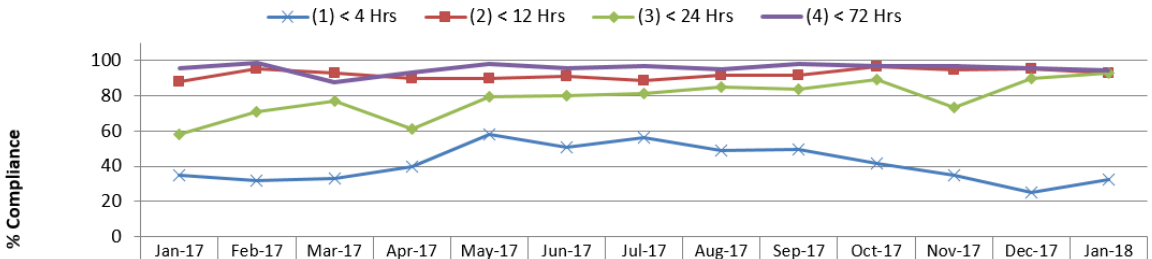
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % compliance with stroke bundle 1 (< 4 Hours), Measure 2: % compliance with stroke bundle 2 (<12 Hours), Measure 3: % compliance with stroke bundle 3 (<24 Hours), Measure 4: % compliance with stroke bundle 4 (<72 Hours)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Jan 2018	IMTP Profile Target : (1) 70% (2)95% (3)75% (4)97%	WG Target : 95%	Current Status :	Movement : Imp

Current Trend: Jan 17- Jan 18

72 Hour Pathway Care Indicators



	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
(1) < 4 Hrs	34.69	31.8	32.9	40	58.2	50.5	56.5	48.8	49.5	41.8	35.2	25.3	32.4
(2) < 12 Hrs	87.76	95.5	92.7	90	89.8	90.8	88.4	91.9	91.9	96.7	94.5	95.4	93.2
(3) < 24 Hrs	58.16	71.2	76.8	61.1	79.6	79.8	81.2	84.9	83.8	89	73.6	89.7	93.2
(4) < 72 Hrs	95.92	98.5	87.8	93.3	98	95.4	97.1	95.3	98	96.7	96.7	95.4	94.6

Benchmarking

72 Hour Care Indicators Jan 18	AB	ABM	BCU	C&V	CTaf	HDda
1. < 4 Hours Care Indicators	35.5%	32.4%	40.4%	23.3%	51.0%	63.9%
2. < 12 Hours Care Indicators	96.8%	93.2%	89.9%	90.0%	100.0%	100.0%
3. < 24 Hours Care Indicators	67.7%	93.2%	97.0%	71.7%	67.3%	81.9%
4. < 72 Hours Care Indicators	92.5%	94.6%	97.0%	91.7%	98.0%	86.4%

Thrombolysis Indicators Jan 18	AB	ABM	BCU	C&V	CTaf	HDda
1. Access						
1a - % All Strokes Thrombolsyed	10.8%	12.2%	3.0%	11.7%	10.2%	9.7%
2b - % Eligible Patients Thrombolsyed	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%
2. Time						
1a - Door-to-Needle <= 30 mins	10.0%	0.0%	0.0%	0.0%	0.0%	28.6%
2b - Door-to-Needle <= 45 mins	10.0%	0.0%	0.0%	14.3%	20.0%	57.1%
3c - Onset to-Needle <= 90 mins	10.0%	0.0%	0.0%	0.0%	20.0%	0.0%
4d - % with Pre and Post NIHSS Score	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

>= Target Within 10% < Target More than 10% < Target

Source : ACUTE STROKE QUALITY IMPROVEMENT MEASURES REPORT (NHS Wales Delivery Unit)

Measure 1: % compliance with stroke bundle 1 (< 4 Hours), Measure 2: % compliance with stroke bundle 2 (<12 Hours)
Measure 3: % compliance with stroke bundle 3 (<24 Hours), Measure 4: % compliance with stroke bundle 4 (<72 Hours)

How are we doing?

- Health Board performance in January 2018 improved against the 4 hour bundles when compared with December 2017. Stroke services however were affected by the wider unscheduled care pressures in January which had a particular impact on the 4 hour bundle, and was affected by staff sickness and staffing capacity as a result of turnover.
- Performance against the 12 and 72 hour bundles deteriorated slightly compared with December 2017, but demonstrated significant improvement when compared with January 2017.
- Performance against the 72 hour bundles improved from December 2017.

What actions are we taking?

Weekly multi disciplinary meetings are held in Morriston and Princess of Wales hospitals to review individual patient pathways and opportunities for improvement. Actions being progressed include:

Morriston

- Training sessions for out of hours nurse practitioners planned in February to improve the identification and assessment of stroke who arrive overnight
- Process mapping undertaken on the stroke pathway with the support of 1000 Lives - further work required to review 12 hour access and supported need for additional medical registrar cover to improve timeliness of assessment. Recruitment to additional post con
- Recruitment to CNS roles to enable 7 day extended cover to be reinstated - return to full establishment will be achieved in March

Princess of Wales

- Training new cohort of medical doctors on stroke pathway, SAFER flow, board rounds to improve flow.
- Business case developed for support to implement 3 month trial of an electronic system to capture and map patients as they move through the stroke pathway
- Review of stroke pathway with the support of the Delivery Unit - to identify potential for targeted improvement.

ABMU wide

- Improved and ongoing communication and awareness of the stroke pathway within hospital units and between services.
- Ongoing planning in terms of working towards the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from nation to fund a dedicated project manager to support this work.
- Undertake Bridges management training on self care for patients who have suffered a stroke.

What are the main areas of risk?

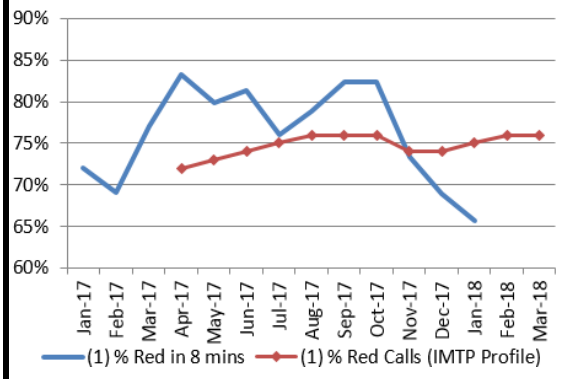
- Insufficient capacity and workforce resilience to support 7 day working which will ultimately require a strategic change to centralise acute stroke services.
- Unscheduled care pressures and increasing waits for transfers of care affecting stroke care capacity.

How do we compare with our peers?

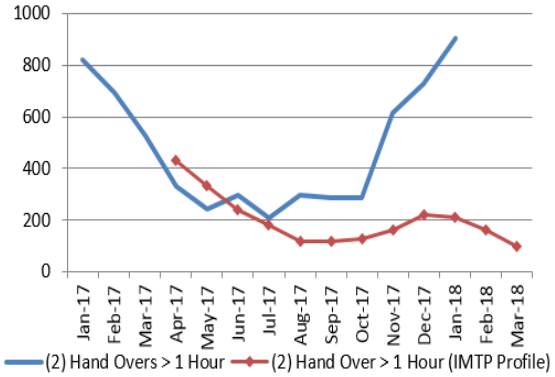
- Performance against the 4 hour bundle continued to be the main challenge for ABMU Health Board in January. The Health Board performed was generally comparable with other Health Boards on 24 and 72 hour bundles. The thrombolysis rates reported in January are being reviewed and may result in the overall HB performance improving as a result. Further review of the 12 hour performance bundle is taking place.

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE				
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				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Chris White**	
Period : Jan 2018	**IMTP Profile Target : (1) 75% (2) 210**	**WG Target : (1)65% (2) Zero**	**Current Status:**	**Movement :** W
Current Trend: Jan 17- Jan 18				

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

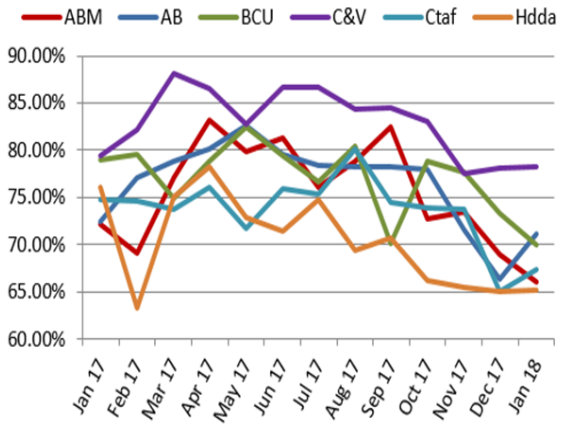


(2) Number of patients waiting more than 1 hour for an ambulance handover

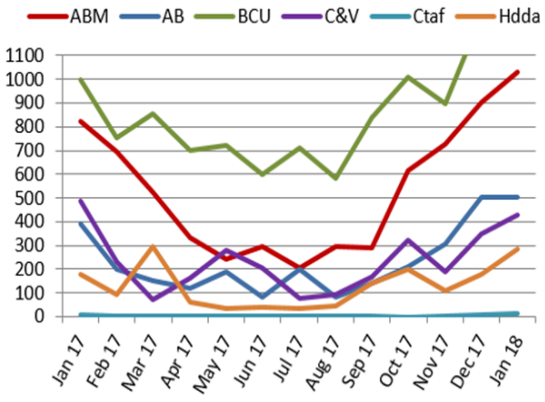


Benchmarking

(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 : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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 65.7% in January 2018, against the National shared target of 65%. Response times for the most urgent calls reduced from 69% in December 2017, and also from 72.1% in January 2017.
- There was a 27% increase in patient handover delays in January 2018 when compared with January 2017.
- January 2018 experienced a 9% reduction in ambulance arrivals at ED when compared with January 2017. Within this overall reduction however there has been a 38% increase in red calls (life threatening calls), a 14 % reduction in amber calls and a 2% reduction in green (lower acuity calls) The number of patients conveyed to ED requiring a red call response was the second highest experienced in the last 2 years, closely following December 2017, which was the highest recorded month for red calls. This suggests that the acuity and complexity of patients arriving at ED by ambulance is increasing, whilst the lower acuity calls are continuing to be redirected to appropriate alternative pathways and services.

What actions are we taking?

- The Health board continues to work closely with WAST to improve the handover process and to ensure that patients are directed to the most appropriate service or pathway of care that best meets their needs.
- An Executive to Executive meeting is being scheduled in March to review the changing pattern of ambulance demand within ABMU Health Board
- Continued development of pathways, models of care and the workforce to reduce health care professional requests for an emergency ambulance response. This includes the community acute clinical response teams having direct access to ambulance control to intercept calls that can be managed by them in the community - therefore averting the need for an ambulance response, supporting the 111 service with an ambulance paramedic to redirect appropriate calls and to also attend house visits. 2 new ambulance advanced paramedic practitioners funded by the Health Board to support the management of patients in the community avoiding the need for ambulance conveyance to hospital have also recently taken up post.
- Using non recurrent additional winter pressures monies to strengthen the non injury falls pathway to support a reduction in conveyance to hospital as these incidents generate the highest request for an ambulance response within ABMU Health Board. • Closer links developed with our District nursing service to redirect suitable patients. Trialing a dedicated mental health response/ community psychiatric nurse response car to jointly support the management of community mental health patients.

What are the main areas of risk?

- Ambulance resourcing to respond to demand within the 8 minute response time.
- Hospital and system wide flow 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.

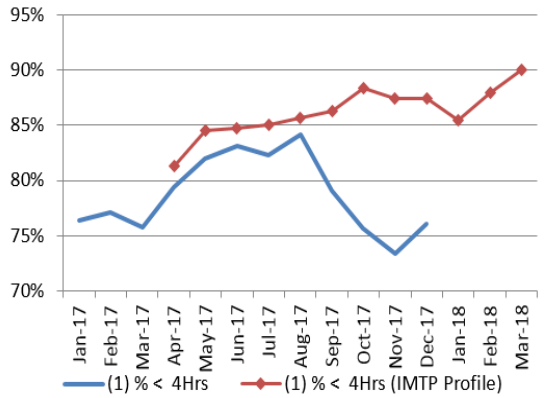
How do we compare with our peers?

- In line with other Health Boards, ABMU performance against the Category A - Red calls target struggled during January, and at 65.7% was below the all-Wales average performance of 69.7% for the month.

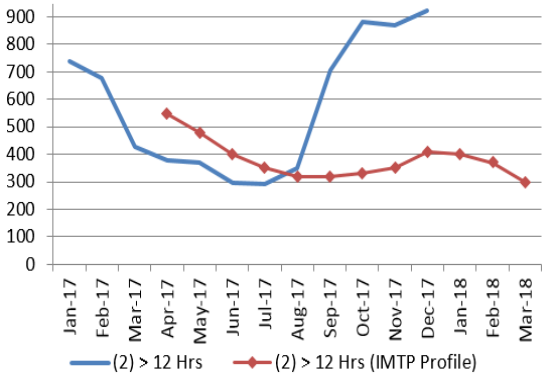
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE				
Measure 1: % new patients spending no longer than 4 hours in an Emergency Department **Measure 2:** Number of patients spending more than or equal to 12 hours in A&E				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Chris White**	
Period : Jan 2018	**IMTP Profile Target : (1) 85% (2) 400**	**WG Target : (1) 95% (2) 0**	**Current Status :** ✖	**Movement :** ⇧ ● W

Current Trend: Jan 17- Jan 18

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



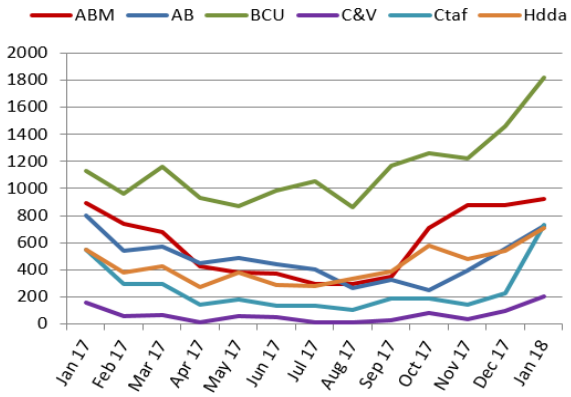
(2) Number of patients spending more than or equal to 12 hours in A&E



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 : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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 January 2018 was 76.06%. This position has deteriorated when compared with January 2017 (76.42%), but improved compared with December 2017 (73.41%).
- • 924 patients stayed over 12 hours in our Emergency Departments (ED's) during January. This was a 6% increase on December 2017, and a 4% increase when compared with January 2017.
- • The overall number of patients attending the Emergency departments is comparable with January 2017 with only a 0.3% increase across the Health Board- Morriston saw a 2% increase and Singleton saw a 10% increase in attendances whereas Princess of Wales saw a 1% reduction adn NPT minor injuries unit saw a 3% reduction..

What actions are we taking?

- The ongoing and increased focus on implementation of the SAFER flow bundle to support patient flow and release bed days. Go Launch in Morriston took place in November and the Singleton stronger together event took place in December, to raise awareness and education staff and public on the impact of unnecessary or avoidable hospital stays on patient outcomes.
- Implementation of our winter plan for 2017/18. Additional surge capacity above the baseline has been activated during December, with further additional planned capacity coming on stream in early January.
- The NHS improvement team in England will be commencing support at the Princess of Wales hospital on 8th and 9th January, programme of work implemented at Morriston in early 2017.
- Working with Local Authorities on arrangements to develop more sustainable models of care to support patient flow.
- Developing new models between the ambulance service and primary and community care services to support patients at home - see ambulance report.

What are the main areas of risk?

- Capacity gaps in Care Homes, Community Resource Teams. Capacity and fragility of private domiciliary care providers , leading to in the number of patients in hospital who are 'discharge fit' and increasing length of stay
- Workforce - with ongoing challenges in nursing and medical roles in some key speciality areas.
- 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 79.1% in October 2017 compared to the all-Wales 4 hour performance of 83.5% for t
- The increase in the number of 12 hour waits within ABMU Health Board in October 2017 reflects the trend experienced by all the Boards in Wales.

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

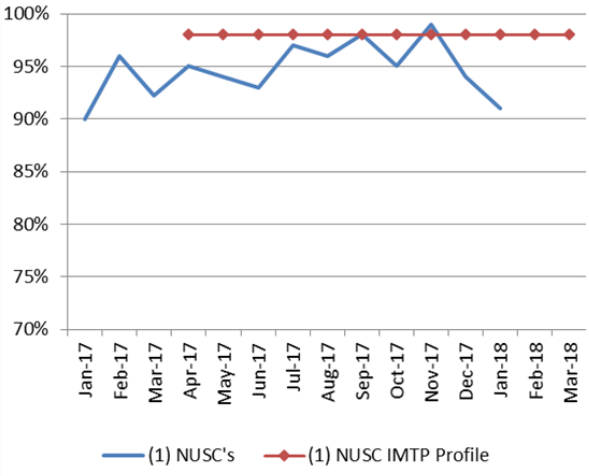
Measure 1: % of patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days

Measure 2: % of patients newly diagnosed with cancer via the urgent suspected route that started definitive treatment within 62 days

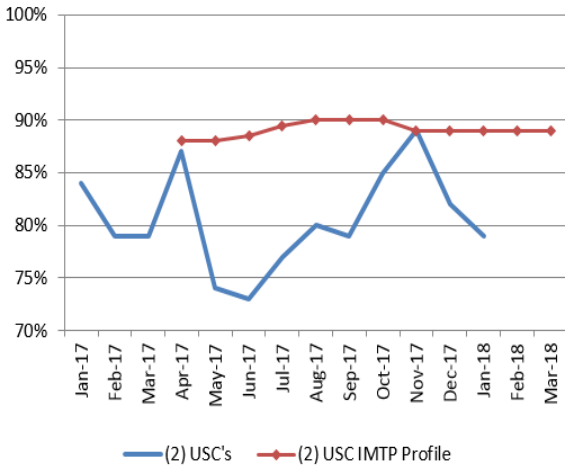
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Jan 2018	IMTP Profile Target: (1) 98% (2) 89%	WG Target : (1) 98% (2) 95%	Current Status :	Movement : Imp

Current Trend: Jan 17- Jan 18

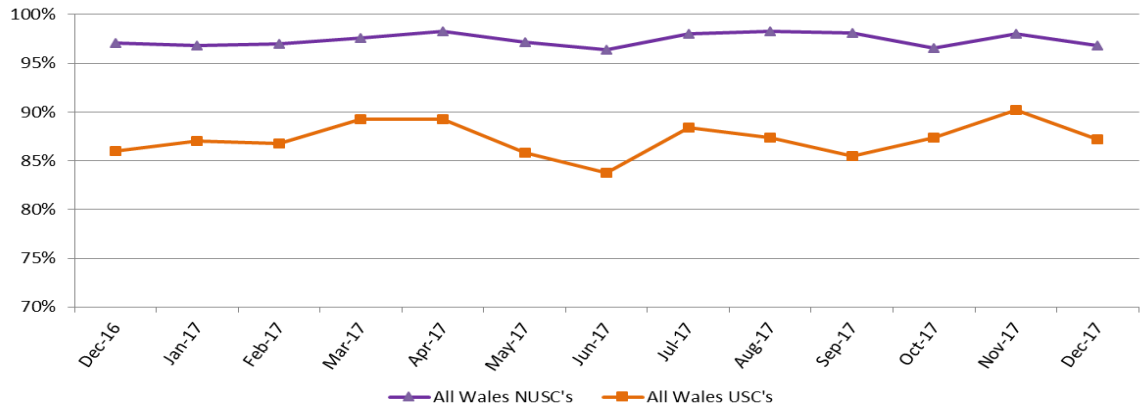
(1) % of patients newly diagnosed with cancer not via the urgent route that started treatment within 31 days



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



Benchmarking



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

Measure 1: % of patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days
Measure 2: % of patients newly diagnosed with cancer via the urgent suspected route that started definitive treatment within 62 days

How are we doing?

- NUSC performance for January 2018 is 91% (16 breaches).
- USC performance for January 2018 is 79% (24 breaches). USC activity (treated malignancies) is the lowest it has been in several years for the month of January.
- USC referrals received by the Health Board remain high during quarter three. The monthly average during the 13 months January 2017 to January 2018 is 1,740. 1792 referrals were received in January.
- The overall backlog position increased through December and January, peaking at 108 at the end of January 2018. Backlog reduced through February 2018.

What actions are we taking?

- Delivery Units continue to progress with the 30, 60 & 90 day Cancer Improvement Plans with measurable objectives.
- The Medical Director to meet the Unit and MDT lead for Urology in February to review the performance and the pathways in this tumour site.
- Gynaecology - Increased focus on theatre booking and utilisation. Revised PMB /Diagnostic pathway now agreed by MDT. Pathway will reduce the diagnostic element by 2 weeks. A variation of the one-stop diagnostic clinic will continue whilst new scopes are procured and the new pathway is fully implemented. Meeting also being organised with MDT Lead / NPTH Unit Director
- Breast MDT reconfiguration steering group established to work to align clinical pathways and protocols across both breast MDTs, initial meeting held and agreed principles, further meeting of MDT groups scheduled in March.
- USC outpatient demand and capacity dashboards have been developed for Gastroenterology Swansea, Breast HB wide and Gynaecology - PMB. To be released as dashboards to the service to monitor waits and impact of any additional capacity provided.
- Breast: Change to Job Plans of Radiologists in February to reduce waits to one stop clinics at Singleton. There remains a capacity deficit that both radiology units are working together for a solution.
- Pilot of Surgical direct to test model for gastroenterology patient

What are the main areas of risk?

- Vacancies continue at Consultant level in key tumour sites - Gastroenterology; Oncology and Radiology.
- Long Term Sickness of key clinical staff in Urology & Oncology
- Service pressures within Urology continue at POWH, resulting in delays across most aspects of patient pathways.
- Unscheduled Care pressures resulting in cancelled and/or delayed procedures at Morriston

How do we compare with our peers?

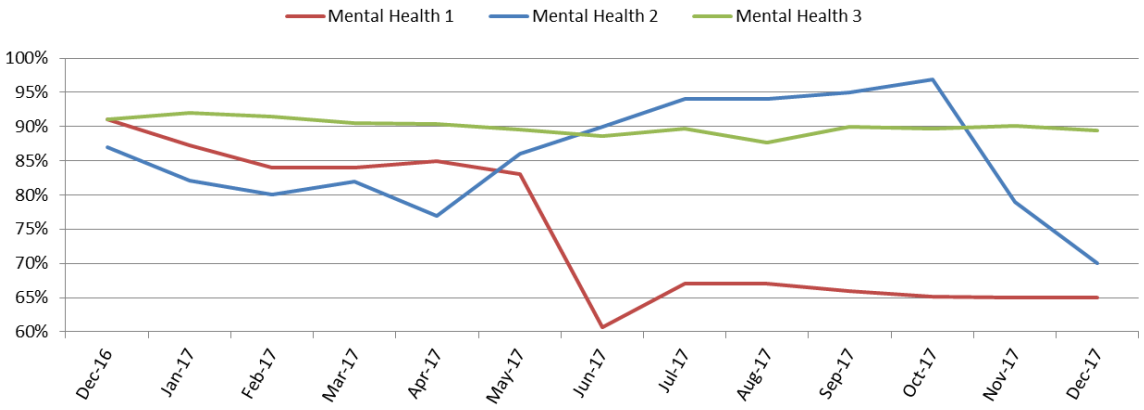
- USC performance continues to struggle in comparison with other Health Boards, demonstrating the lowest performance of all Health Boards. In contrast however, ABMU has the highest volumes of USC patients treated per month, second only to Betsi Cadwalader UHB. Cardiff & Vale UHB have generally demonstrated improved performance against the USC performance since the beginning of 2017.

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

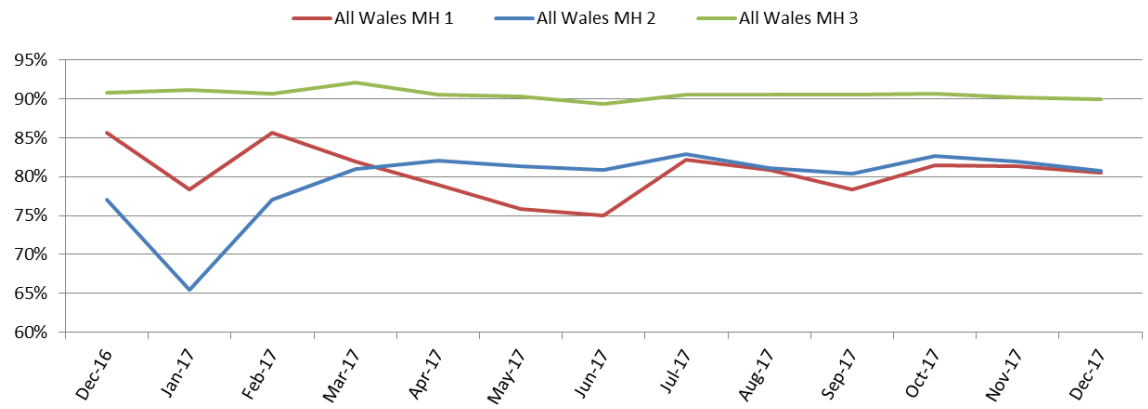
Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral
Measure 2: % of therapeutic interventions started within 28 days following an assessment by LPMHSS
Measure 3: % of Health Board residents in receipt of secondary Mental Health services (all ages) to have a valid Care and Treatment Plan (CTP)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Dec 2017	IMTP Profile Target : (1) 90% (2) 85% (3) 85%	WG Target : (1) 80% (2) 90% (3) 90%	Current Status : ✖	Movement : ↓ ● Worsening

Current Trend: Dec 16- Dec 17



Benchmarking



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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 an 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)

How are we doing?

- Mental Health 1 - ABMU met the target from 6 of the 12 months. Prior to June 2017 ABMU HB had not included CAMHS data. A series of meetings has taken place with representatives from Cwm Taf HB to finalise the arrangements for collating of CAMHS data. Agreement was reached to allow for the commencement of CAMHS data reporting from June 2017. The data previously submitted for June excluding CAMHS met the target. However, the assimilation of CAMHS data into the reporting framework has seen a negative impact to the assessment target. It should be noted that actual waiting time is irrespective of weekends and bank holidays.
- Mental Health 2 - intervention levels met the target 11 of the 12 months shown. There was a slight dip in November to 79% as a result of the change in analysing CAMHS intervention data in Cwm Taf. 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. Of note, from the 1st of January 2018 each Health Board is responsible to report the new "Access to Psychological Therapies in Specialist Adult Mental Health Services", which will impact on Part 1 intervention data.
- Mental Health 3 - This data covers Adult, Older People, CAMHS and Learning Disability Services. ABMU met the target from 10 of the 12 months shown. The Delivery Unit continues to conduct annual CTP audits within each Community Mental Health Team, utilising the All Wales CTP Audit Tool.

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 over capacity.

How do we compare with our peers?

December 2017

- All-Wales MH1 measure ranged from 65.3% to 86.8% 65.3% ABM
- All-Wales MH2 measure ranged from 70.4% to 86.4% 70.4% ABM
- All-Wales MH3 measure ranged from 87.5% to 93.9% 89.4% ABM

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

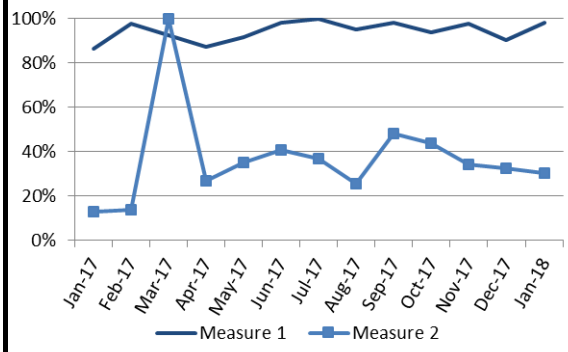
Measure 1: % of Urgent Assessment by the Child and Adolescent Mental Health Services (CAMHS) undertaken within 48 Hours from receipt of referral
Measure 2: % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral
Measure 3: % Patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks
Measure 4: % of therapeutic interventions started within 28 days following assessment by LPMHSS
Measure 5: % of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Siân Harrop-Griffiths	
Period : Jan 2018	IMTP Profile Target :	WG Target : (1, 2, 3, 4) 100% (5) 90%	Current Status :	Movement : In

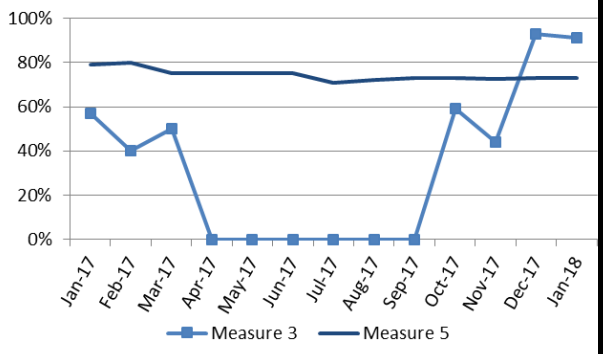
Current Trend: Jan 17- Jan 18

(1) % of Urgent Assessments undertaken within 48 Hours from receipt of referral,

(2) % of Routine Assessments undertaken within 28 days from receipt of referral.



(3) % Patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks, (5) % of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP).



Benchmarking

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
% of urgent assessments undertaken within 48 hours from receipt of referral	↓ 95.0%	↑ 98.0%	↓ 94.0%	↑ 97.8%	↓ 90.5%	↑ 98.2%
% of routine assessments undertaken within 28 days from receipt of referral	↓ 25.6%	↑ 48.0%	↓ 44.0%	↓ 34.5%	↑ 32.6%	↓ 30.4%
% of patients with NDD receiving diagnostic assessment and intervention within 26 weeks	→ 0.0%	→ 0.0%	↑ 59.0%	↓ 44.0%	↑ 93.0%	↓ 91.0%
% of therapeutic interventions started within 28 days following assessment by LPMHSS	→ 100.0%	→ 100.0%	→ 100.0%	↓ 59.0%	↑ 71.0%	→ 71.0%
% of Health Board residents in receipt of CAMHS who have a Care and Treatment Plan	↑ 72.0%	↑ 73.0%	→ 73.0%	↓ 72.5%	↑ 72.8%	↑ 73.2%

Source : Cwm Taf LHB

Measure 1: % of Urgent Assessment by the Child and Adolescent Mental Health Services (CAMHS) undertaken within 48 Hours from receipt of referral, Measure 2: % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral, Measure 3: % Patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks, Measure 4: % of therapeutic interventions started within 28 days following assessment by LPMHSS, Measure 5: % of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)

How are we doing?

- Measure 1: 100% of urgent assessments by CAMHS undertaken within 48 hours from receipt of referral - compliance has been consistent over the last 12 months with 98.2% compliance achieved at the end of January 2018.
- Measure 2: Performance has continued to deteriorate since October 2017 with 30.4% of assessments undertaken within 28 days from receipt of referral. Cwm Taf UHB have progressed plans to hold waiting list initiatives in the Bridgend area, offering appointments to people who are willing to travel from NPT as well. This has improved performance in Bridgend with 78.8% achieved, 52% in NPT, but Swansea, which has the greatest number of people waiting, is only running at 24.3%. Swansea staff have been supporting waiting list activity in NDD and are therefore unable to support further waiting list initiatives for specialist CAMHS. The position is expected to improve by the end of March, but Cwm Taf have confirmed that they will not achieve the Welsh Government target set at 80% for Measure 1 by end of March 2018 for the ABMU population.
- Measure 3: Additional NDD activity has been undertaken since September and has continued into 2018 to remove the backlog. Achievement against this target is much improved with 91% compliance at the end of January compared to 44% in November. The Welsh Government target for this was initially 100%, but has been revised to 80% compliance by 31st March 2018, which ABMU has already achieved.
- Measure 4: 71% target achieved (relates to specialist CAMHS only) - an improved position since November (59%). This is being supported by Integrated Care Funding from Western Bay which enables staff to be dedicated to Part 1 assessments under the Mental Health Measure.
- Measure 5: Compliance of 73.2% reported in January- A decline in the number patients on the measure - this is due to vacancies and CBT Therapists unable to Care Co-ordinate.

What actions are we taking?

- **NDD** - Expressions of interest were circulated to all CAMHS consultants first week of December to obtain additional consultant psychiatrist sessions. Additional consultant sessions have been secured as a result, and plans are underway to implement from 1st April.
  - Capacity Plan to be developed by Quarter 1 of 2018-19 to to inform sustainable service model.
  - Plans are underway to secure additional office space and dedicated clinic space on the Neath Port Talbot site, because there is insufficient clinical space currently to increase activity to the level required to stabilise demand/capacity, this will also improve patient experience and efficiency of the team as it will be easier to record activity and avoid transfer of notes.
  - A Priority for Q4 will be to advertise the nurse post within the service to support medication monitoring.
- **Specialist CAMHS** - ABMU Health Board continues to scrutinise performance and improve governance as commissioner of CAMHS. CAPA was introduced by the CAMHS Network in September across ABMU and this model should support the long term sustainability of the Service, because more robust demand and capacity assessments can be undertaken once local data is available following implementation of CAPA. Waiting list initiative clinics have commenced in Bridgend. The service has been working towards delivery of the 80% target for compliance against the 28 day S-CAMHS target by the end of March 2018, however while the position is expected to improve by then, Cwm Taf have confirmed that they will not achieve this target for the ABMU area by end of March 2018. Ongoing detailed scrutiny of the performance of Specialist CAMHS is ongoing, with at least monthly meetings as well as more detailed service based discussions required. The performance of the CAMHS Network and the risk caused by long waiting times has been included on the Health Board's risk register.

What are the main areas of risk?

- The inabaility to recruit and retain staff is a recurring theme, and is a concern that ABMU will continue to discuss with Cwm Taf via formal commissioning meetings. Accessibility of CAMHS is a key risk with long waiting times in Swansea (9.9weeks average).

How do we compare with our peers?

- Unable to compare performance for ABMU residents with Cardiff & Vale and Cwm Taf residents as performance information not available for comparison. ABMU working jointly with Cardiff & Vale and Cwm Taf Health Boards to look at benchmarking data.

3.3 Demonstrating Value and Sustainability

The table on page 4 above sets out the assessed performance of the key metrics under this Corporate Objective. All of the available data relates to November 2017. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 91.

Further detail on current performance and proposed actions going forward can be found for the following measure via a dedicated report card:

- DNA Rates (WG Measures 94 and 95)

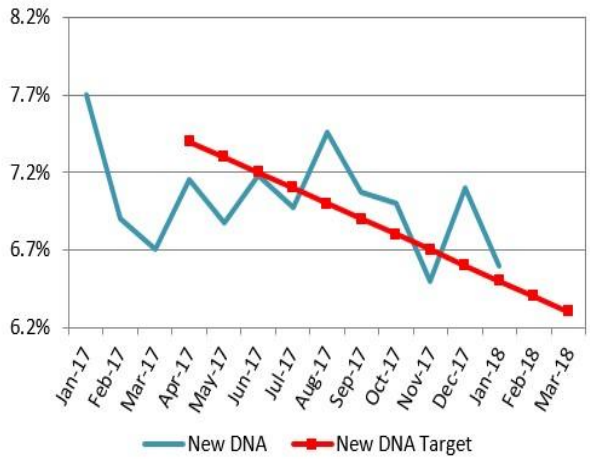
OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

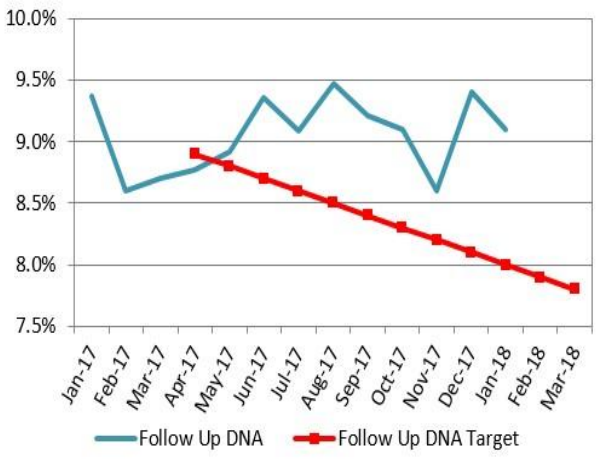
Measure 1: **% New Outpatient that Did Not Attend (DNA) For Specific Specialties**
Measure 2: **% Follow Up Outpatient that Did Not Attend (DNA) For Specific Specialties**
Specific Specialties: *includes General Surgery, Urology, T&O, ENT, Ophthalmology, Oral Surgery, Neurosurgery, Combined Medicine, Dermatology, Rheumatology, Paediatrics and Gynaecology*

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Jan 2018	**IMTP Profile Target :** (1) 6.5% (2) 8.1%	**WG Target :** 12 month reduction trend	**Current Status :** ✓	**Movement :** Improving

Current Trend: Jan 17 - Jan 18

(1) % New Outpatient that Did Not Attend **(2) % Follow Up Outpatient that Did Not Attend**





Benchmarking

(1) % New Outpatient that Did Not Attend **(2) % Follow Up Outpatient that Did Not Attend**

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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

How are we doing?

- New Outpatient DNA: From Jan 2017 - January 2018 performance has improved from 7.7% to 6.6%. In-month performance has improved from 7.1% at December 2017.
- Follow-Up DNA: From Jan 2017 - Jan 2018 performance has improved from 9.4% to 9.1%. In month performance has improved from 9.4% at December 2017.

What actions are we taking?

- Outpatient appointment text reminder service implementation ongoing (full implementation by October 2018).
- Each Delivery Unit has been requested to develop a plan to address their DNA position. These plans, overseen by the Outpatient Improvement Group, need to explicitly detail the specific deliverables, milestones and expected impact on the Health Board DNA position. The plans are also to reflect specialty targets for DNA reduction (New and Follow Up) to deliver best in Wales / best in UK. Where performance is already below best practice baseline, local targets to be set. (Plans for 2018/19 to be produced by 31 March 2018).
- Delivery Units reviewing compliance with Health Board DNA policy guidance (by March 2018).
- Work ongoing with 'We Predict' to increase understanding of the causes for DNA and to undertake predictive modelling of initiatives to understand the potential impact on DNA rates (to be completed by October 2018).

What are the main areas of risk?

- The Wales Audit Office identified in a review of ABMU Outpatients in 2015 the need to ensure patients receive appointment letters in a timely manner in order to reduce DNAs. The Outpatient Transformation workstream is exploring electronic appointment management options to help address this issue.
- 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 under utilised 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 December 2017, ABMU performance was better than the all-Wales average on New and Follow Up DNA performance.
- New DNA: ABM, AB, BCU, C&V and HD have experienced an improved performance from December 2016; Powys and CT position has deteriorated.
- Follow Up DNA: AB, BCU and Powys experienced an improved performance from December 2016; ABMU, C&V, CT and HD position has deteriorated.

3.4 Securing a Fully Engaged and Skilled Workforce

The table which starts on page 4 above sets out the assessed performance of the key metrics under this Corporate Objective. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 94.

Mental Health training in Dementia Care (WG measure 59)
2016/17 is the latest published data for the percentage of GP practice teams that have completed mental health training in dementia care or other training as outlined under the Directed Enhanced Services for mental illness. In 2016/17 the Health Board achieved 16.7% which is a deterioration from 21.6% achieved in 2015/16. The below table show how ABMU compares with the other Health Boards in Wales and historical activity trends.

LHB	Current	Previous		
	2016/17	2015/16	2014/15	2013/14
Wales	21.6%	↓ 39.1%	↓ 27.5%	↓ 46.2%
ABM	16.7%	↓ 21.6%	↓ 18.9%	↑ 20.8%
AB	15.2%	↓ 76.5%	↓ 34.5%	↓ 86.2%
BCU	31.2%	↓ 56.3%	↓ 36.8%	↑ 53.9%
C&V	31.8%	↑ 30.3%	↓ 33.3%	↓ 41.8%
CTaf	4.9%	↑ 2.3%	↑ 4.4%	↓ 10.6%
HDda	24.5%	↑ 24.1%	↓ 29.6%	↓ 46.4%
Powys	0.0%	→ 0.0%	→ 0.0%	↓ 18.8%

The Primary Care Teams will receive reports from Practices in April 2018 which will form the basis of the 2017/18 compliance rates. It is hoped that the 2017/18 position will be an improvement as the teams have been encouraging practices to use in-house PT4L sessions or cluster based sessions as a way of promoting uptake.

Further detail on current performance and proposed actions going forward can be found for the following measures via dedicated report cards:

- Appraisals (WG Measure 100)
- Sickness absence (WG Measure 104)

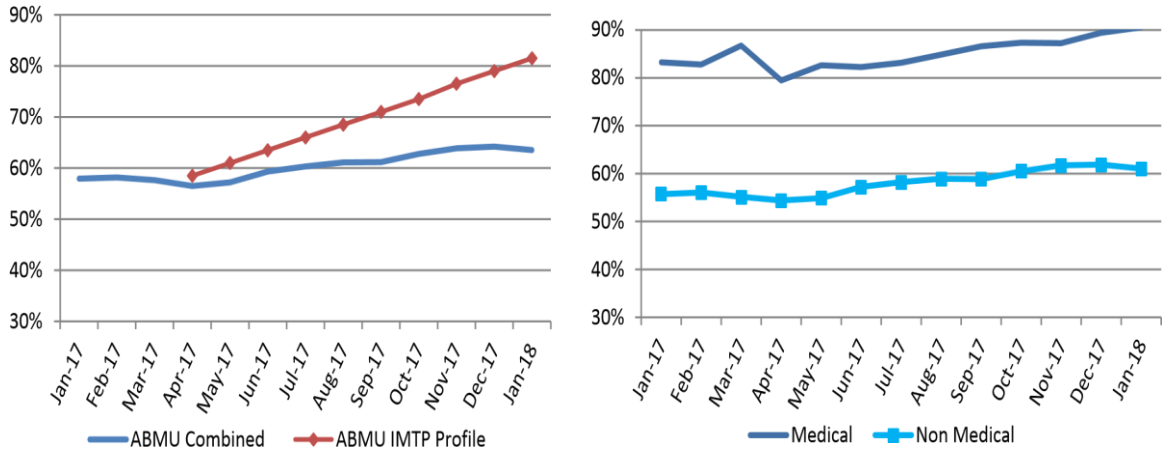
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Securing a Fully Engaged and Skilled Workforce			Executive Lead : Kate Lorenti	
Period : Jan 2018	**IMTP Profile Target :** 81.50%	**WG Target :** Improve	**Current Status :**	**Movement :** Imp

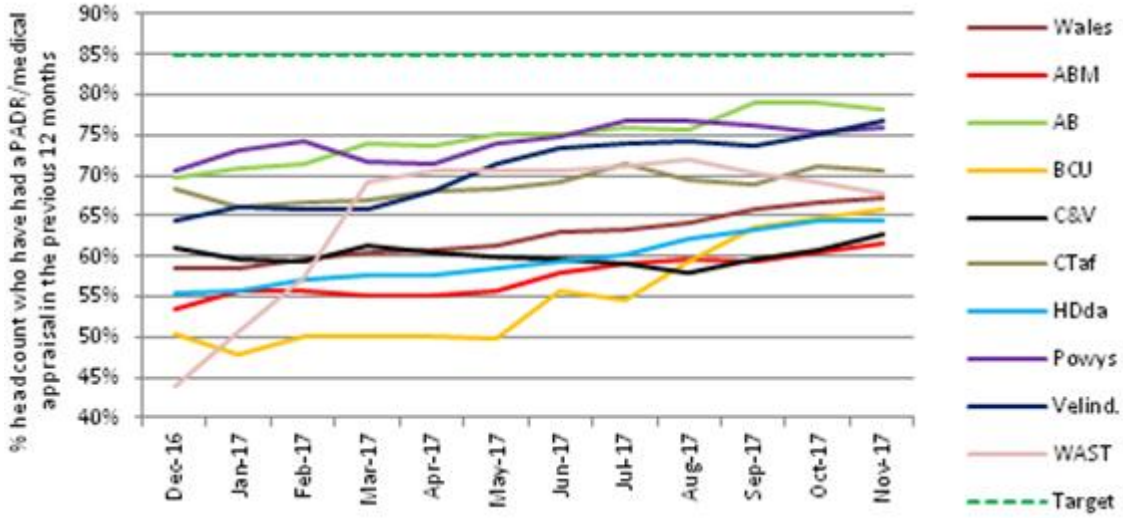
Current Trend: Jan 17- Jan 18

(1) % 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 OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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

How are we doing?

Medical:

- Not including any exemptions (new starters, absences e.g. long term sickness, maternity leave etc) the appraisal rate for the rolling period to November 2017 was 91%.
- Appraisals undertaken have continued to be consistent since April.
- The dip in April 2017 reflects a change in the 'denominator', the number of doctors employed / contracted and 'connected' to the Health Board increased from 1255 to 1335. This varies throughout the year but for consistency, the statistics are based on numbers at the beginning of April each year.

Non Medical:

- Reporting figures demonstrate an increase in PADR compliance- Jan 2017 55.73% to Jan 2018 61.07%
- PADR Monitoring has been added to Estates and Facilities Performance Board Agendas meaning a greater focus on compliance figures.
- From the 6 SDUs: 1 is over 80%, 2 are over 70% compliant, 1 is over 60% compliant and the other 2 are over 55% compliant. . Informatics has fallen slightly to 12.5%

What actions are we taking?

Medical:

- Maintain current performance levels through continuing engagement with Unit Medical Directors, exception management, working with doctors to realign Appraisal Quarters to revalidation requirements.
- The new MARS online appraisal system has undertaken further of enhancements since its launch in August 2017 to improve functionality in line with identified changes.
- Nominations received for Unit based Appraisal Leads, once formally appointed they will drive appraisal quality forward and maximise delivery of appraisal benefits.

Non Medical:

- Focus on training Managers to complete Values Based PADR/use ESR to improve reporting figures is now been completed on a request basis with bespoke sessions for teams/ units when requested.
- Actions from internal audit include further training of Administrators-extra date added for January 2018. Roll out of updated slides to strengthen training session. Heightened scrutiny process for units.

What are the main areas of risk?

Medical:

- Doctors fall 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 fail to engage.
- Poor quality appraisals - lack of personal / service development and progression; continuation of sub-optimal practices; resistance to change.
- Poor implementation of MEP leading to dissatisfaction, demotivation, reduction in engagement, need for greater support.

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.

How do we compare with our peers?

Medical:

- Recent stats from the RSU (Revalidation Support Unit) show appraisals undertaken from 1st April 2017 - 31st December 2017 in ABMU as 61% (based on appraisals completed) this is in line with other Health Boards within Wales.

Non Medical: ABMU remains in line with other Health Boards across Wales. Risk areas which are much lower than the national average remain as Estates, Facilities and Informatics.

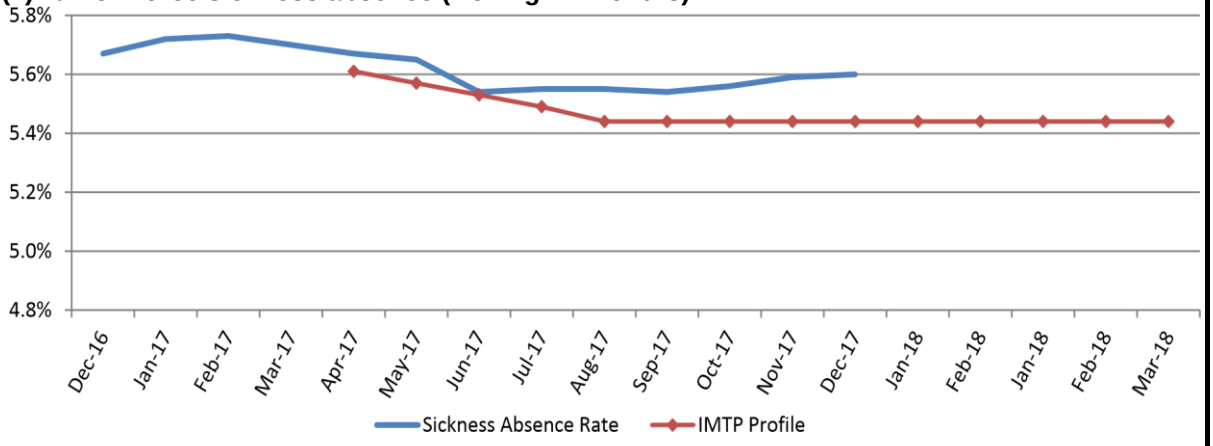
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Securing a Fully Engaged and Skilled Workforce			Executive Lead : Kate Lorenti	
Period : Dec 2017	**IMTP Profile Target :** (1) 5.44%	**WG Target :** Reduction	**Current Status :**	**Movement :** Imp

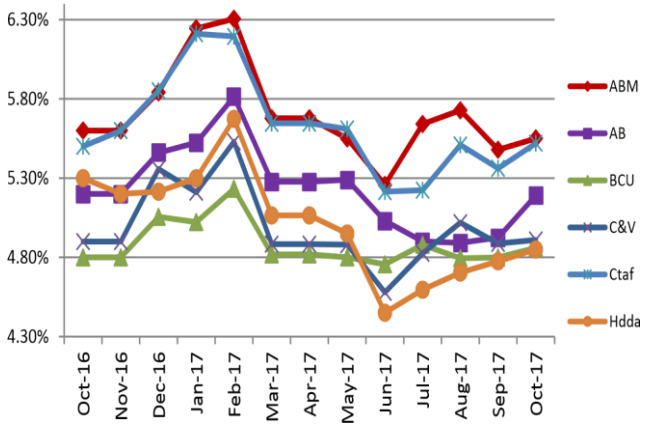
Current Trend: Dec 16- Dec 17

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



Benchmarking

In-Month Sickness Absence Rates



% workforce sickness absence (Rolling 12 months)

LHB	Current	Same Period Comparison		
	Oct-17	Oct-16	Oct-15	Oct-14
Wales	5.10%	↑ 5.14%	↑ 5.39%	↑ 5.52%
ABM	5.55%	↑ 5.58%	↓ 5.45%	↑ 5.79%
AB	5.19%	↑ 5.22%	↑ 5.56%	↑ 5.37%
BCU	4.86%	↓ 4.84%	↑ 4.99%	↑ 5.19%
C&V	4.91%	↓ 4.87%	↑ 5.44%	↑ 5.75%
CTaf	5.52%	↑ 5.57%	↑ 5.80%	↑ 5.90%
HDda	4.85%	↑ 5.24%	↑ 5.65%	↑ 5.31%
Powys	4.65%	↓ 4.41%	↓ 4.04%	↑ 4.86%
PHW	3.89%	↓ 3.55%	↑ 3.95%	↓ 3.52%
Velind.	3.79%	↓ 3.62%	↑ 4.13%	↓ 3.63%
WAST	6.79%	↑ 7.05%	↑ 7.29%	↑ 8.18%

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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

How are we doing?

Rolling 12 month performance:

- Jan 15 - Dec 16 = 5.65%
- Dec 16 - Nov 17 = 5.58%
- Jan 17 - Dec 17 = 5.58%

In Month performance:

- Nov 17 = 6.0%%
- Dec 17 = 6.15% (was 6.36% in Dec 16)

- Four of the six Delivery Units saw a decline in their in-month performance compared with the previous month. Only one Unit (POW) saw an improvement in their 12 month rolling performance with the overall Health Board performance remaining static.
- Short-term sickness (STS) increased by 0.02% to 1.69% in December 2017 compared with the previous month, but remains high mainly due to coughs and colds and flu related absence where fte days lost has increased by 1,400 compared to that in September 17. Long term sick (LTS) absence increased by 0.17% compared with the previous month to 4.46%.
- Stress and other mental health illnesses remains our top reason for absence, accounting for just under 30% of absence in December. This is a 1% decrease on the previous month.

What actions are we taking?

- Currently developing a plan to introduce a new model of OH delivery, offering telephone based service to speed up assessments and provide advice.
- Developing a plan to formally launch the new all-Wales Health and Wellbeing guidance which has been developed.
- Continue to review the 10 worst long term sickness cases in each Unit in order to assure effective management of cases. This approach has resulted in 30 of out of the longest 60 cases being resolved either due to a return to work or termination in the first month of this process.
- As flu continues to be a concern our current flu campaign encouraging staff to have a vaccination is continuing and well over 9,000 staff have received the vaccination as part of this campaign.

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.

How do we compare with our peers?

- The latest 12 month cumulative differential between ABMU and the all-Wales performance is 0.47%.
- The latest differential between our monthly sickness absence rates and the all-Wales average is 0.6%.

3.5 Embedding Effective Governance and Partnerships

The table which starts on page 4 above sets out the assessed performance of the key metrics under this Corporate Objective. For the majority of cases this data relates to January 2018. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 101.

Further detail is provided on the following measure in the absence of dedicated report cards where new data has become available since the last performance report to the Board in January 2018.

Health and Care Research Wales (WG Measures 46 to 49)
This measure is reported quarterly and the latest available information is quarter 2 for 2017/18. The table below shows the performance in 2017/18 (Q1-2) compared with 2016/17. As these are annual improvement measures, the table below confirms that two of the four measures were achieved in 2017/18.

Measure	2016/17 (Q1-Q2)	2017/18 (Q1-Q2)	Variance
No. Health and Care Research Wales CRP Studies	79	72	-7
No. Commercially sponsored studies	23	28	+5
No. patients recruited into Health and Care Research Wales CRP Studies	1,256	884	-372
No. patients recruited into commercially sponsored studies	81	120	+39

In order to strive to meet the targets as we move forward, a focus will be placed on ensuring R&D leads exists within each Unit, tasked with oversight of research activity. The leads should link research interested clinicians with corporate R&D & foster links with national R&D speciality leads, who are themselves tasked with securing portfolio studies to Wales and opening these opportunities to all the Health Boards. A balance is required between increasing the number of Health Board Chief Investigators, who should have the protected time to submit for major grants with local PIs on externally sponsored hosted studies. A key aim will be to support non-medical community to be included as co-applicants on grant submissions, if not lead them utilising academics links to provide the necessary support. The R&D Budget will continue to be used strategically to identify areas where investment is required, such as clinical fellows to further develop research activity. The Joint Clinical Research Facility (JCRF) will continue the focus on commercial research but will also undertake a focus on Primary care with new opportunities shaped through the development of City Deal initiatives, notably the Llanelli Wellbeing Village, opening opportunities for JCRF regional working.

The slight decrease in non-commercial portfolio studies can be attributed to more than 30 studies over the last year closing to recruitment. The research delivery team are working closely with clinicians across the Health Board and the Health and Care Research Wales Infrastructure to identify new research studies across a wide spectrum of specialties. There are 2 research nurses permanently based in Morriston Hospital to support portfolio research, demand for portfolio research team support is continuing to increase; we anticipate that more office space will be required in Morriston as the nurses working out of Singleton may be required to support studies in Morriston as clinical services move. The research midwifery team continue to grow, supporting studies across Singleton and Princess of Wales Hospital.

Further detail on current performance and proposed actions going forward can be found for the following measures via dedicated report cards:

- Serious Incidents and never events (WG Measures 28 and 29)
- Complaints (Local Measures)

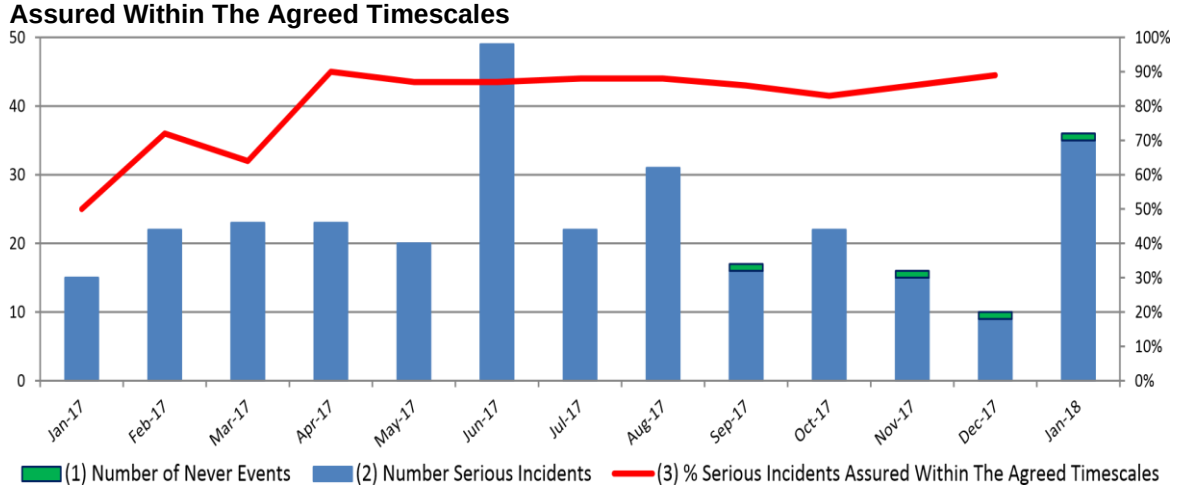
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Jan 2018	**IMTP Profile Target :** (1) 0, (2) Improve, (3) 80%	**WG Target :** (1) 0, (2) Improve, (3) 90%	**Current Status :** N/A	**Movement :** Worse

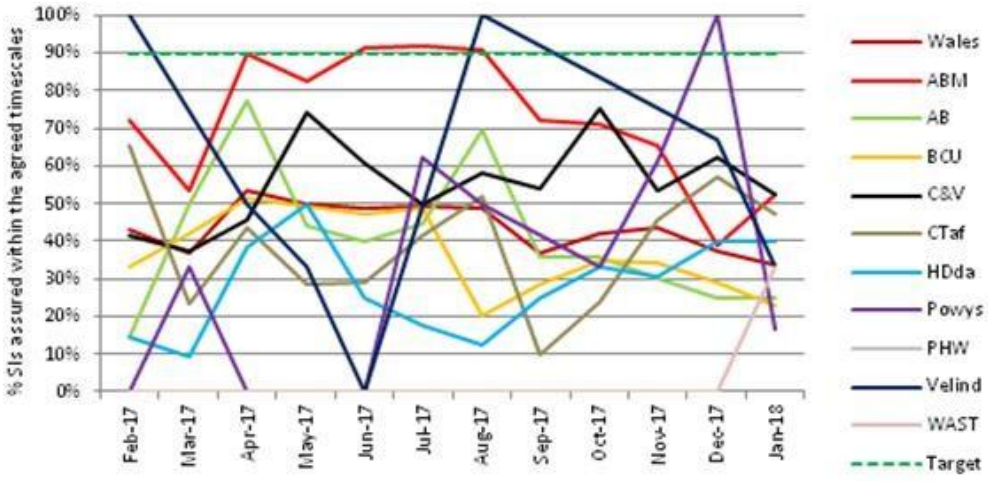
Current Trend: Jan 17 - Jan 18

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



Benchmarking

(3) Serious Incidents Assured Within The Agreed Timescales



Jan-18	
Wales	1
ABM	1
AB	0
BCU	0
C&V	0
Ctaf	0
Hdda	0
Powys	0
PHW	0
Velind	0
WAST	0

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2018)

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?

- Total number of incidents reported in January 2018 was 2,338. This compares with 1,948 incidents reported in January 2017, an increase of 390 incidents for the month of January (increase of 20%).
- 35 Serious Incidents were reported to Welsh Government (WG) in January 2018 representing 1.5% of all incidents. In comparison, 16 SI's were reported to WG in January 2017, an increase of 19 incidents (increase of 54%). Of the 35 new serious incidents reported to Welsh Government, 18 (51%) related to pressure ulcer incidents (grade 3 and above), 8 related to patient falls, 2 were related to service disruptions (influenza), 3 related to unexpected deaths and 4 related to therapeutic processes (which included 1 Never Event - wrong lens implant).
- In terms of severity of incidents, the percentage of incidents resulting in severe harm for January 2018 was 0.55% (total incidents reported 2,338). The Health Board's target for incidents resulting in severe harm has reached 0.5% of the total number of incidents reported.
- One Never Event was reported in January 2018. This relates to a similar Never Event reported in December 2017.
- Performance against the WG target of closing SI's within 60 working days for January 2018 was 85% against the WG target of 80%
- All closure forms submitted to WG in January 2018 received assurance from WG and were closed.

What actions are we taking?

- Performance against the WG target to gain assurance on the reports within 60 working days (80%), remains consistently above the 80% target since April 2017. All submitted closure forms received assurance by WG in January 2018 evidencing continued improvement in the quality of forms submitted.
- The SI Team continued to provide support to the Delivery Unit (DU) in providing documentation/further information as part of their targeted interventions on the HB's serious incident and never event processes. The DU's draft report is awaited.
- In response to the new Never Event an Executive led strategy meeting has been held. The Serious Incident Team have proposed that a learning and reflection event will be held following positive feedback of this new approach to investigating and learning from never events. The approach has been trialled on two previous NEs where the SI Team facilitated a multidisciplinary team reflection event. The change in process will be evaluated in relation to timeliness of investigation and quality of reports. The initial view is that the learning and reflection events have so far resulted in immediate learning, actions taken and clear ownership by the clinical teams. The SI Team are continuing to develop the methodology for wider consultation.

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.
- Similar Never Event in Ophthalmology Theatres in Princess of Wales Hospital (2 received in last two months). Research has identified that the types of incidents which occurred are recognised as occurring nationally and the learning nationally has been shared with the clinical teams when considering the actions to be taken to minimise reoccurrence.

How do we compare with our peers?

- The Health Boards compliance in closing serious incidents down by the Welsh Government target date has been consistently above the all Wales average and remains above the 80% closure target since April 2017.

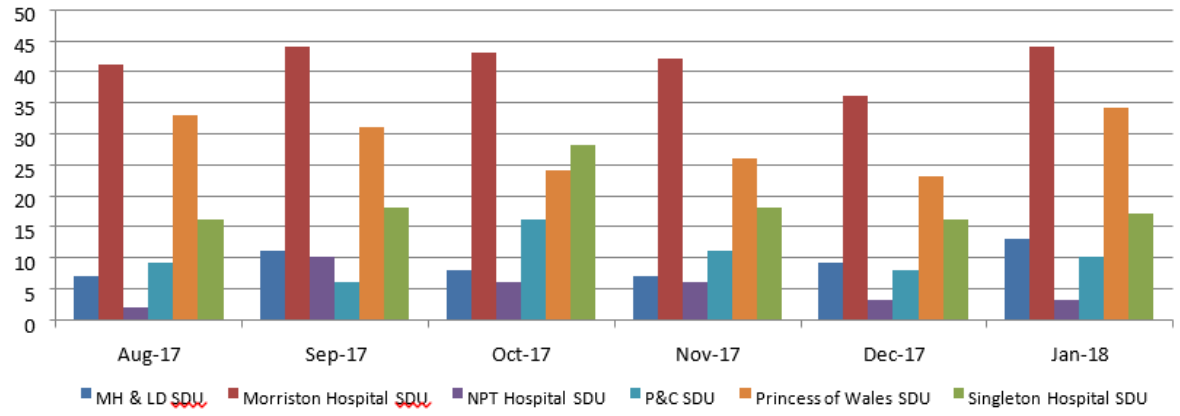
DIGNIFIED CARE - PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

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

Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Jan 2018	IMTP Profile Target : Reduce	WG Target : (1) Monitor, (2) 80%	Current Status : N/A	Movement : Imp

Current Trend: Dec 17- Jan 18

(1) Number of new formal complaints received.



(2) % of responses sent within 30 working days

% of responses sent within 30 working days	2016	2017											
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MH & LD SDU	60%	75%	50%	71%	55%	44%	71%	86%	100%	64%	75%	71%	88%
Morriston Hospital SDU	55%	68%	74%	86%	86%	93%	86%	88%	78%	84%	86%	75%	88%
NPT Hospital SDU	67%	88%	80%	40%	50%	80%	100%	57%	50%	78%	83%	83%	67%
Princess of Wales SDU	69%	86%	94%	95%	96%	100%	83%	83%	81%	68%	67%	62%	64%
P&C SDU	60%	60%	42%	50%	46%	55%	56%	88%	67%	60%	75%	82%	100%
Singleton Hospital SDU	10%	54%	69%	77%	63%	60%	81%	65%	81%	83%	79%	72%	73%
Health Board Total	**55%**	**69%**	**71%**	**80%**	**75%**	**77%**	**82%**	**80%**	**80%**	**76%**	**78%**	**73%**	**80%**

(3) % of acknowledgements sent within 2 working days

Percentage Acknowledgements Sent ≤ 2 Working Days	2017												2018
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Benchmarking

Welsh Government benchmarking data is not yet available. It is expected at some point during 2017/18

Source : COMPLAINTS MODULE FROM DATIX

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 119 formal complaints in January 2018, an increase of 32 compared with December 2017. Morriston consistently remains the Service Delivery Unit (SDU) receiving the highest number of formal complaints, 32% of the formal complaints received by the Health Board. In December 2017 Morriston received 36 complaints compared with 43 in January 2018.
- The Health Board achieved the target of 80% compliance with 30 day response rate for March, June, July and August 2017. For the month of December 2017, the overall 30 day response rate has reached 80%, a 7% increase compared to November 2017 when 73% was reported. The overall Health Board response rate for 30 day responses, on aggregate, for the period April to December 2017 is 79%.
- The Health Board is consistently maintaining the 2 day acknowledgement target at 100%.
- Princess of Wales (PoW) SDU is showing for the month of January 2018, 32 formal complaints received compared with 23 formal complaints for December 2017. The 30 day response rate for December is 64%, this is a slight increase in response rate as November 2017 showed 62%. From September 2017 a downward projection has continued for the past 4 months, Executive Directors will discuss this during the performance meeting with the SDU.

What actions are we taking?

- Performance in the 30 day response targets is addressed consistently at all performance reviews.
- Princess of Wales Service Delivery Unit (SDU) is the lowest performing Unit with 64% for 30 day responses. The Unit Nurse Director and Governance Team have been alerted to this and it will be further discussed at the Unit's performance review with Executive Directors to seek assurances on improvements in the response rate.
- Mental Health & Learning Disabilities, Morriston, Singleton and Primary Care SDU's are the highest performing Unit for 30 day responses, with Primary Care achieving a 100% target for 30 day responses.
- Neath Port Talbot SDU has reduced its overall response rate this month, achieving 67% compared with 82% in November 2017. The SDU has been alerted to the performance.
- Patient Advice Liaison Service (PALS) activity for the period April 2017 - January 2018, identified 2,900 contacts of which 3.5% (102) converted to formalised complaints. The largest number of these complaints are attributed to the Princess of Wales SDU who had 58 formal complaints out of the overall total.
- SDU's 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 is communication. A training programme for communication for all staff grades is being undertaken in all Units by the Patient Experience Training officer, with further SDU discussions during attendance at Concerns and Redress Group.
- Open investigation cases for the Ombudsman is 37. Breakdown of the 37 open investigations is as follows- Morriston 11, Princess of Wales 12, Singleton 8, MH &LD 4, Primary Care and Community Service 2. Princess of Wales is the Unit showing the highest number of Ombudsman investigations. Recurring themes from the Ombudsman investigations are discharge process, communication, documentation lacking information poor complaints handling. The Health Board has met with the Ombudsman Improvement Officer to discuss the increase in Ombudsman investigations and the actions being taken in terms of developing training and awareness sessions tackling the themes and the deep dive reviews into complaint responses of the Service Delivery Units through the Concerns & Redress Assurance Group. A meeting has been arranged in March, with the Ombudsman Improvement Officer.

What are the main areas of risk?

- Deviation from the Health Board 80% target for 30 day responses;
- Maintaining Quality of Complaint responses while achieving the 30 day response rate target and;
- Increase in Ombudsman cases. The Health Board has received 38% more cases in 2017/18 to date, compared with 2016/17.

How do we compare with our peers?

- No monthly all-Wales data to compare.