Meeting Date	**22nd August 2018**	**Agenda Item**	**2a**
Report Title	Integrated Performance Report		
Report Author	Hannah Roan, Performance and Contracting Manager Darren Griffiths, Assistant Director of Strategy		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Chris White, Chief Operating Officer		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide an update on the current performance of the Health Board at the end of the most recent reporting window in delivering key performance measures outlined in the 2018/19 NHS Wales Delivery Framework.		
Key Issues	This Integrated Performance Report provides an overview of how the Health Board is performing against the National Delivery measures and key local quality and safety measures. Actions are listed where performance is not compliant with national or local targets as well as highlighting both short term and long terms risks to delivery. A suite of performance report cards have also been included in this report as a detailed summary of end of quarter one performance.		
Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Recommendations	Members are asked to: • **Note** the current Health Board performance against key measures and targets and the actions being taken to improve performance.		

Governance and Assurance							
Link to corporate objectives *(please ✓)*	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships		
	✓	✓	✓	✓	✓		
Link to Health and Care Standards *(please ✓)*	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	✓	✓	✓	✓	✓	✓	✓

Quality, Safety and Patient Experience

The performance report outlines performance over the domains of quality and safety and patient experience, and outlines areas and actions for improvement.

Quality, safety and patient experience are central principles underpinning the National Delivery Framework and this report is aligned to the domains within that framework. There are no directly related Equality and Diversity implications as a result of this report.

Financial Implications

At this stage in the financial year there are no direct impacts on the Health Board's financial bottom line resulting from the performance reported herein except for planned care.

Planned Care additional capacity is funded by £8.3m to support delivery of target levels. Failure to deliver these target levels will result in claw back of funds by Welsh Government. The decision on whether to apply clawback or not, it is understood, will be made at the end of quarter 3.

The achievement of releasable efficiency and productivity targets could deliver savings to support the financial position.

Legal Implications (including equality and diversity assessment)

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

Staffing Implications
A number of indicators monitor progress in relation to Workforce, such as Sickness and Personal Development Review rates. Specific issues relating to staffing are also addressed individually in this report.
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
The '5 Ways of Working' are demonstrated in the report as follows: Long term – Actions within this report are both long and short term in order to balance the immediate service issues with long term objectives. In addition, profiles have been included for the Targeted Intervention Priorities for 2018/19 which provides focus on the expected delivery for every month as well as the year end position in March 2019. Prevention – the NHS Wales Delivery framework provides a measureable mechanism to evidence how the NHS is positively influencing the health and well-being of the citizens of Wales with a particular focus upon maximising people's physical and mental well-being. Integration – this integrated performance report brings together key performance measures across the seven domains of the NHS Wales Delivery Framework, which identify the priority areas that patients, clinicians and stakeholders wanted the NHS to be measured against. The framework covers a wide spectrum of measures that are aligned with the Well-being of Future Generations (Wales) Act 2015. Collaboration – in order to manage performance, the Corporate Functions within the Health Board liaise with leads from the Delivery Units as well as key individuals from partner organisations including the Local Authorities, Welsh Ambulance Services Trust, Public Health Wales and external Health Boards. Involvement – Corporate and Delivery Unit leads are key in identifying performance issues and identifying actions to take forward.

Report History	The last iteration of the Integrated Performance Report was presented to the Performance & Finance Committee in June 2018. Quality and Safety elements of the report are also presented to the Quality & Safety Committee.
Appendices	None

Summary of performance against national and local measures

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1. Overview

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

Successes	Priorities
• Internal profiles for stage 1 > 26 weeks have been achieved for every month for 2018/19 and total waiting time over 36 weeks continue to reduce. • In July 2018 the percentage of patients waiting under 26 weeks from referral to treatment was the highest since November 2013. • Therapy waiting times continue to be maintained at (or below) 14 weeks. • Sustained nil position in July 2018 for Endoscopy patients waiting over 8 weeks. • Continued achievement of stroke patients assessed by stroke specialist within 24 hours. • The Health Board is the best in Wales for Universal Mortality Reviews. • No Never Events reported since 21st March 2018.	• Embed newly ratified Falls policy into all Delivery Units. • Evaluate impact of #endpjparalysis campaign. • Increase number of clinical staff who have been Aseptic Non Touch Technique (ANTT) competency assessed by March 2019. • Continued implementation and adherence with restricted Antimicrobial Prescribing Policy. • Implementation of quarter 2 unscheduled care improvement plans and learn lessons from Cardiff and Vale on improving and sustaining performance against the 4 hour target. • Increased communication and awareness of stroke pathway with hospital units and between services. • Review compliance with Health Board's DNA policy to be undertaken by Delivery Units.
Opportunities	**Risks & Threats**
• Testing and further developing ambulatory care and frailty models to support admission avoidance. • Implementation of the SAFER flow bundle will aid patient flow and unscheduled care. • Executive to Executive meeting with WAST to explore additional opportunities to improve unscheduled care pathways. • Learn lessons from recent C. difficile outbreak in Morriston. • Dialogue with Hywel Dda and Cardiff regarding specialist and regional services (Cardiac, Spinal and OG Cancer). • Development of long term sickness pathways to help guide managers in managing common absence conditions. • Continued resilience on tackling theatre safety and inefficiencies.	• Additional work required by services to prepare for Boundaries change. • Quarter 2 requires a stepped improvement in long waiting patient volumes at a time when orthopaedic services are under pressure. • ABMU has highest number of ambulance handovers > 1 hr in Wales. • ABMU has the second highest rate of C. difficile and E.Coli cases in Wales, and the highest rate of S. Aureus Bacteraemia. • ABMU continues to be the only Health Board in Wales not to use HPV or UV-C decontamination process; not utilising these technologies is a risk to achieving infection reduction. • Ongoing medical and nursing staffing gaps in acute services. • GP practice sustainability. • An increasing amount of frail older people at home are at increased risk of developing pressure damage. • Capacity gaps in Care Homes, Community Resource Teams.

2. Targeted Intervention Priority Measures Summary- Health Board Level – July 2018

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	75.6%	78.9%	81.0%	79.9%								
		Profile	*83%*	*83%*	*83%*	*88%*	*88%*	*88%*	*89%*	*90%*	*90%*	*90%*	*90%*	*90%*
	12 hour A&E waits	Actual	737	624	476	590								
		Profile	*323*	*194*	*190*	*229*	*227*	*180*	*255*	*315*	*288*	*283*	*196*	*179*
	1 hour ambulance handover	Actual	526	452	351	443								
		Profile	*256*	*126*	*152*	*159*	*229*	*149*	*223*	*262*	*304*	*262*	*183*	*139*
Stroke	Direct admission within 4 hours	Actual	34.9%	37.5%	40.0%	37.5%								
		Profile	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*	*50%*	*50%*	*50%*	*65%*	*65%*	*65%*
	CT scan within 1 hour	Actual	41.4%	43.3%	51.3%	40.3%								
		Profile	*40%*	*40%*	*40%*	*45%*	*45%*	*45%*	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*
	Assessed by Stroke Specialist within 24 hours	Actual	83.9%	93.3%	88.2%	80.6%								
		Profile	*75%*	*75%*	*75%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*85%*	*85%*	*85%*
	Thrombolysis door to needle within 45 minutes	Actual	0.0%	11.1%	37.5%	21.4%								
		Profile	*20%*	*25%*	*25%*	*30%*	*30%*	*30%*	*35%*	*35%*	*35%*	*40%*	*40%*	*40%*
Planned care	Outpatients waiting more than 26 weeks	Actual	*166*	*120*	*55*	*30*								
		Profile	*249*	*200*	*150*	*100*	*50*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*3,398*	*3,349*	*3,319*	*3,383*								
		Profile	*3,457*	*3,356*	*3,325*	*3,284*	*3,287*	*3,067*	*2,773*	*2,709*	*3,045*	*2,854*	*2,622*	*2,664*
	Diagnostic waits over 8 weeks	Actual	*702*	*786*	*915*	*740*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Therapy waits over 14 weeks	Actual	*0*	*1*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	92%	90%	95%	99%								
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	77%	89%	83%	91%								
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	26	18	15	29								
		Profile	*21*	*18*	*26*	*20*	*22*	*20*	*20*	*24*	*13*	*19*	*15*	*21*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	14	21	19	17								
		Profile	*13*	*18*	*13*	*18*	*11*	*13*	*13*	*15*	*21*	*13*	*19*	*15*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	42	43	41	51								
		Profile	*45*	*39*	*40*	*45*	*42*	*45*	*44*	*37*	*41*	*45*	*39*	*42*

**RAG status derived from performance against trajectory*

3. QUARTER 1 TRAJECTORIES SUMMARY

The following provides a summary of the quarter one position against the national measures with agreed profiles submitted to Welsh Government as part of the Annual Plan, where June 2018 data is available. Section seven of this report contains detailed report cards for key national and local measures summarising the quarter one position and actions planned for quarter two.

✓ 53%

Q1 profiles achieved

✖ 47%

Q1 profiles not achieved

Q1 trajectories achieved	Q1 trajectories not achieved
Unscheduled Care: ✓ Emergency responses to red calls arriving within 8 minutes ✓ Number of mental health Delayed Transfers of Care (DTOCs) **Stroke:** ✓ CT scan within 1 hour ✓ Stroke specialist assessment within 24 hours ✓ Thrombolysis door to needle within 45 minutes **Planned Care**: ✓ RTT stage 1 > 26 weeks ✓ RTT 36 weeks ✓ Therapies waiting over 14 weeks **Healthcare Acquired Infections:** ✓ Number of C. difficile cases **Quality & Safety:** ✓ New Never Events ✓ Of the serious incidents due for assurance, the % which were assured within the agreed timescales ✓ Administration, dispensing and prescribing medication errors reports as serious incidents **Mental Health:** ✓ % of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral ✓ % of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS ✓ % of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA ✓ % of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP) ✓ 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 **Workforce:** ✓ % compliance for all completed Level 1 competency with the Core Skills and Training Framework	**Unscheduled Care:** ✖ A&E 4 hours *(3% below profile)* ✖ A&E 12 hours *(286 above profile)* ✖ Ambulance handovers > 1 hour *(199 above profile)* ✖ Number of non-mental health Delayed Transfers of Care (DTOCs)-need to confirm numbers **Stroke:** ✖ Stroke- direct admissions within 4 hours *(5% below profile)* **Planned Care:** ✖ Reported diagnostics waiting over 18 weeks ✖ Delayed follow-ups(need to confirm numbers) ✖ % of patients who did not attend a new outpatient appointment *(0.3% above profile)* **Cancer:** ✖ Cancer- NUSC patients starting treatment in 31 days *(3% below profile)* ✖ Cancer- USC patients starting treatment in 62 days *(6% below profile)* **Healthcare Acquired Infections:** ✖ Number of S.Aureus Bacteraemia cases *(6 cases above profile)* ✖ Number of E.Coli Bacteraemia cases *(2 cases above profile)* **Quality & Safety** ✖ Universal Mortality Reviews undertaken within 28 days *(5% below profile)* ✖ % of episodes clinically coded within 1 month of discharge *(1% below profile)* ✖ Falls reported as serious incidents *(1 above profile)* **Workforce:** ✖ % of staff who have had a PADR/medical appraisal in the previous 12 months *(5% below profile)*

3. Integrated Performance Dashboard

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

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

Sub Domain	Measure	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Childhood Immunisation & Health Visiting	% children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1			95%														*Awaiting publication of 2018/19 data.*			
	% of children who received 2 doses of the MMR vaccine by age 5	Q1 17/18	91%	95%	92%	✗	89.3%				92%			91%			89%			91%	
	% 10 day old children who have accessed the 10-14 days health visitor contact component of the Healthy Child Wales Programme	Q3 17/18	54%	4 quarter ↑ trend			83.1%				61%			54%						0%	
Influenza	% uptake of influenza among 65 year olds and over	2017/18	68%	75%	70%	✗	69%					33%	66%	66%	68%	68%	68%				
	% uptake of influenza among under 65s in risk groups	2017/18	47%	55%	65%	✗	49%					18%	43%	43%	46%	47%	47%				
	% uptake of influenza among pregnant women	2017/18	93%	75%		✓	73%										93%				
	% uptake of influenza among children 2 to 3 years old	2017/18	49%		40%	✓						6.6%	44.9%	44.9%	48.4%	49.1%	49%				
	% uptake of influenza among healthcare workers	2017/18	58%	50%	60%	✗	58%					49%	54%	55%	57%	58%	58%				
Smoking	% of pregnant women who gave up smoking during pregnancy (by 36- 38 weeks of pregnancy)	2016/17	4.8%	Annual ↑			23.7%		2016/17= 4.8%												
	% of adult smokers who make a quit attempt via smoking cessation services	Jun-18	0.6%	5% annual target	0.8%	✗			0.8%	1.0%	1.2%	1.4%	1.6%	1.7%	2.1%	2.3%	2.5%	0.2%	0.5%	0.6%	
	% of those smokers who are co-validated as quit at 4 weeks	Q4 17/18	56.0%	40% annual target	40.0%	✓	42.6%				54%			53%			56%			0%	
Learning Disabilities	% people with learning disabilities with an annual health check			75%														*Awaiting publication of 2018/19 data.*			
Primary Care	% people (aged 16+) who found it difficult to make a convenient GP appointment	2016/17	37.2%	Annual ↓			38.7%		2016/17= 37.2%												

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

Sub Domain	Measure	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Prescribing	Total antibacterial items per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)	Q4 17/18	364	4 quarter ↓			340				299			346			364				
	Fluroquinolone, cephalosoporin, clindamycin and co-amoxiclav items as a % of total antibacterial items prescribed	Q4 17/18	9%	4 quarter ↓			7.6%				10%			9%			9%				
	NSAID average daily quantity per 1,000 STAR-Pus	Q4 17/18	1,496	4 quarter ↓			1,405				1,559			1,541			1,496				
	Number of administration, dispensing and prescribing medication errors reported as serious incidents	Jun-18	0	12 month ↓	0	✓	2					0	0	0	0	0	0	0	0	0	
infection control	Cumulative cases of E.coli bacteraemias per 100k pop	Jul-18	98.9	<67			82.36											96.6	96.1	96.2	98.9
	Number of E.Coli bacteraemias cases	Jul-18	51		45	✗	224		52	51	53	52	39	43	47	18	40	42	43	41	51
	Cumulative cases of S.aureus bacteraemias per 100k pop	Jul-18	37.3	<20			28.06											32.2	39.6	40.9	37.3
	Number of S.aureus bacteraemias cases	Jul-18	17		18	✓	56		20	12	14	14	17	25	14	21	15	14	21	19	17
	Cumulative cases of C.difficile cases per 100k pop	Jul-18	50.3	<26			31.71											59.8	49.7	44.7	50.3
	Number of C.difficile cases	Jul-18	29		20	✗	86		24	26	24	24	28	14	22	18	27	26	18	15	29
	Hand Hygiene Audits- compliance with WHO 5 moments	Jul-18	96%		95%	✓			96%	97%	94%	96%	94%	96%	95%	95%	94%	95%	96%	95%	96%
Incidents & Risks	Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale	Q4 17/18	0	0			1		0			2			0						
	Of the serious incidents due for assurance, the % which were assured within the agreed timescales	Jul-18	81%	90%	80%	✓	27.8%		88%	88%	86%	83%	86%	89%	85%	92%	92%	79%	85%	85%	81%
	Number of new Never Events	Jul-18	0	0	0	✓	2		2	1	1	0	1	1	1	2	4	0	0	0	0
	Number of risks with a score greater than 20	Jul-18	67		12 month ↓	✗			39	35	61	64	59	60	78	57	57	58	57	60	67
	Number of Safeguarding Adult referrals relating to Health Board staff/ services	Jul-18	22		12 month ↓	✓			29	26	23	11	6	11	12	8	10	8	12	10	22
	Number of Safeguarding Children Incidents	Jul-18	12		0	✗			3	8	10	10	5	2	8	5	12	6	11	5	12
Pressure Ulcers	Total number of pressure ulcers acquired in hospital	Jul-18	56		12 month ↓	✓			46	33	34	47	43	49	51	37	46	48	47	39	56
	Total number of pressure ulcers acquired in hospital per 100k admissions	Jul-18	654		12 month ↓	✓			530	387	382	522	524	564	595	472	546	611	524	477	654
	Number of grade 3, 4, suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital	Jul-18	21		12 month ↓	✓			14	15	12	18	19	19	22	13	26	17	9	14	21
	Number of grade 3, 4, suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100k admissions	Jul-18	245		12 month ↓	✓			143	176	127	204	205	228	252	161	302	212	100	171	245
	Total Number of pressure ulcers developed in the community	Jul-18	68		12 month ↓	✗			68	72	47	27	62	69	52	57	69	67	80	81	68
	Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers developed in the community	Jul-18	20		12 month ↓	✗			18	17	9	12	16	19	9	23	20	24	24	27	20
	Number of grade 3, 4 and unstageable healthcare acquired pressure ulcers reported as serious incidents	Jun-18	21	12 month ↓	10	✗	112		19	18	8	10	5	6	18	6	13	12	13	21	
Inpatient Falls	Number of Inpatient Falls	Jul-18	300		12 month ↓	✓			346	379	331	326	347	318	344	309	357	333	357	326	300
	Number of Inpatient Falls reported as serious incidents	Jun-18	3	12 month ↓	2	✗	32		1	2	2	4	2	3	8	5	2	2	4	3	
Self Harm	Rate of hospital admissions with any mention of intentional self-harm of children and young people (aged 10-24 years) 1k pop.	2016/17	3.25	Annual ↓			3.99		2016/17= 3.25												
Mortality	Amenable mortality per 100k of the European standardised pop.	2016	142.9	Annual ↓			140.6		2016= 142.9												
HAT	Number of potentially preventable hospital acquired thromboses (HAT)	Q2 17/18	2	4 quarter ↓			17		2												

EFFECTIVE CARE- People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that acre successful																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
DTOCs	Number of mental health HB DToCs	Jul-18	27		27	✔			24	29	35	30	30	31	29	21	25	28	22	30	27
	Number of mental health HB DToCS (12 month rolling)	Jul-18	337	10% ↓			4,177		272	279	295	305	319	331	340	334	333	335	331	334	337
	Number of non-mental health HB DToCs	Jul-18	74		38	✘			42	53	69	59	68	55	41	53	44	34	64	75	74
	Number of non-mental health HB DToCs (12 month rolling)	Jul-18	689	10% ↓			993		610	613	623	621	628	623	615	625	624	613	625	657	689
Mortality	% of universal mortality reviews (UMRs) undertaken within 28 days of a death	Jul-18	95%	95%	96%	✘	67.2%		94.7%	89.6%	89.7%	90.8%	94.9%	92.9%	90.8%	90.6%	91.1%	95.4%	95.2%	92.9%	94.6%
	Crude hospital mortality rate (74 years of age or less)	Jun-18	0.80%	12 month ↓			0.75%		0.81%	0.82%	0.83%	0.81%	0.81%	0.80%	0.80%	0.80%	0.81%	0.81%	0.81%	0.80%	
NEWS	% patients with completed NEWS scores & appropriate responses actioned	Jul-18	99%		100%	✘			92.0%	98.9%	99.1%	99.7%	94.4%	98.6%	97.5%	98.0%	96.9%	96.4%	98.3%	97.9%	99.1%
Info Gov	% compliance of level 1 Information Governance (Wales training)	Jul-18	0%	85%					51%	54%	55%	57%	59%	59%	60%	60%	61%	62%	64%	66%	0%
Coding	% of episodes clinically coded within 1 month of discharge	Jun-18	94%	95%	96%	✘	84.1%		95%	96%	96%	95%	89%	95%	93%	91%	93%	94%	93%	94%	
	% of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	2017/18	93%	Annual ↑			91.7%		2017/18= 93%												
E-TOC	% of completed discharge summaries	Jul-18	59%		100%	✘			66.0%	60.0%	64.0%	66.0%	66.0%	67.0%	62.0%	64.0%	65.0%	68.0%	64.0%	60.0%	59.0%
Treatment Fund	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	Q4 17/18	100.0%	100%	100%	✔	97%				98%			100%			100%				
Research	Number of Health and Care Research Wales clinical research portfolio studies	Q4 17/18	96	10% annual ↑	120	✘	317				72			85			96				
	Number of Health and Care Research Wales commercially sponsored studies	Q4 17/18	41	5% annual ↑	38	✔	101				28			38			41				
	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	Q4 17/18	2,206	10% annual ↑	3,062	✘	9,134				884			1492			2,206				
	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	Q4 17/18	294	5% annual ↑	232	✔	691				120			223			294				

DIGNIFIED CARE- People in Wales are treated with dignity and respect and treat others the same																						
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**		**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
Patient Experience	Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	2016/17	5.97	Annual ↑			6.19		2016/17= 5.97. Awaiting publication of 2017/18 data.												
	Number of new formal complaints received	Jul-18	126		12 month ↓ trend	✔			107	117	125	129	111	97	122	91	115	119	119	90	126
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	Jun-18	80%	75%	78%	✔			80%	80%	76%	78%	73%	80%	80%	61%	71%	80%	83%	80%	
	% of acknowledgements sent within 2 working days	Jul-18	100%		100%	✔			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	% 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	2017/18	83.4%	Annual ↑			85.5%		2017/18= 83.4%												
	% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital	2017/18	89.0%	Annual ↑			89.8%		2017/18= 89.0%												
	Number of procedures postponed either on the day or the day before for specified non-clinical reasons	May-18	4,187	> 5% annual ↓			19,144												4,187		
Dementia	% of patients aged>=75 with an Anticholinergic Effect on Condition of >=3 for items on active repeat	Q4 17/18	8.0%	4 quarter ↓			7.3%				7.9%			8.2%			8.0%				
	% of people with dementia in Wales age 65 years or over who are diagnosed (registered on a GP QOF register)	2016/17	58.8%	Annual ↑			53.3%		2016/17= 58.8%. Awaiting publication of 2017/18 data.												
	% GP practices that completed MH DES in dementia care or other direct training	2016/17	16.7%	Annual ↑			21.6%		2016/17= 16.7%. Awaiting publication of 2017/18 data.												

TIMELY CARE- People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
Primary Care	% of GP practices open during daily core hours or within 1 hour of daily core hours	Jun-18	94%	Annual ↑	95%	✗	87%		89%	89%	89%	89%	88%	88%	88%	93%	93%	94%	94%	94%	
	% of GP practices offering daily appointments between 17:00 and 18:30 hours	Jun-18	82%	Annual ↑	95%	✗	84%		84%	84%	84%	84%	84%	84%	84%	82%	81%	82%	82%	82%	
	% of population regularly accessing NHS primary dental care	Dec-17	62.6%	4 quarter ↑			55%				62%			63%							
Out of Hours/ Unscheduled Care	% of P1 calls that were logged and patients started their definitive assessment within 20 minutes of the initial calls being answered	May-18	85.0%	12 month ↑					85%	87%	87%	85%	85%	82%	80%	77%	78%	83%	85%		
	% of patients prioritised as P1 and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage	May-18	60.0%	12 month ↑					20%	91%	100%	56%	100%	75%	83%	33%	67%	50%	60%		
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	Jul-18	77%	65%	65%	✓	76.1%		76%	79%	82%	73%	73%	69%	66%	69%	67%	78%	77%	78%	77%
	Number of ambulance handovers over one hour	Jul-18	443	0	107	✗	1,562		206	295	289	617	727	903	1,030	805	1,006	526	452	351	443
	% 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	Jul-18	81%	95%	88%	✗	82%		83%	82%	84%	79%	76%	73%	76%	74%	71%	76%	79%	81%	80%
	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	Jul-18	476	0	229	✗	2,827		296	294	347	706	875	871	924	957	1,051	737	624	476	590
	% of survival within 30 days of emergency admission for a hip fracture	Apr-18	72.4%	12 month ↑			75.6%		78.2%	85.2%	84.6%	80.2%	80.8%	74.3%	84.5%	85.9%	84.9%	72.4%			
Stroke	Direct admission to Acute Stroke Unit (<4 hrs)	Jul-18	38%	58.7%	50%	✗	49.5%		51%	47%	44%	44%	33%	24%	29%	22%	32%	35%	38%	40%	38%
	CT Scan (<1 hrs)	Jul-18	40%	52.80%	45%	✗	57.0%		36%	35%	80%	36%	38%	36%	35%	44%	36%	41%	43%	51%	40%
	Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)	Jul-18	81%	84.5%	80%	✓	86.3%		81%	83%	83%	89%	80%	72%	81%	73%	73%	84%	93%	88%	81%
	Thrombolysis door to needle <= 45 mins	Jul-18	21%	12 month ↑	30%	✗	26.5%		18%	25%	0%	17%	22%	10%	0%	8%	6%	0%	11%	38%	21%
Planned Care	% of patients waiting < 26 weeks for treatment	Jul-18	89.3%	95%	89.2%	✓	87.4%		87.5%	86.5%	86.1%	86.9%	86.2%	85.3%	86.2%	87.5%	87.8%	87.8%	88.1%	88.7%	89.3%
	Number of patients waiting > 26 weeks for outpatient appointment	Jul-18	30	-	100	✓	17,010		1,134	1,599	1,567	1,438	1,524	1,679	1,111	732	292	166	120	55	30
	Number of patients waiting > 36 weeks for treatment	Jul-18	3,383	0	3,284	✗	15,344		4,388	4,642	4,284	4,463	4,561	4,714	4,609	4,111	3,363	3,398	3,349	3,319	3,383
	Number of patients waiting > 8 weeks for a specified diagnostics	Jul-18	740	0	0	✗	3,993		533	601	455	349	361	460	444	226	29	702	786	915	740
	Number of patients waiting > 14 weeks for a specified therapy	Jul-18	0	0	0	✓	347		224	258	117	111	111	95	32	3	0	0	1	0	0
	Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (all specialties)	Jul-18	64,318		55,780	✗			59,551	61,120	62,346	59,828	59,584	62,797	62,492	64,316	66,271	66,526	65,287	63,776	64,318
	Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (planned care specs only)	Jul-18	21,673	12 month ↓			181,227		21,289	21,694	22,161	21,075	20,648	22,364	22,414	23,198	24,475	24,628	24,288	24,469	21,673
Cancer	% of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to and including) 31 days of diagnosis (regardless of referral route)	Jul-18	99%	98%	98%	✓	96.5%		97%	96%	98%	95%	99%	94%	91%	94%	93%	92%	90%	95%	99%
	% of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to and including) 62 days receipt of referral	Jul-18	91%	95%	90%	✓	84.2%		77%	80%	79%	85%	89%	82%	79%	83%	88%	77%	89%	83%	91%
Mental Health	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	Jun-18	82%	80%	80%	✓	85.1%		67%	67%	66%	65%	65%	65%	67%	74%	70%	84%	86%	82%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	Jun-18	80%	80%	80%	✓	85.7%		94%	94%	95%	97%	79%	70%	75%	89%	86%	79%	81%	80%	
	% of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA	Jun-18	100%	100%	100%	✓	99.90%				100%			100%			100%			100%	
CAMHS	% of urgent assessments undertaken within 48 hours from receipt of referral (Crisis)	Jul-18	100%		100%	✓			100%	95%	98%	94%	98%	91%	98%	100%	96%	100%	100%	100%	100%
	% Patients with Neurodevelopmental Disorders (NDD) receiving a Diagnostic Assessment within 26 weeks	Jul-18	91%		80%	✓			0%	0%	0%	59%	44%	93%	91%	95%	98%	94%	95%	91%	91%
	P-CAHMS - % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral	Jul-18	33%		80%	✗			2%	2%	3%	2%	1%	4%	6%	6%	8%	43%	43%	33%	22%
	P-CAHMS - % of therapeutic interventions started within 28 days following assessment by LPMHSS	Jul-18	78%		80%	✗			100%	100%	100%	100%	59%	71%	71%	88%	82%	44%	77%	78%	63%
	S-CAHMS - % of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)	Jul-18	76%		90%	✗			71%	72%	73%	73%	73%	73%	73%	79%	73%	75%	71%	76%	75%
	S-CAHMS - % of Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral	Jul-18	70%		80%	✗			36%	25%	29%	43%	34%	32%	29%	41%	54%	63%	73%	70%	49%

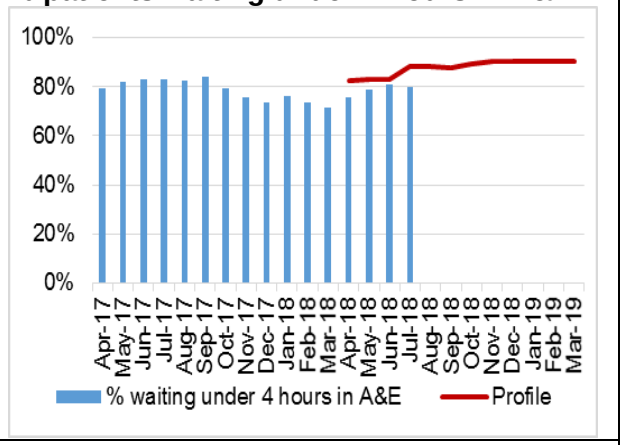
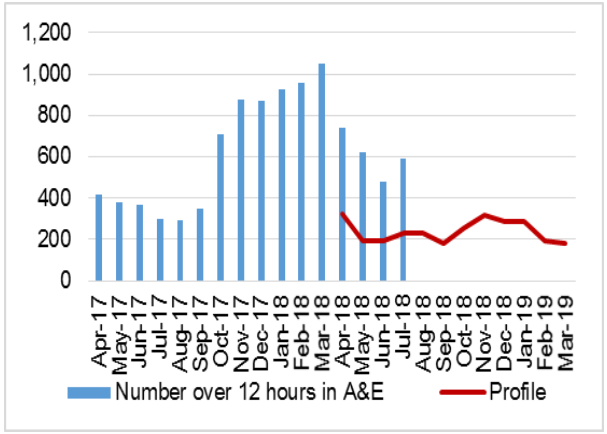
INDIVIDUAL CARE- People in Wales are treated as individuals with their own needs and responsibilities																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
Helplines	Rate of calls to the mental health helpline C.A.L.L. per 100k pop.	Q4 17/18	107.5	4 quarter ↑			173.9				116.0			122.1			107.5				
	Rate of calls to the Wales dementia helpline per 100k pop.	Q4 17/18	4.4	4 quarter ↑			7.6				5.1			5.1			4.4				
	Rate of calls to the DAN helpline per 100k pop.	Q4 17/18	36.3	4 quarter ↑			34.4				33.6			25.9			36.3				
Mental Health	% residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan (CTP)	Jun-18	88%	90%	90%	✔	88.9%		89.7%	87.6%	89.2%	89.7%	90.1%	89.4%	88.8%	89.0%	88.8%	90.0%	89.6%	88.0%	
	% residents assessed under part 3 to be sent their outcome assessment report 10 working days after assessment	Jun-18	100%	100%	100%	✔	94.3%		100%	100%	100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	
Patient Experience	Number of friends and family surveys completed	Jul-18	5563		12 month ↑	✘			5,734	6,157	6,250	6,375	6,136	4,318	5,230	5,685	5,126	4,638	3,086	6,246	5,563
	% of who would recommend and highly recommend	Jul-18	96%		90%	✔			94%	94%	96%	95%	96%	95%	95%	95%	95%	95%	95%	96%	96%
	% of all-Wales surveys scoring 9 out 10 on overall satisfaction	Jul-18	85%		90%	✘			84%	85%	88%	83%	84%	84%	83%	87%	84%	87%	89%	84%	85%

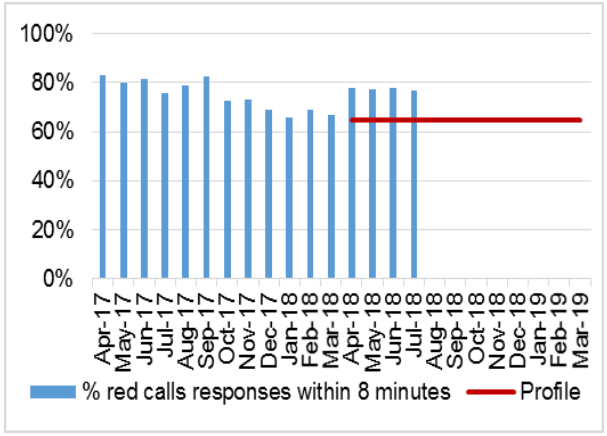
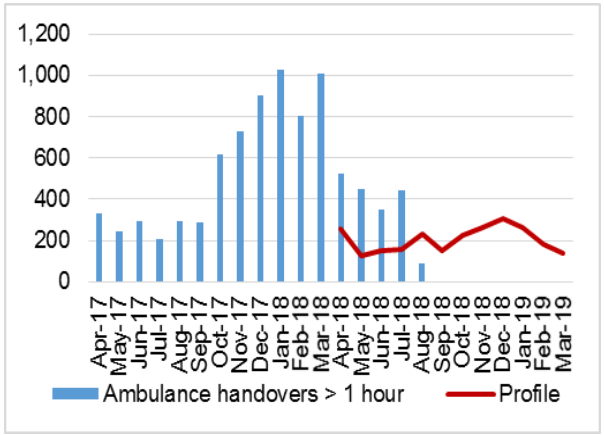
OUR STAFF & RESOURCES- People in Wales can find information about how their NHS is resourced and make careful use of them																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**
DNAs	% of patients who did not attend a new outpatient appointment	Jul-18	5.9%	12 month ↓	5.9%	✔	6.9%		6.8%	7.0%	6.7%	6.4%	5.8%	6.6%	5.9%	5.9%	5.6%	6.3%	5.9%	5.5%	5.9%
	% of patients who did not attend a follow-up outpatient appointment	Jul-18	6.7%	12 month ↓	7.7%	✔	8.3%		8.9%	8.8%	8.6%	8.1%	7.7%	8.5%	8.0%	7.7%	7.1%	7.1%	7.2%	6.2%	6.7%
Theatre Efficiencies	Theatre Utilisation rates	Jul-18	74%		Increase	✔			73%	68%	76%	75%	75%	72%	73%	73%	70%	72%	76%	74%	72%
	% of theatre sessions starting late	Jul-18	41%		Reduce	✘			39%	41%	43%	41%	42%	40%	43%	43%	46%	41%	41%	41%	38%
	% of theatre sessions finishing early	Jul-18	39%		Reduce	✘			37%	36%	36%	36%	35%	37%	34%	36%	43%	39%	37%	39%	41%
Prescribing	Biosimilar medicines prescribed as % of total 'reference' product plus biosimilar	Q4 17/18	12%	Quarter on quarter ↑			10.6%				10.4%			12.3%			12.2%				
Elective Procedures	Elective caesarean rate	2016/17	14%	Annual ↓			12.8%		2016/17= 14%. Awaiting publication of 2017/18 data.												
Workforce	% of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	Jul-18	65%	85%	70%	✘	65.1%		60%	61%	61%	63%	64%	64%	64%	63%	64%	64%	63%	63%	65%
	% staff who undertook a performance appraisal who agreed it helped them improve how they do their job	2016	55%	Improvement			53%		2016= 55%. Awaiting publication of 2017 data.												
	Overall staff engagement score – scale score method	2016	3.68	Improvement			3.65		2016= 3.68. Awaiting publication of 2017 data.												
	% compliance for all completed Level 1 competency with the Core Skills and Training Framework	Jul-18	59.5%	85%	48%	✔	68.1%		44%	45%	46%	47%	48%	49%	49%	50%	51%	53%	55%	57%	59%
	% workforce sickness and absent (12 month rolling)	May-18	5.84%	12 month ↓			5.24%		5.55%	5.55%	5.56%	5.57%	5.59%	5.60%	5.65%	5.71%	5.76%	5.77%	5.81%	5.84%	
	% staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	2016	70%	Improvement			68%		2016= 70%. Awaiting publication of 2017 data.												

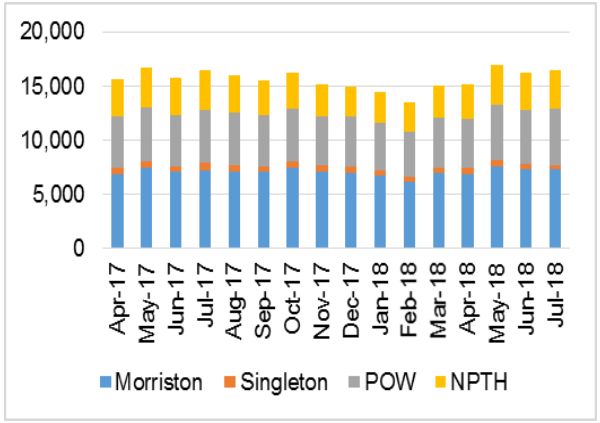
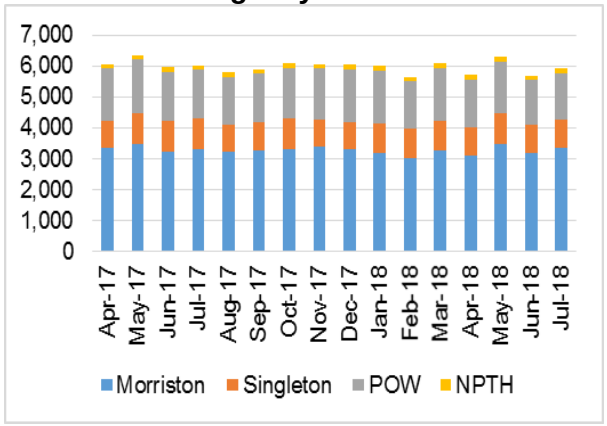
4. Exception Reporting

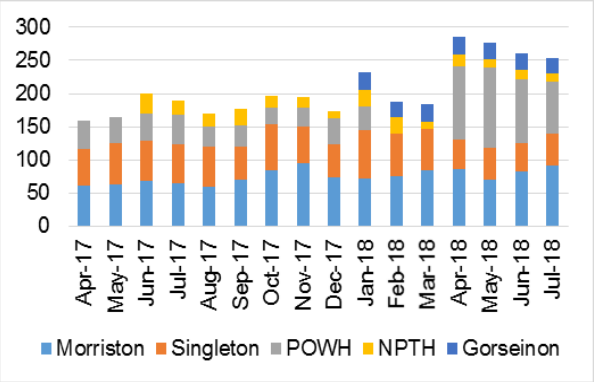
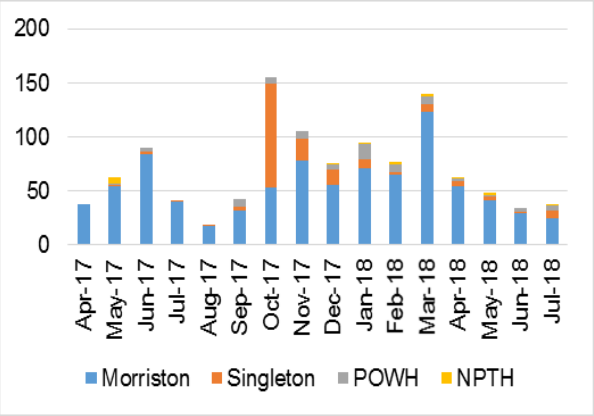
This section of the report provides further detail on key measures that are below internal profiles or required levels.

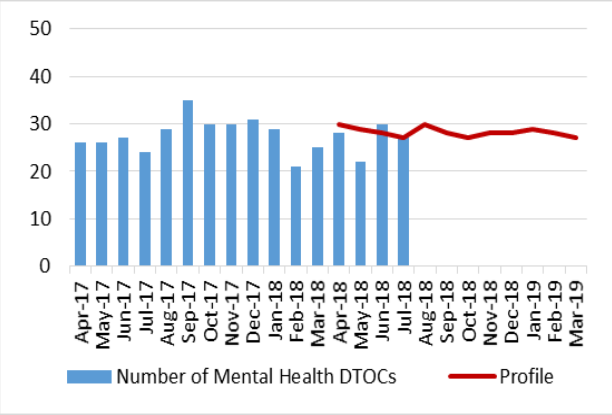
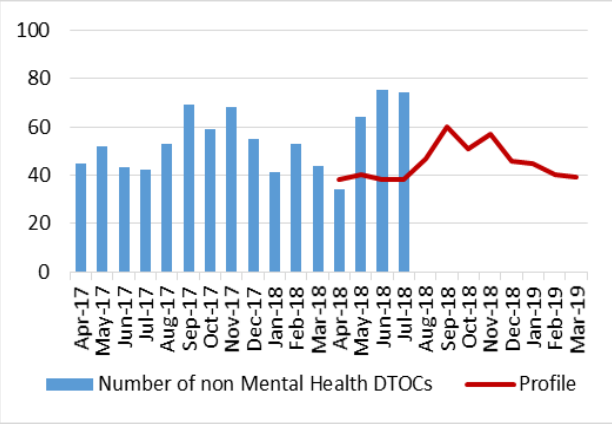
4.1 Unscheduled Care (WG measures 67- 70)

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	In July 2018 performance against the 4 hour performance metric deteriorated from the position reported at the end of Quarter 1 from 81.02% to 79.87% and was below the internal profile of 88.3%. Singleton and Neath Port Talbot Hospitals continue to exceed the national target of 95% but Morriston and Princess of Wales hospital (POWH) are below profile, achieving 70.26% and 80.14% respectively.	**% patients waiting under 4 hours in A&E** 	• Ongoing and increased focus on implementation of the SAFER flow bundle to support patient flow, reducing unnecessary stays in hospital and increasing avoidable admissions. • Implementation of Quarter 2 USC improvement plans with a particular focus on frailty services, ambulatory care models and working with partners in Local Authorities and the 3rd sector on arrangements to develop more sustainable models of care to support patient flow. • Implementation of action plan developed following Breaking the Cycle to support sustainable improvement in patient flow and safety. • Improved system escalation arrangements. • Developing a business case for the provision of a surgical assessment unit at the Princess of Wales hospital which demonstrated a positive impact on patient flow and performance when piloted in March and June 2018. • Development of the winter assurance planning arrangements. • Strengthen medical staffing cover within the Emergency departments following junior doctor changeover and recruitment.
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 deteriorated when compared with June 2018 and also July 2017. In July 2018, the Health Board had 590 12 hour breaches of which 447 were attributed to Morriston Hospital, 141 to Princess of Wales Hospital and 2 to Singleton Hospital.	**Number of patients waiting over 12 hours in A&E** 	

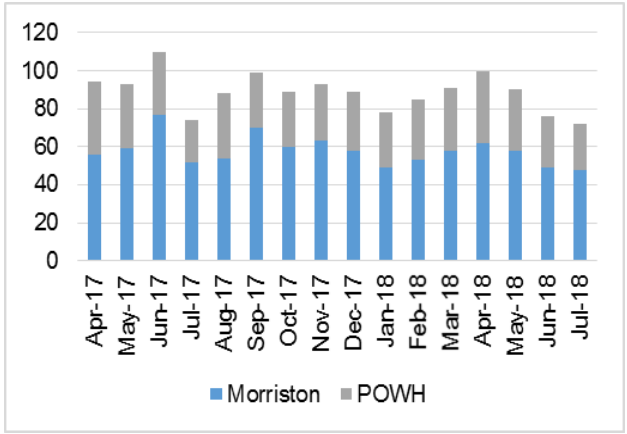
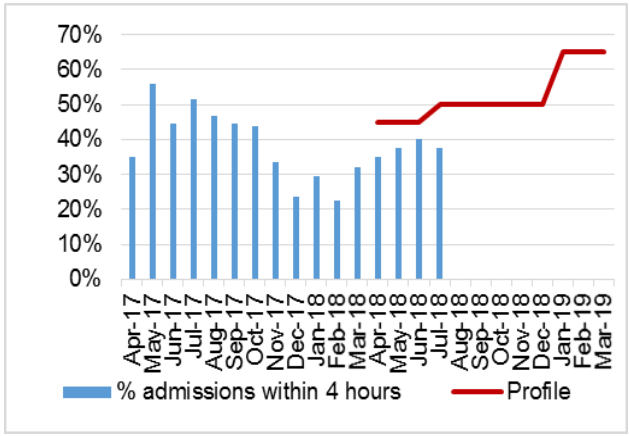
Description	Current Performance	Trend	Actions planned for next period
Ambulance responses The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Ambulance response times are consistently above the national target and local profile of 65%, reporting 77% at the end of July, which was the second highest performance across Wales. The number and proportion of red call conveyances continues to increase, with Welsh Ambulance Services Trust (WAST) data suggesting that ABMU HB has the highest proportion of red calls in Wales for the population served.	**Percentage of red call responses within 8 minutes** 	• Work with WAST to direct patients to appropriate services or pathways, ensuring emergency ambulance capacity is utilised appropriately. Green (HCP) call conveyances to hospital have reduced by 14% in Q1 when compared with the same period in 2017/18 and amber conveyances have reduced by 8%. • Review of amber 1 and 2 call demand in conjunction with WAST and participate in the National review of amber call demand initiated by the Cabinet Secretary.
Ambulance handovers The number of ambulance handovers over one hour	The number of ambulance handovers to local hospitals taking over 1 hour continues to be over profile which is a reflection of the pressures being felt across the unscheduled care system. In July 2018, Morriston Hospital saw an increase of 237 compared with July 2017 (138 to 348). Princess of Wales Hospital (POWH) saw an increase of 9 (52 to 61) and Singleton Hospital saw an increase of 18 (16 to 34). The number of > 1 hour ambulance patient handover delays increased by 92 from 351 in June 2018 to 443 in July 2018.	**Number of ambulance handovers over one hour** 	• Implement the recommendations of the WAST internal audit report on hospital handover that are applicable to ABMU Health Board. • Implement USC improvement plans to deliver system capacity to support timely patient handover. • Executive to Executive meeting held with WAST identifying further opportunities and actions to reduce demand and improve handover times.

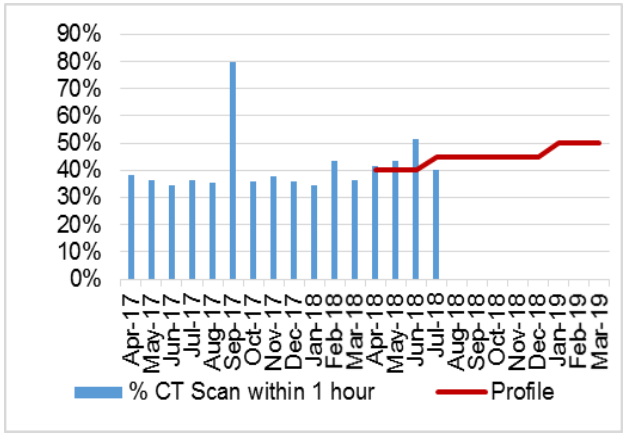
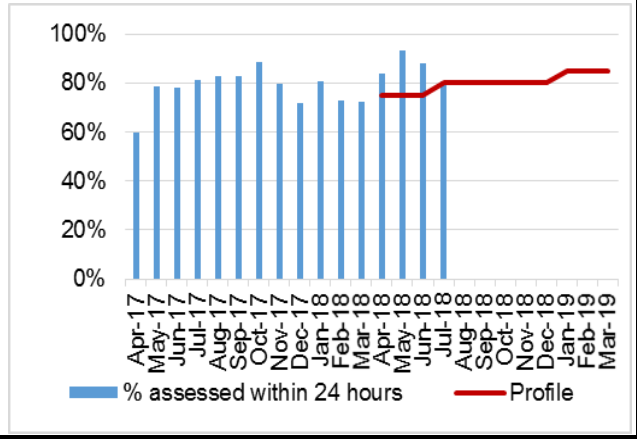
Description	Current Performance	Trend	Actions planned for next period
A&E Attendances The number of attendances at emergency departments in the Health Board	In July 2018, there were at total of 16,534 A&E attendances across the Health Board which is 92 more than July 2017: • Morriston Hospital: 0.6% increase in the number of attendances (7,275 to 7,317) • Singleton Hospital Minor Injury Unit (MIU): 38% reduction in attendances (633 to 393) • Princess of Wales Hospital: 7% increase in attendances (4,852 to 5,204) • Neath Port Talbot Hospital MIU: a 1.7% reduction in attendances (3,682 to 3,620).	**Number of A&E attendances** 	• 111 awareness campaign continues and 111 Directory of ABMU services will be reviewed in Q2. • Public Health and Health Board communications on tips for keeping safe and well in hot weather. • Continued implementation of the sustainability plan for the out of hours service including completing the recruitment of Nurse Clinical Lead for the multidisciplinary non-medical workforce. • GMS Access Action Plan being prepared in response to CHC patient satisfaction Survey. • Roll out of the Common Ailments Service (CAS) to all eligible pharmacies (124/125) by Q2.
Emergency Admissions The number of emergency admissions across the Health Board by site	In July 2018, there were a total of 5,946 emergency admissions across the Health Board which is 72 less than July 2017, but 206 more than June 2018. The reduction masks increases in trauma and regional surgery admissions of 7.6% and 17 % respectively, which can be attributable to the unusually hot weather experienced in July 2018.	**Number of emergency admissions** 	• Testing and further developing ambulatory care and frailty models to support admission avoidance. • Developing a business case for the provision of a surgical assessment unit at the Princess of Wales hospital which demonstrated a positive impact on patient flow and performance when piloted in March and June 2018. • Scoping potential options to increase the number of patients who are discharged home to determine their ongoing care support needs in conjunction with LA and 3rd sector partners. Proposals will be discussed at the unscheduled care board on 21st August.

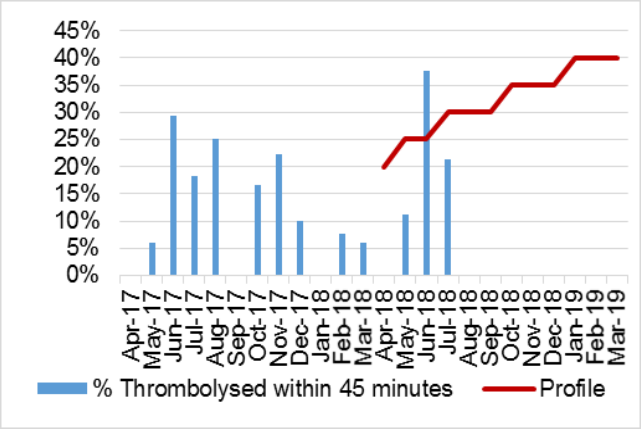
Description	Current Performance	Trend	Actions planned for next period
Medically Fit The number of patients waiting at each site in the Health Board that are deemed discharge/ medically fit	In July 2018, there were on average 254 patients who were deemed medically/ discharge fit but were still occupying a bed in one of the Health Board's Hospitals. This is a 34% increase when compared with July 2017. However it must be noted that data collection has significantly improved recently which could also attribute to the increase in numbers.	**The number of discharge/ medically fit patients by site**  *****_Standardised collection of data from Gorseinon Hospital only commenced in January 2018 and no data available for POWH in February & March 2018._	• Supporting and promoting the national #endpjparalysis campaign between April and August to support earlier and timelier patient discharge, and to raise awareness of the impact of unnecessary or avoidable hospital stays on patient outcomes The evaluation of this approach will be considered by the USC board in September 2018. • Exploring options for models of care to provide more timely discharge and value based care for frail older people. A proposal to enhance discharge to assess capacity is being considered by the USC board in August. • Continue to promote and implement the SAFER flow principles and to develop the safety huddle approach to managing flow with the support of the NHS Wales Delivery Unit.
Elective procedures cancelled due to lack of beds The number of elective procedure cancelled across the hospital where the main cancellation reasons was	In July 2018, the number of elective procedures cancelled due to lack of beds on the day of surgery was 7% less than in July 2017. Across the Health Board 38 procedures were cancelled in July 2018 compared with 41 in July 2017.	**Total number of elective procedures cancelled due to lack of beds** 	• Introduce revised escalation process in Morriston Hospital to reduce ward delays and early release of bed space for admissions. • Continue to develop and implement models of care that mitigate the impact of unscheduled care pressures on elective capacity – such as ambulatory emergency care models and enhanced day of surgery models.

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 July 2018 was in line with the internal profile of 27.	**Number of Mental Health DTOCs** 	• Discussions are taking place with Local Authority partners at all levels to discuss collaborative opportunities to improve the discharge pathway and patient experience, and to consider how this may be supported through the Transformation Funds in 2018/19 or via invest to save proposals.
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board - Non Mental Health (age 75+)	In July 2018, the number of non-mental health and Learning disability delayed transfers of care was 74 which is higher than the internal profile of 38. Swansea Locality usually has the largest proportion of delays but in July NPT had the largest proportion (48%) followed by Swansea with 28% and Bridgend with 25%. The growth in NPT is attributed to an increase in patients waiting LA placement of care or completion of assessment; and patients waiting for CRT input (but there is currently no capacity in the service).	**Number of Non Mental Health DTOCs** 	• Define and maximise opportunities to increase patients who are discharged home to determine their ongoing care support needs. Proposal on discharge to assess to be considered by the USC board in August. • Discussions are taking place with Local Authority partners at all levels to discuss collaborative opportunities to improve the discharge pathway and patient experience, and to consider how this may be supported through the Transformation Funds in 2018/19 or via invest to save proposals. • Continue to promote and implement the SAFER flow principles and to develop the safety huddle approach to managing flow with the support of the NHS Wales Delivery Unit

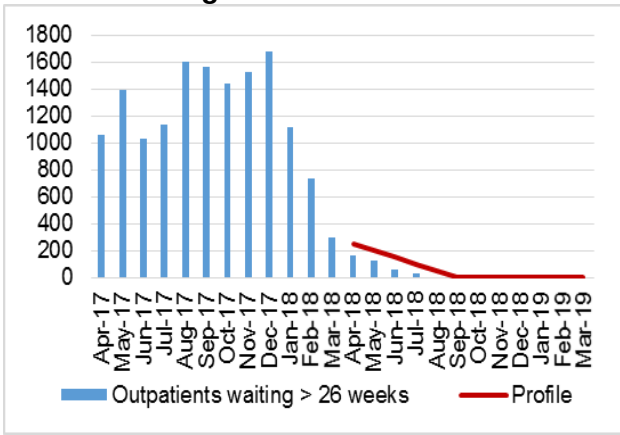
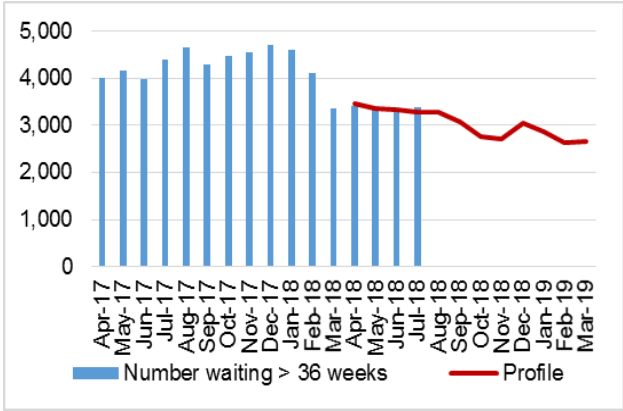
4.2 Acute Stroke Care (WG Measures 63- 66)

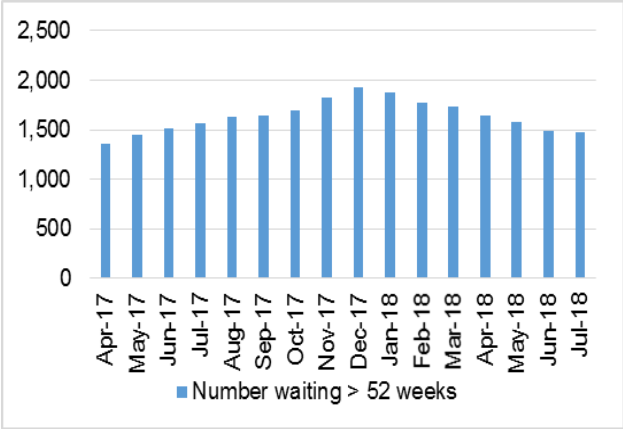
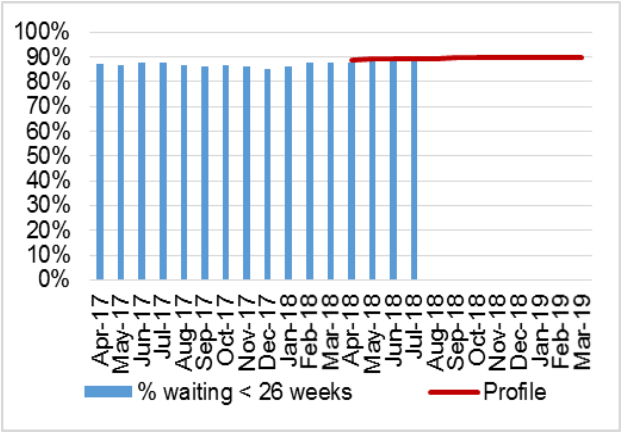
Description	Current Performance	Trend	Actions planned for next period
Stroke Admissions The total number of stroke admissions into the Health Board	In July 2018, there were 72 confirmed stroke admissions across the Health Board; 48 in Morriston and 24 in Princess of Wales. This is 3% less when compared with June 2017 (74 to 72).	**Total number of stroke admissions** 	• Continue to roll out and support the impact of the Directed Enhanced Service for INR and Direct-Acting Oral Anticoagulants (DOAC) service. • Continue to implement suite of improvement actions to support people to live a healthy lifestyle (inc. smoking cessation, weight management). • Evaluate and prepare a report on the success of Stroke Retrieval Pilot undertaken in Morriston during June to identify areas of opportunity and challenge further improvements. • An additional 9 Senior Clinical Fellows have taken up their Morriston appointments in August which will allow an additional middle tier - each night and week-ends.
Stroke 4 hour access target % of patients who have a direct admission to an acute stroke unit within 4 hours	In July 2018 only 27 out of 72 patients had a direct admission to an acute stroke Unit within 4 hours (38%). The four hour target appears to be a challenge across Wales. The latest all-Wales published data is June 2018 which confirms that performance ranged from 34.1% to 62.7%. ABMU achieved 40.0%.	**Percentage of patients admitted to stroke unit within 4 hours** 	• Monitor Morriston medical On-Call rota with the additional senior Medical staff to support greater cover into wards and medical cover to support A&E. • Continue with the additional training to improve swallow screening compliance within the Emergency department staff. • POWH – will build on two recent workshops to develop 5 key Task and Finish groups to focus on improving stroke performance. • An SpR is anticipated to be appointed for August in POW for the first time in over a year. • Consultant Job Plans have been agreed to ensure sufficient ward cover.

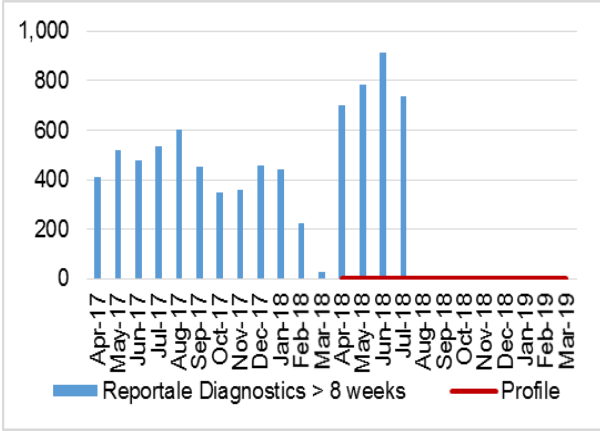
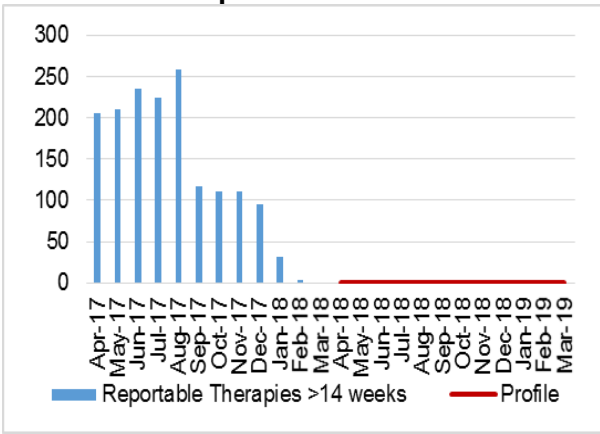
Description	Current Performance	Trend	Actions planned for next period
Stroke CT scan Percentage of patients who receive a CT scan within 1 hour	In July 2018, ABMU achieved 40% which was is below the internal profile of 45%.	**Percentage of patients receiving CT scan within 1 hour** 	• Await the decision of the IBG re the development of an Early Supportive Discharge service at Morriston / Singleton hospitals. • Final DU report for POW has been received – Unit now planning and implementing recommendations. • Continue to roll out amended Stroke documentation in POW. • The stroke team at POW working closely with the patient flow team, particularly the newly appointed Clinical Site Managers to ensure a focus on stroke flow and a prioritisation for creating assessment capacity. • At Singleton the team will examine all processes including senior review / early discharge / effective Board rounds on ward 7. • Singleton will also review their Rehabilitation pathway / hand over assessments and criteria between Ward F and ward 7.
Stroke assessment within 24 hours Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	In July 2018, ABMU achieved 81% which was above the internal profile of 80%.	**Percentage of patients assessed by stroke consultant within 24 hours** 	

Description	Current Performance	Trend	Actions planned for next period
Thrombolysed Patients with Door-to-Needle <= 45 mins	In July 2018, 100% of eligible patients were thrombolysed but only 3 of the 14 patients were thrombolysed within the 45 minutes (door to needle) standard.	**Thrombolysed patients within 45 minutes** 	• As above

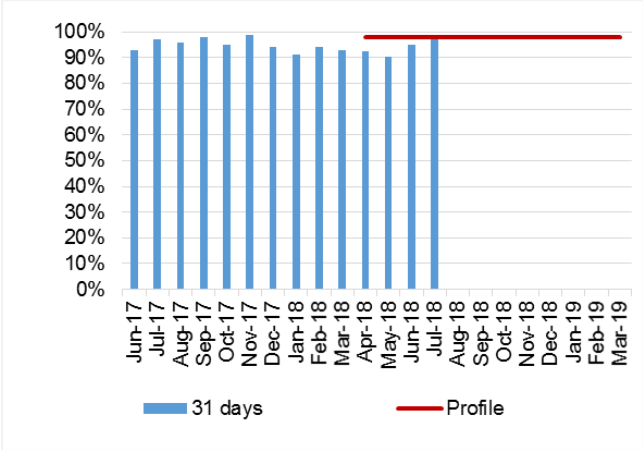
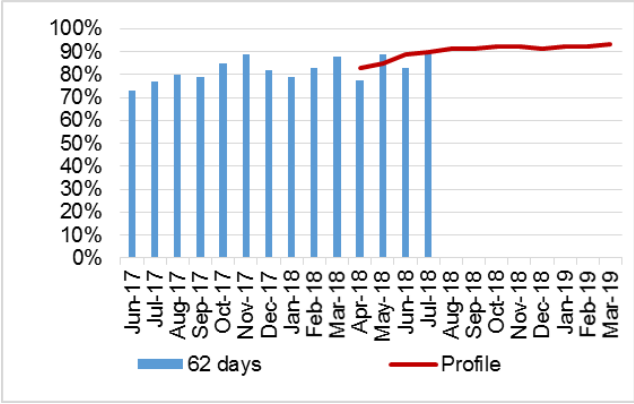
4.3 Planned Care (WG Measures 58- 61)

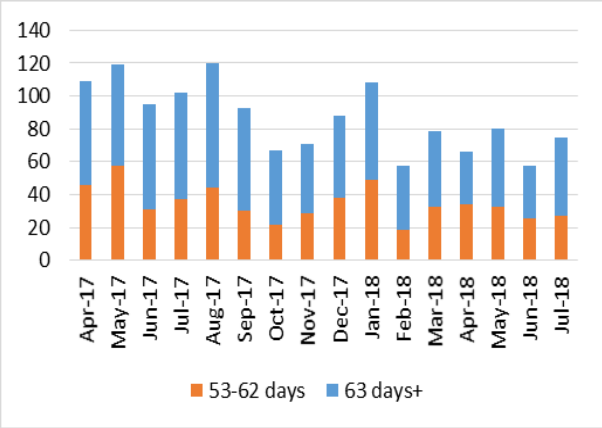
Description	Current Performance	Trend	Actions planned for next period
Outpatient waiting times The number of patients waiting more than 26 weeks for an outpatient appointment (stage 1)	The number of patients waiting over 26 weeks for a first outpatient appointment continues to reduce in line with the internal trajectory. In July 2018 there were 30 patients waiting over 26 weeks. Gynaecology had 12 breaches, followed by OMFS with 8 and Cardiology with 6. The remaining 4 breaches were in Ophthalmology (3) and Spinal (1).	**Number of stage 1 over 26 weeks** 	• Core capacity being maximised and additional clinics being secured. Ophthalmology and Paediatrics will recover their position to Nil in July. • Ongoing sickness absence in Gynaecology at Princess of Wales affecting 50% of the clinical team. Locum appointed, commencing in August. • Risk in Cardiology due to consultant unavailability to undertake additional clinics through the summer months.
Total waiting times The number of patients waiting more than 36 weeks for treatment	The number of patients waiting longer than 36 weeks from referral to treatment continues to be a challenge. In July 2018 there were 1,005 less patients waiting over 36 weeks compared with July 2017. 97% of patients are waiting in the treatment stage of the pathway and Orthopaedics accounts for 67% of the breaches, followed by General Surgery with 17%.	**Number of patients waiting longer than 36 weeks** 	• Increasing Orthopaedic outsourcing in Quarter 2 for the West in addition to exploring the transfer of simpler hand surgery procedures to outpatient treatment facilities. • Upscale recruitment of Spinal consultant workforce through appointment of two locums. • Decision around the feasibility of utilising staffed mobile theatre units to be concluded by the middle of August. • Progress actions in Gynaecology at Singleton around pooling of lists, focussed attention to Treat in Turn and booking and backfilling through Quarter Two.

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. The position has improved by 94 patients in July 2018 and is 253 ahead of the March 2018 position.	**Number of patients waiting longer than 52 weeks** 	• The actions relating to > 52 week patients are the same as 36 week patients. • Targeted treat in turn and clinical discussions to prioritise longest waiting patients. • Units challenged to produce sustainable step change plans to maintain continual improvement and compress the tail end of the longest waiting patients.
Total waiting times Percentage of patients waiting less than 26 weeks from referral to treatment	Throughout 2017/18 the overall percentage of patients waiting less than 26 weeks from referral to treatment has been consistently around 86%. So far in 2018/19 the percentage continues to improve with June 2018 reaching 89.3% which is the highest percentage since November 2013.	**Percentage of patient waiting less than 26 weeks** 	• Plans as outlined in previous tables.

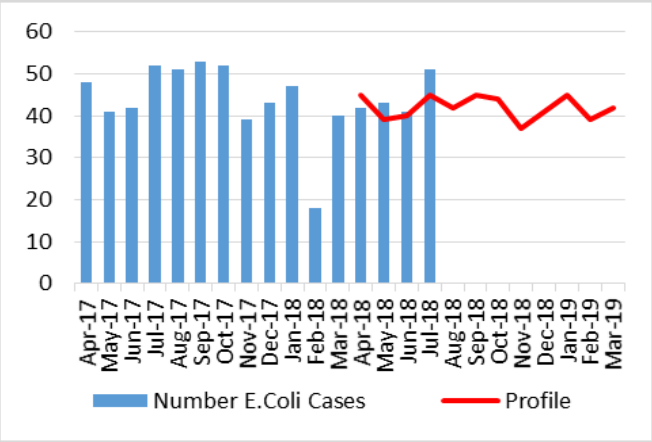
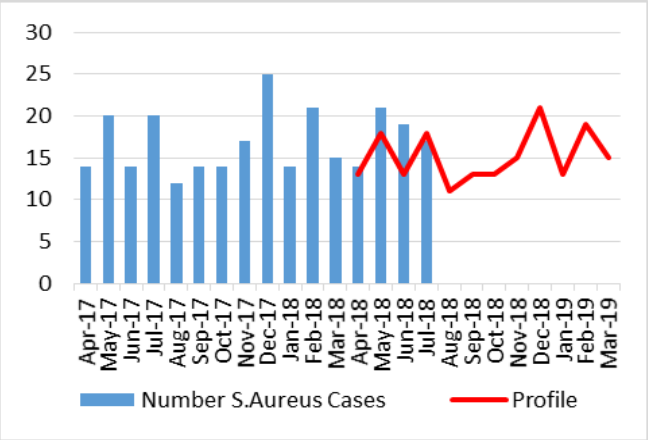
Description	Current Performance	Trend	Actions planned for next period
Diagnostics waiting times The number of patients waiting more than 8 weeks for specified diagnostics	In June 2018, there were 740 patients waiting over 8 weeks for specified diagnostics. However, the significant increase in breaches is due to the introduction of new Cardiac diagnostic tests in April 2018. The main elements of the 740 breaches are split as follows: • Cystoscopy= 1 • Non Obstetric Ultrasound= 89 • Cardiac Tests= 650	**Number of patients waiting longer than 8 weeks for diagnostics** 	• Sustain Nil position for Endoscopy by maximising backfill and utilising the capacity of the insourcing company. • Outsourcing of Cystoscopy cases agreed to sustain Nil position in Q2. • Progress recruitment of two band 7 sonographers. • Appoint two locum vascular lab technicians to sustain Nil position in Q2. • Develop joint improvement plans for Health Board wide solutions for the new suite of reportable cardiology diagnostic tests, including scoping of mobile MRI unit.
Therapy waiting times The number of patients waiting more than 14 weeks for specified therapies	There has been significant improvement in Therapy waiting times over the last 12 months and there were no patients waiting over 14 weeks in April 2018. The July 2018 position shows a Nil position for Therapies waiting over 14 weeks.	**Number of patients waiting longer than 14 weeks for therapies** 	• Continuation of current plans to manage patients into early appointments to provide headroom for re-booking any late cancellations.

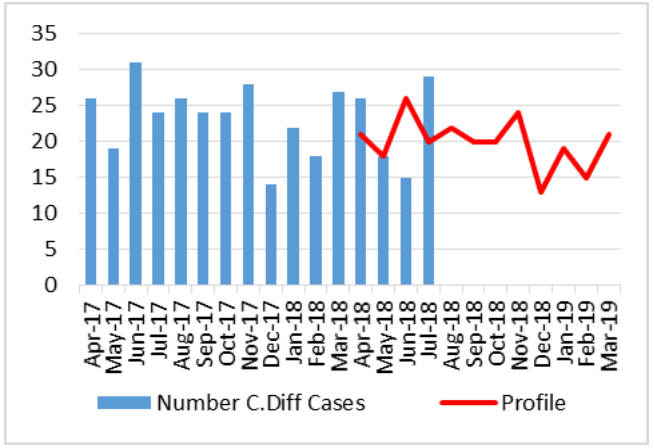
4.4 Cancer (WG Measures 71 and 72)

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	July 2018 figures will be finalised on 31st August. Draft figures indicate achievement of 99% for the percentage of patients' starting treatment within 31 days. At the time of writing this report there was 1 breach across the Health Board in June 2018: • Urological: 1	**Percentage of NUSC patients starting treatment within 31 days of diagnosis** 	• Additional consultant surgeons for Gynae-oncology to be progressed. • The Macmillan Quality Improvement Manager vacancy has been appointed to and due to commence in post 3rd September 2018. 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	July 2018 figures will be finalised on 31st August. Draft figures indicate achievement of 91% for the percentage of patients starting treatment within 62 days. At the time of writing this report there were 12 breaches in total across the Health Board: • Breast: 1 • Gynaecological: 3 • Haematological: 1 • Lower Gastrointestinal: 2 • Skin: 1 • Upper Gastrointestinal: 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 and Cancer Clinical Lead continue. • Additional Waiting List Initiatives (WLI's) being held when feasible over the Summer • Lower GI capacity and demand modelling for OPA/Straight to test pathways is progressing • Urology capacity and demand modelling for straight to test • Endoscopy capacity and demand modelling is underway, a prototype has been developed and awaiting Informatics to include as live data within the dashboard.

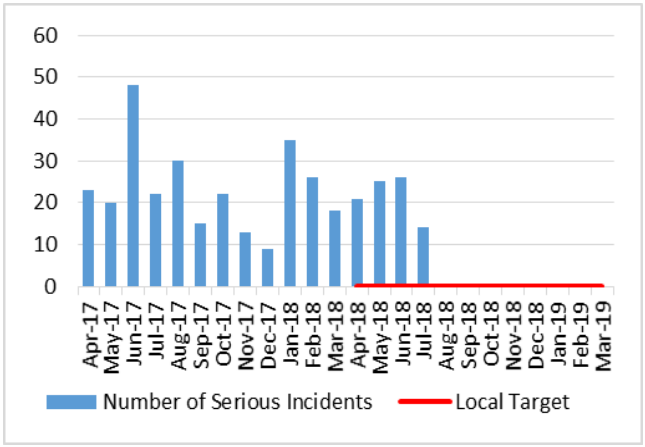
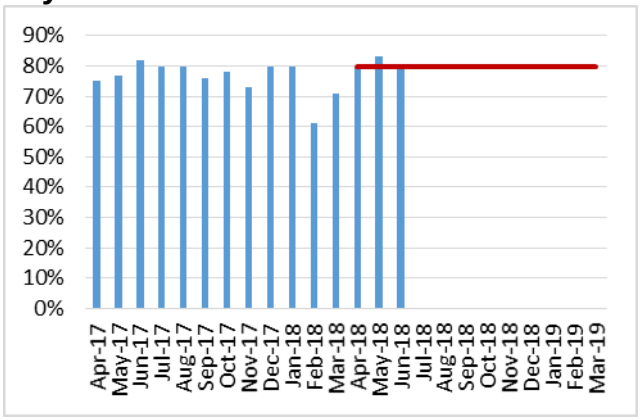
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>USC backlog
The number of patients with an active wait status of more than 53 days</td>
<td>End of July 2018 backlog by tumour site:
<table>
<tr><th>Tumour Site</th><th>53 - 62 days</th><th>63 ></th></tr>
<tr><td>Breast</td><td>4</td><td>4</td></tr>
<tr><td>Gynaecological</td><td>7</td><td>5</td></tr>
<tr><td>Haematological</td><td>0</td><td>3</td></tr>
<tr><td>Head and Neck</td><td>2</td><td>0</td></tr>
<tr><td>Lower GI</td><td>3</td><td>1</td></tr>
<tr><td>Lung</td><td>0</td><td>2</td></tr>
<tr><td>Other</td><td>0</td><td>3</td></tr>
<tr><td>Skin</td><td>1</td><td>1</td></tr>
<tr><td>Upper GI</td><td>3</td><td>3</td></tr>
<tr><td>Urological</td><td>7</td><td>26</td></tr>
<tr><td>Grand Total</td><td>27</td><td>48</td></tr>
</table>
</td>
<td>Number of patients with a wait status of more than 53 days
 
</td>
<td>In addition to the actions described above.
• Meetings held with Delivery Units at the end of June 2018 to review tracking/management arrangements. Recommendations to improve processes for tracking have been made and shared with COO in July. Meeting scheduled for early September to progress this.
• Tracking vacancies in areas, adverts and appointments are being progressed. New Gynaecology tracker for Swansea in post since end of July and undergoing training.</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 July 2018 the percentage of patients seen within 14 days to first appointment/assessment ranged between 32% and 43%.</td>
<td>The number of patients waiting for a first outpatient appointment (by total days waiting)- End of July 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>5</td><td>8</td><td>102</td><td>105</td><td>220</td></tr>
<tr><td>Gynaecological</td><td>3</td><td>45</td><td>5</td><td>3</td><td>56</td></tr>
<tr><td>Head and Neck</td><td>18</td><td>13</td><td>0</td><td>0</td><td>31</td></tr>
<tr><td>Lower GI</td><td>14</td><td>25</td><td>0</td><td>0</td><td>39</td></tr>
<tr><td>Lung</td><td>1</td><td>2</td><td>0</td><td>1</td><td>4</td></tr>
<tr><td>Other</td><td>22</td><td>48</td><td>12</td><td>4</td><td>86</td></tr>
<tr><td>Skin</td><td>25</td><td>102</td><td>6</td><td>2</td><td>135</td></tr>
<tr><td>Urological</td><td>4</td><td>19</td><td>3</td><td>1</td><td>27</td></tr>
<tr><td>Total</td><td>92</td><td>262</td><td>128</td><td>116</td><td>598</td></tr>
</table>
</td>
<td>Cancer Improvement Team undertaking Demand & Capacity for USC first outpatient waits.
Live data in place for:
• Breast
• Gynaecology (PMB)
• Urology
• LGI (Surgery)
• Gastroenterology
Under development:
• Radiotherapy
• Chemotherapy
• Endoscopy
• Gynae-oncology
To be developed:
• Urology straight to test
• Gynae-oncology surgery</td>
</tr>
</table>

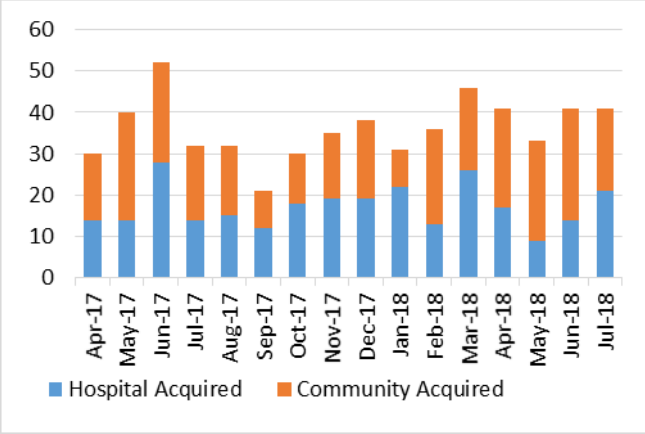
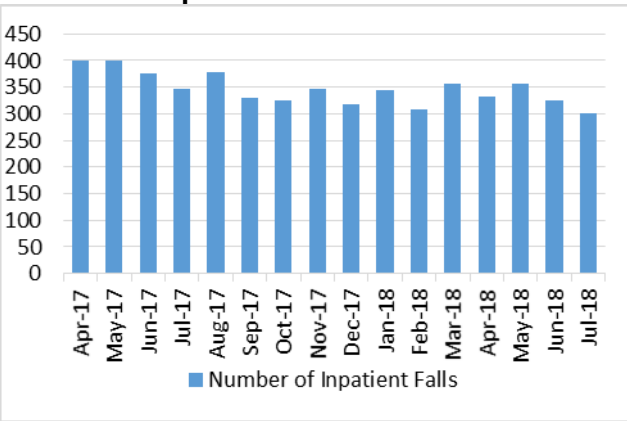
4.5 Healthcare Acquired Infections (WG Measures 18-20)

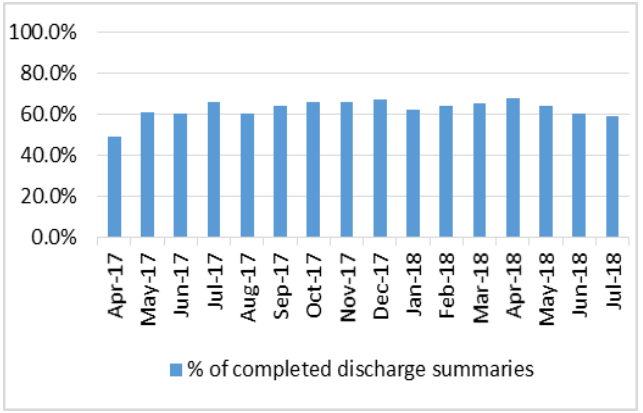
Description	Current Performance	Trend	Actions planned for next period
E.coli bacteraemia- Number of laboratory confirmed E.coli bacteraemias cases	In July 2018, there was a total of 51 cases of *E. coli* bacteraemia; 6 more than the internal profile. 31 cases were community acquired infections; 20 cases were hospital acquired infections (MH DU- 7; SH DU- 7; NPTH DU- 4; POWH DU- 2). *High bed occupancy is a risk to achieving infection reduction.*	**Number of *healthcare acquired E.coli* bacteraemias cases** 	• Quarter 2 programmes: reducing peripheral cannulae & urinary catheters; daily review within Board Rounds; use of catheter labels. Extend these to NPTH and POWH. • Ward-based training on the prevention of Urinary Infections – to be cascaded to staff. Targeted approach for care homes in Quarter 2. • Delivery Units to improve numbers of clinical staff who have been Aseptic Non Touch Technique (ANTT) competency assessed by March 2019, with quarterly incremental increases.
S.aureus bacteraemias- Number of laboratory confirmed S.aureus bacteraemias (MRSA & MSSA) cases	In July 2018, there were 17 cases of *Staph. aureus* bacteraemia; 1 case less than the internal profile. 9 cases were community acquired infections; 8 cases were hospital acquired infections (MH DU – 3; POWH DU – 3; SH DU- 2). *High bed occupancy is a risk to achieving infection reduction.*	***Number of healthcare acquired S.aureus* bacteraemias cases** 	• Quarter 2 programmes as above, blood culture collection protocol published on COIN. Extend QI programmes to NPTH and POWH. • Focus on MRSA bacteraemia. Ward-based training on new MRSA decolonisation to be completed; new decolonisation to be introduced in August 2018 to improve compliance with treatment.

Description	Current Performance	Trend	Actions planned for next period
C.*difficile*- Number of laboratory confirmed C.difficile cases	In July 2018, there were 29 cases of Clostridium difficile infection; 9 more than the internal profile. 5 cases were community acquired infections; 24 cases were hospital acquired (MH DU –16; SH DU- 5, POWH DU- 2; PCCS- 1). *High bed occupancy is a risk to achieving infection reduction.* *ABMU continues to be the only Health Board in Wales not to use HPV or UV-C decontamination process; not utilising these technologies is a risk to achieving infection reduction.*	***Number of healthcare acquired C.difficile* cases** 	• Continue restricted Antimicrobial policy. • Appointment of Quality Improvement Clinical Leads in each Delivery Unit, with dedicated sessions and clear objectives – slippage in DU timescales. • Delivery Units to ensure all single and multi-bedded source rooms are reactively emptied and deep cleaned/decontaminated and develop a proactive programme for Quarter 2. • Report has been received from the HSE relating to the use of UVC in the Health Board; if UVC is to be re-introduced, the HB must ensure adequate training and safe systems of work. Agree a Health Board wide strategy on in-house HPV and UV-C use, or tender for external contract in Quarter 2.

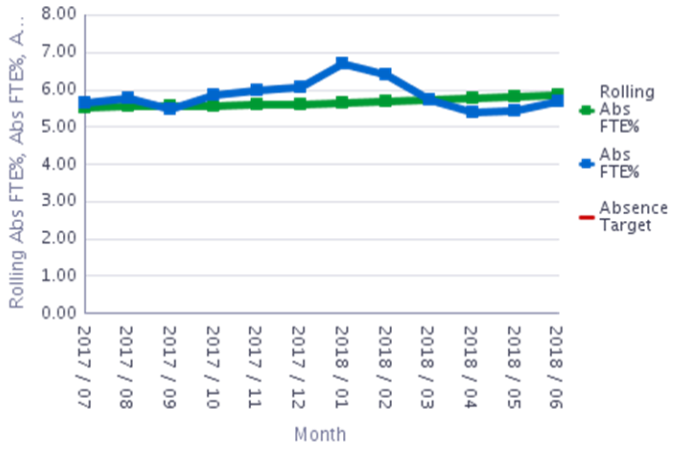
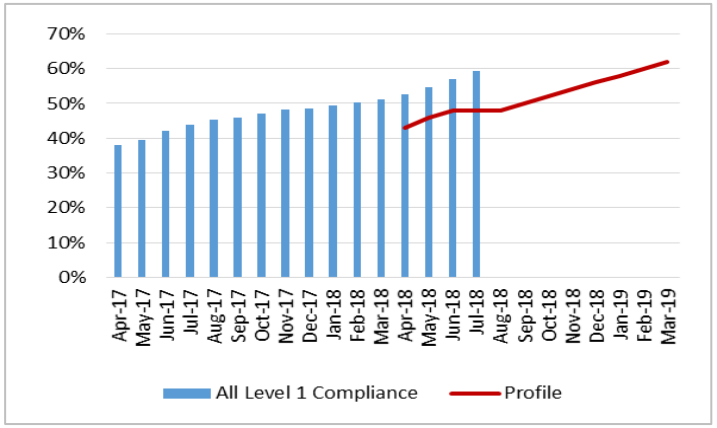
4.6 Quality & Safety Measures (Local and WG measures 24 and 46)

Description	Current Performance	Trend	Actions planned for next period
Number of Serious Incidents- Number of new Serious Incidents reported to Welsh Government	• The Health Board reported 14 Serious Incidents for the month of July 2018 to Welsh Government. • Last Never Event reported was on 21st March 2018. • In July 2018, the performance against the 81% target of submitting closure forms within 60 working days was 85%.	**Number of Serious Incidents** 	• Continue to trial the new reflective methodology approach to review serious incidents managed by the Serious Incidents (SI) Team. • Presentations promoting the approach are being undertaken across the Health Board to help promote an organisational learning culture. • The Welsh Risk Pool have suggested that the Pressure Ulcer Improvement methodology be applied to the Falls Improvement work and will coincide with the upcoming relaunch of the Health Board's Fall Prevention and Management Policy.
30 day response rate for concerns- The percentage of concerns that have received a final reply or an interim reply up to and including 30 working days from the date the concern was first received by the organisation	• The overall Health Board response rate for responding to concerns within 30 working days was 80% in June 2018 against the Welsh Government target of 75% and Health Board target of 80%.	**Response rate for concerns within 30 days** 	• Performance is discussed at all Unit performance meetings. For the first 3 months of this financial year the Health Board has achieved an 80% in responses for the 30 day target. • A Task and Finish group has been established following the PALS workshop in June to review the work of these teams. • Monitoring of the 30 day complaint responses to ensure compliant with Putting Things right Regulations and the contents of the response is valued based is undertaken on a monthly audit basis , at a Concerns and Assurance meeting with the Units.

Description	Current Performance	Trend	Actions planned for next period
Number of pressure ulcers The number of grade 3, 4 suspected deep tissue injury and unstageable pressure ulcers	• The number of Grade 3+ pressure ulcers remained steady between June 2018 and July 2018 however the split between hospital and community acquired pressure ulcers notably changed. The in-patient figures deteriorated from 14 in June 2018 to 21 in July 2018, whereas the number of community cases improved from 27 to 20.	**Total number of hospital and community acquired Pressure Ulcers (PU)** 	• Independent review of deep PU's for 2017-18 was presented at PUPSG meeting in June. The review identified 23.2% cases as avoidable and 65.5% as unavoidable. • The review offers strong assurance that the causal factor map is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The causal factor analysis also provides insight for individual SDU's to focus on location specific work. • Work streams will be tracked in the Strategic Quality Improvement Plan & capture quality measures which are indicators of performance.
Inpatient Falls The total number of inpatient falls	• The number of Falls reported via Datix web reduced from 346 in July 2017 to 300 in July 2018. • The Health Board has agreed a targeted action to reduce falls causing harm by 10%. • The number of falls within the Health Board decreased between April 2017 and March 2018 with the number of falls causing harm decreasing by 16%	**Number of inpatient falls** 	• Health Board's Falls Policy was ratified by HB Q&S committee in August 2018. • Training needs analysis ongoing and will form part of the implementation plan of the new policy. • HB falls group have cascaded PowerPoint educational training presentation to all delivery units • A further review of equipment is ongoing; an update will be provided to the HB falls group in September

Description	Current Performance	Trend	Actions planned for next period
Discharge Summaries The percentage of discharge summaries approved and sent to patients' doctor following discharge	• In July 2018 the percentage of electronic discharge summaries signed and sent via eToC was 59% which is 7% lower when compared with July 2017. • Performance varies between Service Delivery Units (range 53% to 77% in July 2018) and between clinical teams within the Units	**% discharge summaries approved and sent** 	• Performance and improvement actions will continue to be monitored via the Discharge Information Improvement Group (DIIG) • Now that overall signed and sent performance has improved, the focus will be on improving the timeliness of discharge information i.e.SDUs' performance in providing discharge information to GPs <24hrs and <5days after discharge. • UMDs' plans for addressing variation between teams and improving overall SDU performance will be discussed and agreed at the next quarterly DIIG meeting. • The Health Board will be piloting Medicines Transcribing and e-Discharge (MTeD) from August – October 2018

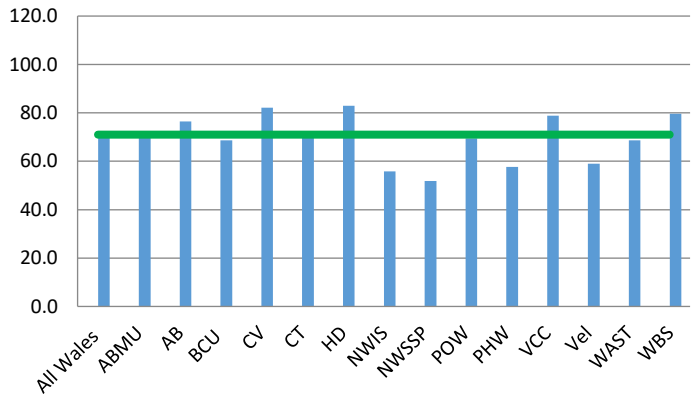
4.7 Workforce Measures (Revised Workforce Measures)

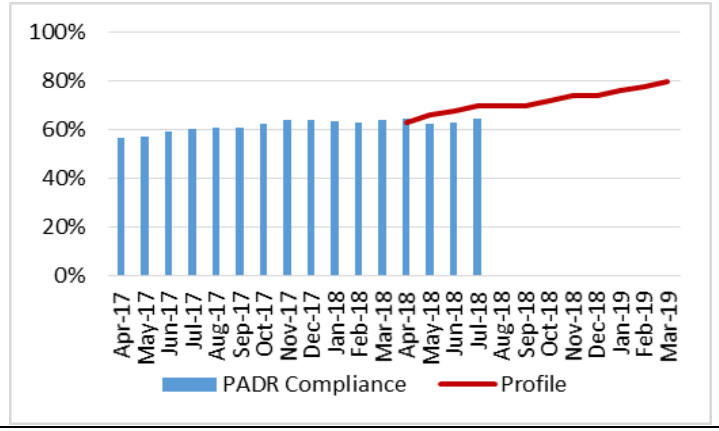
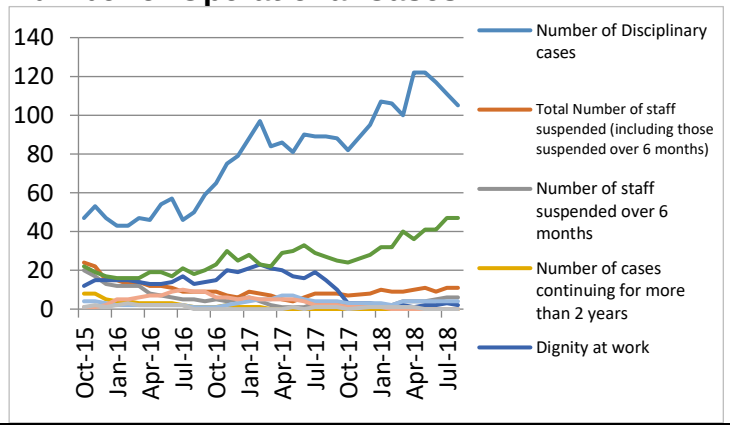
Description	Current Performance	Trend	Actions planned for next period
Staff sickness rates- *Percentage of sickness absence rate of staff*	• The 12 month rolling performance to the end of June 2018 is 5.84% (up 0.05% on May 2018). Our in month performance in June 18 was 5.68%, a reduction of 0.24% on the previous month.	**% of full time equivalent (FTE) days lost to sickness absence (12 month rolling)** 	• Improve access to staff health and wellbeing services in a timely manner • Enable managers to recognise and support staff with common manageable health problems in the workplace • Standardising long term sickness review process in Delivery Units with focus on progressing decision making, return to work and data collection. • Development of LTS pathways to help guide managers in managing common absence conditions. • Best practise case study being conducted in three areas of good sickness performance.
Mandatory & Statutory Training- *Percentage compliance for all completed Level 1 competencies within the Core Skills and Training Framework by organisation*	• Compliance against 10 core competencies policies 59.5% in July 2018. This is an improvement from 38% in April 2017.	**% of compliance with Core Skills and Training Framework** 	• Highlighted as a risk around resourcing in the paper prepared for Audit Committee. • Reformatting of Mandatory and Statutory Training guides to fit ABMU • Investigation into Inter Authority Transfer Process and Direct Hire Process around transfer of compliance in Mandatory and Statutory Training data. • Resource bid for investment into ESR/ Mandatory Training.

Description	Current Performance	Trend	Actions planned for next period
Vacancies *Medical and Nursing and Midwifery*	• Vacancies recorded as budgeted post not filled.		• Joint CT / ABMU recruitment protocol to begin to address boundary change issues is in draft and will be implemented through the period up to transfer.

Grade - Medical & Dental	Budget WTE	WTE	(Under) / Over Establishment
Total	**1538.61**	**1131.49**	**-407.12**
21000-Consultant (M&D)	615.99	540.53	-75.46
21100-Locum Consultant (M&D)	25.66	31.86	6.20
22110-Associate Specialist (M&D)	68.09	57.28	-10.82
22200-Locum Associate Specialist (M&D)	0.00	0.45	0.45
22250-Specialist Dental Officer	3.60	3.40	-0.20
22260-Senior Dental Officer	1.80	1.20	-0.60
22270-Dental Officer	10.22	6.63	-3.59
22310-Speciality Doctor (M&D)	104.64	78.75	-25.89
22320-Locum Speciality Doctor (M&D)	2.10	1.10	-1.00
23100-Specialty Registrar (M&D)	530.98	253.37	-277.61
23120-Locum Specialty Registrar (M&D)	0.50	13.60	13.10
23200-Specialist Registrar (M&D)	6.78	0.00	-6.78
23300-Locum Specialist Registrar (M&D)	1.20	2.00	0.80
24100-F2 foundation year 2 (M&D)	65.65	16.99	-48.66
24400-F1 foundation year 1 (M&D)	83.00	104.53	21.53
24900-Dental Trainees in Hosp Post	1.64	3.00	1.36
25000-Clinical Assistant (M&D)	1.37	0.91	-0.46
25100-Senior Lecturer (M&D)	2.90	1.00	-1.90
25300-G.P.Sessions / Staff Fund	12.49	14.90	2.41

Grade - Nursing & Midwifery	Budget WTE	WTE	(Under) / Over Establishment
Total	**4867.97**	**4430.55**	**-437.42**
2A182-Nurse Consultant Band 8B	4.00	2.69	-1.31
2A281-Nurse Manager Band 8A	76.30	80.20	3.90
2A282-Nurse Manager Band 8B	20.80	24.78	3.98
2A283-Nurse Manager Band 8C	12.00	15.00	3.00
2A284-Nurse Manager Band 8D	9.00	6.00	-3.00
2A451-Registered Nurse Band 5	2679.14	2307.71	-371.43
2A461-Registered Nurse Band 6	1233.34	1213.35	-19.99
2A471-Registered Nurse Band 7	778.49	726.71	-51.78
2A481-Registered Nurse Band 8A	50.90	50.10	-0.80
2A482-Registered Nurse Band 8B	4.00	4.00	0.00

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>Recruitment
Metrics provided by NWSSP. ABMU comparison with All wales benchmarking</td>
<td>• ABMU overall performance is at the target level for NHS Wales and has been for over 6 months.
• Of the key ABMU measures where we are not yet at target - time to complete sifting has steadily improved towards the three day target.</td>
<td>Vacancy Requested to Unconditional Offer June 2018
(working days: including outliers) T18
 
</td>
<td>• Outlier data is passed to Delivery Units for review.
• If Outliers (activity well outside the normal expected timescale) are excluded ABMU is well under the 71 day target. Action to sanitise the data will improve accuracy of the reports.</td>
</tr>
<tr>
<td>Turnover
% turnover by occupational group</td>
<td>• Overall Turnover has reduced over the last 5 months and is now below 8%.
• There has been a steady reduction (-1.38%) in Nursing turnover since April 2018.</td>
<td>
<table>
<tr><th>Staff Group</th><th>FTE</th><th>Headcount</th><th>Change</th></tr>
<tr><td>Add Prof Scientific and Technic</td><td>8.80%</td><td>9.05%</td><td>↓</td></tr>
<tr><td>Additional Clinical Services</td><td>7.75%</td><td>8.12%</td><td>↓</td></tr>
<tr><td>Administrative and Clerical</td><td>7.57%</td><td>7.79%</td><td>↓</td></tr>
<tr><td>Allied Health Professionals</td><td>9.26%</td><td>9.64%</td><td>↑</td></tr>
<tr><td>Estates and Ancillary</td><td>5.79%</td><td>5.90%</td><td>↑</td></tr>
<tr><td>Healthcare Scientists</td><td>3.95%</td><td>4.25%</td><td>↑</td></tr>
<tr><td>Medical and Dental</td><td>9.93%</td><td>10.43%</td><td>↑</td></tr>
<tr><td>Nursing and Midwifery Registered</td><td>8.30%</td><td>8.63%</td><td>↓</td></tr>
</table>
<table>
<tr><th>Overall Rate</th><th>FTE</th><th>Headcount</th><th></th></tr>
<tr><td>Overall Rate</td><td>7.86%</td><td>8.14%</td><td>↓</td></tr>
</table>
</td>
<td>• Roll out of exit interviews across the Health Board follow the pilot in Nursing.</td>
</tr>
</table>

Description	Current Performance	Trend	Actions planned for next period
PADR *% staff who have a current PADR review recorded*	• The percentage of staff who have had a Personal Appraisal and Development Review (PADR) in the last 12 months was 65% in July 2018: • Non-medical staff- 62.25% • Medical staff= 90.80%	**% of staff who have had a PADR in previous 12 months** 	• 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. • Heightened scrutiny process for Delivery Units.
Operational Casework *Number of current operational cases by category.*	• Some reduction in live cases over the last two months but volume of activity is still significantly increased on averages pre Mid 2016.	**Number of Operational Cases** 	• IGB have approved purchase of case management software which will aid improved reporting and recording of activity, currently resolving procurement pathway. • Case to be submitted to IGB for Investigating officer team - dedicated resource will deal with cases quicker reducing the number of live cases and improve quality of reports. This will address HiW recommendations regarding management of cases.

5. Key performance measures by Delivery Unit

5.1 Morriston Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	63.5%	67.1%	70.0%	70.3%								
		Profile	*71%*	*76%*	*76%*	*83%*	*81%*	*81%*	*85%*	*87%*	*87%*	*86%*	*86%*	*86%*
	12 hour A&E waits	Actual	574	468	333	447								
		Profile	*259*	*124*	*125*	*148*	*168*	*101*	*162*	*206*	*239*	*198*	*143*	*135*
	1 hour ambulance handover	Actual	380	291	245	348								
		Profile	*210*	*79*	*120*	*107*	*171*	*72*	*137*	*177*	*239*	*194*	*139*	*104*
Stroke	Direct admission within 4 hours	Actual	33.9%	33.3%	43.8%	39.6%								
		Profile	*45.0%*	*45.0%*	*45.0%*	*50.0%*	*50.0%*	*50.0%*	*50.0%*	*50.0%*	*50.0%*	*65.0%*	*65.0%*	*65.0%*
	CT scan within 1 hour	Actual	32.3%	44.8%	38.8%	41.7%								
		Profile	*40.0%*	*40.0%*	*40.0%*	*45.0%*	*45.0%*	*45.0%*	*45.0%*	*45.0%*	*45.0%*	*50.0%*	*50.0%*	*50.0%*
	Assessed by Stroke Specialist within 24 hours	Actual	91.9%	100.0%	98.0%	85.4%								
		Profile	*75.0%*	*75.0%*	*75.0%*	*80.0%*	*80.0%*	*80.0%*	*80.0%*	*80.0%*	*80.0%*	*85.0%*	*85.0%*	*85.0%*
	Thrombolysis door to needle within 45 minutes	Actual	0.0%	0.0%	20.0%	27.3%								
		Profile	*20.0%*	*25.0%*	*25.0%*	*30.0%*	*30.0%*	*30.0%*	*35.0%*	*35.0%*	*35.0%*	*40.0%*	*40.0%*	*40.0%*
Planned care	Outpatients waiting more than 26 weeks	Actual	128	101	37	15								
		Profile	*249*	*200*	*150*	*100*	*50*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	2,379	2,309	2,250	2,285								
		Profile	*2,374*	*2,183*	*2,251*	*2,253*	*2,153*	*1,997*	*1,784*	*1,809*	*1,992*	*1,898*	*1,777*	*1,901*
	Diagnostic waits over 8 weeks	Actual	623	655	638	602								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	89%	91%	93%	100%								
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	75%	82%	76%	88%								
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	10	6	6	16								
		Profile	*9*	*5*	*9*	*7*	*7*	*7*	*8*	*9*	*4*	*5*	*4*	*7*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	3	5	5	3								
		Profile	*4*	*5*	*3*	*5*	*4*	*3*	*3*	*2*	*6*	*5*	*5*	*6*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	2	3	4	7								
		Profile	*8*	*3*	*6*	*4*	*6*	*4*	*4*	*6*	*7*	*10*	*4*	*5*
Quality & Safety Measures	Discharge Summaries	Actual	63%	58%	59%	53%								
		Profile	*69%*	*72%*	*75%*	*77%*	*80%*	*83%*	*86%*	*89%*	*92%*	*94%*	*97%*	*100%*
	Concerns responded to within 30 days	Actual	93%	83%	90%									
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate	Actual	5.94%	5.94%	5.97%									
		Profile	*5.87%*	*5.79%*	*5.71%*	*5.63%*	*5.55%*	*5.48%*	*5.40%*	*5.32%*	*5.24%*	*5.16%*	*5.08%*	*5.00%*
	Personal Appraisal Development Review	Actual	62%	59%	60%	62%								
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	50%	52%	55%	57%								
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*
	Vacancies- Doctors	Actual	12.85	16.39	15.88	19.38								
	Vacancies- Other Medical Staff	Actual	77.75	70.06	71.53	154.01								
	Vacancies- Nursing	Actual	103.49	128.75	143.00	143.95								
	Vacancies- A&C	Actual	18.20	23.84	26.37	25.99								
	Vacancies- Other	Actual	-20.85	-15.63	-8.47	-7.05								

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

5.1 Morriston Delivery Unit- Overview

Successes	Priorities
• RTT - Reporting the Best Stage 1 position for patients waiting in excess of 26 weeks for first outpatient appointment since March 2017 • Theatres to be considered for service improvement award next year for the development of PU scrutiny documentation. • Reconciliation of medical agency cap spreadsheet and feedback to Service Groups • Recruitment of 3 Physician Associate Internships • ED - New pathways implemented to support GP expected patients no longer attending the ED from July 9th 2018 • ED - Well supported junior doctors with consultant leadership on the clinical floor until 11pm daily. • 100% of eligible patient's thrombolysed for Stroke. • Positive response to 'master class' training event held on the 3rd July. • Good compliance with revised restrictive antimicrobial policy • Chairman's Awards.	• RTT - Agreement and delivery of the draft TAVI action plan • Reduce numbers of patients who are medically fit for discharge from Morriston Hospital • Reduce average length of stay for surgical patients. • Theatres - Detailed workforce plan completed reviewing banding and proportion of part time staff and banding • Workforce – Reduce sickness & improve PDR compliance • ED - Build on delivery of high quality care already provided with timely assessment and decision making. • ED - DU Stay huddles project and risk based assessments training underway. • Reducing unnecessary delays to improve the patient experience with Stroke patients. • Review and resolve the 47 incidents which occurred in 2016 at Morriston. • RTT – Progressing the staffed mobile theatre unit for arthroplasty surgery. • Healthcare acquired c. difficile infection reduction – environmental standards, nurse staffing levels & cleanliness
Opportunities	**Risks & Threats**
• RTT - Improving the treatment in turn rates for OMFS and Plastic Surgery • Theatres - Consolidation of pre assessment services in MDU releasing additional capacity in SDU and increasing cohort activity • Staff engagement open day planned for October 2018 • Role redesign review of all vacancies at the weekly workforce panel • Band 5 Paediatrics nurse recruitment underway • Review of Quality & Safety resource to support data quality issues within Datix. • Closer working with site management to help facilitate the smooth flow of patients between A & E and the ASU • Maximise income opportunities for tariff specialties as part of Financial Recovery Plan (B & P, Pancreatic, Bariatric and Cardiac Services) • Dialogue with Hywel Dda and Cardiff regarding specialist services (Cardiac, Spinal and OG Cancer).	• RTT - Theatre staffing/Anaesthetists for the delivery of baseline activity during August and further additional activity longer term • Theatres - Separate recruitment initiatives for theatres across 3 sites • Nursing and Medical vacancies – recruitment challenges • Ongoing staffing gaps across all specialties are causing an impact on assessment times. • No Out of Hours cover to aid retrieval and identification of stroke patients in A & E. • Resignation of single handed Cleft Lip and Palate Surgeon (31/10/2018). • Morriston occupancy levels, lack of deep cleaning infrastructure, decant facility & single rooms • Reduction in capacity to accommodate patients flowing out of Morriston Hospital. Level of bed occupancy routinely exceeding 100%.

5.2 Neath Port Talbot Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	98.4%	96.8%	98.9%	96.9%								
		Profile	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
	12 hour A&E waits	Actual	0	0	0	0								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Planned care	Outpatients waiting more than 26 weeks	Actual	*0*	*0*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*0*	*0*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Therapy waits over 14 weeks	Actual	*0*	*1*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	-	-	100%	100%								
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	100%	100%	100%	100%								
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	4	3	0	0								
		Profile	*0*	*1*	*0*	*0*	*1*	*1*	*1*	*0*	*0*	*2*	*2*	*1*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	0	0	0	0								
		Profile	*0*	*0*	*0*	*1*	*1*	*0*	*1*	*0*	*1*	*1*	*0*	*0*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	1	2	2	4								
		Profile	*0*	*2*	*1*	*2*	*1*	*1*	*3*	*1*	*3*	*3*	*1*	*1*
Quality & Safety Measures	Discharge Summaries	Actual	81%	77%	82%	77%								
		Profile	68%	71%	74%	77%	80%	83%	85%	88%	91%	94%	97%	100%
	Concerns responded to within 30 days	Actual	100%	100%	100%									
		Profile	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Workforce Measures	Sickness rate	Actual	5.00%	5.06%	5.24%									
		Profile	5.85%	5.78%	5.70%	5.62%	5.54%	5.47%	5.39%	5.31%	5.23%	5.16%	5.08%	5.00%
	Personal Appraisal Development Review	Actual	72%	69%	68%	72%								
		Profile	63%	66%	68%	70%	70%	70%	72%	74%	74%	76%	78%	80%
	Mandatory Training	Actual	61%	65%	67%	70%								
		Profile	43%	46%	48%	48%	48%	50%	52%	54%	56%	58%	60%	62%
	Vacancies- Doctors	Actual	0.43	0.53	0.63	0.63								
	Vacancies- Other Medical Staff	Actual	7.27	7.12	6.3	9.3								
	Vacancies- Nursing	Actual	14.88	9.56	17.51	25.45								
	Vacancies- Therapies	Actual	-	-										
	Vacancies- A&C	Actual	6.97	5.93	7.87	8.94								
	Vacancies- Other	Actual	-12.16	-20.1	-11.39	-12.35								

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

5.2 Neath Port Talbot Delivery Unit- Overview

Successes	Priorities
• MIU – 99% of patients seen within 4 hours. No 12 hour breaches. • TOCALS – 1,650 bed days saved during July 2018. • There were 0 stage 1 patients waiting over 26 weeks at end of July 2018 for an outpatient appointment. • There were 0 stage 1 therapy patients waiting over 14 weeks in July. • DNA rate improvements 18/19 vs 17/18 being maintained. • Delayed Follow-Up Not Book reduction being maintained. • No USC breaches during July 2018. • 0 cases of Staph.aureus bacteraemia and E-Coli trajectory maintained. • Maintaining delivery of WFI activity levels. • No never events and no serious incidents. • Continued improvement in ETOC sign off rate. • 100% complaints response within 30 working days. • 99% of patients and visitors recommend services (Friends & Family test) • Integration of pharmacists as core members of primary care teams. • Community Pharmacy Care Homes enhanced service supporting medicines management to reduce patient harm and waste.	• Continue integrated working with primary and community care DU, local authority and third sector to promote flow. • Earlier escalation of constraints to flow. • Maximise opportunities for planned care improvements by end of Q2 (stretch targets of 5 wks per specialty other than respiratory – 2 wk improvement target; and Rheumatology – 8 wk improvement target). • Improve DNA performance to achieve 2018/19 targets to achieve 10% reduction as per annual plan. • USC stretch target to reduce 1st appointment to 8 days by end of Q2. • Zero tolerance for all avoidable pressure damage. • Learn from infection control outbreak to identify causes of increased incidence and develop action plan to address improvement. • Implement referral pathway for Fibromyalgia. • Pharmacy Transformation Programme. • Consultant Antimicrobial Pharmacist and Antimicrobial Stewardship. • MHRA licence for Singleton PTS and replacement air handling plant for Morriston PTS.
Opportunities	**Risks & Threats**
• RDC – continued collaboration with GPs to ensure appropriate referrals; work with Swansea University for Economic and Financial Evaluation. • Secure support to Lung CNS in response to peer reviews. • Opportunity to utilise MacMillan Lead CNS. • Continued focus on co-production clinics and patient initiated follow ups. • Deliver national average of 35% for pregnancy per cycle (WFI). • Service remodelling to reduce bed compliment by further 12 beds. • Implementation of the SAFER bundle. • Continued focus on reducing sickness, increasing PADR and mandatory training compliance. • Improve Ward Average Length of Stay, Delayed Transfers of Care and	• Infection control – 8 cases of C.Diff year to date. • Pressure damage – 2 avoidable cases year to date. • Capacity within Care Homes, LA Packages of Care and Community Resource Teams with potential to adversely affect hospital length of stay for discharge fit patients. • Clinical Risks associated with Delayed Follow up patients. • Relatively low number of training technician posts and therefore capacity for new technician role expansion. • Recruitment of pharmacists to acute sector and loss to cluster roles. • Increased workload from NICE / New Treatment Fun appraisals. • EIA patients NICE guidelines advise need to be seen within 2 weeks. Utilising capacity for routine patients with risk of not achieving stretch target.

monthly bed days lost position. • Possible centralisation of booking office for medical specialties. • Further development of pharmacy specialty teams to support inpatients and specialist clinics.	• Pressures in therapy services with sickness (surgery) and maternity leave. Discussions ongoing to mitigate impact on 14 week target.

5.3 Princess of Wales Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	75.4%	81.1%	82.6%	80.1%								
		Profile	*85%*	*85%*	*85%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*
	12 hour A&E waits	Actual	163	155	141	141								
		Profile	*63*	*68*	*49*	*78*	*57*	*77*	*92*	*109*	*49*	*85*	*53*	*43*
	1 hour ambulance handover	Actual	101	130	88	61								
		Profile	*38*	*34*	*26*	*40*	*42*	*58*	*68*	*81*	*35*	*55*	*41*	*28*
Stroke	Direct admission within 4 hours	Actual	34.4%	33.3%	33.3%	0.0%								
		Profile	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*	*50%*	*50%*	*50%*	*65%*	*65%*	*65%*
	CT scan within 1 hour	Actual	40.6%	74.1%	37.5%	0.0%								
		Profile	*40%*	*40%*	*40%*	*45%*	*45%*	*45%*	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*
	Assessed by Stroke Specialist within 24 hours	Actual	75.0%	70.4%	70.8%	0.0%								
		Profile	*75%*	*75%*	*75%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*85%*	*85%*	*85%*
	Thrombolysis door to needle within 45 minutes	Actual	16.7%	66.7%	0.0%	0.0%								
		Profile	*20%*	*25%*	*25%*	*30%*	*30%*	*30%*	*35%*	*35%*	*35%*	*40%*	*40%*	*40%*
Planned care	Outpatients waiting more than 26 weeks	Actual	31	15	17	12								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	1,003	1,026	1,038	1,077								
		Profile	*1,059*	*1,150*	*1,073*	*1,028*	*1,122*	*1,070*	*989*	*900*	*1,053*	*956*	*845*	*763*
	Diagnostic waits over 8 weeks	Actual	0	0	0	138								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	95%	91%	93%	95%								
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	75%	100%	90%	97%								
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	3	2	1	2								
		Profile	*6*	*5*	*4*	*8*	*6*	*6*	*5*	*4*	*2*	*4*	*3*	*3*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	3	1	1	3								
		Profile	*1*	*3*	*0*	*2*	*0*	*1*	*1*	*1*	*2*	*1*	*1*	*1*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	3	4	2	2								
		Profile	*1*	*2*	*2*	*3*	*2*	*3*	*3*	*5*	*4*	*3*	*1*	*3*
Quality & Safety Measures	Discharge Summaries	Actual	72%	64%	60%	64%								
		Profile	*55%*	*59%*	*63%*	*67%*	*71%*	*76%*	*80%*	*84%*	*88%*	*92%*	*96%*	*100%*
	Concerns responded to within 30 days	Actual	75%	90%	64%									
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate	Actual	5.23%	5.18%	5.25%									
		Profile	*5.17%*	*5.16%*	*5.14%*	*5.13%*	*5.11%*	*5.10%*	*5.08%*	*5.06%*	*5.05%*	*5.03%*	*5.02%*	*5.00%*
	Personal Appraisal Development Review	Actual	61%	59%	58%	60%								
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	52%	54%	55%	58%								
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*
	Vacancies- Doctors	Actual	11.1	10.4	10.3	12.8								
	Vacancies- Other Medical Staff	Actual	45.36	44.56	45.56	84.54								
	Vacancies- Nursing	Actual	98.1	91.03	97.74	79.58								
	Vacancies- A&C	Actual	6.96	7.83	15.68	17.41								
	Vacancies- Other	Actual	8.45	9.71	9.24	11.6								

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

5.3 Princess of Wales Delivery Unit- Overview

Successes	Priorities
• Continued delivery of the 36wk targets for treatments • Appointment of Gynaecology CNS • 80.15% 4hr performance achieved in July 2018; the third consecutive month above 80%. This is following the focus on Minors and the pilot of Ambulatory Emergency Surgery. • 1 new Consultant in Emergency Medicine Consultant commenced in post with a further consultant starting in September 2018 when extended consultant cover will be provided from 20:00 to 21:30. • Sonographer posts x 2 advertised. • Paediatric Consultant Radiologist commencing on 04/09/2018. • Consultant Radiologist advert prepared and approved by Royal College of Radiology assessor. Will now be advertised in August with at least one suitable candidate interested. • Further improvement in sickness performance • Stroke CT in 1 hour performance – best in Wales • Thrombolysis – 100% of eligible patients thrombolised (5th month running), 2nd highest thrombolysis rate in Wales	• Continue to work with Clinical teams to increase our treatment in turn rates • Further improve PDR and mandatory training compliance • Implement the actions set out for Q2 to build improved performance & increased resilience in our Emergency Departments (ED) • Focus on refining winter planning arrangements • Progress workforce plan in Radiology to achieve more sustainable service & less reliance on locums. Consultant and sonographer recruitment to vacant posts. • Explore potential for part time Breast Consultant Radiographer (2-3 days per week) to build in resilience to breast radiology support. • Continue to drive theatre efficiencies through reduction of cancellations on the day, and reducing late starts and early finishes. • Expansion of preoperative assessment in terms of incorporating all specialties and use of screening and CPET (with appointment of new anaesthetists on 13th August) • Progress project plan for ITU refurbishment, consideration of PACU on the back of the Health Minister announced £15m recurring fund.
Opportunities	**Risks & Threats**
• Recent recruitment into T&O rota with MTI scheme – opportunity to review and implement trauma team model • Going out to advert for consultant Radiologist in August high confidence in appointing a suitable candidate. • Meeting planned with potential Breast Consultant Radiographer. This is in line with workforce redesign group led by Christine Morrell and would provide more resilience in the Breast Radiology support as well as help us develop talent and succession planning within. • Continued resilience on tackling theatre safety and inefficiencies • Completion of the DU review of stroke pathways with the team and agreement on way forward • Out to advert for gastroenterologist and CNS Skin • Transfer of Cardiac CT to POW from Singleton increasing Health Board capacity arranged for October.	• Ongoing workforce issues in Gynae and Urology. Plus inability to run weekend lists and outsource T&O make ongoing delivery of 36wk target challenge • Increasing ED demand for majors and increasing minors attendances (seasonal) is resulting in unprecedented levels of attendances in addition to the acuity and complexity of patients arriving at ED by ambulance is increasing. • Continued real Risk of large financial overspend covering lost consultant sessions at NPTH Radiology (12 sessions of DCC being covered with expensive locums and outsourcing) • Additional Consultant sick leave from Swansea Radiologists who perform Ultrasound scans at NPTH losing a large number of patient slots in July and going into August • Continuing risk in sub specialist radiology (Ultrasounds) requiring outsourcing to try and maintain targets. • Cost pressures of supporting additional activity through Radiology and Theatres to support delivery of Health board tier 1 targets. • Staffing in theatres (sickness, suspension, disciplinary and resignation) • Additional work to prepare for Cwm Taf “merger”

5.3 Singleton Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Unscheduled Care	4 hour A&E waits	Actual	99.8%	99.7%	99.5%	98.7%								
		Profile	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*	*99.0%*
	12 hour A&E waits	Actual	0	1	2	2								
		Profile	*1*	*2*	*5*	*3*	*2*	*2*	*1*	*0*	*0*	*0*	*0*	*1*
	1 hour ambulance handover	Actual	45	31	18	34								
		Profile	*8*	*12*	*6*	*12*	*16*	*19*	*17*	*4*	*31*	*13*	*4*	*8*
Planned care	Outpatients waiting more than 26 weeks	Actual	*6*	*4*	*1*	*3*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*16*	*14*	*31*	*21*								
		Profile	*24*	*23*	*1*	*3*	*12*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Diagnostic waits over 8 weeks	Actual	*0*	*0*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual	93%	89%	100%	100%								
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	83%	89%	84%	90%								
		Profile	*83%*	*85%*	*89%*	*90%*	*91%*	*91%*	*92%*	*92%*	*91%*	*92%*	*92%*	*93%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	2	1	3	5								
		Profile	*3*	*0*	*4*	*3*	*3*	*3*	*2*	*8*	*3*	*3*	*3*	*3*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	0	2	1	2								
		Profile	*2*	*0*	*1*	*3*	*1*	*3*	*1*	*1*	*2*	*0*	*1*	*1*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	3	4	1	7								
		Profile	*6*	*4*	*4*	*4*	*5*	*4*	*4*	*4*	*2*	*1*	*1*	*3*
Quality & Safety Measures	Discharge Summaries	Actual	73%	72%	61%	67%								
		Profile	*73%*	*76%*	*78%*	*81%*	*83%*	*86%*	*88%*	*90%*	*93%*	*95%*	*98%*	*100%*
	Concerns responded to within 30 days	Actual	60%	65%	88%									
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate	Actual	5.73%	5.79%	5.91%									
		Profile	*5.56%*	*5.51%*	*5.46%*	*5.41%*	*5.36%*	*5.31%*	*5.25%*	*5.20%*	*5.15%*	*5.10%*	*5.05%*	*5.00%*
	Personal Appraisal Development Review	Actual	58%	60%	59%	62%								
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	49%	50%	53%	55%								
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*
	Number of Vacancies- Consultants	Actual	16.55	17.25	17.25	18.15								
	Number of Vacancies- Other Medical Staff	Actual	16.07	17.47	19.35	48.81								
	Number of Vacancies- Nursing/ Midwives (Qualified)	Actual	60.19	59.56	68.36	76.06								
	Number of Vacancies- Nursing/ Midwives (Unqualified)	Actual	-23.99	-25.73	-22.38	-20.3								
	Number of Vacancies- A&C	Actual	11.17	4.35	12.2	18.6								
	Number of Vacancies- Other	Actual	17.71	19.83	38.25	34.79								

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

5.4 Singleton Delivery Unit- Overview

Successes	Priorities
• LIN A in place fully operational. • Achieved full accreditation against ISO 15189 standards for ABMU Laboratory Medicine and Histology Pathology Laboratories. • Achievement of no patients waiting over 8 weeks for an Endoscopy procedure. • Successful development of an implementation plan and consultation process for Health Roster and standardisation of shifts (Allocate). • First Health Board in Wales to establish Clinical Scientist who is a registered Magnetic Resonance Safety Expert providing expert scientific safety advice to patients with metal and electronic implants needing MRI. • Grow own training scheme for BMS skilled in Laboratory Medicine techniques successfully delivered on training to reduce agency need from 7 locums to 1 (June 2018).	• RTT. • Service Resign: Redesign Services Ward 4&7 and embedding ICOPS model. Maintaining engagement levels with our workforce. • Improvement in Workforce Measures. • Finalise consultation and begin Implement Shift Standardisation. • Medical workforce efficiency programme (e Job Planning / Agency Cap / Junior Doctor Rotas / Attendance). • Integrated workforce planning. • Develop a plan to support Radiotherapies waiting times. • Continue Linear accelerator programme to be funded by WG with fully funded business case including engineering support.
Opportunities	**Risks & Threats**
• ARCH Project to create regional pathology lab for sustainable state of art histology services in South West Wales – DSOC for submission to WG. • Undertake review of impact of the new drug treatment fund on available capacity. • Develop new Cost Reduction or Increased Income Opportunities. • All Wales procurement agreed for implementation of Digital Scanners in ABMU Histology to improve flexibility of cover by reporting Pathologists.	• SARC –Need to confirm reporting structure within ABMU. • Cwm Taf Boundary Remapping. • Support in relation to HD LTA to recognise continuing over-performance in gynae-oncology. • Ophthalmology services Additional support will be required to ensure future delivery & sustainability. • Cladding. • New treatment Fund / Introduction of new drugs- Limited capacity in CDU for delivery of infusion therapies. • Pressures on front door. • Under delivery of Waterfall elements.

5.5 Mental Health & Learning Disabilities Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Mental Health Measures	% MH assessments undertaken within 28 days	Actual	90.0%	94.0%	91.2%									
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
	% therapeutic interventions started within 28 days	Actual	83%	81%	79%									
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
	% of qualifying patients who had 1st contact with an Independent MH Advocacy (IMHA)	Actual			100%									
		Profile			*100%*			*100%*			*100%*			*100%*
	% of residents in receipt of secondary MH services who have valid care and treatment plan (CTP)	Actual	90%	90%	88%									
		Profile	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*	*90%*
	Residents assessed under part 3 of MH measure sent a copy of their outcome assessment report within 10 working days of assessment	Actual	100%	100%	100%									
		Profile	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
Healthcare Acquired Infections	Number of healthcare acquired C.difficile cases	Actual	1	1	0	0								
		Profile	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Number of healthcare acquired S.Aureus Bacteraemia cases	Actual	0	0	0	0								
		Profile	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Number of healthcare acquired E.Coli Bacteraemia cases	Actual	1	1	0	0								
		Profile	*0*	*0*	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Quality & Safety Measures	Discharge Summaries completed and sent	Actual	74%	71%	81%									
		Profile	*77%*	*79%*	*81%*	*83%*	*85%*	*88%*	*90%*	*92%*	*94%*	*96%*	*98%*	*100%*
	Concerns responded to within 30 days	Actual	71%	100%	100%									
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate	Actual	6.07%	6.11%	6.11%									
		Profile			*6.03%*			*5.93%*			*5.83%*			*5.73%*
	Personal Appraisal Development Review	Actual	85%	77%	79%	77%								
		Profile			*80%*			*83%*			*85%*			*85%*
	Mandatory Training *(all staff- ESR data)*	Actual	64%	66%	68%	69%								
		Profile			*60%*			*70%*			*80%*			*85%*
	Vacancies- Doctors	Actual	35.65	37.95	37.95	44.95								
	Vacancies- Nursing	Actual	142.12	144.1	145.79	108.29								
	Vacancies- Other Professionals	Actual	50.41	50.21	49.69	51.74								
	Vacancies- A&C	Actual	16.59	15.38	15.4	13.57								

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

5.5 Mental Health & Learning Disabilities Delivery Unit- Overview

Successes	Priorities
• The Delivery Unit continues to meet all requirements of the Mental Health Measure. • Maintaining low number of healthcare acquired infections, with each occurrence reviewed for lessons learnt. • Maintaining compliance with the PADR measures.	• Ongoing intervention with frequent areas of poor compliance. Awareness on importance of timely discharge summaries with all Clinical Staff. • Recruitment and retention of staff for critical nursing and medical vacancies. • Hold and improve current rate of sickness through, Staff Health & Wellbeing Action Plan 18/19; Pilot DU Staff Counsellor; Pilot Performing Medicine Staff Wellbeing programme; Promote Well Being Champions roles (47)
Opportunities	**Risks & Threats**
• Leads from Strategy continue to progress discussions with Cwm Taf towards the improvement of the CAMHS element of the Mental Health Measure. • Mandatory training has improved however, Localities are working to improve this further towards compliance. • Terms of reference for the serious incident group have been updated and the format of the reports has been changed in line with the recommendations from the DU report to be in line with the rest of the Health Board. A learning matrix has been developed to embed and share the learning identified from serious incidents. • A new system for supporting performance on complaints has been put in place with weekly reviews by the Q&S team lead by the Head of Operations to support the localities to respond within the 30 day time scale.	• Capacity gaps in Care Homes. Capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit' and increasing length of stay. • Recruitment market for substantive nursing and medical vacancies

5.6 Primary Care & Community Services Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Planned Care	*Outpatients waiting more than 26 weeks*	Actual	*1*	*0*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*0*	*0*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Therapy waits over 14 weeks	Actual	*0*	*0*	*0*	*0*								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Primary Care Access Measures	% of GP practices open during daily core hours or within 1 hour of daily core hours	Actual	94%	94%	94%									
		Profile	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*
	% of GP practices offering daily appointments between 17:00 and 18:30	Actual	82%	82%	82%									
		Profile	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*
	% population regularly accessing NHS primary dental care- 2 year rolling position	Actual												
		Profile												
Healthcare Acquired Infections	Clostridium Difficile cases (Community acquired)	Actual	6	5	5	5								
		Profile	*3*	*6*	*9*	*2*	*5*	*3*	*3*	*3*	*3*	*5*	*3*	*6*
	Clostridium Difficile cases (Community Hospitals)	Actual	0	0	0	1								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*1*	*0*	*0*	*1*
	Staph.Aueurs bacteraemia cases - (Community acquired)	Actual	8	13	12	9								
		Profile	*6*	*10*	*9*	*6*	*4*	*5*	*7*	*11*	*10*	*6*	*12*	*7*
	Staph.Aueurs bacteraemia cases - (Community Hospitals)	Actual	0	0	0	0								
		Profile	*0*	*0*	*0*	*0*	*1*	*1*	*0*	*0*	*0*	*0*	*0*	*0*
	E.Coli cases (Community acquired)	Actual	32	28	31	31								
		Profile	*30*	*28*	*27*	*31*	*28*	*33*	*30*	*21*	*25*	*28*	*32*	*30*
	E.Coli cases (Community Hospitals)	Actual	0	1	1	0								
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Quality & Safety	Concerns responded to within 30 days	Actual	57%	63%	63%									
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate	Actual	5.76%	5.71%	5.73%									
		Profile	*5.72%*	*5.66%*	*5.59%*	*5.53%*	*5.46%*	*5.40%*	*5.33%*	*5.26%*	*5.20%*	*5.13%*	*5.07%*	*5.00%*
	Personal Appraisal Development Review	Actual	80%	80%	79%	78%								
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	60%	62%	64%	67%								
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*
	Number of Vacancies- Doctors	Actual	2	2.5	2.5	2.3								
	Number of Vacancies- Other Medical Staff	Actual	-1.72	-0.29	-0.56	2.24								
	Number of Vacancies- Nursing	Actual	38.46	47.15	43.19	55.07								
	Number of Vacancies- A&C	Actual	22.5	47.75	19.85	23.8								
	Number of Vacancies- Other	Actual	33.17	65.87	50.01	52.37								

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

5.6 Primary Care & Community Services Delivery Unit- Overview

Successes	Priorities
• The Pulmonary Rehab Team has had a COPD article published in the Journal of Community Nursing, to promote the importance of nutrition. • Appointment of 3 Physician Associates to the 12 Month PCSU Internship Programme. • Achieved Oral Health Delivery Plan financial and service targets at year end (confirmed when GDS activity data available end June) • Common Ailments Service now operating in 95% of ABMU's 125 pharmacies (remainder delayed because of ownership changes): 755 consultations undertaken in July, 144% increase on previous month. This is the outcome of extensive engagement with GP Clusters, Community Pharmacy Wales, Medicines Management colleagues • Maintained RTT 26 and 52 week waits (Chronic Pain) • Mobilisation devices roll out to Podiatry confirmed. • New Hearing Loss Pathway to begin in September (reducing demand on ENT) • Positive television (ITV) and Evening Post coverage of wellbeing activity for patients in Gorseinon hospital	• Business case for investment in SLT staffing for critical care • Winter pressures bid for additional SLT in secondary care. • Response to POWH DU re SLT workforce into stroke services in response to Q4 performance review • Community hospital mandatory and statutory training • Community hospital performance reporting on NEWS • Bridgend Boundary Change workforce mapping • Progress Primary Care estates programme – in liaison with corporate strategy -submission of Murton and Penclawdd Business Justification cases to WG. • Develop a Focus group with the Cymmer Community to rebuild the trust and engagement with the local population. • Final Primary Care Annual Report for submission with National Primary Care Report to September Public Board • Safe provision of general medical services for patients of the current Cockett practice for circa 1400 patients. • Further reduce risk associated with provision of paediatric GA and deep sedation at Parkway clinic and report same formally
Opportunities	**Risks & Threats**
• Out of hours provision across primary and community services • Identify primary/secondary care services that can possibly transfer to Parkway Clinic for delivery. • National allocation of funding £21K to ABMU to support Primary Care Health Care Support Worker Development • Anticipated that the 13% increase in community pharmacies commissioned to provide flu services (plus broadening of eligibility criteria) will increase delivery by 25%: 10,000 vaccines total • To support USC, GMS sustainability and sexual health services with roll out of independent prescribers within community • Head & Neck Services - Hywel Dda – Regional service development	• Contingency plans likely to minimise rather than eliminate projected RTA breaches in Restorative Dentistry led RD/Special Care Dentistry GA patients (PoW list) • Opening of new dental practice in Port Talbot due to building restrictions still delayed (limiting intended access for approx. 1000 patients). Currently assumed Council will lift restrictions September; opening this calendar year now feasible. • Temporary closure of Murton & Penclawdd clinics • Implications of Additional Learning Needs bill • Bridgend Boundary Change

7. PERFORMANCE REPORT CARDS

7.1 Staying Healthy

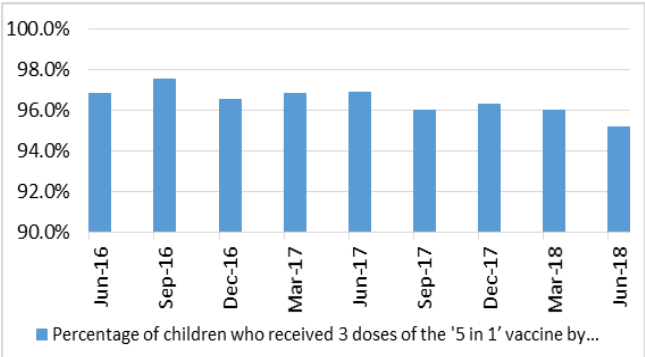
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

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

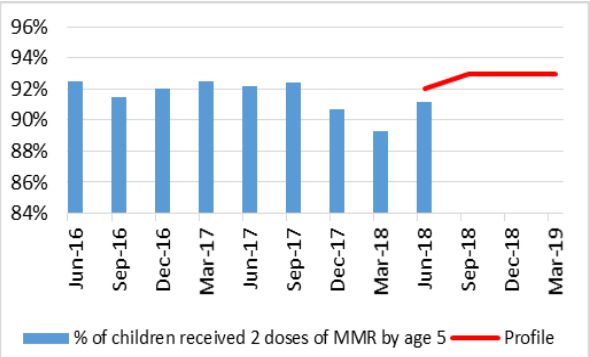
Corporate Objective : Promoting & Enabling Healthier Communities			**Executive Lead :** Sandra Husbands, Director of Public Health	
Outcome Statement : My children have a good healthy start in life				
Period: June 18	**Annual Plan Profile :** (2) 92%	**WG Target :** (1), (2) 95%	**Current Status :** ✖	**Movement :** ↓ ● Worsening

Current Trend: Jun 16 - Jun 18

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



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



Benchmarking

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

LHB	Current	Same Period Comparison		
	Q4 17/18	Q4 16/17	Q4 15/16	Q4 14/15
Wales	89.3%	↓ 90.4%	↓ 91.4%	↓ 93.6%
ABM	89.3%	↓ 92.5%	↓ 91.6%	↓ 94.0%
AB	89.6%	↑ 88.7%	↓ 90.8%	↓ 93.5%
BCU	91.8%	↑ 91.6%	↓ 93.2%	↓ 95.0%
C&V	87.1%	↓ 88.8%	↓ 89.2%	↓ 91.3%
CTaf	89.4%	↓ 93.4%	↓ 92.9%	↓ 94.7%
HDda	87.3%	↓ 88.7%	↓ 90.0%	↓ 93.5%
Powys	88.3%	↑ 86.8%	↓ 92.3%	↓ 91.3%

Source : Vaccine Uptake in Children in Wales April to June 2018 (COVER Report 127)

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

How are we doing?

- Measure 1 - Although there is a small decrease in uptake rates, ABMU continues to achieve uptake rates which are consistently above 95%.

- Measure 2 - During the first quarter we have seen an increase in the number of children, who by the age of 5 years have received 2 doses of the MMR vaccine.

What actions are we taking?

- Health Visitors (HV's) receive weekly reports from the Child Health department, of the names of children who are currently on their caseload, who have missed immunisation appointments. This requires HV's to follow local and National guidance prior to instructing Child Health to re-appoint these children for their immunisations. The accuracy of the immunisation history held on the Child Health (CH) system is reliant on information forwarded by HV's and GP practices. At present there is no data linkage between the CH systems to that of the GP systems.
- The Healthy Child Wales programme ensures contact between the HV and family at 3.5 years and also requires the HV to hand over to the named school health nurse upon school entry if the child remains to have outstanding immunisations.
- Primary care managers are monitoring current waiting lists and cancelled clinics, and are working with practices to reduce the current waiting list of over 300 children across ABMU. There is an expectation that no practice should have a queue of children waiting for an appointment for their routine immunisations. The process of cancelling immunisation clinics has been strengthened.

What are the main areas of risk?

- In respect of Measure 1 - overall we are above 95% which is positive, however in view of cancelled immunisations clinics and waiting lists there is a risk that some resident children across ABMU are not in receipt of timely vaccinations, which could leave some children susceptible to a vaccine preventable disease. The immunisation coordinator will plan to audit the timeliness of primary immunisations, this being dependant on time and resources.
- In respect of Measure 2 - overall we are below the 95% target which is required in order to achieve herd immunity. This is a risk given the cases of measles that have recently been confirmed in South East Wales. Following a recent internal audit a business case will be submitted in order to increase existing resources into the child health department. This will enable the department to undertake regular data cleansing in order to ensure data held on the child health system and GP systems are the same.

How do we compare with our peers?

- Measure 2 - ABMU is currently in line with the Welsh average (89.3%) and ranked fourth amongst the Welsh Health Boards. Betsi Cadwaladr is highest ranking Health Board achieving uptake rates of 91.8%

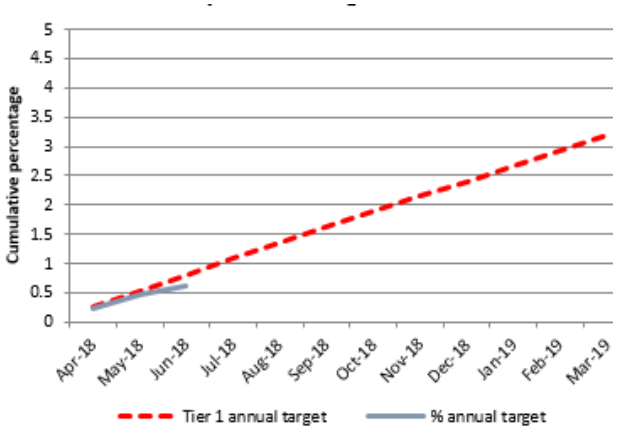
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

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)

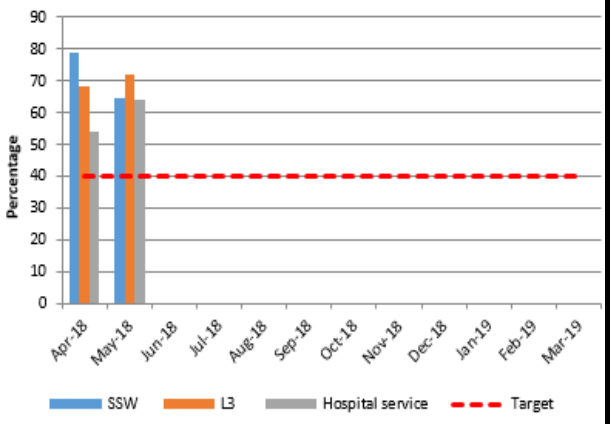
Corporate Objective : Promoting & Enabling Healthier Communities			**Executive Lead :** Sandra Husbands, Director of Public Health	
Outcome Statement: I am healthy and active and do the things to keep myself healthy				
Period : June 18	**Annual Plan Target :** (1) 0.8% (2) 40%	**WG Target :** (1) 5% (2) 40%	**Current Status :**	**Movement :** Im

Current Trend: 2017-2018 (monthly)

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



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



Benchmarking

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

LHB	Current Q1-Q3 17/18	Previous Q1-Q3 16/17
Wales	2.3%	⇧ 2.1%
ABM	1.8%	⇩ 1.8%
AB	2.6%	⇧ 2.0%
BCU	2.7%	⇩ 2.9%
C&V	1.2%	⇧ 1.0%
CTaf	3.5%	⇧ 2.9%
HDda	1.9%	⇧ 1.6%
Powys	1.7%	⇧ 1.6%

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

LHB	Current Q1-Q3 17/18	Previous Q1-Q3 16/17
Wales	42.6%	⇧ 40.9%
ABM	53.4%	⇧ 50.7%
AB	40.4%	⇩ 41.1%
BCU	31.9%	⇧ 30.2%
C&V	59.3%	⇧ 56.3%
CTaf	36.1%	⇩ 37.6%
HDda	56.8%	⇩ 56.9%
Powys	41.2%	⇩ 47.3%

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

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)

How are we doing?

- To achieve the 5% smoking cessation target approximately 4,711 smokers need to be treated in ABMU stop smoking services per year, with an average of 393 smokers treated per month. A target of 3.2% has been set for the Health Board's Annual Plan, to achieve this 3.2% target approximately 3,015 smokers need to be treated in ABMU stop smoking services per year, with an average of 251 smokers treated per month. ABMU has treated 588 smokers (monthly activity data) against the cumulative monthly target of 753, achieving to June 2018 0.62% of the overall target, against a year to date trajectory of 0.8%.
- In April and May 2018, all three smoking cessation services exceeded the 40% target for CO-Validated 4 week quitters.
- The most recent data from the National Survey for Wales 2016/17 estimates that 21% of ABMU's population (aged 16+) smoke. This is higher than the all-Wales average of 19%.

What actions are we taking?

- 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.
- Telephone support pilot with Stop Smoking Wales (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.
- Cessation pathway in development

What are the main areas of risk?

- Focus currently on cessation services and driving the demand to services, without addressing the broader supportive environments and wider determinants agenda. This work will be 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. Community pharmacies may not have the desire and/or capacity to deliver the Level 3 service to expected levels.
- Management of hospital based stop smoking service - currently under discussion between head of service and exec lead

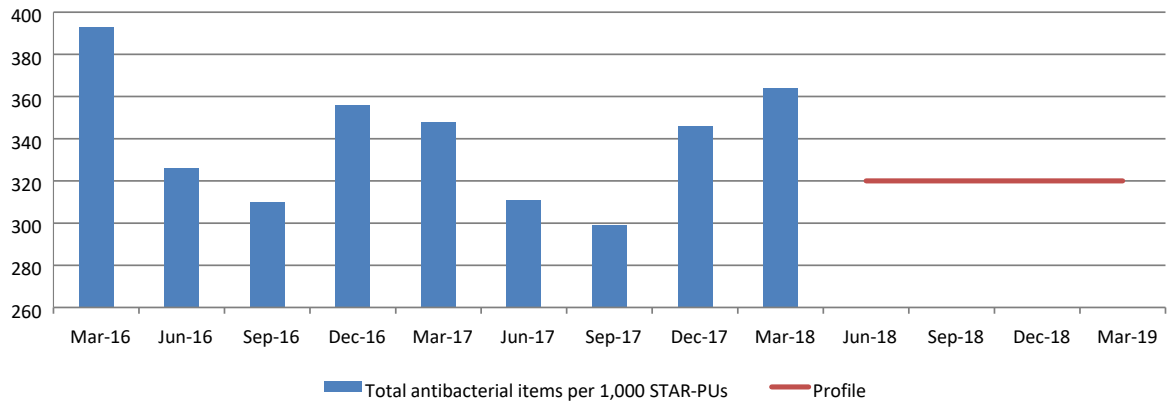
How do we compare with our peers?

- The latest published data available from Welsh Government shows that during Q1-3 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.
- In 2017/18, ABMU was shown to have improved performance for smokers who CO- validated compared with 2016/17 but the percentage of smokers making a quit attempt was the same for time periods.

7.2 Safe Care

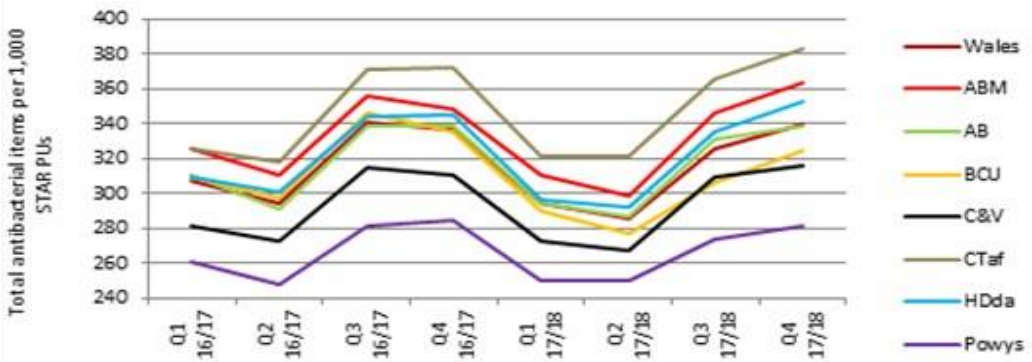
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM				
Measure 1: Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : March 2018	**Annual Plan Profile :** 320	**WG Target :** 4 Quarter reduction trend	**Current Status :** ✖	**Movement :** ⇧ Worsening
Current Trend: Mar 16 - Mar 18				

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



Benchmarking

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



Source : ALL WALES PERFORMANCE SUMMARY (JULY 2018)

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

How are we doing?

- While the long term trend is down, an increase was seen in March 2018 quarter. This may be attributable in part to high levels or circulating respiratory infections at that time.

What actions are we taking?

To maintain focus and build on the legacy of the ABMU Big Fight Campaign, the following are in place:

- Included in the 2018-19 Prescribing Management Scheme
- Highlighted in every practice's annual prescribing visit
- Supported audits in target practices
- Regular guideline updates
- Regular updates via prescribing leads meetings
- Highlighting links and resources to national campaigns

What are the main areas of risk?

- The main risk is to maintain and build on progress made. Any increases could increase risk of resistance and C. difficile.

How do we compare with our peers?

- ABMU had shown significant progress over the last 2-3 years and is no longer the highest in Wales. However, there is still much to do to continue to improve appropriate prescribing.

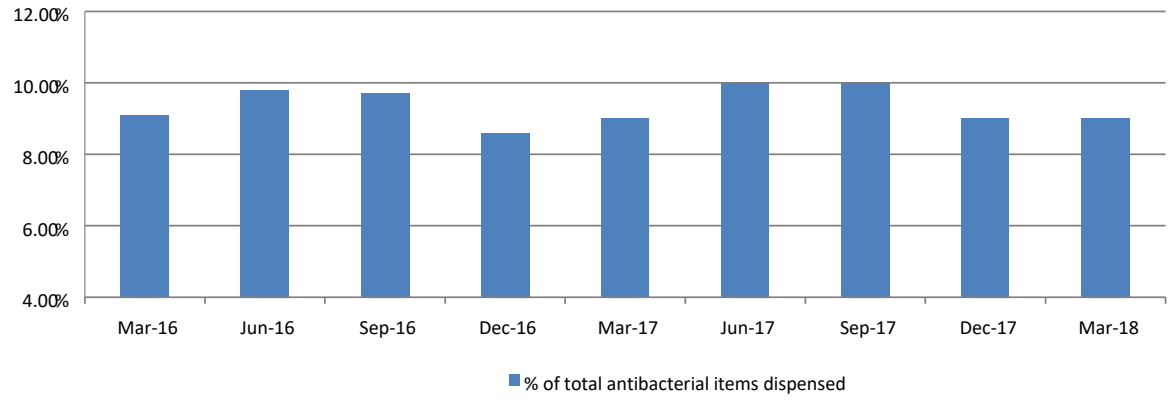
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period: March 2018	**Annual Plan Profile :**	**WG Target :** 4 Quarter reduction trend	**Current Status :** ✓	**Movement :** ↓ ● **Improving**

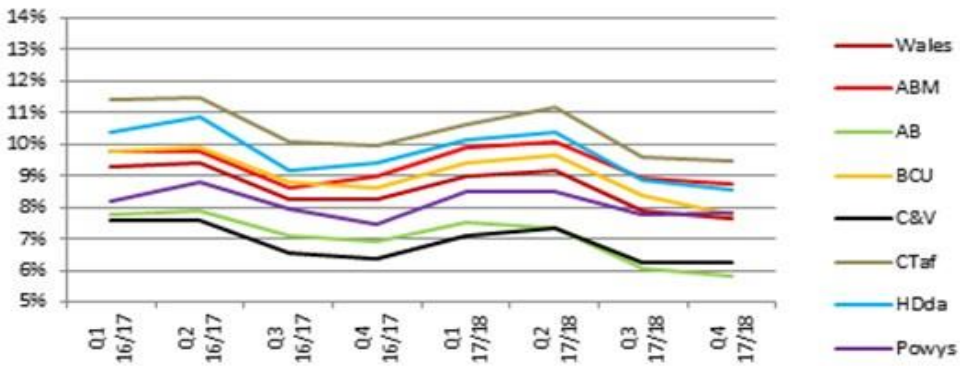
Current Trend: Mar 16 - Mar 18

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



Benchmarking

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



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

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

How are we doing?

- After an initial significant reduction 2-3 years ago, these antibiotics have shown some increases, although this seems to be falling again.

What actions are we taking?

To maintain focus, the following are in place:

- Included in the 2018-19 Prescribing Management Scheme (overall prescribing and a co-amoxiclav audit)
- Highlighted in every practice's annual prescribing visit
- Supported audits in target practices
- Regular guideline updates
- Regular updates via prescribing leads meetings
- Significant changes in co-amoxiclav use in acute will also impact on primary care prescribing culture

What are the main areas of risk?

- The main risk is to maintain and build on progress made. Any increases could increase risk of resistance and C. difficile.

How do we compare with our peers?

- ABM performance needs to show further improvements as we are above the Welsh average

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

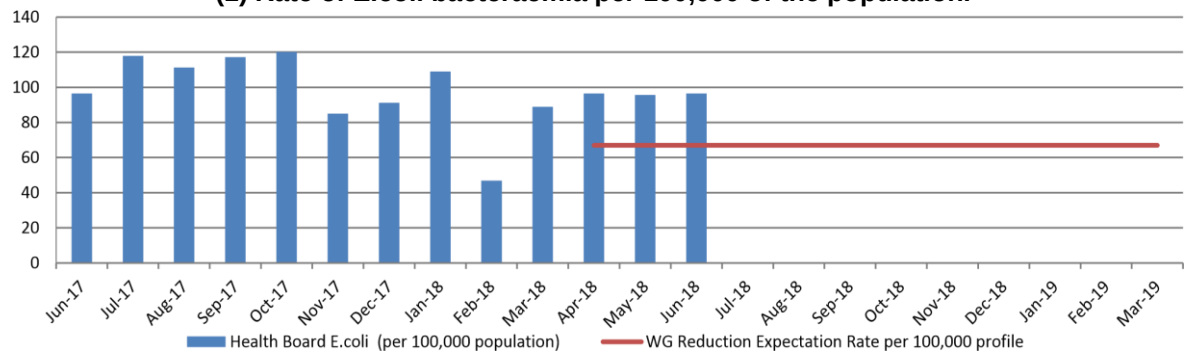
Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population
Measure 2: Number of E.coli cases
Measure 3: Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access	**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support	

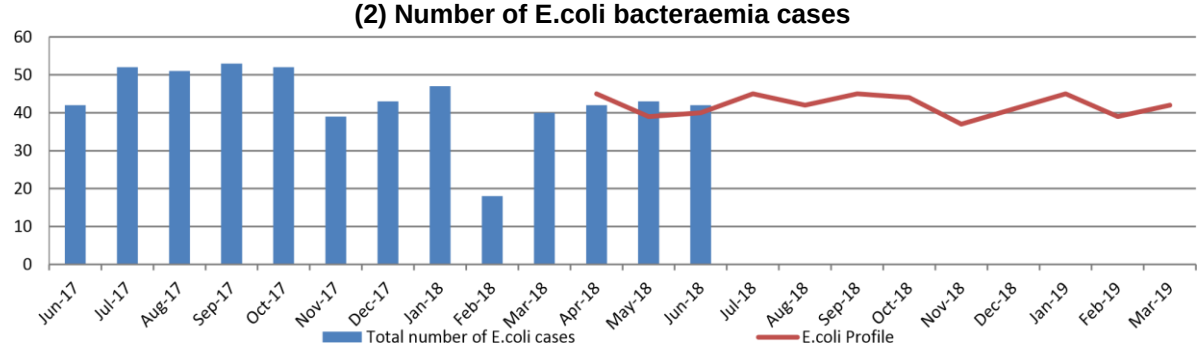
Period : June 2018	**Annual Plan Profile :** (2) 40	**WG Target :** (1) < 67	**Current Status :** ✖	**Movement :** ↓ ● Improving

Current Trend: Jun 17 - Jun 18

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



(2) Number of E.coli bacteraemia cases



Benchmarking

(3) Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

LHB	Cumulative Cases (Apr 18-Jun 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	633	479	+154
ABM	127	88	+39
AB	120	89	+31
BCU	132	116	+16
C&V	90	73	+17
Ctaf	72	49	+23
Hdda	92	64	+28

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

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population
Measure 2: Number of E.coli cases
Measure 3: Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

How are we doing?

- In June 2018, the Health Board's total number of cases was 41. This was 1 case more than the Annual Plan profile for June 2018.
- Of the 41 cases, 31 (76%) were community acquired infections (HAI); 10 (24%) were hospital acquired infections. Of the 10 hospital acquired cases, there were 4 cases associated with Morriston Hospital Delivery Unit (DU). Princess of Wales Hospital DU and Neath Port Talbot Hospital DU each had 2 cases; Singleton Hospital DU and Gorseinon Hospital each had 1 hospital acquired case.
- To date, in 2017/18, 40% of the total cases of E. coli bacteraemia had a probable urinary source and 16% of these were associated with urinary catheters. Identifying the probable source of E. coli bacteraemia is key to developing focussed Quality Improvement programmes.
- There were 2.3% fewer cases of E. coli bacteraemia in June 2018 compared with June 2017.

What actions are we taking?

- PDSA-based Quality Improvement programmes focussed on preventing urinary tract infections has commenced in a small number of key wards. For example, Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters –into Q1, 2018/19; Morriston DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters in 6 wards – into Q1, 2018/19 with a plan to roll this out to more wards in the next quarter. Also a hydration awareness programme has been commenced at Morriston DU; Princess of Wales DU has commenced a pilot of using urinary catheter labels to record review of continued use – into Q1, 2018/19.
- Delivery Units are to focus on improving compliance with the number of staff that have completed Aseptic Non Touch Technique (ANTT) training - 10% improvement on staff trained by 31 March 2019.
- Delivery Units are to focus on improving compliance with the number of staff that have been ANTT competence assessed. Currently, there is no baseline data. To establish a system for recording ANTT competence assessments via ESR – by end of Q2, 2018/19.

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?

- In June 2018, ABMU had the second highest incidence of E.coli bacteraemia in comparison with the other major Welsh Health Boards.
- To date in 2018/19 ABMU has the second highest cumulative incidence of E.coli bacteraemia in comparison with the other Welsh Health Boards.

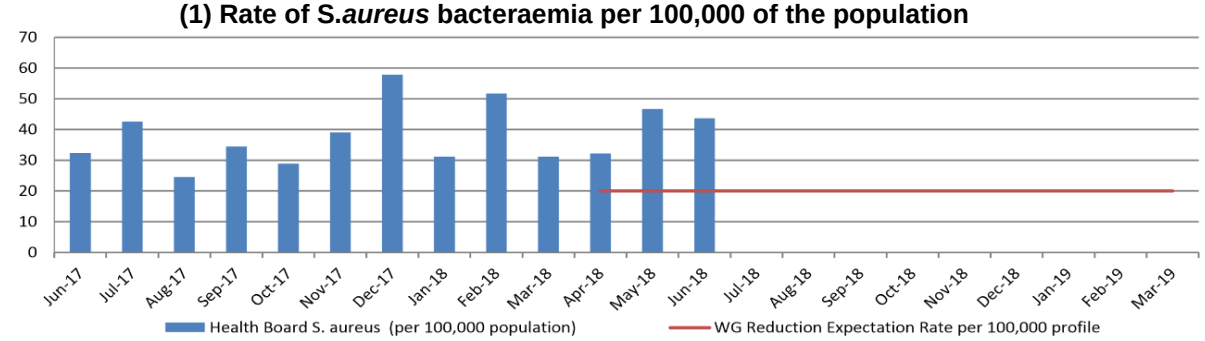
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population
Measure 2: Number of S. aureus bacteraemia cases
Measure 3: Number of cumulative cases of S. aureus bacteraemia against March 2019 reduction expectation

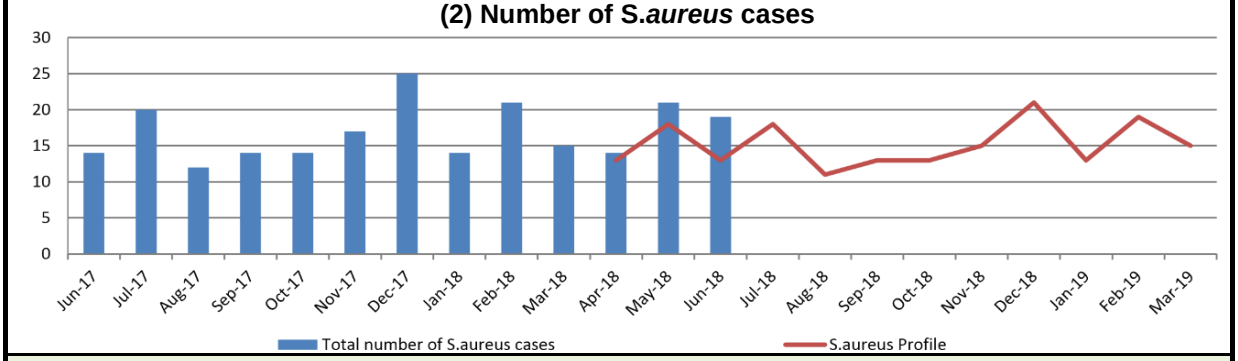
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : June 2018	**Annual Plan Profile :** (2) 13	**WG Target :** (1) <20	**Current Status :**	**Movement :** Wor

Current Trend: Jun 17 -Jun 18

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



(2) Number of S.*aureus* cases



Benchmarking

(2) Number of cumulative cases of S.*aureus* bacteraemia against March 2019 reduction expectation

LHB	Cumulative Cases (Apr 18-Jun 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	236	143	+93
ABM	54	26	+28
AB	41	27	+14
BCU	44	34	+10
C&V	39	24	+15
Ctaf	25	14	+11
Hdda	33	18	+15

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

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population
Measure 2: Number of S. aureus bacteraemia cases
Measure 3: Number of cumulative cases of S. aureus bacteraemia against March 2019 reduction expectation

How are we doing?

- In June 2018, the Health Board's total number of cases was 19 cases. This exceeded the Annual Plan profile for June by 6 cases.
- Of the 19 cases, 8 (37%) were hospital acquired infections; 12 (63%) were community acquired infections. Morriston Hospital accounted for 71% of the hospital acquired cases. There were four Cases of MRSA bacteraemia; 4 of these were community acquired cases.
- There were 5 more cases of Staph. aureus bacteraemia in June 2018 compared with June 2017.

What actions are we taking?

- Delivery Units (DU) are to focus on improving compliance with the number of staff that have completed Aseptic Non Touch Technique (ANTT) training - 10% improvement on staff trained by 31 March 2019.
- Delivery Units are to focus on improving compliance with the number of staff that have been ANTT competence assessed. Currently, there is no baseline data. To establish a system for recording ANTT competence assessments via ESR – by end of Q2, 2018/19.
- Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters – ongoing into Q1, 2018/19.
- Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters in 6 wards – ongoing into Q1, 2018/19.
- Neath Port Talbot and Princess of Wales Delivery Units will commence QI programmes to reduce the prevalence of invasive devices in Q2.

What are the main areas of risk?

- 63% of Staph. aureus bacteraemia is community acquired, with many patient related contributory factors, such as recreational drug use, arthritis, chronic conditions, etc. As such, it is a challenge to prevent a significant proportion of these.
- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which frequently is close to, or exceeds, 90%. Analysis by the Department of Health, reported in Tackling Healthcare associated infections through effective policy action (BMA, June 2009), suggested that when all other variables are constant, an NHS organisation with an occupancy rate above 90 per cent could expect a 10.3% higher MRSA rate compared with an organisation with an occupancy levels below 85%.
- High bed turnover. In the same BMA report, the impact on MRSA rates of turnover intervals were suggested to have a greater impact on MRSA rates than bed occupancy levels.

How do we compare with our peers?

- In June 2018, ABMU had the second highest incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards.
- To date in 2018/19 ABMU has the highest cumulative incidence of Staph. aureus bacteraemia in comparison with the other Welsh Health Boards.

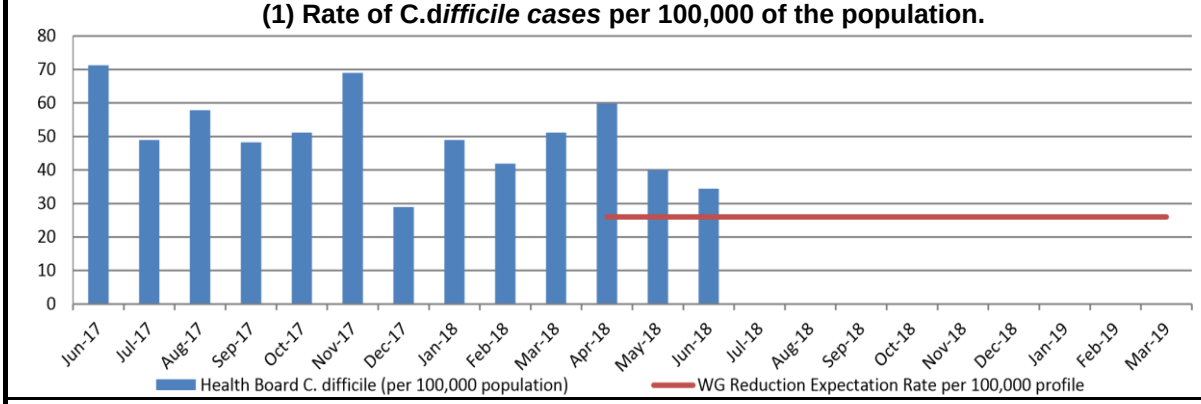
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

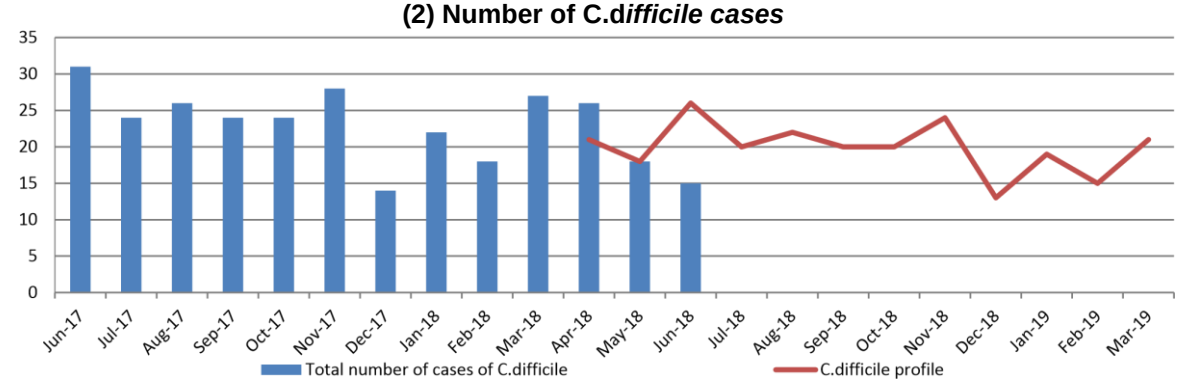
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : June 2018	**Annual Plan Profile :** (2) 26	**WG Target :** (1) < 26	**Current Status :**	**Movement :** Impr

Current Trend: Jun 17 - Jun 18

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



(2) Number of C.d*ifficile cases*



Benchmarking

(3) Number of cumulative cases of C.*difficile* against March 2019 reduction expectation

LHB	Cumulative Cases (Apr 18-Jun 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	238	179	+59
ABM	59	34	+25
AB	36	36	0
BCU	46	45	+1
C&V	25	27	-2
Ctaf	18	13	+5
Hdda	54	24	+30

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

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

How are we doing?

- In June 2018, the Health Board's total number of cases was 15 cases. This was fewer cases than the Annual Plan profile for June by 11 cases.
- Of the 15 cases, 10 (67%) were hospital acquired infections (HAI); 5 (33%) were community acquired infections. Morriston Hospital DU accounted for 60% of the hospital acquired cases. Singleton Hospital DU accounted for 30% of HAI.
- Morriston Hospital DU had periods of increased incidence of infection in June (Ward T & AMAU West).
- There were 17 fewer cases of C. difficile infection in June 2018 than in June 2017.

What actions are we taking?

- Restrictive antimicrobial guidelines were implemented on 12 June 2018.
- The Risk Assessment and Safe System of Work protocol in relation to UVC was accepted as satisfactory by HSE in June 2018. Updated training programme, based on new safe system, has been developed. Staff side continued to express concern regarding re-introduction of UV-C and the process was not implemented on 30 June 2018 as planned. The Health Board continue to pursue a way forward with this.
- Invitations have been circulated for expressions of interest for the QI Lead for Infection in each of the Delivery Units – these expressions of interest were to be considered by the Delivery Units by 30 June 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. The deep cleaning process is disjointed and depends on three separate staff groups to each play their part in the right timescale for the process to be effective and robust. This requires a redesign, moving all resourcing to one team. This will improve outcome and increase assurance.
- C. difficile spores may be found in 49% rooms of patients with C. difficile infection; 29% rooms of asymptomatic carriers.
- Public Health Wales implemented a new, more sensitive testing methodology for C. difficile. The likely impact of this will be a 10-20% increase in the detection of C. difficile carriage.

How do we compare with our peers?

- In June 2018, ABMU had the second highest incidence of C. difficile in comparison with the other major Welsh Health Boards.
- To date in 2018/19 ABMU has the second highest cumulative incidence of C. difficile bacteraemia in comparison with the other Welsh Health Boards.

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

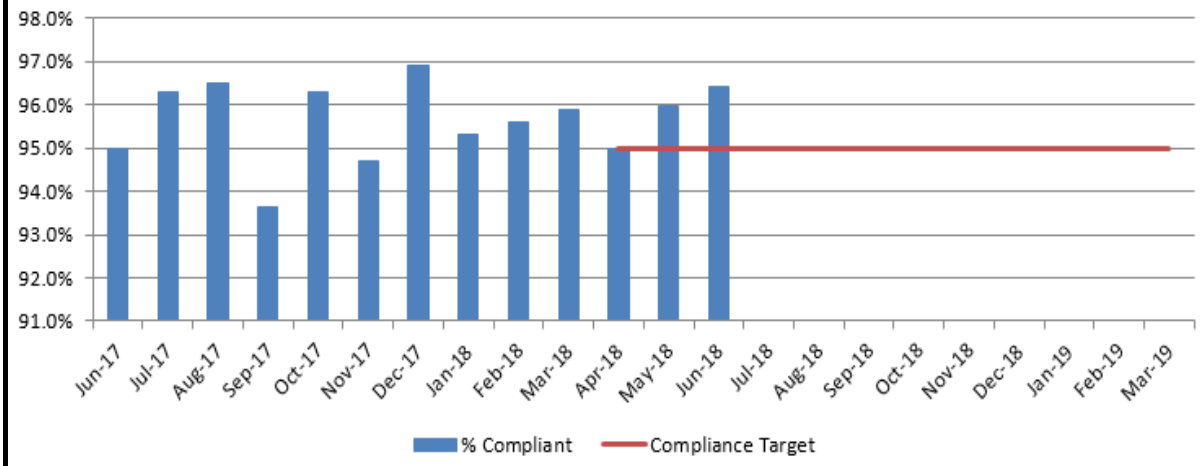
Measure 1: % compliance with Hand Hygiene Audits

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access	**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support	

Period : June 2018	**Annual Plan Profile :**	**Local Target :** 95%	**Current Status :** ✓	**Movement :** ⇧ Improving

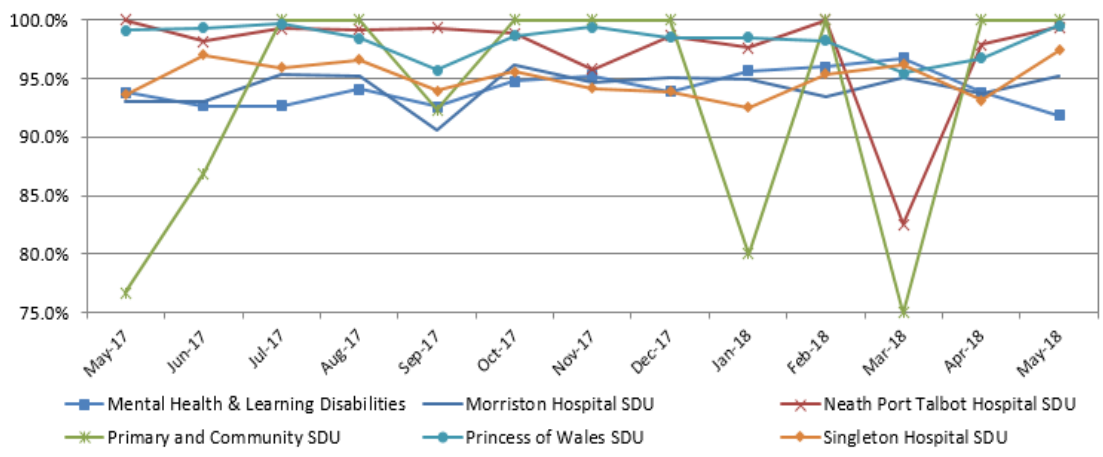
Current Trend: Jun 17 - Jun 18

(1) % compliance with Hand Hygiene Audits.



Benchmarking

(1) % compliance with Hand Hygiene Audits



Source : ABMU Care Metrics

Measure 1: % compliance with Hand Hygiene Audits

How are we doing?

- Compliance with hand hygiene (HH) for June 2018 was approximately 96%.
- For June 2018, 74 wards/units (51%) reported compliance ≥95%.
- 13 wards/departments (9%) reported compliance between 90% and 94%; 12 wards/units (8%) reported compliance of 89% or below.
- 47 wards/departments had not uploaded the results of their audits undertaken in June 2018.
- Five of the six Service Delivery Units (SDU) reported compliance ≥95%. Morriston reported compliance of 93% in June 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. This had not taken place during or since the influenza season.
- Peer review auditing is being considered within the Health Board (between wards/departments units).
- The updated Hand Hygiene Training programme is being delivered.

What are the main areas of risk?

- Main route of infection transmission is by direct contact, particularly by hands of staff.
- Poor compliance with good hand hygiene practice is likely to result in transmission of infection.
- Current scoring system may be giving an overly assuring picture of compliance; greater validation of the scores needs to be undertaken.
- The current system and format of scoring fails to highlight particular staff groups with lower compliance rates than others.

How do we compare with our peers?

- The HH score has been removed from the all-Wales dashboard because of the inherent difficulty in using one score to represent a whole Health Board.

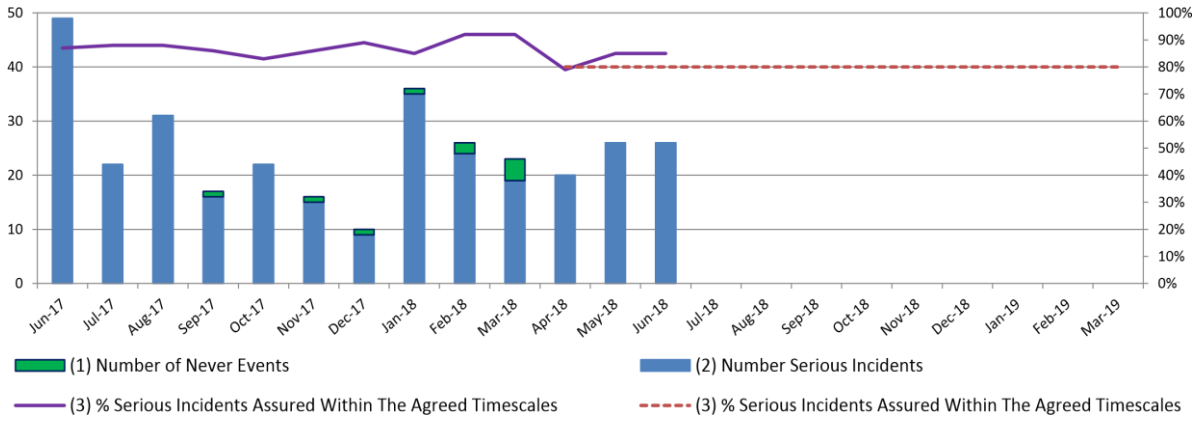
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 :** Gareth Howells, Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : June 2018	**Annual Plan Profile :** (1) 0, (3) 80%	**WG Target :** (1) 0, (2) 12 month reduction trend, (3) 90%	**Current Status:** ✓	**Movement :** Worsening

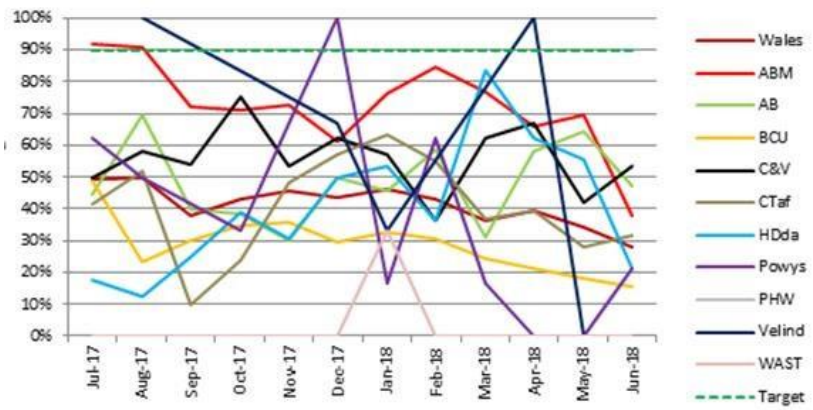
Current Trend: Jun 17 - Jun 18

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



Benchmarking

Serious Incidents Assured Within The Agreed Timescales



Never Events

Jun-18	
Wales	2
ABM	0
AB	0
BCU	1
C&V	0
Ctaf	0
Hdda	1
Powys	0
PHW	0
Velind	0
WAST	0

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 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?

SI Scorecard – completed on 16th July 2018.

- Total number of incidents reported in June 2018 was 2,134. This compares to 2,132 incidents reported in June 2017, an increase of 2 incidents for the month of June (increase of 0.1%).
- 26 Serious Incidents were reported to Welsh Government (WG) in June 2018 representing 1.2% of all incidents. In comparison, 49 SI's were reported to WG in June 2017, a decrease of 23 incidents. This decrease is not of concern as the increased number report in June 2017 was following audit of pressure ulcer incidents. Of the 26 new serious incidents reported to WG in June 2018, 20 (77%) related to pressure ulcer incidents (grade 3 and above), 4 (15%) related to patient falls, 1 (4%) related to Diagnostic Processes/Procedures and 1 (4%) related to Infection control.
- In terms of severity of incidents, the percentage of incidents resulting in severe harm for June 2018 was 0.6% (total incidents reported 2,219). The Health Board's target for incidents resulting in severe harm is 0.5% of the total number of incidents reported.
- No Never Events were reported in June 2018.
- Performance against the WG target of closing SI's within 60 working days for June 2018 was 85% against the WG target of 80%

What actions are we taking?

- The SI Team continues to trial the new reflective methodology approach to review serious incidents managed by the SI Team. Presentations promoting the approach are being undertaken across the Health Board to help promote an organisational learning culture. External presentation at Powys Health Board is also planned.
- The SI Team are leading on work to reduce variation in approaches to falls investigations. This includes the development of guidance to support reporting, investigation and learning from falls related incidents that resulted in severe harm. New investigation templates to support this work are currently being developed.

What are the main areas of risk?

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

How do we compare with our peers?

- Annual work plan updated for 2018/19 to include recommendations from the National inpatient falls audit. Plan will be monitored by the Falls Prevention and Management group (FPMG)

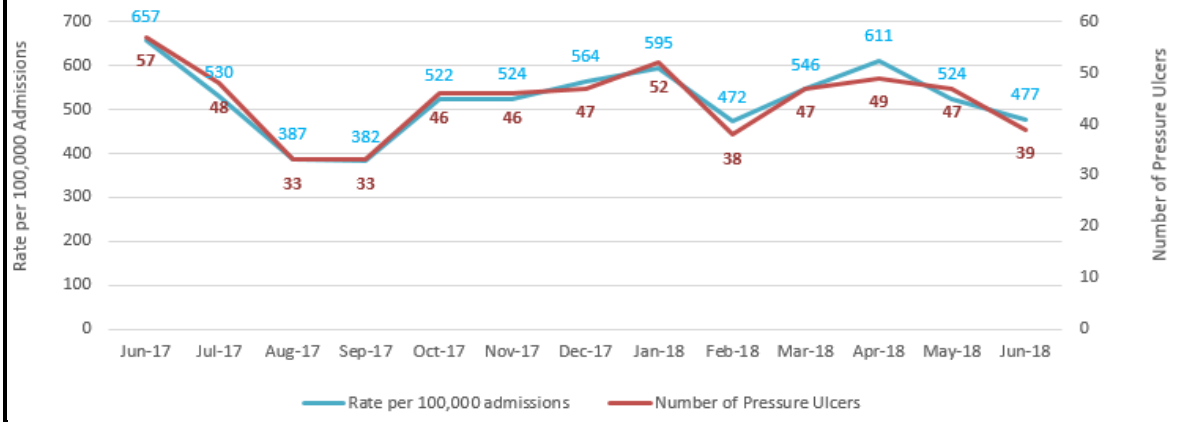
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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.

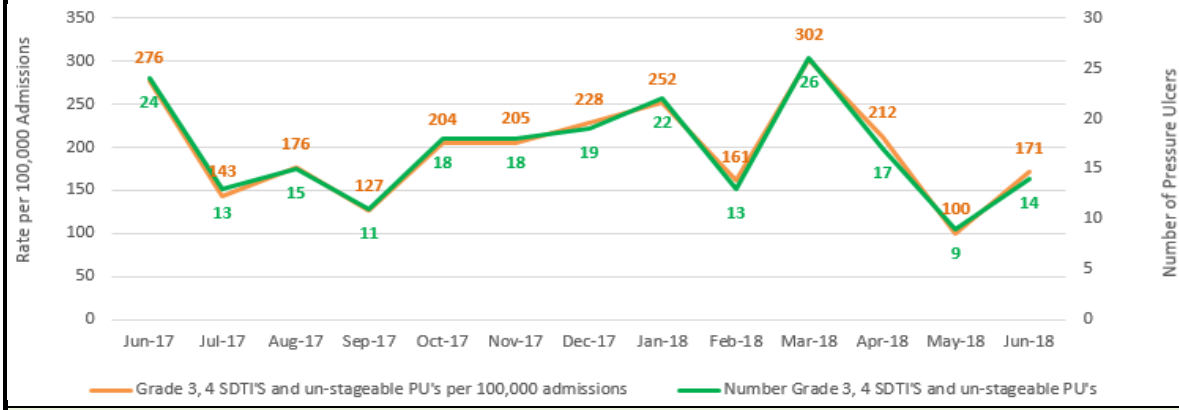
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience	
Period : June 2018	**Annual Plan Profile :** Reduce	**WG Target :** Reduce	**Current Status : N/A**	**Movement :** Impr

Current Trend: Jun 17 - Jun 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

Benchmarking data not available

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 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 a decrease in the rate of pressure ulcer development for in-patients during June 2018. The rate per 100,000 admissions fell from 524 in May to 477 in June 2018. This reflects a decrease in the number of pressure ulcers developing from 47 in May 2018 to 39 in June 2018.
- More than one pressure ulcer developed in 4 patients during June 2018, accounting for 8 of the pressure ulcer incidents reported.
- Device related pressure ulcers account for 2 of the reported pressure ulcers in June, a decrease from the 5 reported in May 2018.
- The rate of Grade 3+ pressure ulcers has increased from 100 per 100,000 admissions in May, to 171 per 100,000 admissions in June 2018.
- Comparison with the same period last year indicates significant reduction in the rate per 100,000 admissions of Grade 3+ incident reports, from 276 in June 2017 to 171 in June 2018
- Of the 14 Grade 3+ pressure ulcer incidents reported in June, 2018, 2 were classified as deep damage and met the criteria for Serious Incident reporting.

What actions are we taking?

- The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) was held in June 2018. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- An Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 was presented at PUPSG in June. The review examined 164 incidents and identified 23.2% cases as being avoidable and 65.5% as unavoidable.
- The review utilised the causal factor map developed by PUPSG and offers strong assurance that it is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The causal factor analysis also provides insight for individual Service Delivery Unit's (SDU's) to focus on location specific work.
- The most common causal factor for avoidable pressure ulcers was identified as inadequate frequency of patient repositioning. The revised Prevention and Management of Pressure Ulcers Policy clearly identifies the minimum requirement for repositioning for in-patients.
- Singleton Hospital is the pilot site for the development of a local strategic quality improvement plan. Progress on the plan was presented to the PUPSG in June 2018.
- Pressure Ulcer Investigator and Scrutiny Panel Development workshops have been delivered across the Health Board to support and develop the skills of senior staff involved in the new pressure ulcer investigation and scrutiny process that went live on Datix on June 4th 2018. Attendance was excellent and 149 senior staff attended.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all Service Delivery Unit's and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
- Datix scrutiny was conducted for June 2018 data, duplicate entries were identified and the data rectified to ensure accuracy.

What are the main areas of risk?

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.

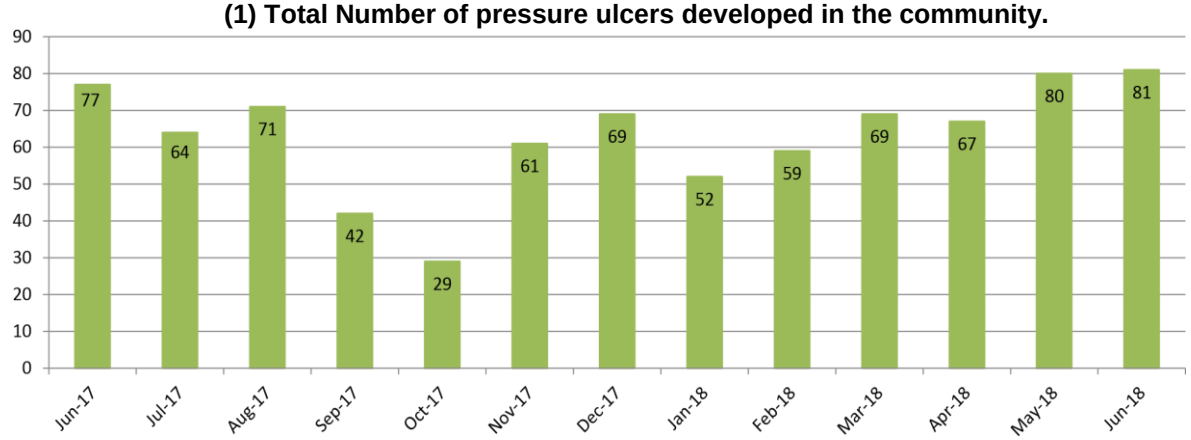
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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.

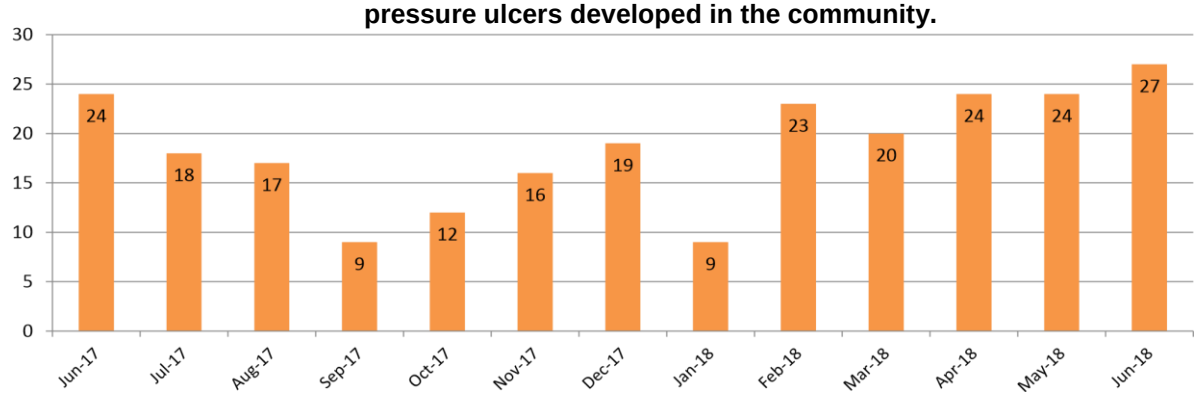
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience	
Period : June 2018	**Annual Plan Profile:**	**Local Target :** 12 month reduction trend	**Current Status :** ✖	**Movement :** ⇧ ● Worsening

Current Trend: Jun 17 - Jun 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

Benchmarking data not available

Source : PRESURE ULCERS FROM DATIX

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.

How are we doing?

- During June 2018, 81 incidents of pressure ulceration were reported in the community, this is a small increase compared to the 80 incidents reported in May 2018.
- More than one pressure ulcer developed in 9 patients during June 2018, accounting for 19 of the pressure ulcer incidents reported.
- Swansea locality reported 36 pressure ulcers, Bridgend locality 28 and Neath Port Talbot locality 17.
- Of the pressure ulcers reported in June 11 were grade 1 (intact reddened skin). There is an increasing trend for reporting Grade 1 damage indicating improved skin inspection and recognition of the early stage of injury to the skin.
- Device related damage accounts for 10 pressure ulcers, of those 3 were caused by devices owned by patients.
- There has been an increase in the number of Grade 3+ pressure ulcers reported, from 24 in May to 27 in June 2018.
- Of the Grade 3+ pressure ulcers reported in June, 15 were considered deep damage and met the criteria for Serious Incident (SI) reporting.

What actions are we taking?

- The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) was held in June 2018. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- An Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 was presented at PUPSG in June. The review examined 164 incidents and identified 23.2% cases as being avoidable and 65.5% as unavoidable.
- The review utilised the causal factor map developed by PUPSG and offers strong assurance that it is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The causal factor analysis also provides insight for individual SDU's to focus on location specific work.
- The most common causal factor for avoidable pressure ulcers was identified as inadequate frequency of patient repositioning. The revised Prevention and Management of Pressure Ulcers Policy clearly identifies the minimum requirement for repositioning for in-patients. However, the frequency of repositioning in patient's homes is sometimes challenging due to patient choice and the availability of care services.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all localities and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting. NPT locality has the most established scrutiny panel process and has seen a significant improvement in pressure ulcer prevention.
- Pressure Ulcer Investigator and Scrutiny Panel Development workshops have been delivered across the Health Board to support and develop the skills of senior staff involved in the new pressure ulcer investigation and scrutiny process that went live on Datix on June 4th 2018. Attendance was excellent and 149 senior staff attended.
- 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.

What are the main areas of risk?

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

How do we compare with our peers?

- No benchmark data available.

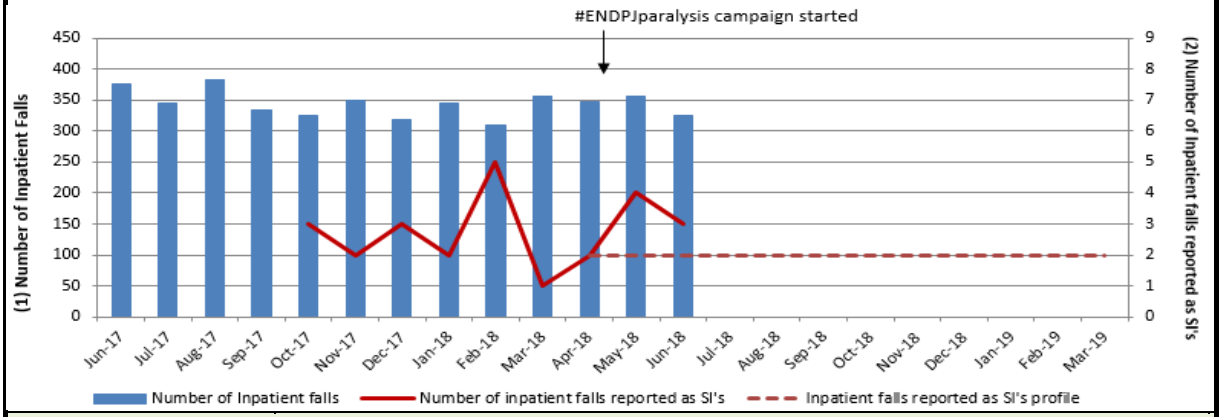
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Total Number of Inpatient Falls
Measure 2: Number of inpatients falls reported as serious incidents

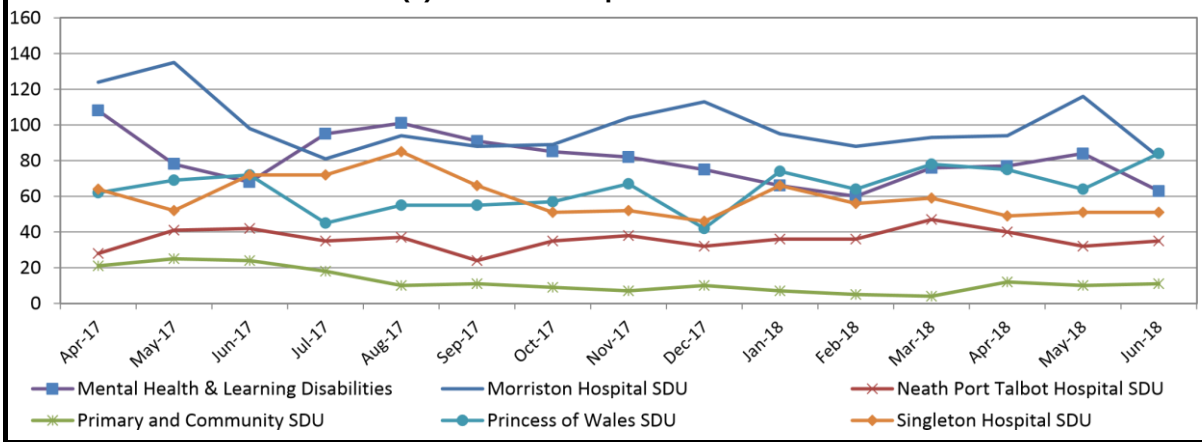
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead :** Gareth Howells, Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from abuse and neglect				
Period : June 2018	**Annual Plan Profile :** (2) 2	**WG Target :** (1), (2) 12 month reduction trend	**Current Status :** ✓	**Movement :** ↓ ● Improving

Current Trend: Jun 17- Jun 18

(1) Number of Inpatient Falls (2) Number of inpatients falls reported as serious incidents



(1) Number of Inpatient Falls



Benchmarking

No benchmarking data available

Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of Inpatient Falls
Measure 2: Number of inpatients falls reported as serious incidents

How are we doing?

- The number of falls reported via Datix in May 2018 showed an increase of 10 from the figures reported in April 2018; those reported for June 2018 showed a decrease of 31 compared to May 2018. The following Units reported a decrease in all falls recorded via Datix in May, Neath Port Talbot Hospital, Princess of Wales and Singleton, Primary and Community and Mental Health. Morriston reported an increase in falls during this period. In June, Mental Health and Morriston unit's reported a decrease in falls; with Neath Port Talbot Hospital, Princess of Wales and Primary and Community reporting an increase.

What actions are we taking?

The Falls Prevention and Management Group (FPMG) continues to meet monthly:

- The Falls Policy was taken to the Health Board Quality and Safety Forum for ratification in July, the Chair of the Quality and Safety forum will take the policy to the Health Board Quality and Safety Committee for ratification.
- Review of equipment ongoing - hi-lo beds purchased and insitu in Delivery Unit's, currently reviewing hoists.

What are the main areas of risk?

- Training needs remain a priority for the Health Board. A baseline audit of manual handling equipment also needs to be revisited. Once policy ratified a comprehensive implementation plan will be developed requiring sign up by multidisciplinary teams

How do we compare with our peers?

- Annual work plan updated for 2018/19 to include recommendations from the National inpatient falls audit. Plan will be monitored by the FPMG

7.3 Effective Care

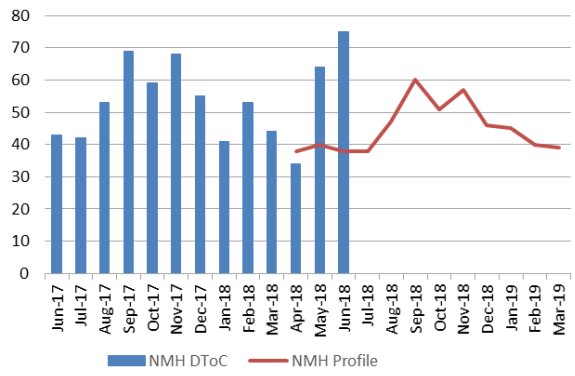
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

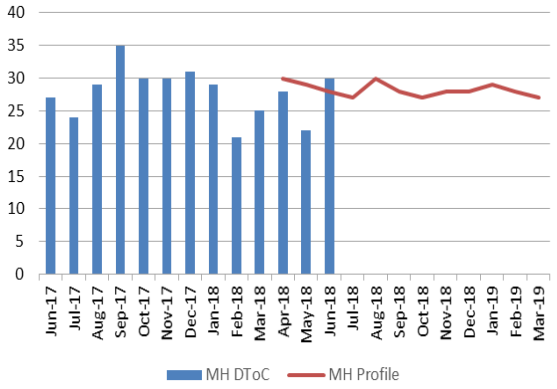
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : Health care and support are delivered at or as close to my home as possible				
Period : June 2018	**Annual Plan Profile:** (1) 38, (2) 28	**WG Target :** (3) ≥5% reduction (4) ≥10% reduction	**Current Status :** ✓	**Movement :** ⇩ ● Improving

Current Trend: Jun 17 - Jun 18

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



Measure 2: Number of Delayed Transfers of Care (DTOCs) for mental health (All ages)



Benchmarking

Measure 3: Number of non mental health Delayed Transfers of care (Rolling 12 months)

LHB	Current	Same Period Comparison		
	May-18	May-17	May-16	May-15
Wales	4,177	⇩ 4,156	⇧ 4,635	⇧ 4,352
ABM	625	⇧ 626	⇩ 540	⇩ 339
AB	965	⇩ 774	⇩ 930	⇩ 921
BCU	1,133	⇧ 1,372	⇧ 1,327	⇩ 1,053
C&V	461	⇧ 592	⇧ 863	⇧ 1,058
CTaf	280	⇧ 338	⇧ 350	⇧ 398
HDda	446	⇩ 230	⇩ 311	⇩ 241
Powys	259	⇩ 221	⇧ 310	⇧ 338
Velind.	8	⇩ 3	⇩ 4	⇩ 4

Measure 4: Number of mental health Delayed Transfers of Care (Rolling 12 months)

LHB	Current	Same Period Comparison		
	May-18	May-17	May-16	May-15
Wales	993	⇧ 1,121	⇧ 1,264	⇧ 1,280
ABM	331	⇩ 266	⇧ 340	⇩ 282
AB	84	⇧ 128	⇧ 117	⇧ 201
BCU	233	⇩ 202	⇧ 251	⇩ 205
C&V	124	⇧ 276	⇧ 251	⇧ 304
CTaf	85	⇧ 92	⇧ 121	⇧ 143
HDda	87	⇧ 151	⇧ 170	⇧ 143
Powys	49	⇩ 6	⇩ 14	⇩ 2

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

Measure 1: Number of Delayed Transfers of Care (DTOCs) for non-mental health specialities (age 75+)
Measure 2: Number of Delayed Transfers of Care (DTOCs) for mental health (all ages)
Measure 3: Number of Delayed Transfers of Care (DTOCs) per 10,000 LA population for non-mental health specialities (age 75+)
Measure 4: 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 residents reported as delayed at a Health Board site in June 2018 was 105. This is the highest number of patients reported as a delayed transfer of care within the Health Board area. This was an increase when compared with the 86 delayed transfers of care reported in May 2018, and an increase when compared with the 70 delayed transfers of care reported in June 2017.
- The overall bed days associated with delayed transfers of care in June 2018 was the highest reported level.

What actions are we taking?

- Continued implementation of the SAFER Flow Bundle to enable improvements in patient flow, working as an integrated system between health and social care to improve discharge planning. This includes supporting the National #EndPJaralysis campaign aimed at reducing patient risk and harm as a result of deconditioning in hospital as a consequence of prolonged discharge processes.
- Working with Local Authority partners around sustainable and integrated models of care in the community, developing cases for transformation/invest to save funds. A community services workshop was held on 3rd July with Western Bay partners to review the Western Bay Optimal model. This included agreeing standard definitions to code medically fit for discharge patients and working with Western Bay partners to start to develop a business case for a Total Discharge model to meet the growing demand for community care closer to home.
- The NHS Wales Delivery Unit will be conducting a follow-up review of the complex discharge process in August which will inform the Health Board's work programme going forward.
- Strengthening frailty models within the Health board which will support admission avoidance and reduce DToC'S

What are the main areas of risk?

- Capacity in the care home sector 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.
- Workforce including social work capacity.
- Effective Implementation of the patient choice policy and the discharge policy.
- Capacity to support ongoing care needs and placements out of area.

How do we compare with our peers?

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

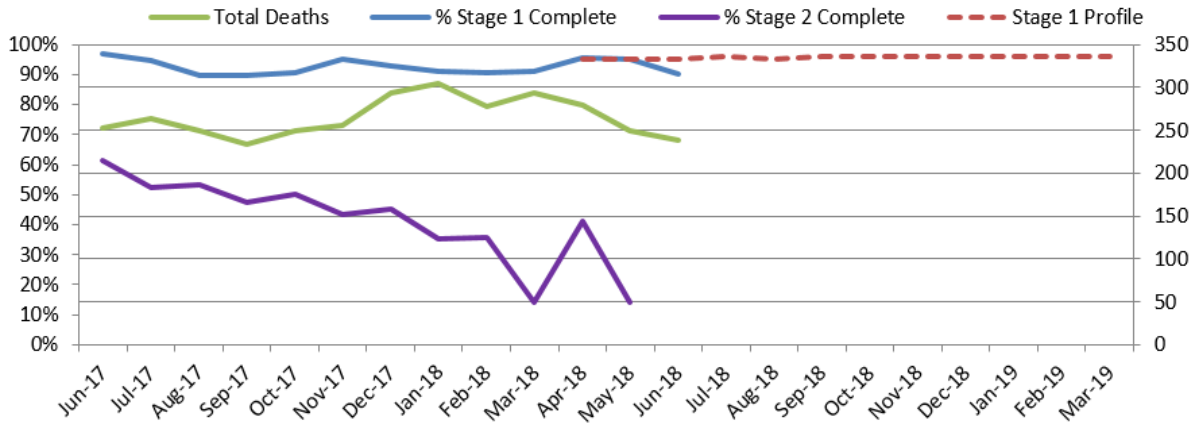
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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, Executive Medical Director	
Outcome Statement : Interventions to improve my health are based on good quality and timely research and best practice				
Period : June 2018	**Annual Plan Profile :** (1) 95%	**WG Target :** (1) 95%	**Current Status:** ✖	**Movement :** ⇧ ● Improving

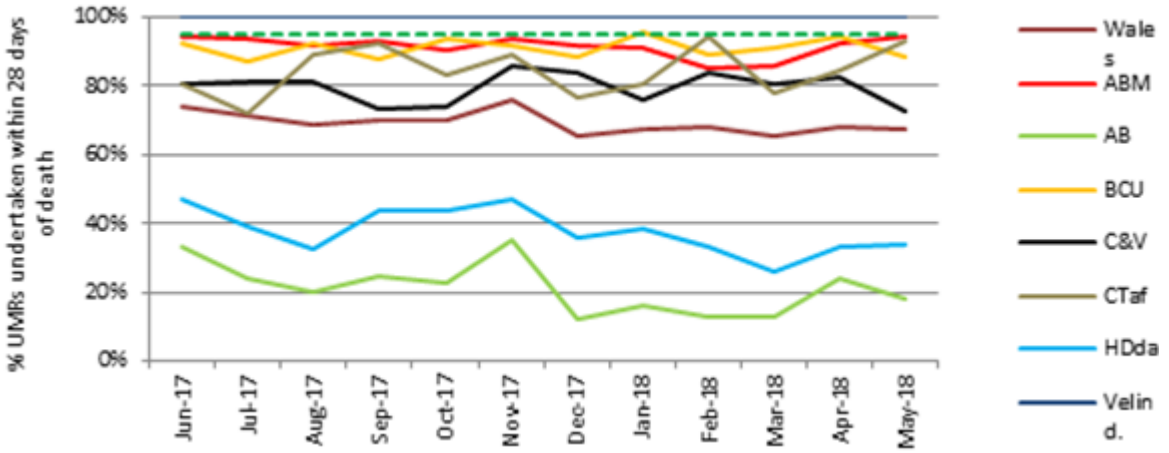
Current Trend: Jun 17 - Jun 18

(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



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 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?

- The Health Board UMR rate in June was 92.9%, 3% lower than April & May
- Singleton and Neath Port Talbot Hospital (NPTH) achieved 100%, Princess of Wales Hospital (POWH) 96% and Morriston 88%.
- There were 23 missing UMR forms, 19 in Morriston and 4 in POWH. 9/19 in Morriston were in General Medicine. 5/23 of the missing forms were from Palliative Medicine
- 15 deaths triggered a Stage 2 review in June
- Completion of Stage 2 reviews within 8 weeks (April deaths) was 41%. There are 80 outstanding Stage 2 reviews from April 2017 - March 2018. 40/80 (50%) from Morriston & 28/80 (35%) from POWH.
- Mental Health and Community data are unavailable via the eMRA application at present. This is being addressed by Informatics.
- Thematic (Stage 3) reviews - Nothing untoward was found in the majority of thematic reviews. Where a theme is identified, infection remains the most common, often pneumonia in elderly patients

What actions are we taking?

- Morriston Delivery Unit (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 new process has now been implemented by the Patient Affairs Team. They are working with doctors across the DU to raise awareness of the change and reinforce the requirement to complete the UMR as part of the administration process when a patient dies. There were fewer missing UMRs at Morriston this month which suggests that the changes are making a positive impact
- 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 has been piloted in the NPT Locality since January 2018.
- 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. Progress towards clearing the backlog of outstanding Stage 2 reviews has been good in Morriston and NPTH but not as good as anticipated in POWH and Singleton. The Unit Medical Directors (UMDS) have been asked to ensure that all outstanding Stage 2 reviews are completed by the end of May

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 (94.4% compared with 67.2%).

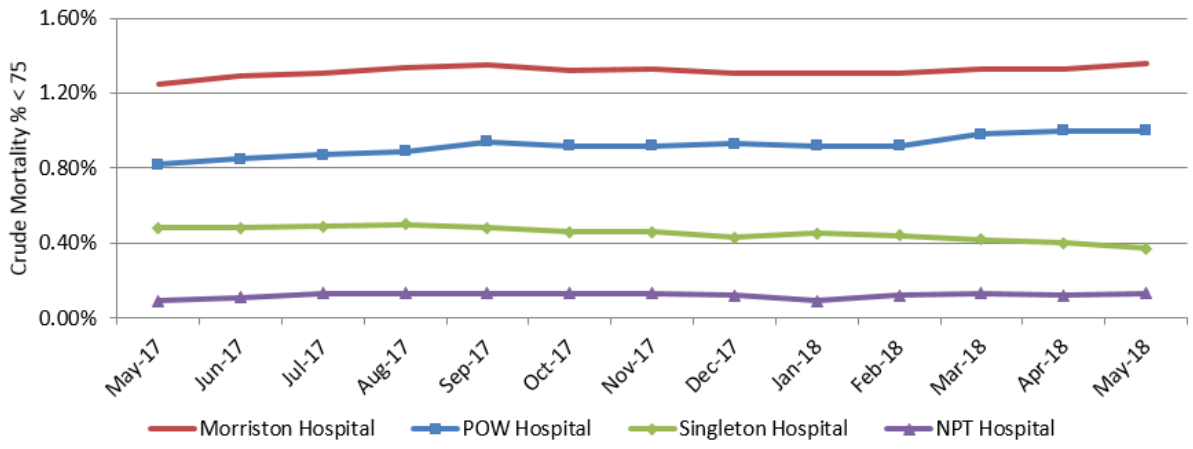
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access **Outcome Statement :** Interventions to improve my health are based on good quality and timely research and best practice			**Executive Lead :** Hamish Laing, Executive Medical Director	
Period : May 2018	**Annual Plan Profile :**	**WG Target :** 12 month reduction trend	**Current Status :**	**Movement :** Worsening

Current Trend: May 17 - May 18

(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 (JULY 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 May 2018 was 0.82%, compared with 0.78% for the same period last year
- Site level performance is as follows: (previous year in brackets) Morriston 1.36% (1.24%), Princess of Wales 1.00% (0.82%), Neath Port Talbot 0.13% (0.09%), Singleton 0.37% (0.48%). Site comparison is not possible due to different service models being in place.
- There were 92 in-hospital Deaths in this age group in June 2018 compared with 97 in June 2017: Morriston 43 (53), Princess of Wales Hospital 29 (21), Neath Port Talbot Hospital 1 (4), Singleton 20 (18).
- The number of deaths for Surgical and Elective cases remains consistently low for this age group.
- In the last 12 months the mortality rate at Princess of Wales has risen. Analysis undertaken has shown the number of deaths is not increasing but just demonstrating natural seasonal variation, while the number of patient episodes (the denominator in the calculation) has noticeably decreased. There are two reasons for this, the first being a change of process – some dermatology cases were being incorrectly recorded as day cases, while at other sites they were being recorded as outpatients which are not included in the calculated rate. Secondly, there are currently missing obstetric episodes which the Maternity Service have agreed to retrospectively input. This will increase the number of episodes included in the calculated rate.

What actions are we taking?

- A mortality report is considered by Clinical Outcomes Group (COG), chaired by the Executive Medical Director (EMD).
- 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. Neath Port Talbot service delivery unit presented in the June meeting and no concerns were identified.
- 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 March 2018 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 Quality & Safety Committee (Q&SC) in December and agreed. Good progress has been made in completing outstanding Stage 2 reviews in Morriston and NPTH but slower than anticipated in POWH and Singleton. Unit Medical Directors have been asked by the Exec MD to ensure that the backlog is completely cleared by the end of May. However, there are still a number of outstanding Stage 2s awaiting completion

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 May 18 – 0.82% compared with 0.73%.
- 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%)

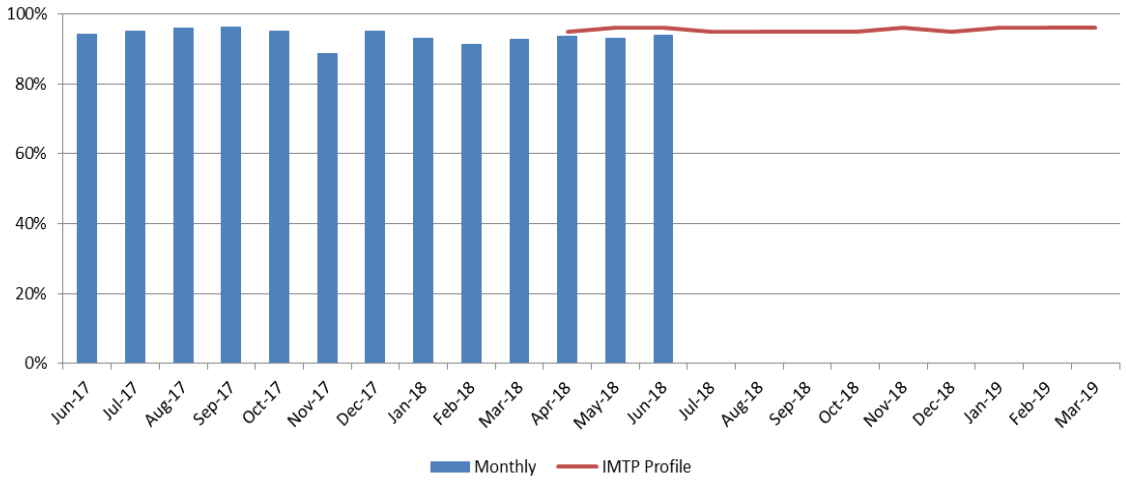
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % episodes clinically coded within one month post episode end date

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Hamish Laing, Executive Medical Director	
Outcome Statement : Interventions to improve my health are based on good quality and timely research and best practice				
Period : June 2018	**Annual Plan Profile :** 96%	**WG Target :** 95%	**Current Status :**	**Movement :**

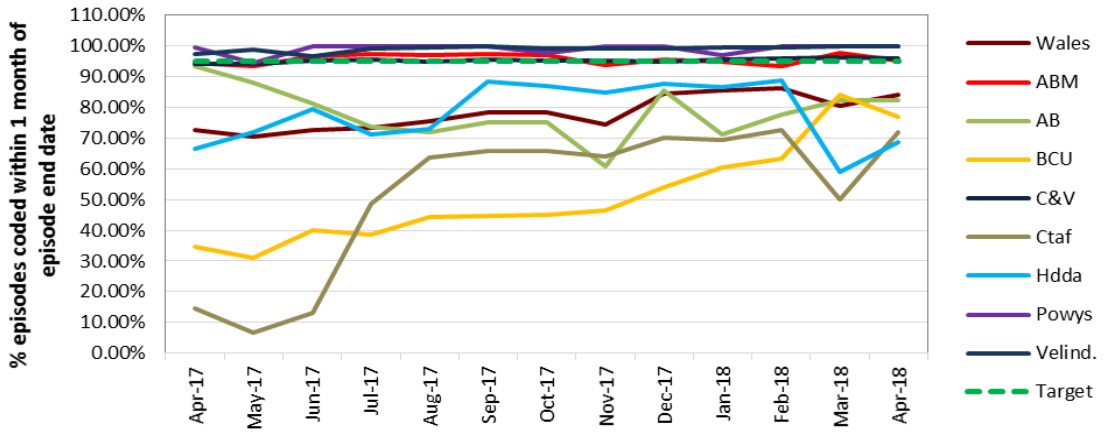
Current Trend: Jun 17 - Jun 18

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



Benchmarking

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



Source : NWIS Clinical Coding Extract JULY 2018

Measure 1: % episodes clinically coded within one month post episode end date

How are we doing?

- The completeness within 30 days for 2018/19 (snapshot positon) was, April 94%, May 93%, June 94%.
- The department has achieved overall cumulative coding completeness for 2018/2019 as follows: April - 98%, May 93%, June 97%
- Therefore despite narrowly missing the in-month compliance by a number of days the cumulative position is hitting the required performance levels. The Annual Plan profile is not currently being met as it was set above the national Welsh Government target and will be achieved once the trainees are qualified.
- The NHS Wales Informatics Service (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 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?

- Review of roles and responsibilities in the department to ensure that processes are performing at optimum levels.
- Continued training of the 6.5 WTE permanent staff which will address the completeness in month once staff are trained and competent - 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 one of the top performing Health Boards. Currently Welsh Government cannot identify the date coded field in the APC extract and therefore the national coding extract is taken 2 weeks after the Health Board position is captured, therefore improving the completion compliance. As a result national reporting of ABMU compliance is higher than that reported internally. ABMU records and monitors the target correctly. NWIS are reviewing the APC extract to address this discrepancy.

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

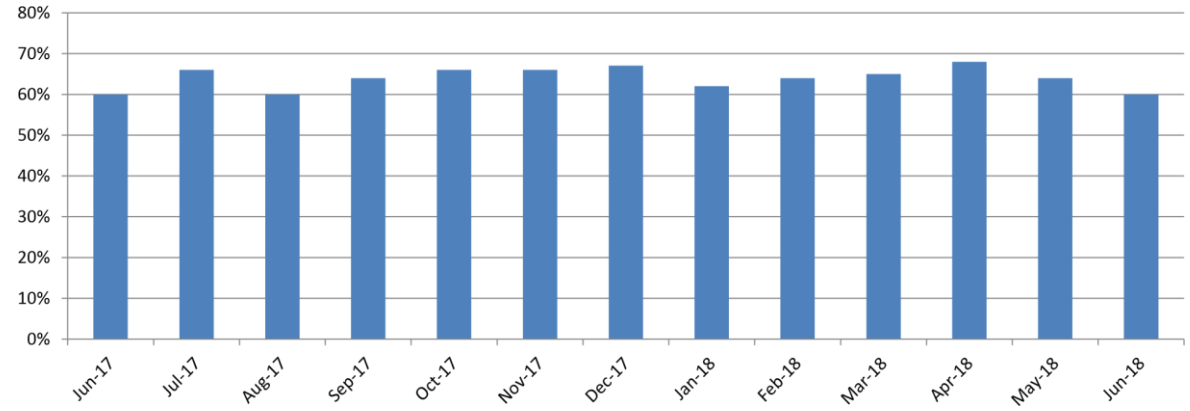
Measure 1: % of completed discharge summaries

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access	**Executive Lead :** Hamish Laing, Executive Medical Director
Outcome Statement : Interventions to improve my health are based on good quality and timely research and best practice	

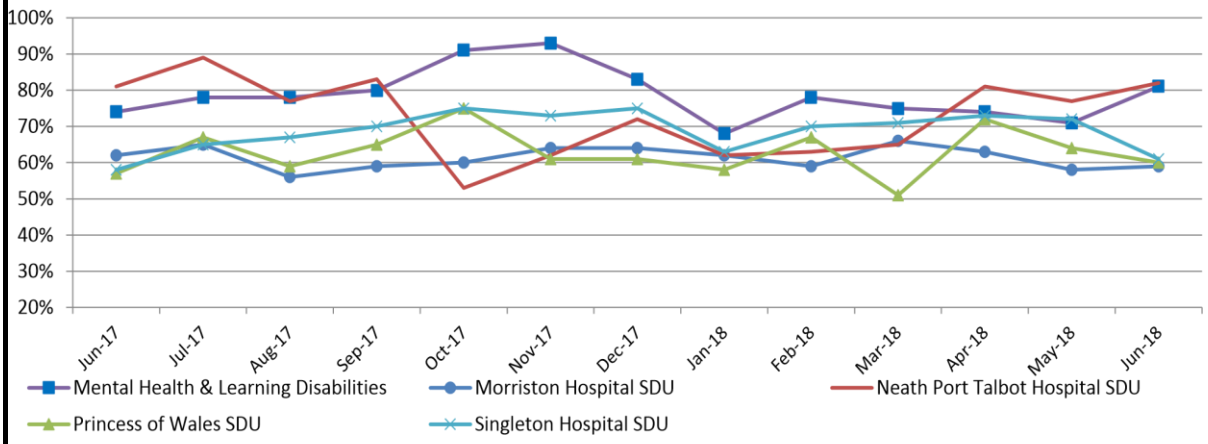
Period : June 2018	**Annual Plan Profile :**	**Local Target :** 100%	**Current Status :**	**Movement :** Worsening

Current Trend: Jun 17 - Jun 18

(1) % of completed discharge summaries ABMU



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



Benchmarking

No benchmarking data available

Source : ETOC Dashboard

Measure 1: % of completed discharge summaries

How are we doing?

- Performance in this quality priority has declined on a Health Board-wide basis in June (60%) compared with May (64%)
- Overall Health Board performance is now at the same level as June 2017 despite reaching 68% in April 2018
- There continues to be performance variance between Service Delivery Units (59%-82%)
- This month the performance has improved in 3/5 Delivery Units, and declined in the remaining two
- In June Neath Port Talbot was again the best performer, achieving 82%
- The most significant improvement in performance from May to June was in Mental Health & Learning Disabilities (81% in June compared with 71% in May)

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 has met with T&O Leads at Morriston and POWH to emphasise the need to prioritise discharge summaries.
- Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician' Associate role could improve communication
- The primary measure being used in Princess Of Wales Hospital 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

7.4 Timely Care

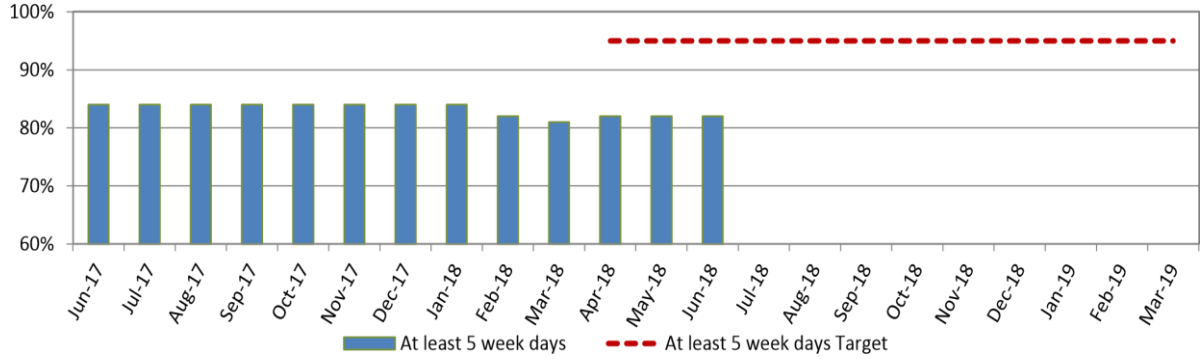
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

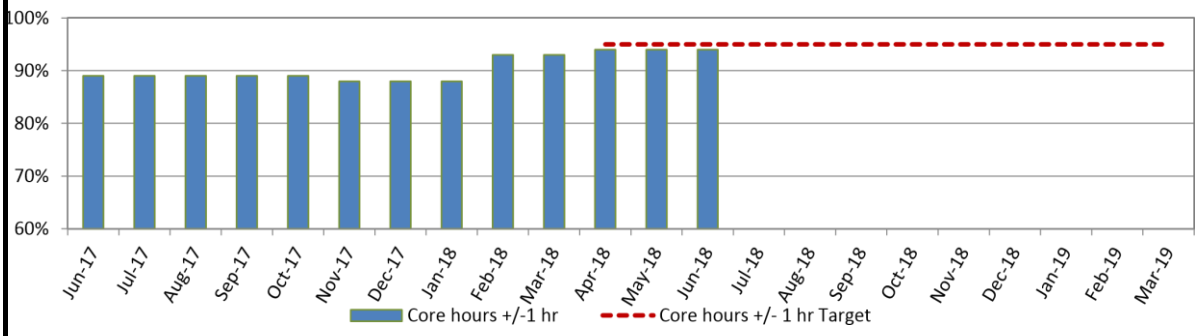
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : I have easy and timely access to primary care services				
Period : June 2018	**Annual Plan Profile:**	**WG Target :** (1) 95% (2) 95%	**Current Status :** ✖	**Movement :** ↓ ● Worsening

Current Trend: Jun 17 - Jun 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		
	2017	2016	2015	2014	2017	2016	2015	2014
Wales	84%	↑ 84%	↑ 79%	↑ 79%	87%	↑ 85%	↑ 82%	↑ 80%
ABM	78%	↓ 79%	→ 78%	↑ 69%	90%	↑ 85%	↑ 85%	↑ 73%
AB	97%	↓ 99%	↑ 95%	↑ 93%	99%	↓ 99%	↑ 93%	↑ 92%
BCU	69%	→ 69%	↑ 55%	↑ 63%	78%	↑ 74%	↑ 73%	↑ 73%
C&V	92%	→ 92%	↓ 94%	↓ 94%	88%	→ 88%	↑ 83%	↑ 83%
CTaf	95%	↓ 95%	↑ 93%	↑ 93%	90%	↓ 90%	↓ 93%	↓ 93%
HDda	80%	↑ 75%	↑ 65%	↑ 65%	73%	↓ 74%	↑ 65%	↑ 67%
Powys	100%	→ 100%	↑ 94%	↑ 94%	100%	→ 100%	→ 100%	→ 100%

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 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 June 2018 56/68 (82%) practices are offering appointments between 17.00 and 18.30 at least 5 nights per week. 68 (94%) practices are now open during daily core hours or within 1 hour of daily core hours. This is a further small improvement since March 2018.

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 over 18 practices who are experiencing sustainability issues.
- Five sets of practices have been supported through a discretionary framework to merge, thereby ensuring ongoing access to more sustainable General Medical Services. Three mergers have been completed and two are currently being progressed.
- 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 (LMC).
- A refreshed submission has been made to Welsh Government on access arrangements. Discussion have commenced with the LMC on the revision of the current access standards.
- Access data has been utilised as one of the criteria to score practices under the GMS governance arrangements is forming part of the visiting programme. Detailed discussions have been held with two practices to date.
- Clusters continue to be 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 transforming primary care model in Wales. Pacesetter funds have been awarded for a pilot of expanding physician associates in primary care and 5 placements will be offered during 18/19.
- 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.

What are the main areas of risk?

- Sustainability of general practice will result in poorer access if practices fail or take action to reduce access whilst still being compliant with their contractual requirements.
- Sustainability issues attributed to lack of ability to recruit, retain and poor locum availability

How do we compare with our peers?

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

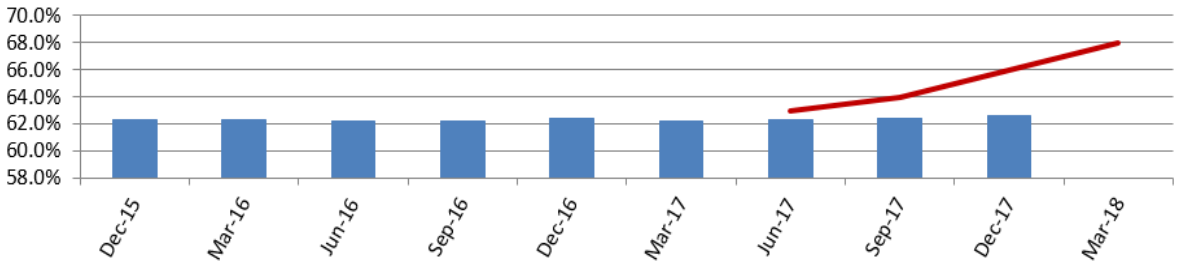
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : I have easy and timely access to primary care services				
Period : Dec 2017	**Annual Plan Profile :**	**WG Target :** Improve	**Current Status :** ✓	**Movement :** Improving

Current Trend: Dec 14 - Dec 17

(1) % Patients who received care or treatment from an NHS dentist at



Patient Group	No. of Patients receiving NHS Treatment in			
	Dec-15	Dec-16	Dec-17	Change, 15-17
Adults	249,760	249,210	250,560	+0.3%
Children	77,488	78,483	80,775	+4.2%
Total	327,248	327,693	331,335	+1.3%

Stats Wales

Benchmarking

LHB	Current	Same Period Comparison		
	Dec-17	Dec-16	Dec-15	Dec-14
Wales	55.0%	54.7%	54.8%	54.6%
ABM	62.6%	61.9%	62.3%	62.0%
AB	57.1%	56.5%	56.8%	56.3%
BCU	49.5%	49.8%	50.1%	50.3%
C&V	56.2%	55.9%	55.7%	55.0%
Ctaf	59.2%	57.9%	57.2%	57.5%
Hdda	45.9%	45.9%	45.4%	45.0%

Source : STATS WALES, Dental Services, NHS Business Services Authority

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

How are we doing?

- The latest Stat Wales release confirms the number/percentage of adults and children who received NHS dental treatment in the period up to December 2017, with a +1.3% increase from Dec 15- Dec'17. This figure demonstrates an overall +0.1% increase in access to GDS care for both adults and children in comparison to September 2015-17 performance report.
- Demand on NHS dentistry continued to remain high in Dec 17 and continues to be high in 2018.
- Previous narrative has documented the award of an additional 15,302 UDAs (£367,248) to GDS practices across the ABMU footprint in November 2017, the impact of this UDA award should be seen progressively in access figures throughout 2018-19. In addition, a new dental contract for 12,500 UDAs (£300,000) was awarded to a new dental provider during the same tender process. Due to problems with a restrictive covenant the establishment of the practice has been significantly delayed but with the recent development of NPT CBC agreeing to remove the covenant it is anticipated the practice should open between Oct/Nov'18 pending successful purchase of the building. This will provide a significant increase in access to dental care within the area during the latter part of 2018.
- The number of unique patients treated within GDS contracts reduced by 3% in 2017 compared to 2016, this reduction will require ongoing monitoring to understand patterns of access/usage.
- 10% increase in patient usage of the GDS urgent dental care services in April-Dec'17 (compared to the same time period in 2016). It should be noted this figure is inclusive of those patients who repeatedly utilise the service and is not the number of unique patients accessing urgent care.
- Practice year-end figures are currently being calculated to ascertain annual performance against contracted UDA targets for 2017-18, early indications show that 75% of practices over achieved or achieved within the tolerance level (95-100%) in 2017-18 as opposed to 82% in 2016. A number of practices that failed to reach their annual UDA target have explained recruiting GDPs to vacant posts has had a negative impact on their annual achievement levels due to posts remaining vacant for months as they have struggled to recruit.

What actions are we taking?

- Support the establishment of the new practice in Port Talbot to open Oct/Nov'18 to increase access to GDS care and monitor access in the practices awarded additional UDAs
- signpost/encourage patients to use mainstream dental services as an alternative to continued access of the urgent dental care services, this work will be supported by the Referral Management Centre based in PTRC with additional resources being added to the team .
- Plan to roll out paediatric dental GA pathway in Sep/Oct 2018 to accommodate urgent referrals into the service. The new pathway has already seen a reduction in GAs for dental treatment for routine patients (only 30% of routine patients are referred for a dental GA) and it is anticipated that a similar reduction will also be seen when urgent referrals utilise the new pathway in June/July 2018.
- Roll out the Contract Reform Programme - 6 practices currently working under new WG contract reform programme will begin to develop new patient pathways from Oct 2018 based on practice profile information gathered via the new ACORN toolkit. From Oct 2018 there will be a further increase in the number of practices joining the contract reform programme in ABMU.
- Consider options to improve the retention of GDPs in the local area- some practices failed to meet 2017-18 year end UDA targets due to vacant GDP positions remaining unfilled due to lack of availability of GDPs.
- Monitor compliance against the quality indicators to monitor the UDA uplift - this scheme should see improved access into these contracts over a 2 year period.

What are the main areas of risk?

- Continued delays in the new practice opening in Port Talbot. Delay in the roll out of the paediatric GA pathway to accommodate urgent referrals due to recruitment of staff. Numbers of unique patients accessing GDS services needs to be understood. Patient demand on the dental urgent care services. Recruitment and retention of GDPs in ABMU Health Board although this is a nationally recognised issue.

How do we compare with our peers?

- ABMU Health Board continues to maintain its positon as provider to the highest percentage of patients receiving dental care compared with all other Health Boards and is significantly higher than the Welsh average. ABMU also have the highest number of practices on the contract reform

programme and have been selected by WG to take the programme to the next level.

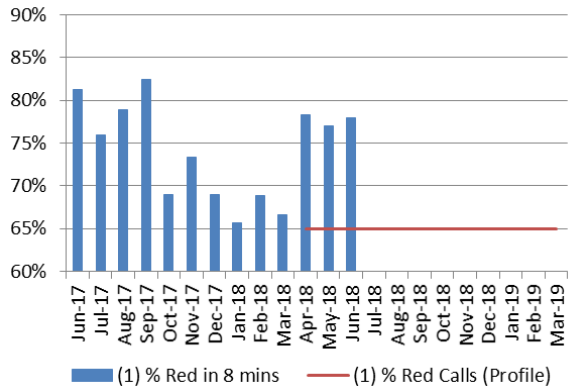
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

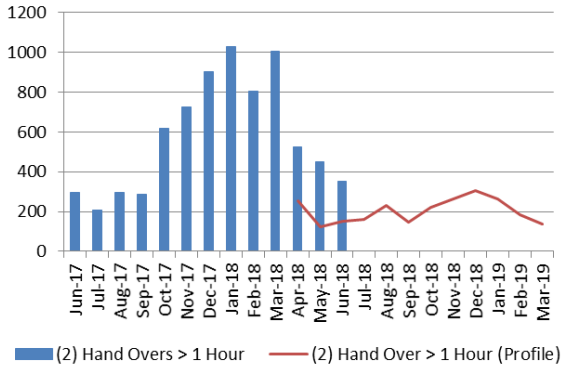
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access				**Executive Lead :** Chris White, Chief Operating Officer
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : June 2018	**Annual Plan Profile :** (1) 65% (2)152	**WG Target :** (1) 65% (2) 0	**Current Status :** ✖	**Movement :** ⇧ Worsening

Current Trend: Jun 17 - Jun 18

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

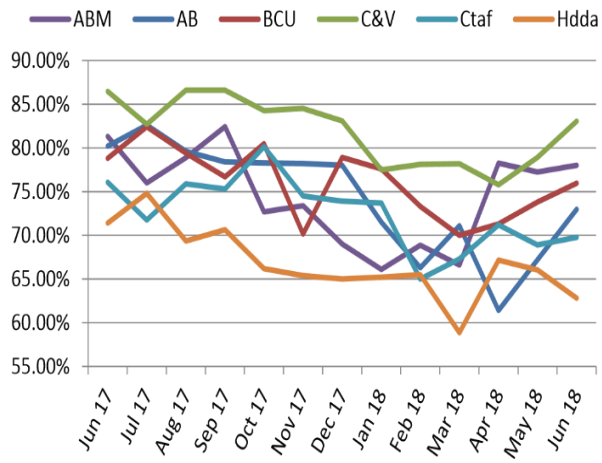


(2) Number of patients waiting more than 1 hour for an ambulance handover

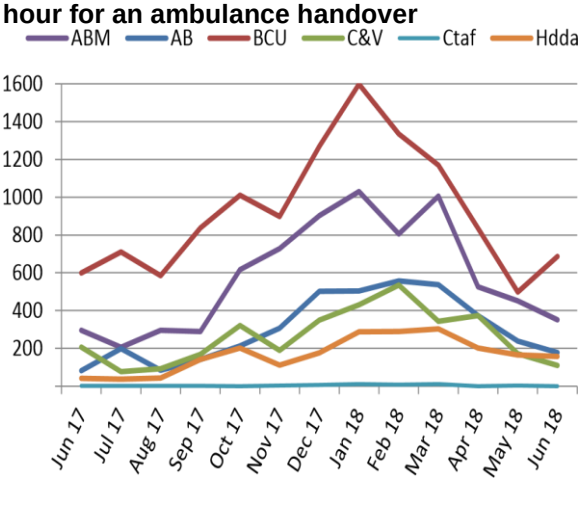


Benchmarking

(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 DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 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 78% in June 2018, against the National shared target of 65%. Response times for the most urgent calls improved from 77.2% in May 2018, but fell from 81.3% in June 2017.
- 1 hour ambulance handover performance has improved month on month during Quarter 1 although there was a 25% increase in the number of delays in June 2018 when compared with June 2017.
- 118 less patients (a 3.3 % reduction) were conveyed to our hospital front doors by ambulance in June 2018 when compared with June 2017. This is a reflection of the comprehensive joint work programme which is in place between the Health Board and WAST to reduce conveyance rates to hospital by an emergency ambulance.

What actions are we taking?

- The Health Board continues to work closely with WAST 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 was scheduled in July to undertake shared learning from the winter period and to explore additional opportunities to further improve the unscheduled care pathway within the HB.
- Continued development of pathways, models of care and the workforce to reduce health care professional requests for an emergency ambulance response.
- The Health Board has developed a management response to the WAST internal audit report on hospital handover which will be considered by the Health Board Audit Committee at the end of July 2018.

What are the main areas of risk?

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

- The Health Board delivered the 2nd highest Category A response time performance in Wales in June, and in line with the majority of other Health Boards in Wales has seen an improving position against this measure during Quarter 1. Whilst there has been an improving trend in the number of patients who have experienced a delayed handover ABMU, the Health Board continues to experience a higher number of delays than the majority of other Health Boards.

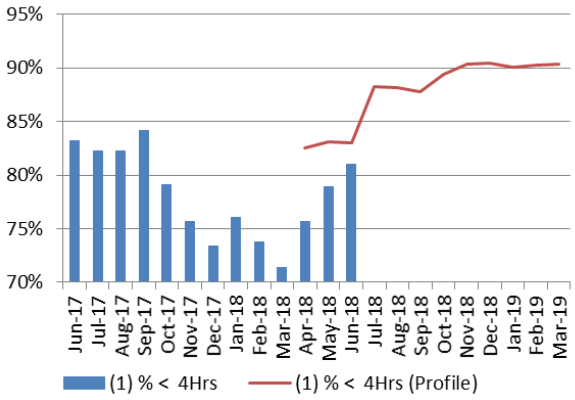
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

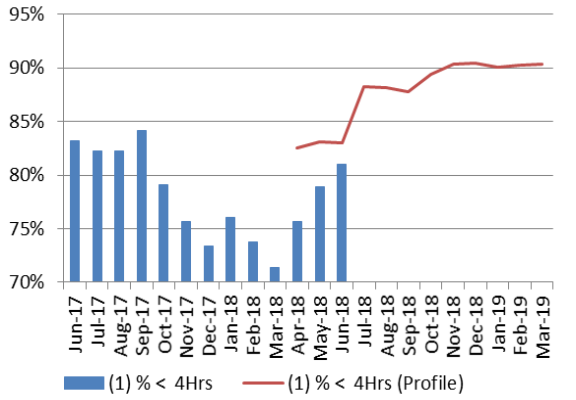
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : June 2018	**Annual Plan Profile :** (1) 83% (2) 190	**WG Target :** (1) 95% (2) 0	**Current Status :**	**Movement :** Wo

Current Trend: Jun 17 - Jun 18

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

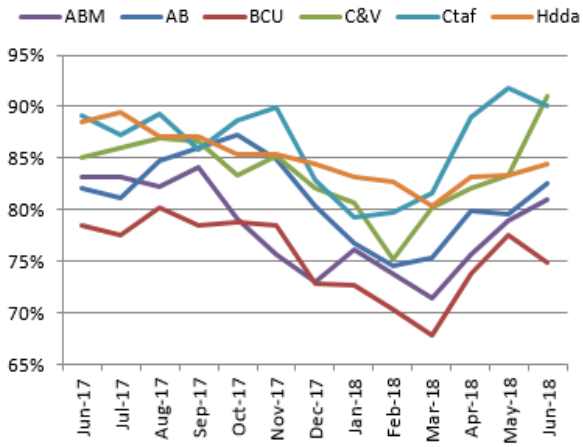


(2) Number of patients spending more than or equal to 12 hours in A&E

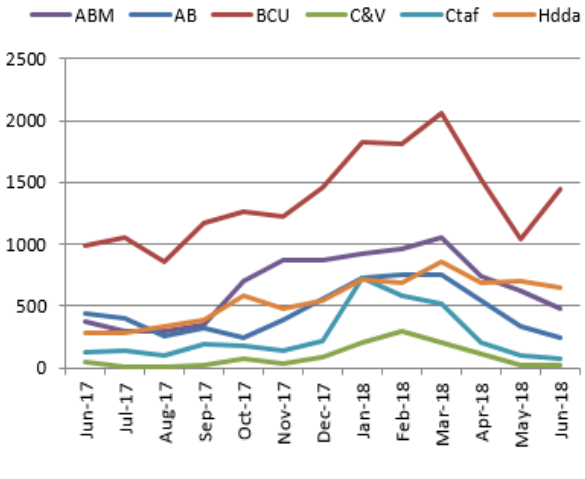


Benchmarking

(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 (JULY 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 June 2018 was 81.02%, which was best Health Board wide performance achieved against this measure since September 2017. 4 hour performance improved month on month during Quarter 1, although did not match the performance achieved in Quarter 1 of 2017.
- 477 patients stayed over 12 hours in our Emergency Departments (ED's) during June 2018, which represented a 24% reduction when compared with May 2018. However the number of patients waiting for admission, discharge or transfer from our ED's increased by 29% when compared with June 2017.
- The overall number of patients attending the Emergency Departments and minor injuries units in June 2018 increased by 521 attendances or 3.3%, compared with June 2018, with all our sites experiencing an increase. The unusually hot weather conditions experienced during the month were considered to be a contributory factor in the increased demand.

What actions are we taking?

- The ongoing and increased focus on implementation of the SAFER flow bundle to support patient flow, reducing un-necessary stays in hospital and increasing avoidable admissions. Supporting and promoting the national #endpjparalysis campaign between April and July to support earlier and more timely patient discharge, and to raise awareness of staff and the general public on the impact of unnecessary or avoidable hospital stays on patient outcomes.
- Working with partners in Local Authorities on arrangements to develop more sustainable models of care to support patient flow.
- Evaluating and developing new models of care between the ambulance service and primary and community care services to support patients at home.
- Implementation of Quarter 2 USC improvement plans.
- Implementation of the action plan developed following Breaking the Cycle to support sustainable improvement in patient flow and safety.
- Planning visit to UHW to obtain learning from the improvement activities that have resulted in improved and sustained 4 hour performance.
- The development of our winter assurance plan for 2018/19.

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 an increase in the number of patients in hospital who are 'discharge fit' and increasing length of stay
- Workforce - with ongoing challenges in general nursing and medical roles in some key speciality areas such as the Emergency Department (ED) and out of hours services.
- 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 81.02% in June 2018, compared with the all-Wales 4 hour performance of 83.2% for this period.
- In ABMU 97.1% of all patients were assessed, treated and transferred from the Emergency Department within 12 hours during June, compared with the all-Wales position of 96.9%.

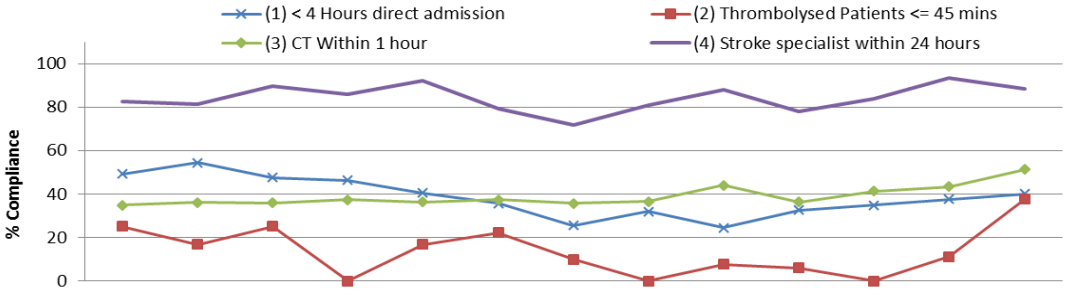
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : June 2018	**Annual Plan Profile :** (1)45% (2)25% (3)40% (4)75%	**WG Target :** 95%	**Current Status :**	**Movement :** In

Current Trend: Jun 17 - Jun 18

Acute Stroke Quality Improvement Measures



	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
(1) < 4 Hours direct admission	49.1	54.5	47.6	46.2	40.4	35.6	25.6	31.9	24.4	32.6	34.9	37.5	40.0
(2) Thrombolysed Patients <= 45 mins	25.0	16.7	25.0	0.0	16.7	22.2	10.0	0.0	7.7	5.9	0.0	11.1	37.5
(3) CT Within 1 hour	34.9	36.2	36.0	37.4	36.3	37.4	35.6	36.5	44.0	36.3	41.4	43.3	51.3
(4) Stroke specialist within 24 hours	82.6	81.2	89.5	85.9	92.3	79.1	71.9	80.8	88.1	78.0	83.9	93.3	88.2

Benchmarking

Thrombolysis Quality Improvement Measures June 18	AB	ABM	BCU	C&V	Ctaf	Hdda
1a - Percentage of All Strokes Thrombolsyed - H16.3	16.7%	21.1%	10.1%	16.7%	23.5%	15.9%
2b - Percentage of Eligible Patients Thrombolsyed - H16.55	100.0%	100.0%	72.7%	100.0%	100.0%	100.0%
1a - Thrombolysed Patients with Door-to-Needle <= 30 mins	10.0%	6.3%	11.1%	0.0%	8.3%	9.1%
2b - Thrombolysed Patients with Door-to-Needle <= 45 mins	20.0%	37.5%	11.1%	16.7%	33.3%	18.2%
3c - Thrombolysed Patients with Onset to-Needle <= 90 mins	10.0%	25.0%	22.2%	0.0%	8.3%	18.2%
4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Sc	90.0%	93.8%	100.0%	100.0%	100.0%	100.0%

Stroke Quality Improvement Measures June 18	AB	ABM	BCU	C&V	Ctaf	Hdda
1. < 4 Hours Care Performance Indicator	60.0%	39.5%	34.8%	41.7%	62.7%	55.1%
1a - Direct Admission to Acute Stroke Unit - H7.18	61.7%	40.0%	34.1%	44.1%	62.7%	46.4%
1b - Swallow Screening - H14.20	68.4%	82.6%	85.3%	51.4%	80.0%	82.0%
2. < 12 Hours Care Performance Indicator	100.0%	97.4%	95.5%	97.2%	98.0%	100.0%
2a - CT Scan - H6.12	100.0%	97.4%	95.5%	97.2%	98.0%	100.0%
3. < 24 Hours Care Performance Indicator	91.7%	85.5%	65.2%	69.4%	56.9%	82.6%
3a - Assessed by Stroke Consultant - H9.3	98.3%	88.2%	66.3%	72.2%	66.7%	94.2%
3b - Assessed by Stroke Nurse - H8.3	98.3%	98.7%	94.4%	94.4%	94.1%	94.2%
3c - Assessed by One of OT, PT, SALT	91.7%	97.4%	94.4%	100.0%	62.7%	89.9%
4. < 72 Hours Care Performance Indicators	98.3%	96.1%	93.3%	86.1%	96.1%	89.9%
4a - Formal Swallow Assessment - H15.24	100.0%	100.0%	93.9%	93.8%	95.2%	71.4%
4b - OT Assessment - H10.24	100.0%	96.6%	95.0%	85.7%	95.7%	92.5%
4d - SALT Communication Assessment - H12.24	100.0%	100.0%	98.8%	91.4%	97.9%	95.2%
5. < 1 Hour Care Performance Indicator	56.7%	51.3%	44.9%	41.7%	70.6%	63.8%
5a - CT Scan	56.7%	51.3%	44.9%	41.7%	70.6%	63.8%

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

Source : ALL WALES PERFORMANCE SUMMARY (JUNE 2018) + ACUTE STROKE QUALITY IMPROVEMENT MEASURES DU REPORT

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

How are we doing?

- Revised stroke measures have been implemented nationally from 1st April 2018, and improvement trajectories for the revised measures have been set.
- Performance against the 4 hour bundle remains a challenge due to unscheduled care pressures and staffing gaps in some key areas as a result of staff turnover and lead in times to recruitment into key clinical roles. However, there has been some strong recent recruitment into key medical posts which ought to support improvements in delivery once in post.
- Morriston stroke unit had 49 confirmed stroke admissions during June 2018 and the Princess of Wales received 27. All eligible patients received thrombolysis.

What actions are we taking?

- Weekly multi-disciplinary meetings are held in Morriston and Princess of Wales hospitals to review individual patient pathways and to identify opportunities for improvement. Actions being progressed in Quarter 2 include:

Morriston

- Appointment of nine additional Senior Clinical fellows in June and who would be taking up post in August should improve timeliness of patient assessment. A review of the On Call arrangements include an additional SpR overnight and on Saturday/Sunday with effect from August 18 is in development.
- Stroke Retrieval pilot planned for June is being evaluated by team to assess viability of continuation. Some improvements in turn around but further work required to be considered by local management team.
- Plans for a refresh of swallow screening training with ED is being taken forward.

Princess of Wales

- The Unit undertook two separate workshops during June - and five Task and Finish groups have been agreed to undertake more focused work in keys areas. An action plan is being prepared with key leads, delivery times for each action with a focus on improving the 4 hours bundle.
- The planned relocation of the TIA clinic in the next few months will release clinical nurse specialist time to support patient flow.
- The Delivery Unit review of the stroke pathway and its initial findings has reported back into the two workshops held in the Unit - and a final draft report is in the process of being completed by the end of July for review.

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 national funding to fund a dedicated project manager to support this work. Appointment has been made and the successful applicant will start in mid-September.
- Business cases have been developed for consideration by the Investments Benefits Group (IBG) to utilise spend to save funding to invest into an Early Supported Discharge service within both the Morriston and Princess of Wales Delivery Units.

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 May and June (although with a small improvement month on month). The Health Board thrombolysis rates for eligible patients were amongst the highest, with performance against the 45 door to needle times the best in Wales in June. Access to specialist assessment within 24 compares well with the majority of Health Boards. CT scanning time within 1 hour is improving but requires further work to match the best performing HB's.

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

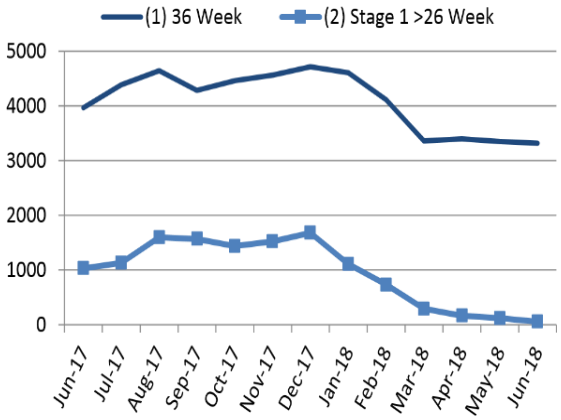
Measure 1: Number of patients waiting more than 36 weeks for referral to treatment (RTT)
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment
Measure 3: % patients waiting less than 26 weeks for referral to treatment (RTT)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access	**Executive Lead :** Chris White, Chief Operating Officer
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need	

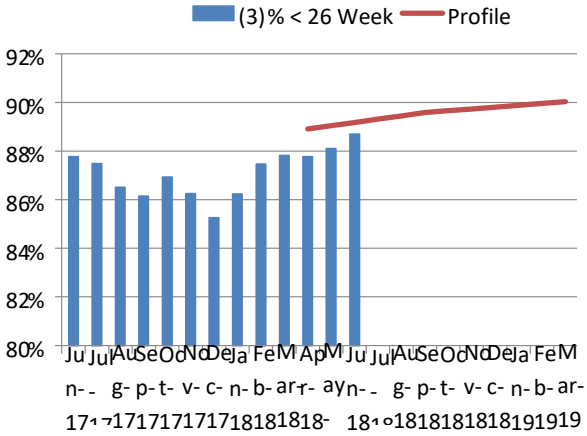
Period : June 2018	**Annual Plan Profile :** (1) 3,325 (2) 150 (3) 89.2%	**WG Target :** (1) 0 (2) 0 (3) 95%	**Current Status :**	**Movement :** Improving

Current Trend: Jun 17 - Jun 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

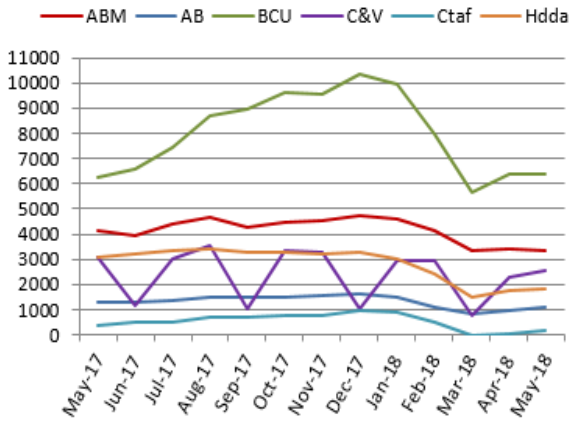


(3) % patients waiting less than 26 weeks for referral to treatment (RTT)

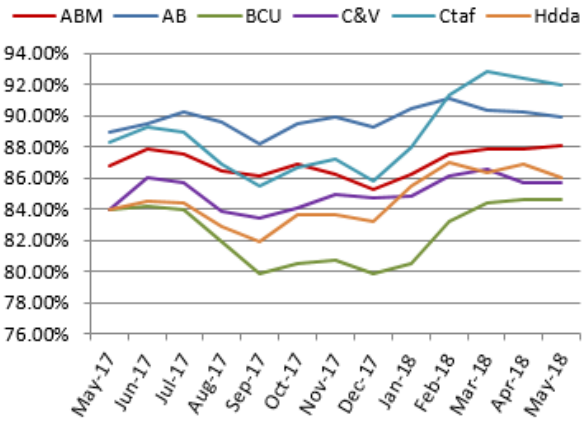


Benchmarking

(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 (JULY 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 June 2018 there are 55 patients waiting over 26 weeks for a new outpatient appointment. This was an in-month reduction of 65 compared with May 2018 (120 to 55) and is contained within Oral/Maxillo Facial (OMF), Gynaecology, Cardiology and Paediatrics.
- There are 3,319 patients waiting over 36 weeks for treatment in June 2018 compared with 3,966 in June 2017, this is an improvement of 647. There was also an in-month reduction of 30 compared with May 2018. ENT, General Surgery, Oral/ Maxillo Facial (OMF) and Orthopaedics collectively account for 3,079 of the over 36 weeks at June 2018. 97% of the patients waiting over 36 weeks are in the treatment stage of their pathway.
- 1,490 patients are waiting over 52 weeks in June 2018 which is 2% less than in June 2017 and 5% less patients than May 2018.
- The overall Health Board RTT target saw an improvement in June 2018 from 88.10% to 88.69%.

What actions are we taking?

- The focus at the weekly RTT meetings is now on Quarter 2 delivery. A range of immediate actions have been agreed in addition to those solutions identified within Unit plans to demonstrate the improvement required to deliver the end of September profiles. A high level summary of these include:-

- POWH and Morriston to explore the potential for a mobile staffed theatre unit to be located on each hospital site for orthopaedic joint work. Site visits have taken place and feasibility plans are expected by the end of July.
- POWH to work up job descriptions for two general surgery consultants in the sub-specialties of upper and lower gastrointestinal surgery for submission to the Royal College for approval by the middle of August.
- Morriston to continue level of outsourcing and scope potential for further capacity to be secured at a third private NHS provider by the 10th August.
- Morriston to explore the shift of carpel tunnel surgery to an outpatient treatment setting, freeing up theatre lists for other hand surgery. Feasibility plan by the middle of August.
- Upscale spinal consultant workforce to cover retirement and long term sickness through the appointment of locums through quarters two and three.
- Singleton to progress series of actions for addressing the sub-specialty pressures in Gynaecology including focussed Treat in Turn and booking management, pooling of lists where clinically appropriate and maximising backfilling opportunities to recover position by the end of quarter two.
- Singleton to increase pre-assessment activity for ophthalmology to ensure there are sufficient cases ready to fill lists through quarter two.

What are the main areas of risk?

- Lack of theatre and 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.
- 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 May 2018, 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) (88.1% compared with 87.4%) 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

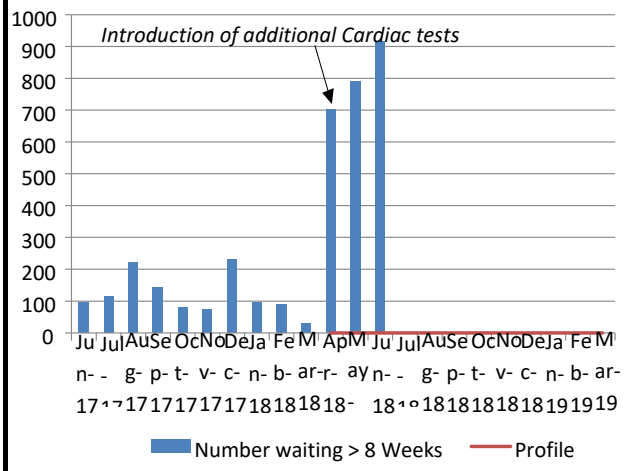
Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)
Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access	**Executive Lead :** Chris White, Chief Operating Officer
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need	

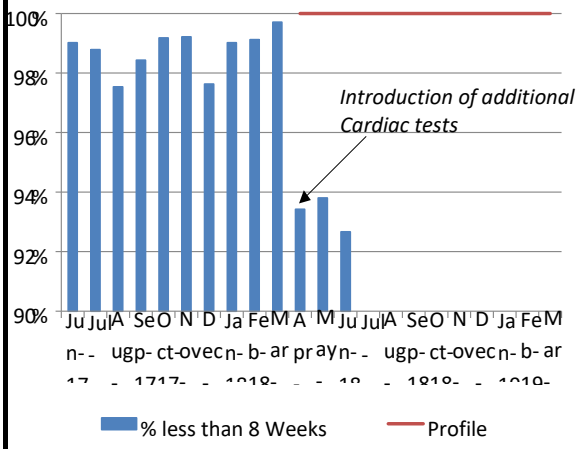
Period : June 2018	**Annual Plan Profile :** (1) 0 (2) 100%	**WG Target :** (1) 0 (2) 100%	**Current Status :** ✖	**Movement :** ⇧ ● Worsening

Current Trend: Jun 17 - Jun 18

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

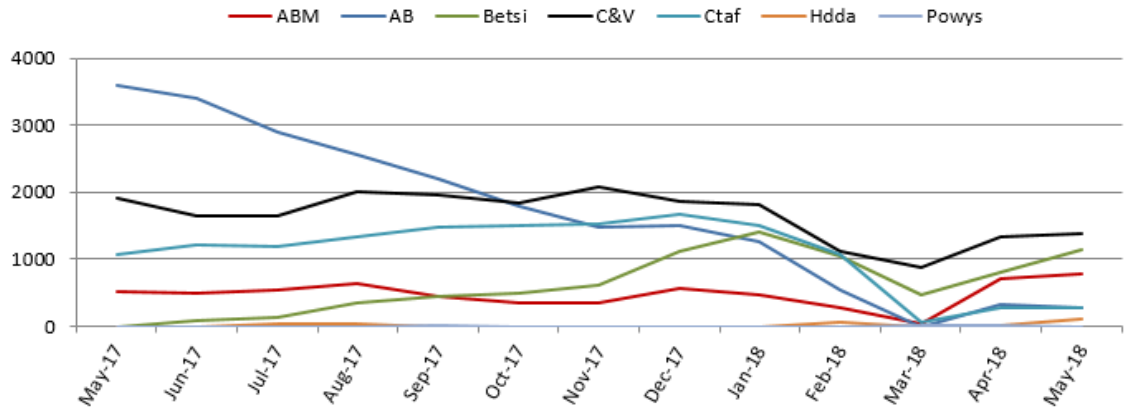


Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy



Benchmarking

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



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 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 915 patients waiting over 8 weeks for reportable diagnostics as at the end of June 2018. 254 breaches are for Non-Obstetric Ultrasounds (NOUS) in Princess of Wales Hospital. The remaining 661 breaches are for the additional Cardiac tests which have been made reportable since April 2018. The reporting of additional tests is intended to provide insight into delays for specific tests that have an impact on overall Cardiac Referral to Treatment Times. The breakdown for patients waiting over 8 weeks for Cardiac Tests in June 2018 is as follows:
  - Trans Oesophageal Echocardiogram (TOE)=10
  - Heart Rhythm Recording= 2
  - Dobutamine Stress Echocardiogram (DSE)= 13
  - Diagnostic Electrophysiology (EP Study)= 2
  - Diagnostic Angiography = 22
  - Cardiac Magnetic Resonance Imaging (Cardiac MRI)= 198
  - Cardiac Computed Tomography (Cardiac CT)= 414
- All of the other diagnostic areas maintained a zero breach position in June 2018.

What actions are we taking?

- The 254 NOUS patients at the end of June were as a result of reduced capacity to carry out extra work as the single Head & Neck Radiologist for Princess of Wales (POW) has been unable to take up additional sessions. All waiting list initiatives sessions planned in the last two weeks of June were cancelled and no further sessions allocated which took the anticipated risk of 60 to 254. Outsourcing is taking place through July to significantly improve the breach position with an aim to clear the backlog fully by the end of August. Discussions are taking place internally to scope the potential to increase the current number of Head & Neck Radiologist sessions from 2/3 per week to 5/6 per week displacing the non Head & Neck work to Radiology colleagues.
- The development of a Health Board wide solution for Cardiac CT and MRI is near completion and a joint meeting with Morriston and POWH service delivery units is scheduled for 2nd August to assess the plan and timelines.
- The suite of newly reportable cardiology diagnostics (excluding Cardiac CT and MRI) will clear at the end of August for Morriston and September for POW.

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 June 2018, which is the latest published data available at the time of writing this report, ABMU was the third worst performing Health Board excluding Powys.

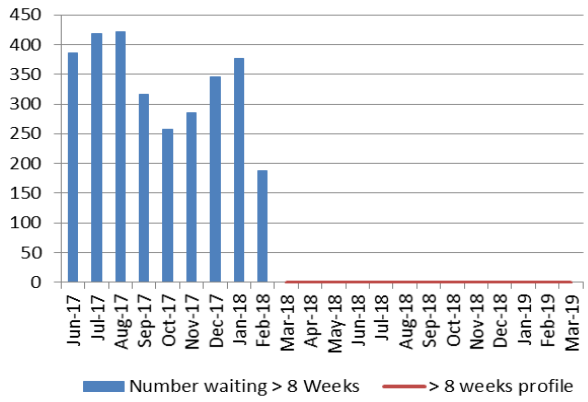
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: Number of patients waiting more than 8 weeks for Endoscopy
Measure 2: % patients waiting less than 8 weeks for Endoscopy

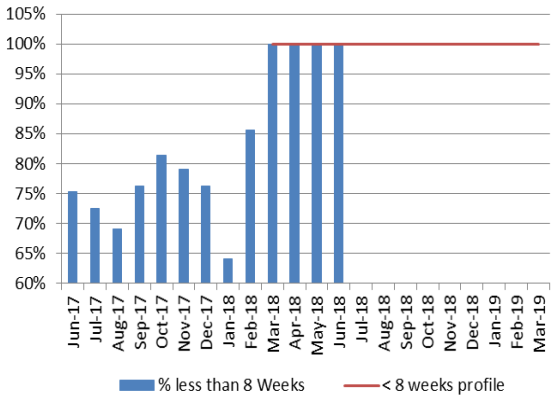
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : June 2018	**Annual Plan Profile :** (1) 0 (2) 100%	**WG Target :** (1) 0 (2) 100%	**Current Status :** ✓	**Movement :** Improving

Current Trend: Jun 17 - Jun 18

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

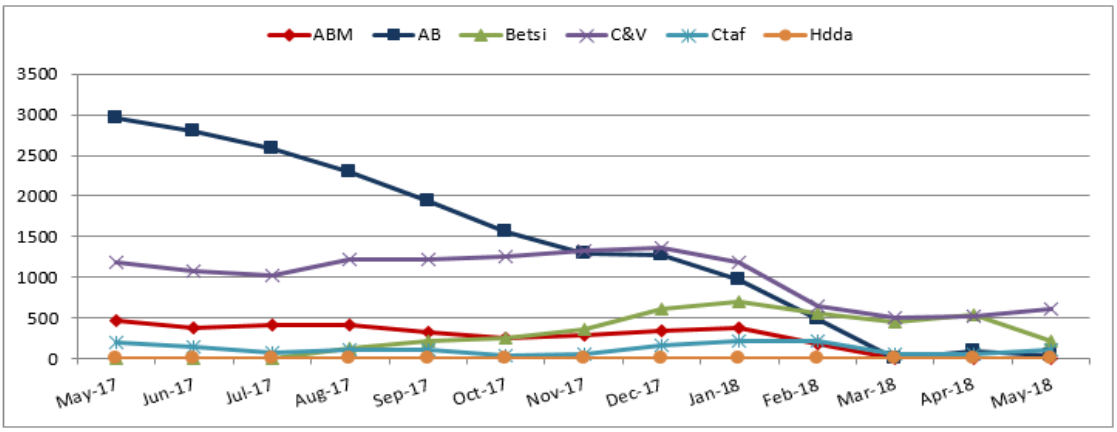


(2) % patients waiting less than 8 weeks for Endoscopy



Benchmarking

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



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 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 has achieved zero position for patients waiting over 8 weeks for endoscopy as of the end of June 2018 and we are currently reporting at 6 weeks.
- Endoscopy continues to see a significant increase in urgent suspected cancer referrals. The majority of these continue to be in the area of Lower Gastroenterology referrals internally from surgical specialties.
- DNA rates continue to remain low at 3%.

What actions are we taking?

- Utilising all available capacity with an average of 30 backfill lists being undertaken per month across 2 sites - current agreement for funding until end of August 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.
- Ongoing additional insourcing support until the end of August 2018 from Medinet to maintain the zero position
- Development of alternative diagnostic pathway in partnership with Radiology (CT colongraphy)
- 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.
- Singleton Endoscopy Unit refurbishment has now been completed and the unit is now environmentally 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.

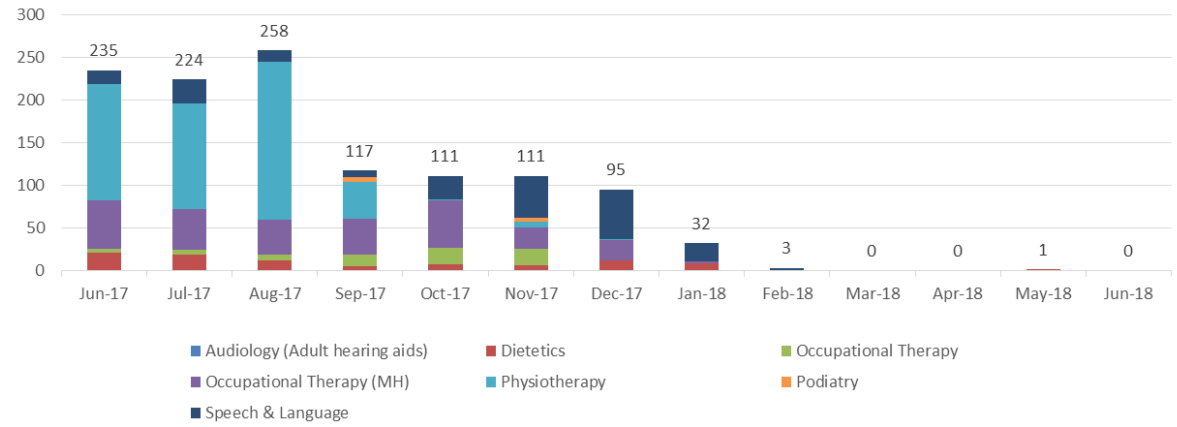
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : June 2018	**Annual Plan Profile :** (1) 0	**WG Target :** (1) 0	**Current Status :** ✖	**Movement :** Improving

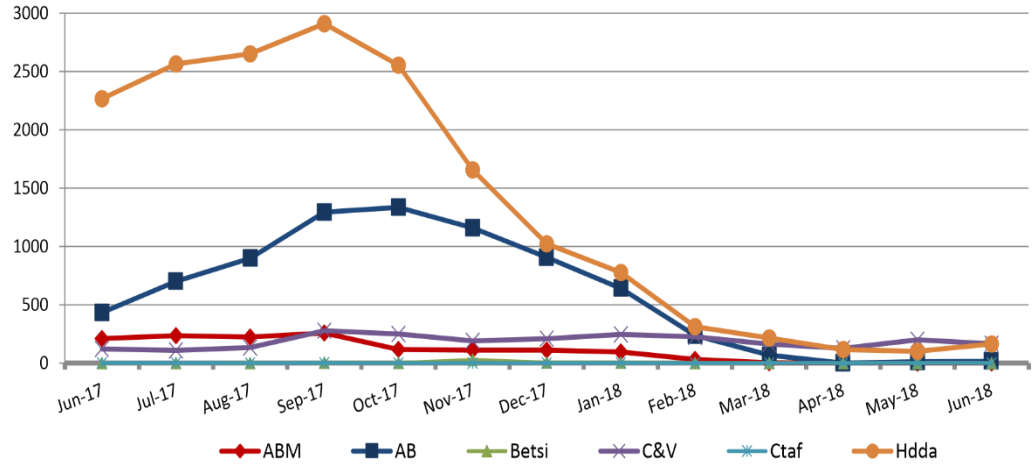
Current Trend: Jun 17 - Jun 18

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



Benchmarking

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



May-18	
ABM	1
AB	15
Betsi	0
C&V	166
Ctaf	0
Hdda	164
Powys	1

Source : NHS STATS WALES JULY 2018

Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy

How are we doing?

- Waiting times targets achieved a Nil position at the end of March 2018 across all therapy services and are being sustainably met currently. Walk in Clinics are supporting therapies such as Physiotherapy and Podiatry to manage new demand on the day and telephone services are also available to provide advice and offer intervention as required.

What actions are we taking?

- Teams continue to support each other across the Health Board to manage equity in waiting lists
- Proactive waiting list tool implemented which enables services to have an overview to flex staff across the Health Board to address 'hot spots' or an influx of referrals in one area
- In house developments continue, redesigning service models to utilise alternative skill mix wherever possible
- Ensuring booking is completed well in advance to provide sufficient headroom should to re-book should patients cancel in month
- Ongoing validation of the waiting lists

What are the main areas of risk?

- Planned maternity leave and inability to backfill with temporary posts
- Increasing demand on Walk in Clinics
- Vacancies and national shortage of qualified therapists

How do we compare with our peers?

- The Health Board is performing as well as or above our peers

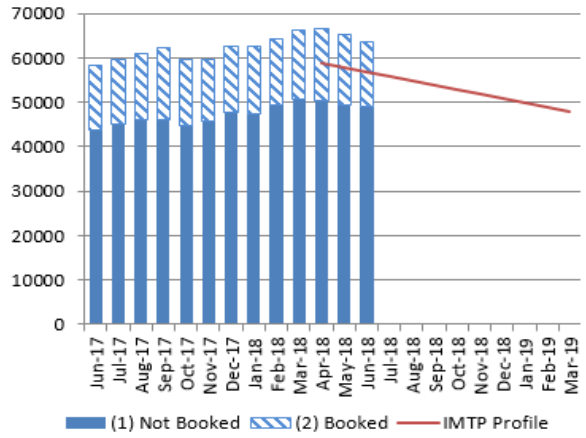
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

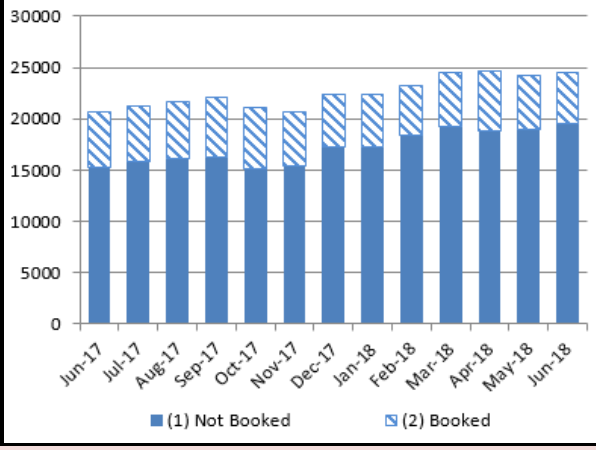
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : June 2018	**Annual Plan Profile :** (1) 56,770	**WG Target :** 12 month reduction trend	**Current Status :** ✖	**Movement :** ⇧ Worsening

Current Trend: Jun 17 - Jun 18

(1) Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for all specialties

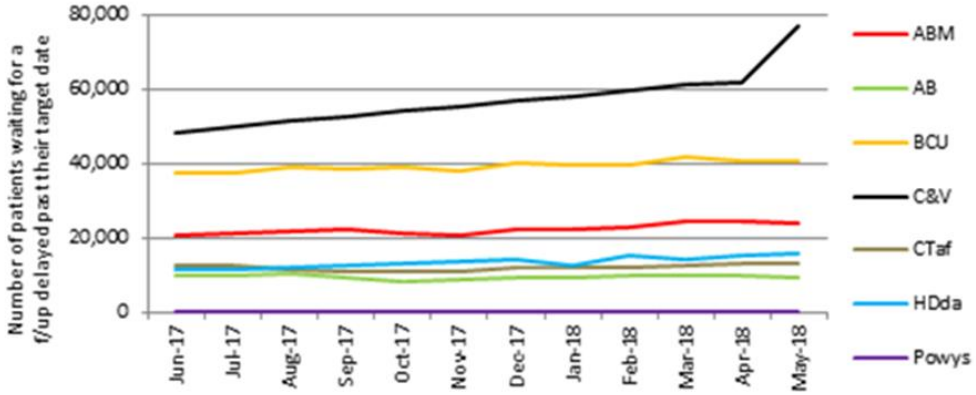


(2) Number of patients waiting for an outpatient follow-up (booked & not booked) who are delayed past their agreed target date for planned care specialties



Benchmarking

(2) Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date for planned care specialties



Source : NHS STATS WALES JULY 2018

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

How are we doing?

- The number of patients waiting for a follow up appointment delayed past their target date (booked and not booked) has increased from 58,490 (June 2017) to 63,776 (June 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 49,493 to 48,953. There are 12% more delayed follow up not booked with the same period 12 months ago (43,766 to 48,953).
- Delayed Follow Up (Booked): In-month performance has slightly improved with a decrease in the number of booked patients waiting for a follow up appointment delayed past their target date from 15,794 to 14,823. There are 1% less delayed follow ups booked with the same period 12 months ago (15,451 to 14,823).
- In June 2018 the Health Board is 4,686 higher than the Annual Plan profile.

What actions are we taking?

- Each Delivery Unit has developed 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 Supporting Delivery Board. The expectation is that the plans are regularly monitored through local delivery mechanisms and the Outpatient Improvement Group to ensure the expected Annual Plan profile for 2018/19 is delivered and to provide assurance that those highest risk patients are being addressed and ensure that patients are not being harmed.
- A Q1 progress update and Q2 plans are expected from the Delivery Units by the 27th July 2018.
- The Wales Audit Office (WAO) in 2015 and 2017 has reviewed follow-up outpatient appointments in ABMU. 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.
- Internal Audit are undertaking a review of progress against the Welsh Audit Office (WAO) recommendations. A report is due by August 2018.

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 delayed follow-up list.
- Need to better prioritise validation activities. Service Delivery Units to provide regular assurance reports to Health Board Quality & Safety Committee and Outpatient Transformation Work stream.

How do we compare with our peers?

- ABMU, BCU, C&V and Hywel Dda have experienced a deteriorating position in the number of patients waiting for an outpatient follow up (booked and not booked) who are delayed past their target date for planned care specialties from June 2017 to May 2018. The CT position has remained stable and the AB position has improved.

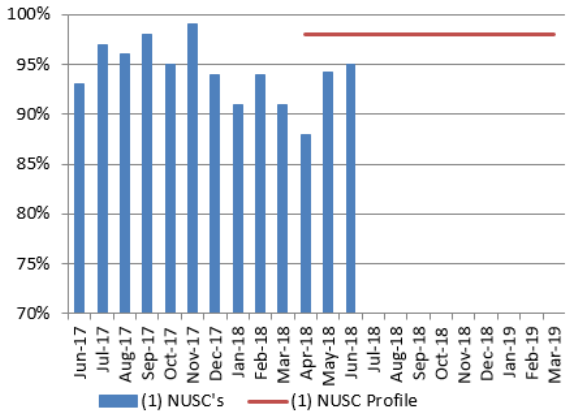
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

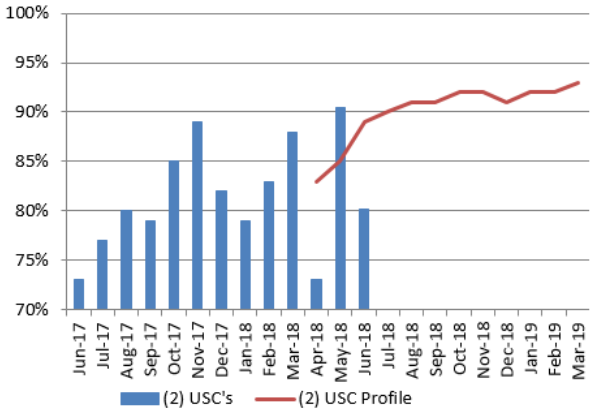
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : June 2018	**Annual Plan Profile :** (1) 98% (2) 89%	**WG Target :** (1) 98% (2) 95%	**Current Status :**	**Movement :** Improving

Current Trend: Jun 17 - Jun 18

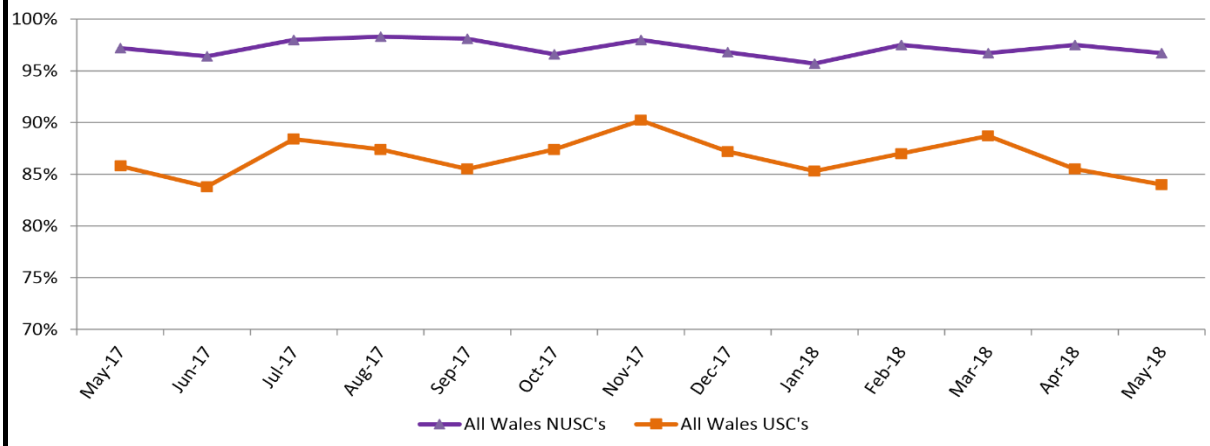
(1) % of patients newly diagnosed with cancer not via the urgent route that started treatment within 31 days



(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 (JULY 2018)

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

How are we doing?

- NUSC performance for June 2018 is 96% (6 breaches).
- USC performance for June 2018 is 84% (22 breaches).
- USC referrals received by the Health Board remain high during Q4. The monthly average during the 13 months May 17 to May 18 is 1810. 2055 referrals were received in May 2018.
- Patients waiting over 62 days in backlog have reduced from its peak of 58 at the beginning of April to 32 at the end of June.

What actions are we taking?

- Full implementation of the Post-Menopausal Bleeding (PMB) pathway with aim to improve waiting times for diagnostics, which will reduce overall wait from referral to treatment.
- All theatre lists reviewed. Additional weekend WLI theatres arranged to accommodate USC and NUSC patients.
- Evening Breast waiting list initiatives being held at Singleton through July and August.
- Additional endoscopy lists undertaken to keep waits to a minimum
- The service improvement lead for Cancer Services is also working with the Oncology department to review processes and improve efficiency.
- Demand and Capacity work completed for Breast outpatients; Urology outpatients; PMB; Colorectal outpatients (General Surgery); Gastroenterology outpatients.
- A prototype of the vitals charts for demand and capacity has been developed for Radiotherapy and work is underway for endoscopy.
- Options to increase capacity for template biopsy are being progressed at POWH.
- Discussion to be held with OG Lead at Morriston to review diagnostic bundling for patients with OG cancer.
- Advert to be placed to progress with the recruitment of a 4th Gynae-oncology surgeon.

What are the main areas of risk?

- Unscheduled Care pressures are having an impact on bed capacity although site management processes aim to minimise impact on cancer cases.
- Continued growth in demand and therefore the backlog
- On-going challenges to appoint to vacant posts and time lag in developing new workforce models
- Delays to diagnostic endoscopy service
- Growing waiting times in Chemotherapy and radiotherapy –pressures around vacancies / planned maternity leave / changes in NICE guidance.
- Ongoing issues with delivery of Urological services at Princess of Wales Hospital
- Delays in Gynaecological theatre capacity
- Ongoing issues with delivery of Breast services

How do we compare with our peers?

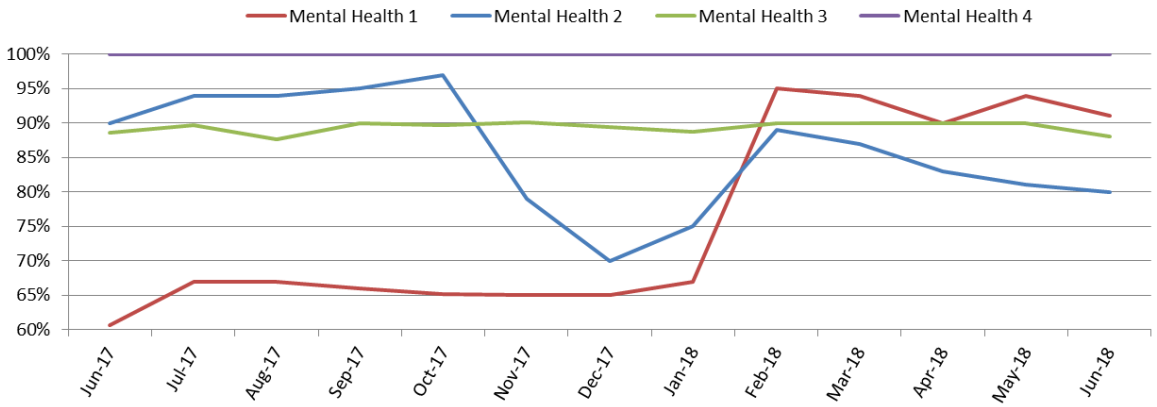
- Overall USC performance continues to struggle in comparison with other Health Boards however comparison of the May performance across Wales by WG demonstrates:
  - BCU was the worst performing HB with 26 reported breaches, followed by ABUHB 25 breaches; C&V 24 breaches; ABMU and Cwm Taf both had 15 reported breaches and Hywel Dda with 4 breaches.
  - Hywel Dda was the only HB to achieve their USC target achieving 95.4%. ABMU achieved 90.4%, Cwm Taf 82.3%, BCU 80.8%, ABUHB 80.5% and C&V with 73.3%, their worst performance since December 2015

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

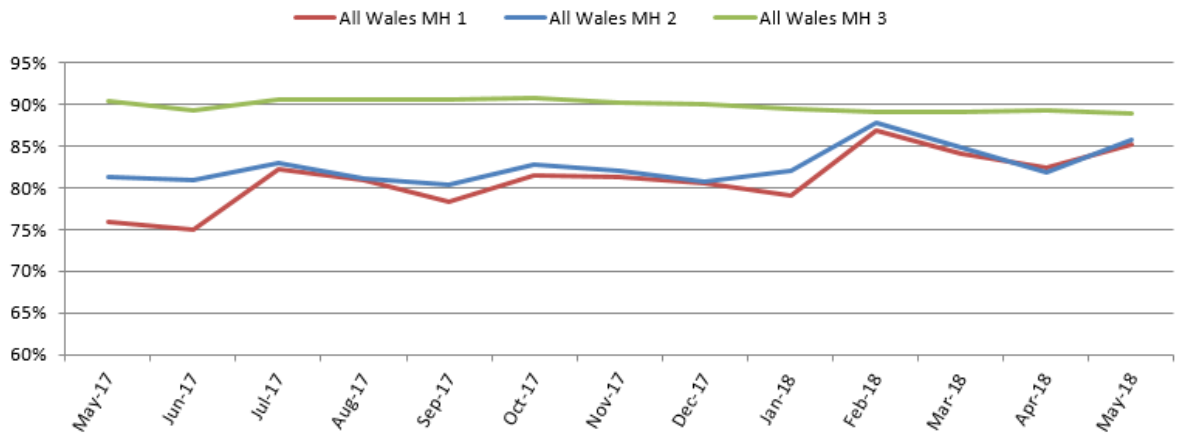
Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral
Measure 2: % of therapeutic interventions started within 28 days following an assessment by LPMHSS
Measure 3: % of Health Board residents in receipt of secondary Mental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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : Jun 2018	**Annual Plan Profile :** (1) 80%, (2) 80%, (3) 90%, (4)100%	**WG Target :** (1) 80%, (2) 80%, (3) 90%, (4) 100%	**Current Status :** ✖	**Movement :** ⇧ Improving

Current Trend: Jun 17 - Jun 18



Benchmarking



Source : ALL WALES PERFORMANCE SUMMARY (JUNE 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)
Measure 4: % of qualifying patients (compulsory & informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA

How are we doing?

- Mental Health 1 - ABMU met the target for 5 of the 13 months shown. This data excludes CAMHS which is collated by Cwm Taf Health Board. It should be noted that actual waiting time is irrespective of weekends and bank holidays.
- Mental Health 2 - intervention levels met the target for the 13 months shown. This data excludes CAMHS from the analysis, which is collated by Cwm Taf HB. Meeting the target does not tell you how many people are waiting or the length of longest waits, but we manage and monitor the lists locally.
- Mental Health 3 - This data covers Adult, Older People, CAMHS and Learning Disability Services. ABMU met the target from 6 of the 13 months shown. The percentage of Care and Treatment Plans reported for June was slightly under target. An audit of CTP's has taken place to capture service user's experience of care and treatment planning. The Delivery Unit has introduced a live CTP register and part of the functionality is to alert practitioners of review due dates. This has been introduced in partnership with the Local Authority and early indicators have seen an improvement in CTP compliant rates.

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?

May 2018

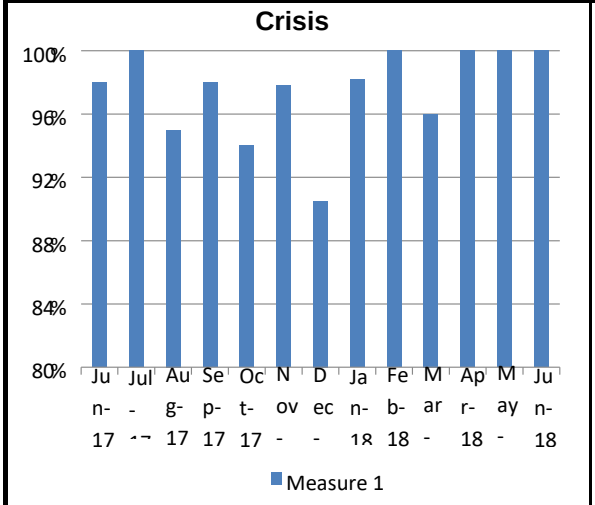
- All-Wales MH1 measure ranged from 71.9% to 97.1% 85.5% ABMU
- All-Wales MH2 measure ranged from 70.3% to 96.0% 80.5% ABMU
- All-Wales MH3 measure ranged from 81.9% to 92.8% 89.6% ABMU

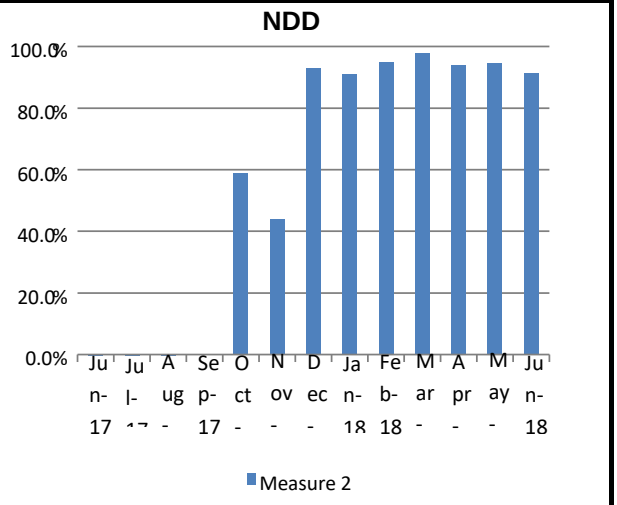
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

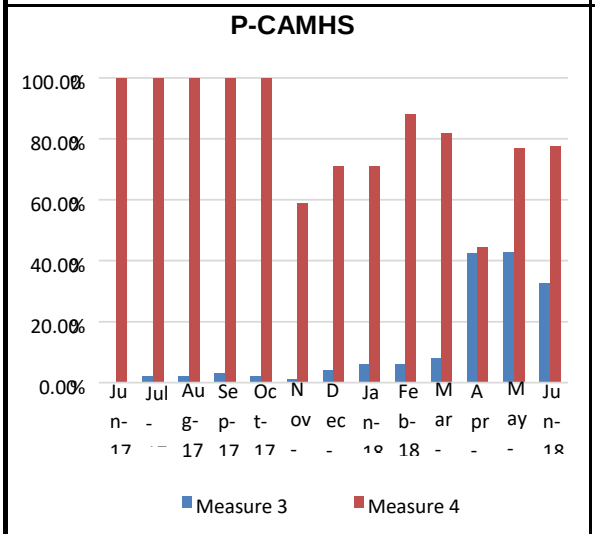
(1) Crisis - % Urgent Assessment by CAMHS undertaken within 48 Hours from receipt of referral
(2) NDD - % Patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks
(3) P-CAHMS - % Routine Assessment by CAMHS undertaken within 28 days from receipt of referral
(4) P-CAHMS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

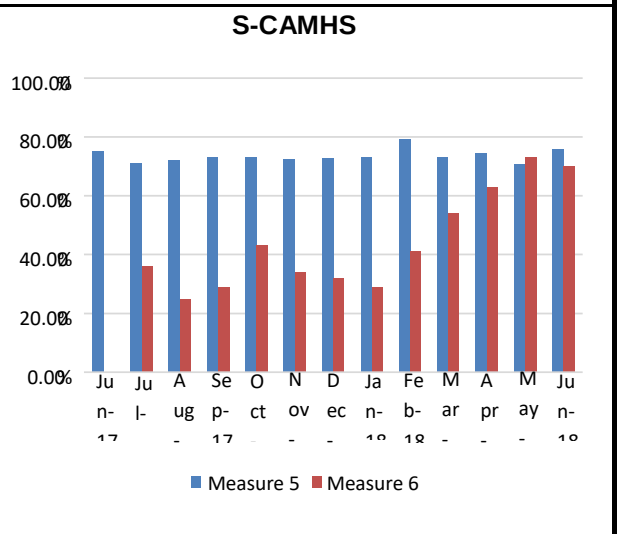
Corporate Objective: Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Siân Harrop-Griffiths, Director of Strategy	
Period : June 2018	**Annual Plan Profile :**	**Local Target :** (1) 100%, (5) 90%, (2,3,4,6) 80%	**Current Status :** ✖	**Movement :** ⇧ ● Improving

Current Trend: Jun-17 - Jun 18









Source : Cwm Taf LHB

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

How are we doing?

- Measure 1: Crisis - The Crisis Service is now operating 7 days a week, and the team have the capacity to consistently achieve this target of 100%.
- Measure 2: NDD - Compliance against this measure has deteriorated to 91.3% in June compared to 94% in May. The 80% target has consistently been achieved since December 2017.
- Measure 3: P-CAMHS - overall waiting times for P-CAMHS have reduced significantly over the last 6 months, however full compliance because of the way the target is measured will not be achieved until all patients are being seen within 28 days. Performance has significantly improved since April 2018 but has deteriorated in June to 32.7% compared to 43% in May. P-CAMHS is a fragile service with a small workforce, and a number of vacancies with limited clinical time is the reason for the recent decline in performance. Posts are being advertised and it is hoped that these will be filled and performance will improve again.
- Measure 4: P-CAMHS - compliance against the 80% target has varied since November 2017. June data has highlighted a slight improvement to 77.8% and this is on target with the trajectory to achieve 80% target by August 2018. However P-CAMHS is a fragile service with a small workforce, and a number of vacancies with limited clinical time is the reason for a decline in performance.
- Measure 5: S-CAMHS - Performance has been consistent over the last 12 months with 77% compliance reported for June against the 90% target. Inconsistencies between how CAMHS and adult MH services record against this measure are being investigated to ensure these are consistent going forward. Vacancies and a lack of clinical time is again behind the non-achievement of this target.
- Measure 6: S-CAMHS - Compliance has steadily improved since January 2018 with 77% compliance against the 80% target in June which is on line with trajectory to achieve the target by August 2018.

What actions are we taking?

- NDD - Additional clinical time will be secured for the service in June 18 including a nurse practitioner and a consultant psychiatrist.
- P-CAMHS - the total patients waiting and longest wait has reduced significantly since December 2017, however total waiting increased in May. This is due to a vacancy that has now been recruited to, with start date awaited. Two further staff are leaving the service and these posts are now out to advert, however it is likely that there will be further gaps which will impact on performance.
- S-CAMHS - the number of referrals received in recent months for S-CAMHS has been high. The median accepted in 2017/18 was 101 per month with an average % accepted of 64%. Work is on-going to improve access to P-CAMHS & S-CAMHS, and the service will be piloting a single point of access over the summer months. Significant efforts have been made to improve compliance against the 80% target - the aim is to achieve the 80% by the end of August 18. Cwm Taf have undertaken a demand & capacity exercise, and plans have been made to jointly review with ABMU by October 18.

What are the main areas of risk?

- The inability to recruit and retain staff is a recurring theme, and the relatively small size of these specialist teams is a concern that ABMU will continue to discuss with Cwm Taf via formal commissioning meetings. Particular issues are evident in Primary CAMHS provision where about half of the substantive staff have obtained other jobs and the opportunity is therefore being taken to discuss with Cwm Taf and the Mental Health / Learning Disability Delivery Unit alternative options for the delivery of this service.

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.

7.5 Our Staff and Resources

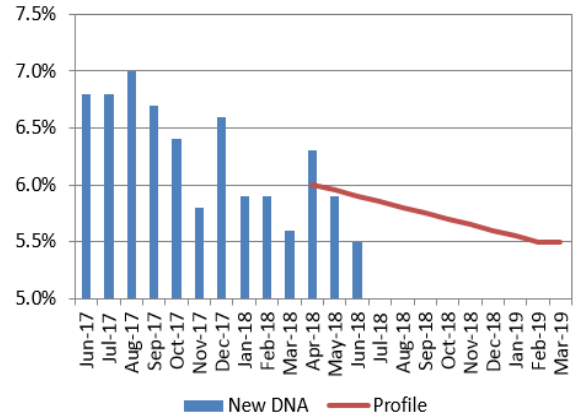
OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

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 *(includes General Surgery, Urology, T&O, ENT, Ophthalmology, Oral Surgery, Neurosurgery, Combined Medicine, Dermatology, Rheumatology, Paediatrics and Gynaecology)*

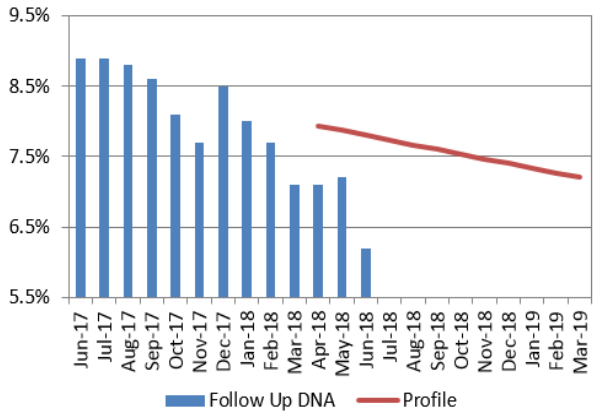
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Chris White, Chief Operating Officer	
Outcome Statement : I work with the NHS to improve the use of resources				
Period : June 2018	**Annual Plan Profile:** (1) 5.85% (2) 7.74%	**WG Target :** 12 month reduction trend	**Current Status:** ✓	**Movement :** Improving

Current Trend: Jun 17 - Jun 18

(1) % New Outpatient that Did Not Attend



(2) % Follow Up Outpatient that Did Not Attend



Benchmarking

(1) % New Outpatient that Did Not Attend

LHB	Current	Same Period Comparison		
	May-18	May-17	May-16	May-15
Wales	6.9%	↑ 7.3%	↑ 7.2%	↑ 7.9%
ABM	5.9%	↑ 6.7%	↑ 7.1%	↑ 7.9%
AB	6.4%	↓ 6.1%	↑ 6.9%	↑ 8.5%
BCU	5.9%	↑ 6.3%	↓ 5.2%	↓ 5.2%
C&V	9.2%	↑ 9.4%	↓ 8.7%	↑ 9.5%
CTaf	6.7%	↑ 7.5%	↑ 8.3%	↑ 10.4%
HDda	8.1%	↑ 9.2%	↑ 8.7%	↓ 8.0%
Powys	6.5%	↓ 5.0%	↓ 4.5%	↓ 4.5%

(2) % Follow Up Outpatient that Did Not Attend

LHB	Current	Same Period Comparison		
	May-18	May-17	May-16	May-15
Wales	8.3%	↑ 8.7%	↑ 9.0%	↑ 9.8%
ABM	7.2%	↑ 8.4%	↑ 8.4%	↑ 9.1%
AB	7.0%	↓ 6.4%	↓ 6.8%	↑ 9.7%
BCU	6.5%	↑ 6.9%	↑ 7.4%	↑ 7.3%
C&V	10.2%	↑ 11.3%	↑ 11.5%	↑ 11.6%
CTaf	10.9%	↓ 10.5%	→ 10.9%	↑ 14.5%
HDda	9.6%	→ 9.6%	↓ 9.4%	↓ 8.1%
Powys	6.5%	↓ 3.6%	↓ 5.0%	↓ 4.6%

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 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 June 2017 - June 2018 performance has improved from 6.8% to 5.9%. In month performance has improved from 5.9%.
- Follow-Up DNA: From June 2017 - June 2018 performance has improved from 8.5% to 6.2%. In month performance has improved from 7.2%.

What actions are we taking?

- Outpatient appointment text reminder service implementation ongoing (full implementation by December 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).
- Each Delivery Unit has developed a plan to address their DNA position. These plans, overseen by the Outpatient Improvement Group, have set out objectives to achieve the Annual Plan 2018/19 target of a reduction in the DNA rate of 10%. Actions to be undertaken in Q2 include:
  - Delivery Units to review patient data extract to determine compliance with Health Board DNA policy.
  - Clinicians to ring patients who DNA to determine reasons for non-attendance and to inform actions that the Health Board can take to address.- Work with GP clusters and patients to inform the development of alternative methods of service delivery to support patients in the most appropriate setting including nurse led/advanced practitioner led clinics.
  - Explore increased opportunities for partial booking.

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 work stream is continuing to explore 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 underutilised capacity for new and follow up appointments with associated financial implications for idle capacity, rearranging appointments and potentially needing to arrange additional waiting list clinics.

How do we compare with our peers?

- At May 2018, ABMU performance was better than the all-Wales average on New and Follow Up DNA performance.
- New DNA: ABM, BCU, CT, C&V, and HD have experienced an improved performance from May 2017; AB and Powys position has deteriorated.
- Follow Up DNA: ABMU, BCU, C&V, experienced an improved performance from May 2017; AB, CT and Powys position has deteriorated.

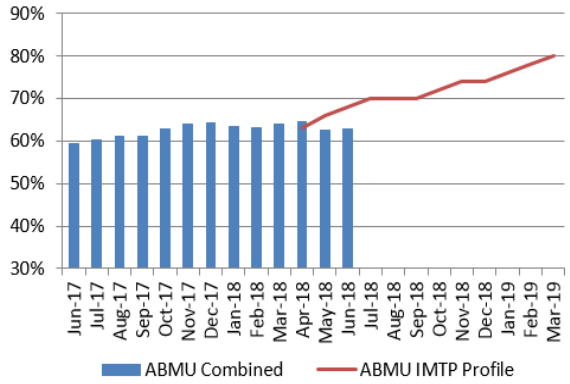
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

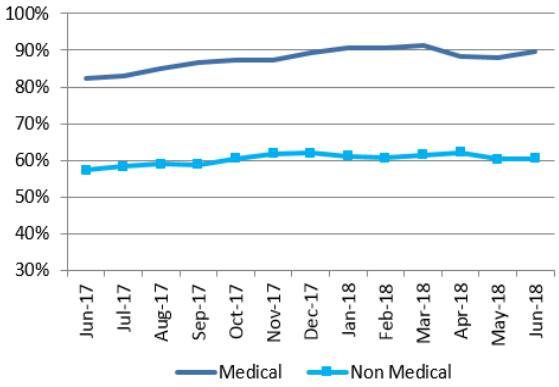
Measure 1: % staff (medical & non medical) undertaking performance appraisals

Corporate Objective : Securing a Fully Engaged and Skilled Workforce **Outcome Statement :** Quality trained staff who are fully engaged in delivering excellent care and support to me and my family			**Executive Lead :** Hazel Robinson, Director of Workforce & OD	
Period : June 2018	**Annual Plan Profile:** 68%	**WG Target :** 85%	**Current Status:** ✖	**Movement :** ⇧ ● Improving

Current Trend: Jun 17 - Jun 18

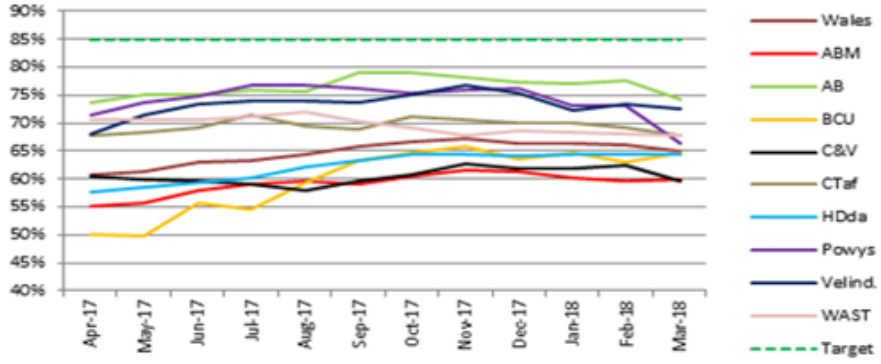
(1) % staff undertaking performance appraisals





Benchmarking

(1) % staff undertaking performance appraisals



Source : Non Medical: Electronic Staff Record (ESR), Medical : Medical Appraisal and Revalidation System (MARS)/ NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (JULY 2018)

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

How are we doing?

Medical:

- Excluding any exemptions (new starters, absences e.g. long term sickness, maternity leave etc.) the appraisal rate for the rolling period to June 2018 is 90%.
- Appraisals undertaken for current period April-June 2018 are at 20% and continue to improve.
- The dip in April 2018 reflects a change in the 'denominator', the number of doctors employed/contracted and 'connected' to the Health Board increased from 1,335 to 1,369. 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 March 2018 61.46%, however between March and June 2018 there has been a decrease of 1%.
- From the 6 Service Delivery Units (SDUs): Mental Health & Learning Disabilities (MHLD) 79.02%, Morriston Delivery Unit (MSDU) 59.63%, Neath Port Talbot (NPT) 67.77%, Primary & Community Care (PCC) 78.85%, Princess of Wales (POW) 58.12%, Singleton Delivery Unit (SSDU) 59.23%, Mental Health & Learning Disabilities have had a 5% decrease, and also Neath Port Talbot. Informatics have had a 10% increase to 21.64%

What actions are we taking?

Medical:

- Maintain current performance levels through continuing engagement with Unit Medical Directors, undertaking quarterly exception management process, providing doctors with training and advice.
- There have been further enhancements since the new version was launched in August 2017 to improve functionality in line with identified changes/developments.
- Unit based Appraisal Leads have been identified for NPT, POW & MH&LD (MH & SH to be confirmed), 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.

What are the main areas of risk?

Medical:

- If 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.
- Ensuring new starters and ad hoc doctors are engaged with the annual appraisal process, and relevant information received from previous RO (Responsible Officer).

Non Medical:

- Misunderstanding around timings of PADR aligning with increment date.
- Dependence on roll out of Supervisor self service for PADR Reporting data accuracy, double reporting, use of ESR, accuracy of ESR, IT skills of staff.
- Time to complete PADR's - risk around the quality of PADR versus the target figures.
- Local administrators and locally held data – change of culture and the time scales to do this. NHS pay scales/ increment linked to PADR

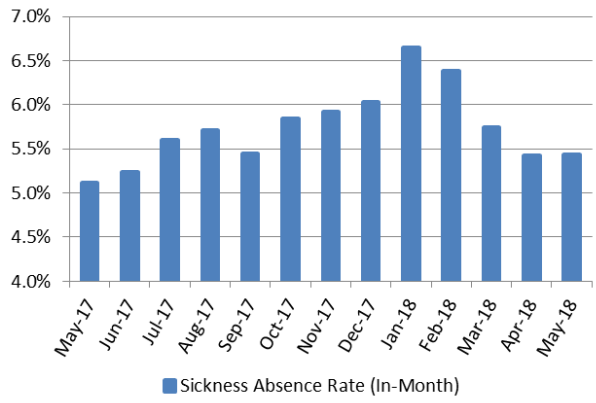
How do we compare with our peers?

- **Medical:** Stats from the RSU (Revalidation Support Unit) show appraisals undertaken from 1st April 2017 - 31st December 2017 in ABMU as 61% of the baseline total number of doctors (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. We will scope actions taken by BCU Health Board in relation to their noticeable increase in PADR's compliance.

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) **Measure 2: % workforce sickness absence (In-month)**				
Corporate Objective : Securing a Fully Engaged and Skilled Workforce			**Executive Lead :** Hazel Robinson, Director of Workforce & OD	
Outcome Statement: Quality trained staff who are fully engaged in delivering excellent care and support to me and family			**(1) Current Status :** ✗	**(1) Movement :** ⇧ ● Worsening
Period: May 2018	**Annual Plan Profile:** 5% by March 2019	**WG Target:** 12 month reduction trend	**(2) Current Status :** ✓	**(2) Movement :** ⇩ ● Improving
Current Trend: May 17 - May 18				

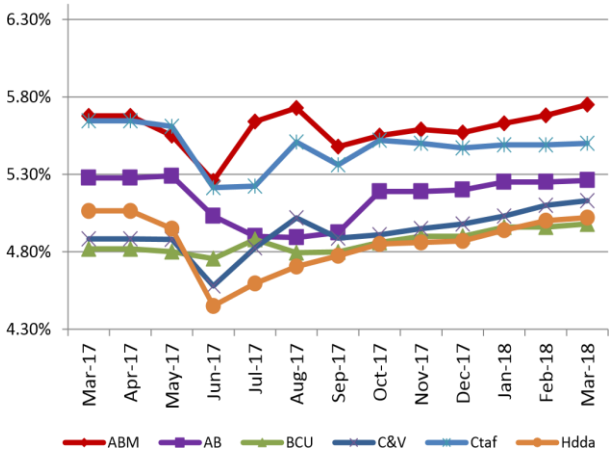
(1) % workforce sickness absence (Rolling 12 months)

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



Benchmarking

Sickness Absence Rates



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

LHB	Current	Same Period Comparison		
	Mar-18	Mar-17	Mar-16	Mar-15
Wales	5.24%	⇩ 5.14%	⇩ 5.22%	⇧ 5.55%
ABM	5.75%	⇩ 5.60%	⇩ 5.51%	⇩ 5.59%
AB	5.26%	⇧ 5.29%	⇧ 5.27%	⇧ 5.56%
BCU	4.98%	⇩ 4.83%	⇩ 4.87%	⇧ 5.19%
C&V	5.13%	⇩ 4.87%	⇩ 5.11%	⇧ 5.72%
CTaf	5.50%	⇧ 5.64%	⇧ 5.52%	⇧ 6.09%
HDda	5.02%	⇧ 5.07%	⇧ 5.52%	⇧ 5.51%
Powys	4.63%	⇧ 4.69%	⇩ 4.16%	⇩ 4.53%
PHW	3.98%	⇩ 3.64%	⇩ 3.95%	⇩ 3.69%
Velind.	3.97%	⇩ 3.59%	⇧ 3.98%	⇩ 3.86%
WAST	7.19%	⇩ 6.84%	⇩ 6.99%	⇧ 8.23%

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

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

How are we doing?

Rolling 12 month performance:
- Jun 16 - May 17 = 5.60%
- May 17 - Apr 18 = 5.77%
- Jun 17 - May 18 = 5.79%

In Month performance:
- Apr 18 = 5.47%
- May 18 = 5.44% (was 5.35% in May 17)

- Whilst four out of six Delivery Units improved their in month sickness performance, only Primary Care and Community and Princess of Wales (POW) improved their rolling 12-month performance, resulting in an increase in the overall rolling 12-month performance.
- Short-term sickness (STS) improved by 0.10% in May 2018 compared to the previous month and are now just above 1% after a challenging end to 17/18 which saw levels of STS well above 2% due to cold/flu related absence.
- Long-term sickness (LTS) however increased slightly by 0.07% to 4.19% compared to the previous month. Stress and other mental health illnesses remains our top reason for absence, accounting for just under 32% of all absence in May 2018.

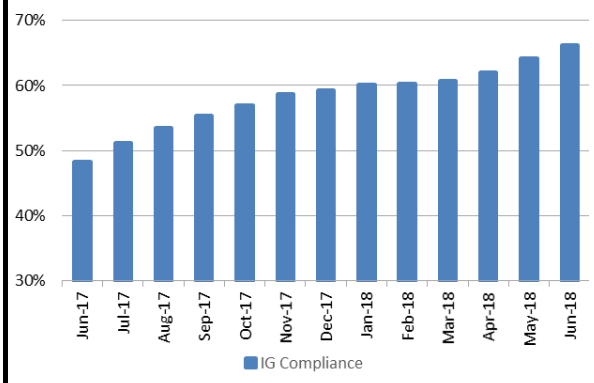
What actions are we taking?

- Currently developing LTS pathways to help guide managers in managing common absence conditions.
- Best practise case study being conducted in three areas of good sickness performance to share good practise.
- Bespoke sickness actions developed based on individual feedback from Units into how to improve sickness absence.
- Text reminder service for Occupational Health appointments to reduce DNA now in use.
- Mental health awareness training provided for 48 managers over six sessions to date.
- Work related stress risk assessment -78 managers trained over eight session to date.
- Appropriate Occupational Health referrals training-83 managers trained over 4 sessions to date.

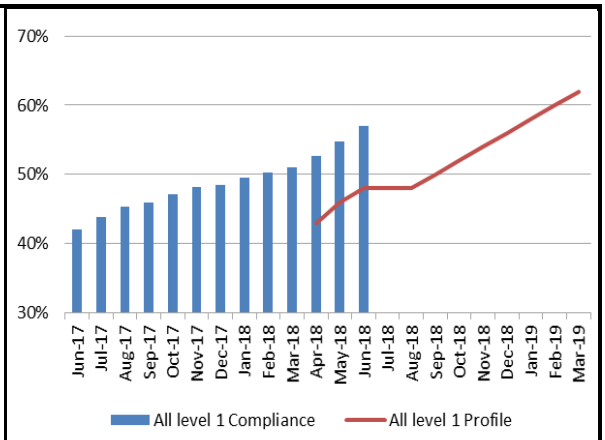
What are the main areas of risk?
• Failure to maintain continued focus on sickness absence performance may lead to levels increasing. • Singular focus on sickness management without measured attention on supporting staff attendance through health and wellbeing interventions congruent with our organisational values. • Direct effect on costs in terms of bank, agency and overtime. • Increasing levels of sick absence increases pressure on those staff who remain at work. • Levels of service change likely to affect health and wellbeing with most likely impact on mental health and stress related sickness.
How do we compare with our peers?
• The latest 12 month cumulative differential between ABMU and the all-Wales performance is 0.51%. • The latest differential between our monthly sickness absence rates and the all-Wales average is 0.63%.

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 for the completed level 1 Information Governance (Wales) training element of the Core Skills and Training Framework **Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework**				
Corporate Objective: Securing a Fully Engaged and Skilled Workforce **Outcome Statement:** Quality trained staff who are fully engaged in delivering excellent care and support to me and family			**Executive Lead :** Hazel Robinson, Director of Workforce & OD	
Period: June 2018	**Annual Plan Profile :** (2) 48%	**WG Target :** (2) 85%	**Current Status :**	**Movement :** Improving
Current Trend: Jun 17 - Jun 18				

Measure 1: % compliance for the completed level 1 Information Governance (Wales) training

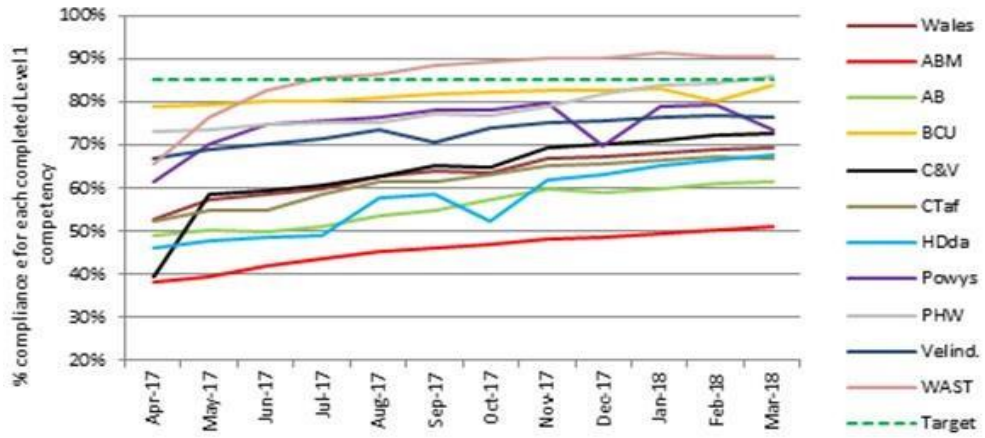


Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework



Benchmarking

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



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

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

How are we doing?

- The current compliance for Information Governance (IG) Level 1 training is 66.21% in June 2018, a 2% increase since May 2018.
- Current compliance has improved from June 2017 to June 2018 by 17.9%. This is a result of awareness raising, continued support with E-Learning Sessions, a move to using ESR to complete ELearning and related data cleanse. A new ESR user guide has been uploaded onto the intranet for employees to access to assist in completion of Mandatory E-Learning.

What actions are we taking?

- Continue to send compliance lists for IG Training compliance to directorates and service delivery units.
- Continue to deliver E Learning Training Sessions across the Health Board.
- Investigate Inter Authority Transfer Process to ensure records transfer with employees.
- Update outstanding individual records from Action Point.

What are the main areas of risk?

- ESR self-service and supervisor self-service roll out and usage.
- IT infrastructures.
- Potential changes to pay progression and increments.
- Lack of resources (highlighted at Audit Committee).

How do we compare with our peers?

- ABMU have showed consistent improvement over the 12 month period reflected. ABMU has the lowest compliance for the 10 core skills Mandatory Training Framework.