Meeting Date	**19th February 2019**	**Agenda Item**	**4a**
Report Title	**Integrated Performance Report**		
Report Author	Hannah Roan, Performance and Contracting Manager		
Report Sponsor	Darren Griffiths, Associate Director of Performance		
Presented by	Darren Griffiths, Associate Director of Performance Leads		
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 three performance. The report cards can be found in section ten of this report.		
Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**
	✓		✓	
Recommendations	Members are asked to: • note 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 Health Board achieved its quarter 3 target, which was the assessment of clawback point. It is critical that the quarter 4 target is now met to avoid any risk of clawback being reassessed.

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 January 2019 and Quality & Safety Committee in December 2018.
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
• The internal profile for the number of patients waiting over 36 weeks for treatment was higher than the January 2019 profile but is a significant improvement on January 2018 with 1,435 (31%) less patients waiting over 36 weeks. • Therapy waiting times continue to be maintained at (or below) 14 weeks. • Sustained nil position in December 2018 for Endoscopy patients waiting over 8 weeks. • Sustained improvement in 4 hour stroke performance in Morriston since September 2018 as a result of the front door pilot. • Internal profiles achieved for the number of reported C. *difficile* cases and E.*Coli* cases in January 2019. • ABMU remains the top ranking Health Board for the percentage of stage one mortality reviews undertaken within 28 days of death	• Full implementation of the winter assurance funding including providing additional inpatient winter 'surge' capacity. • Progress clinically led improvement programme focusing on reducing delayed transfers of care. • Limit unscheduled care pressure on stroke performance through implementation of planned improvement actions in Q4. • Continue to deliver planned care profiles for the remainder of quarter 4 to meet the 2,664 maximum number, through maximising core elective capacity, outsourcing and robust validation of waiting lists. • Reduce cancer backlog through increased focus on tracking cancer patient pathways across Units. • Implement improvement actions identified in a deep dive into the hospital acquired cases in January 2019. • Agree Annual Plan delivery profiles for 2019/20
Opportunities	**Risks & Threats**
• Bridgend boundary changes has provided an opportunity for improvement e.g. theatre management transfer. • Roll out the *I fell down* tool in the care homes with highest call demand on WAST in Swansea and NPT. This tool supports a reduction in the number of 'long lie' residents in care homes following a fall. • Maximise utilisation of surgical unit at NPTH hospital which is not affected by emergency pressures. • Development of medical recruitment strategy and exploring options for further oversea nurse recruitment to reduce the number of vacancies in fragile services across the Health Board.	• Overall impact of Bridgend Boundary Change and ongoing disruption to teams. • Potential impact of Brexit on equipment costs and access to products • Winter bed availability represents a threat to ASU access times • Increasing number of DTOCs and lack of capacity in the community for discharges. • Unscheduled Care pressures and waits for transfers of care affecting stroke care capacity and unscheduled care flow. • Delivery of RTT profiles for Q4 is a risk due to theatre staffing levels and increased cancellations due to emergency pressures. This is being mitigated through robust management of waiting list by the Service Delivery Units. • Increasing sickness rates across the Health Board

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

			Quarter 1			Quarter 2			Quarter 3			Quarter 4			All-Wales benchmark position
			Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Dec-18
Unscheduled Care	4 hour A&E waits	Actual	75.6%	78.9%	81.0%	79.9%	77.9%	77.5%	78.0%	76.7%	76.5%	76.9%			5th
		Profile	*83%*	*83%*	*83%*	*88%*	*88%*	*88%*	*89%*	*90%*	*90%*	*90%*	*90%*	*90%*	
	12 hour A&E waits	Actual	737	624	476	590	511	588	680	665	756	986			6th
		Profile	*323*	*194*	*190*	*229*	*227*	*180*	*255*	*315*	*288*	*283*	*196*	*179*	
	1 hour ambulance handover	Actual	526	452	351	443	420	526	590	628	842	1,164			6th**
		Profile	*256*	*126*	*152*	*159*	*229*	*149*	*223*	*262*	*304*	*262*	*183*	*139*	
Stroke	Direct admission within 4 hours	Actual	34.5%	36.7%	40.0%	37.5%	29.3%	53.8%	56.0%	55.8%	53.2%	35.2%			3rd**
		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%	40.5%	47.5%	52.7%	47.5%	48.7%	48.0%			5th**
		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%	91.1%	68.8%	82.8%	75.0%	85.9%	75.3%			3rd**
		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%	0.0%	11.1%	18.2%	15.4%	28.6%	40.0%			2nd**
		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*	*105*	*89*	*65*	*125*	*94*	*153*			2nd *(Nov-18)*
		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*	*3,497*	*3,381*	*3,370*	*3,193*	*3,030*	*3,174*			5th *(Nov-18)*
		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*	*790*	*915*	*740*	*811*	*762*	*735*	*658*	*693*	*603*			6th *(Nov-18)*
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
	Therapy waits over 14 weeks	Actual	*0*	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*			Joint 1st *(Nov-18)*
		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%	97%	96%	96%	96%	96%	91%			5th** *(Nov-18)*
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	
	USC patients starting treatment in 62 days	Actual	77%	89%	83%	92%	94%	83%	84%	88%	88%	84%			2nd** *(Nov-18)*
		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	15	9	19	10	16	7			3rd *(Jan-19)*
		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	20	10	12	17	11	18			5th *(Jan-19)*
		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	46	49	41	53	38	28			5th *(Jan-19)*
		Profile	*45*	*39*	*40*	*45*	*42*	*45*	*44*	*37*	*41*	*45*	*39*	*42*	

**RAG status derived from performance against trajectory*

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

3. INTEGRATED PERFORMANCE DASHBOARD

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

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

Sub Domain	Measure	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average	Performance Trend	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Childhood Immunisation & Health Visiting	% children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	Q2 18/19	96%	95%			95.3%										96%				
	% of children who received 2 doses of the MMR vaccine by age 5	Q2 18/19	90%	95%	92%	✗	89.5%				89%			91%			90%				
	% 10 day old children who have accessed the 10-14 days health visitor contact component of the Healthy Child Wales Programme	Q1 18/19	81%	4 quarter ↑ trend			90.6%				77%			81%							
Influenza	% uptake of influenza among 65 year olds and over	Jan-19	67.5%	75%	70%	✗	67.8%		68%	68%	68%							42.5%	59.3%	66.1%	67.5%
	% uptake of influenza among under 65s in risk groups	Jan-19	41.7%	55%	65%	✗	42.8%		46%	47%	47%							25.3%	34.0%	40.4%	41.7%
	% uptake of influenza among pregnant women	2017/18	93.3%	75%		✓	72.7%				93%										
	% uptake of influenza among children 2 to 3 years old	Jan-19	47.2%		40%	✓	48.1%		48.4%	49.1%	49%							20.4%	35.9%	46.0%	47.2%
	% uptake of influenza among healthcare workers	Jan-19	53.8%	50%	50%	✓			57%	58%	58%							43.2%	50.4%	52.3%	53.8%
Smoking	% of pregnant women who gave up smoking during pregnancy (by 36- 38 weeks of pregnancy)	2017/18	4.4%	Annual ↑			27.1%		2017/18= 4.4%												
	% of adult smokers who make a quit attempt via smoking cessation services	Nov-18	1.7%	5% annual target	1.9%	✗	1.5%		2.1%	2.3%	2.6%	0.2%	0.5%	0.7%	0.9%	1.1%	1.3%	1.5%	1.7%		
	% of those smokers who are co-validated as quit at 4 weeks	Q2 18/19	56.9%	40% annual target	40.0%	✓	44.6%				55%			62%			57%				
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	2017/18	48.0%	Annual ↓			42.2%		2017/18= 48%												

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	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Prescribing	Total antibacterial items per 1,000 STAR-PUs	Q2 18/19	289	4 quarter ↓			340				364			307			289				
	Fluroquinolone, cephalosporin, clindamycin and co-amoxiclav items as a % of total antibacterial items prescribed	Q2 18/19	10%	4 quarter ↓			7.6%				9%			10%			10%				
	NSAID average daily quantity per 1,000 STAR-Pus	Q1 18/19	1,517	4 quarter ↓			1,405				1,496			1,517							
	Number of administration, dispensing and prescribing medication errors reported as serious incidents	Dec-18	1	12 month ↓	0	✗	5		0	0	0	0	0	0	0	0	0	0	0	1	
Antimicrobial Audits	% indication for antibiotic documented on medication chart	Nov-18	90%		*95%*	✗			*89%*		*87%*				*87%*		*94%*		*90%*		
	% stop or review date documented on medication chart	Nov-18	56%		*95%*	✗			*59%*		*61%*				*61%*		*54%*		*56%*		
	% of antibiotics prescribed on stickers	Nov-18	78%		*95%*	✗			*79%*		*70%*				*77%*		*73%*		*78%*		
	% appropriate antibiotic prescriptions choice	Nov-18	95%		*95%*	✓			*92%*		*94%*				*96%*		*97%*		*95%*		
	% of patients receiving antibiotics for >7 days	Nov-18	9%		*20%*	✓			*9%*		*13%*				*8%*		*15%*		*9%*		
	% of patients receiving surgical prophylaxis for > 24 hours	Nov-18	73%		*20%*	✗			*58%*		*58%*				*25%*		*8%*		*73%*		
	% of patients receiving IV antibiotics > 72 hours	Nov-18	42%		*30%*	✗			*43%*		*39%*				*41%*		*49%*		*42%*		
infection control	Cumulative cases of E.coli bacteraemias per 100k pop	Jan-19	96.7	<67			79.85					96.6	96.1	96.2	98.9	99.6	102.1	100.5	103.2	100.8	96.7
	Number of E.Coli bacteraemia cases (Hospital)	*Jan-19*	*11*		*17*	✓	61		*18*	*4*	*10*	*10*	*15*	*10*	*20*	*16*	*15*	*17*	*23*	*15*	*11*
	Number of E.Coli bacteraemia cases (Community)		*17*		*28*	✓	108		*29*	*14*	*30*	*32*	*28*	*31*	*31*	*30*	*34*	*24*	*30*	*23*	*17*
	Total number of E.Coli bacteraemia cases		*28*		45	✓	169		47	18	40	42	43	41	51	46	49	41	53	38	28
	Cumulative cases of S.aureus bacteraemias per 100k pop	Jan-19	*35.0*	<20			28.93					32.2	39.6	40.9	37.3	41.0	37.7	35.8	36.5	34.9	35.0
	Number of S.aureus bacteraemias cases (Hospital)	*Jan-19*	*9*		*7*	✗	31		*8*	*8*	*10*	*6*	*8*	*7*	*8*	*9*	*7*	*7*	*7*	*5*	*9*
	Number of S.aureus bacteraemias cases (Community)		*9*		*6*	✗	43		*6*	*13*	*5*	*8*	*13*	*12*	*9*	*11*	*3*	*5*	*10*	*6*	*9*
	Total number of S.aureus bacteraemias cases		*18*		13	✗	74		14	21	15	14	21	19	17	20	10	12	17	11	18
	Cumulative cases of C.difficile cases per 100k pop	Jan-19	*36.6*	<26			27.79					59.8	49.7	44.7	50.3	46.4	42.2	42.2	39.9	39.4	36.6
	Number of C.difficile cases (Hospital)	*Jan-19*	*3*		*14*	✓	29		*16*	*14*	*19*	*20*	*13*	*10*	*24*	*8*	*5*	*15*	*9*	*5*	*3*
	Number of C.difficile cases (Community)		*4*		*5*	✓	28		*6*	*4*	*8*	*6*	*5*	*5*	*5*	*7*	*4*	*4*	*1*	*11*	*4*
	Total number of C.difficile cases		*7*		19	✓	57		22	18	27	26	18	15	29	15	9	19	10	16	7
	Hand Hygiene Audits- compliance with WHO 5 moments	Jan-19	96%		95%	✓			95%	95%	94%	95%	96%	95%	96%	97%	98%	97%	97%	98%	96%
Incidents & Risks	Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale	Q2 18/19	No alerts/ notices due	0			2			0				2			-				
	Of the serious incidents due for assurance, the % which were assured within the agreed timescales	Jan-19	80%	90%	80%	✓	33.1%		85%	92%	92%	79%	85%	85%	81%	87%	86%	56%	82%	89%	80%
	Number of new Never Events	Jan-19	0	0	0	✓	1		1	2	4	0	0	0	0	0	0	0	0	0	0
	Number of risks with a score greater than 20	Jan-19	53		12 month ↓	✓			78	57	57	58	57	60	67	77	73	66	45	48	53
	Number of Safeguarding Adult referrals relating to Health Board staff/ services	Jan-19	6		12 month ↓	✓			12	8	10	8	12	10	22	14	7	13	8	12	6
	Number of Safeguarding Children Incidents	Jan-19	13		0	✗			8	5	12	5	11	5	12	14	3	10	9	3	13
Pressure Ulcers	Total number of pressure ulcers acquired in hospital	Jan-19	50		12 month ↓	✗			51	37	46	48	47	39	56	45	53	47	40	40	50
	Total number of pressure ulcers acquired in hospital per 100k admissions	Jan-19	514		12 month ↓	✓			602	497	553	582	505	457	635	496	601	499	432	468	514
	Number of grade 3+ pressure ulcers acquired in hospital	Jan-19	20		12 month ↓	✗			22	13	26	17	9	14	21	12	21	26	13	14	20
	Number of grade 3+ pressure ulcers acquired in hospital per 100k admissions	Jan-19	205		12 month ↓	✓			255	162	306	202	97	164	238	139	219	276	141	164	205
	Total Number of pressure ulcers developed in the community	Jan-19	77		12 month ↓	✗			52	57	69	67	80	81	68	88	71	60	62	58	77
	Number of grade 3+ pressure ulcers developed in the community	Jan-19	33		12 month ↓	✗			9	23	20	24	24	27	20	29	22	26	22	23	33
	Number of grade 3+ pressure ulcers reported as serious incidents	Dec-18	12	12 month ↓	10	✗	119		18	6	13	12	13	21	5	17	8	14	12	12	
Inpatient Falls	Number of Inpatient Falls	Jan-19	341		12 month ↓	✓			344	309	357	333	357	326	300	290	328	293	291	300	341
	Number of Inpatient Falls reported as serious incidents	Dec-18	2	12 month ↓	2	✗	18		8	5	2	2	4	3	5	1	3	9	8	2	
Self Harm	Rate of hospital admissions with any mention of intentional self-harm of children and young people (aged 10-24 years)	2017/18	3.14	Annual ↓			4.00		2017/18= 3.14												
Mortality	Amenable mortality per 100k of the European standardised population	2016	142.9	Annual ↓			140.6		2016= 142.9												
HAT	Number of potentially preventable hospital acquired thromboses (HAT)	Q1 18/19	0	4 quarter ↓			16					0									
Sepsis	% in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' 1st hour care bundle within 1 hour of positive screening	Dec-18	53%	12 month ↑			93%					31%	26%	18%	34%	21%	32%	47%	41%	53%	
	% patients who presented at ED with a positive sepsis screening who have received all elements of the 'Sepsis Six' 1 hour care bundle within 1 hour of positive screening	Nov-18	55%	12 month ↑			83%					38%	48%	34%	44%	41%	53%	75%	55%		

EFFECTIVE CARE- People in Wales receive the right care and support as locally as possible and are enabled to contribute to making that acre successful																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**
DTOCs	Number of mental health HB DToCs	Jan-19	29		29	✓			29	21	25	28	22	30	27	30	29	28	26	25	29
	Number of mental health HB DToCS (12 month rolling)	Jan-19	320	10% ↓			854		340	334	333	335	331	334	337	338	332	330	326	320	320
	Number of non-mental health HB DToCs	Jan-19	104		45	✗			41	53	44	34	64	75	74	85	69	84	125	117	104
	Number of non-mental health HB DToCs (12 month rolling)	Jan-19	928	5% ↓			4,371		615	625	624	613	625	657	689	721	721	746	803	865	928
Mortality	% of universal mortality reviews (UMRs) undertaken within 28 days of a death	Jan-19	81%	95%	96%	✗	77.5%		89%	89%	89%	95%	92%	95%	97%	97%	94%	98%	97%	94%	81%
	Stage 2 mortality reviews required	Jan-19	8						17	14	18	23	14	16	12	19	19	16	22	17	8
	% stage 2 mortality reviews completed	Nov-18	27%		100%				64.7%	71.4%	33.3%	87.0%	64.3%	62.5%	50.0%	44.0%	47.4%	25.0%	27.3%		
	Crude hospital mortality rate (74 years of age or less)	Dec-18	0.77%	12 month ↓			0.72%		0.80%	0.80%	0.81%	0.81%	0.81%	0.80%	0.79%	0.77%	0.76%	0.77%	0.77%	0.77%	
NEWS	% patients with completed NEWS scores & appropriate responses actioned	Jan-19	98.2%		98%	✓			97.5%	98.0%	96.9%	96.5%	98.3%	98.1%	99.2%	99.3%	97.9%	97.5%	99.0%	98.4%	98.2%
Info Gov	% compliance of level 1 Information Governance (Wales training)	Jan-19	83%	85%					60%	60%	61%	62%	64%	66%	71%	74%	77%	78%	81%	83%	83%
Coding	% of episodes clinically coded within 1 month of discharge	Dec-18	91%	95%	95%	✗	88.8%		93%	91%	93%	94%	93%	94%	95%	93%	96%	95%	88%	91%	
	% 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	Jan-19	62%		100%	✗			62.0%	64.0%	65.0%	68.0%	64.0%	60.0%	59.0%	62.0%	61.0%	67.0%	63.0%	61.0%	62.0%
Treatment Fund	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	Q2 18/19	100%	100%	100%	✓	98%				100%			100%			100%				
Research	Number of Health and Care Research Wales clinical research portfolio studies	Q2 18/19	67	10% annual ↑	53	✓					96			60			67				
	Number of Health and Care Research Wales commercially sponsored studies	Q2 18/19	22	5% annual ↑	23	✓					41			17			22				
	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	Q2 18/19	1,116	10% annual ↑	1,214	✓					2,206			732			1,116				
	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	Q2 18/19	59	5% annual ↑	211	✗					294			46			59				

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**	**Performance Trend**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**
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												
	Number of new formal complaints received	Jan-19	138		12 month ↓ trend	✗			122	91	115	119	119	90	126	126	114	140	91	84	138
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	Nov-18	90%	75%	78%	✓	56.8%		80%	61%	71%	80%	83%	80%	81%	81%	83%	88%	90%		
	% of acknowledgements sent within 2 working days	Jan-19	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	Oct-18	3,332	> 5% annual ↓			15,665						4,187		3,528	3,544	3,490	3,332			
Dementia	% of patients aged>=75 with an Anticholinergic Effect on Condition of >=3 for items on active repeat	Q2 18/19	8.0%	4 quarter ↓			7.2%				8.0%			8.0%			8.0%				
	% of people with dementia in Wales age 65 years or over who are diagnosed (registered on a GP QOF register)	2017/18	57.6%	Annual ↑			53.1%		2017/18= 57.6%												
	% GP practices that completed MH DES in dementia care or other direct training	2017/18	16.2%	Annual ↑			16.7%		2017/18=16.2%												

TIMELY CARE- People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care																							
Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**
Primary Care	% of GP practices open during daily core hours or within 1 hour of daily core hours	Dec-18	95%	Annual ↑	95%	✓	87%		88%	93%	93%	94%	94%	94%	94%	90%	95%	95%	95%	95%	
	% of GP practices offering daily appointments between 17:00 and 18:30 hours	Dec-18	88%	Annual ↑	95%	✗	84%		84%	82%	81%	82%	82%	82%	84%	78%	88%	88%	88%	88%	
	% of population regularly accessing NHS primary dental care	Jun-18	62.5%	4 quarter ↑			55%				62.6%			62.5%							
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	Dec-18	84%	12 month ↑					80%	77%	78%	83%	85%	86%	85%	89%	91%	88%	85%	84%	
	% of patients prioritised as P1 and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage	Dec-18	78%	12 month ↑					83%	33%	67%	50%	60%	67%	33%	70%	90%	100%	80%	78%	
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	Jan-19	73%	65%	65%	✓	72.8%		66%	69%	67%	78%	77%	78%	77%	79%	78%	75%	75%	75%	73%
	Number of ambulance handovers over one hour	Jan-19	1,164	0	194	✗	2,310		1,030	805	1,006	526	452	351	443	420	526	590	628	842	1,164
	% 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	Jan-19	76.9%	95%	90%	✗	78%		76.1%	73.8%	71.4%	75.6%	78.9%	81.0%	79.9%	77.9%	77.5%	78.0%	77%	76%	77%
	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	Jan-19	986	0	283	✗	3,900		924	957	1,051	737	624	476	590	511	588	680	665	756	986
	% of survival within 30 days of emergency admission for a hip fracture	Oct-18	83.9%	12 month ↑			84.1%		84.5%	85.9%	84.9%	72.4%	85.0%	78.3%	70.8%	81.3%	76.8%	83.9%			
Stroke	Direct admission to Acute Stroke Unit (<4 hrs)	Jan-19	35%	59.7%	65%	✗	48.7%		29%	22%	32%	34%	37%	40%	38%	29%	54%	56%	56%	53%	35%
	CT Scan (<1 hrs)	Jan-19	48%	54.40%	50%	✗	54.7%		35%	44%	36%	41%	43%	51%	40%	41%	48%	53%	48%	49%	48%
	Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)	Jan-19	75%	84.0%	85%	✗	81.8%		81%	73%	73%	84%	93%	88%	81%	91%	69%	83%	75%	86%	75%
	Thrombolysis door to needle <= 45 mins	Jan-19	40%	12 month ↑	40%	✓	25.0%		0%	8%	6%	0%	11%	38%	21%	0%	11%	18%	15%	29%	40%
Planned Care	% of patients waiting < 26 weeks for treatment	Jan-19	88.7%	95%	89.9%	✗	87.8%		86.2%	87.5%	87.8%	87.8%	88.1%	88.7%	89.3%	89.1%	89.1%	89.1%	88.8%	88%	89%
	Number of patients waiting > 26 weeks for outpatient appointment	Jan-19	153	-	0	✗	18,248		1,111	732	292	166	120	55	30	105	89	65	125	94	153
	Number of patients waiting > 36 weeks for treatment	Jan-19	3,174	0	3,045	✓	13,510		4,609	4,111	3,363	3,398	3,349	3,319	3,383	3,497	3,381	3,370	3,193	3,030	3,174
	Number of patients waiting > 8 weeks for a specified diagnostics	Jan-19	603	0	0	✗	2,674		1,179	925	670	702	790	915	740	811	762	735	658	693	603
	Number of patients waiting > 14 weeks for a specified therapy	Jan-19	0	0	0	✓	380		32	3	0	0	1	0	0	0	0	0	0	0	0
	Number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their agreed target date (all specialties)	Jan-19	65,743		49,842	✗			62,492	64,316	66,271	66,526	65,287	63,776	64,318	65,407	66,269	63,538	61,889	64,535	65,743
	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)	Jan-19	23,026	12 month ↓			194,184		22,414	23,198	24,475	24,628	24,288	24,469	24,954	24,813	24,200	22,553	22,091	22,931	23,026
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)	Jan-19	91%	98%	98%	✗	97.3%		91%	94%	93%	92%	90%	95%	99%	97%	96%	96%	96%	96%	91%
	% 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	Jan-19	84%	95%	92%	✗	85.3%		79%	83%	88%	77%	89%	83%	92%	94%	83%	84%	88%	88%	84%
Mental Health	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	Dec-18	83%	80%	80%	✓	77.7%		67%	74%	70%	84%	86%	82%	84%	80%	76%	84%	78%	83%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	Dec-18	85%	80%	80%	✓	81.4%		75%	89%	86%	79%	81%	80%	79%	90%	89%	92%	88%	85%	
	% of qualifying patients (compulsory & informal/voluntary) who had their first contact with an IMHA within 5 working days of the request for an IMHA	Dec-18	100%	100%	100%	✓	100%				100%			100%			100%			100%	
CAMHS	% of urgent assessments undertaken within 48 hours from receipt of referral (Crisis)	Dec-18	98%		100%	✗			98%	100%	96%	100%	100%	100%	100%	100%	100%	96%	98%	98%	
	% Patients with Neurodevelopmental Disorders (NDD) receiving a Diagnostic Assessment within 26 weeks	Dec-18	62%		80%	✗			91%	95%	98%	94%	95%	91%	91%	87%	81%	76%	68%	62%	
	P-CAMHS - % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral	Dec-18	4%		80%	✗			9%	13%	9%	43%	38%	34%	23%	22%	18%	25%	13%	4%	
	P-CAMHS - % of therapeutic interventions started within 28 days following assessment by LPMHSS	Dec-18	91%		80%	✓			47%	88%	82%	62%	76%	80%	57%	93%	72%	83%	91%	91%	
	S-CAMHS - % of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)	Dec-18	96%		90%	✓			73%	79%	73%	75%	71%	76%	75%	75%	74%	74%	79%	96%	
	S-CAMHS - % of Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral	Dec-18	56%		80%	✗			29%	41%	54%	63%	73%	70%	60%	52%	67%	69%	66%	56%	

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**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**
Helplines	Rate of calls to the mental health helpline C.A.L.L. per 100k pop.	Q2 18/19	103.6	4 quarter ↑			180.9				107.5			101.2			103.6				
	Rate of calls to the Wales dementia helpline per 100k pop.	Q2 18/19	5.1	4 quarter ↑			5.9				4.4			5.4			5.1				
	Rate of calls to the DAN helpline per 100k pop.	Q2 18/19	30.1	4 quarter ↑			40.3				36.3			33.7			30.1				
Mental Health	% residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan (CTP)	Dec-18	91%	90%	90%	✓	88.7%		89%	89%	89%	90%	90%	88%	88%	90%	91%	92%	91%	91%	
	% residents assessed under part 3 to be sent their outcome assessment report 10 working days after assessment	Dec-18	100%	100%	100%	✓	100.0%		96%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Patient Experience	Number of friends and family surveys completed	Jan-19	4,611		12 month ↑	✗			5,230	5,685	5,126	4,607	4,106	6,234	5,581	5,609	4,804	5,536	5,616	3,864	4,611
	% of who would recommend and highly recommend	Jan-19	95%		90%	✓			95%	95%	95%	95%	95%	96%	96%	95%	96%	96%	96%	94%	95%
	% of all-Wales surveys scoring 9 out 10 on overall satisfaction	Jan-19	90%		90%	✓			83%	87%	84%	87%	89%	85%	85%	87%	89%	86%	88%	82%	90%

Sub Domain	**Measure**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average**	**Performance Trend**	**Jan-18**	**Feb-18**	**Mar-18**	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**
DNAs	% of patients who did not attend a new outpatient appointment	Jan-19	5.5%	12 month ↓	5.5%	✓	6.8%		5.9%	5.9%	5.6%	6.2%	5.7%	5.5%	6.0%	5.4%	5.7%	5.7%	5.4%	6.1%	5.5%
	% of patients who did not attend a follow-up outpatient appointment	Jan-19	6.2%	12 month ↓	7.3%	✓	7.8%		8.0%	7.7%	7.1%	6.7%	6.8%	6.2%	7.0%	6.6%	6.6%	7.2%	6.3%	6.4%	6.2%
Theatre Efficiencies	Theatre Utilisation rates	Jan-19	80.0%		90%	✗			73%	73%	70%	72%	76%	74%	69%	62%	74%	73%	74%	67%	80%
	% of theatre sessions starting late	Jan-19	46.0%		<25%	✗			43%	43%	46%	41%	41%	41%	38%	42%	39%	41%	41%	44%	46%
	% of theatre sessions finishing early	Jan-19	40.0%		<20%	✗			34%	36%	43%	39%	37%	39%	40%	36%	36%	39%	40%	43%	40%
Prescribing	Biosimilar medicines prescribed as % of total 'reference' product plus biosimilar	Q2 18/19	77.0%	Quarter on quarter ↑			87.0%				12.2%			20.9%			77.0%				
Elective Procedures	Elective caesarean rate	2017/18	13.2%	Annual ↓			12.8%		2017/18=13.2%												
Workforce	% of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	Jan-19	67%	85%	76%	✗	67.5%		64%	63%	64%	64%	63%	63%	65%	65%	65%	67%	69%	69%	67%
	% staff who undertook a performance appraisal who agreed it helped them improve how they do their job	2018	55%	Improvement			54%		2018= 55%												
	Overall staff engagement score – scale score method	2018	3.81	Improvement			3.82		2018= 3.81												
	% compliance for all completed Level 1 competency with the Core Skills and Training Framework	Jan-19	73%	85%	58%	✓	74.8%		49%	50%	51%	53%	55%	57%	59%	63%	65%	67%	71%	73%	73%
	% workforce sickness and absent (12 month rolling)	Dec-18	5.99%	12 month ↓	5.0% (Mar-19)		5.29%		5.65%	5.71%	5.76%	5.77%	5.81%	5.84%	5.87%	5.88%	5.91%	5.90%	5.96%	5.99%	
	% staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	2018	72%	Improvement			73%		2018= 72%												

4.1 Unscheduled Care- Overview

Chart 1: % GP practices open during core hours or within 1 hour of daily core hours

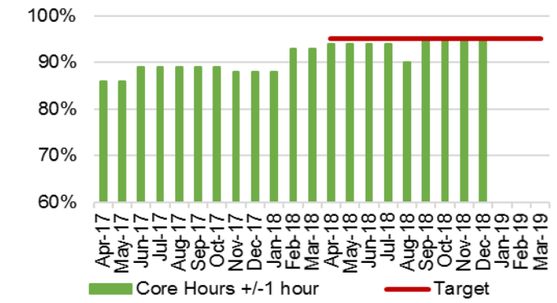


Chart 2: % GP practices offering daily appointments between 5pm- 6:30pm

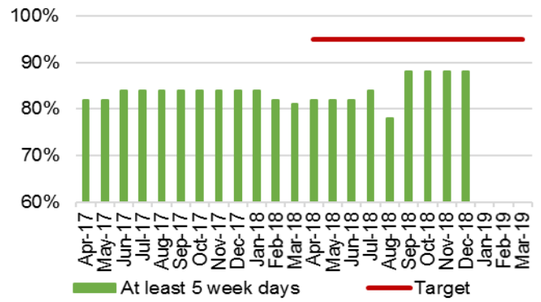


Chart 3: GP Out of Hours

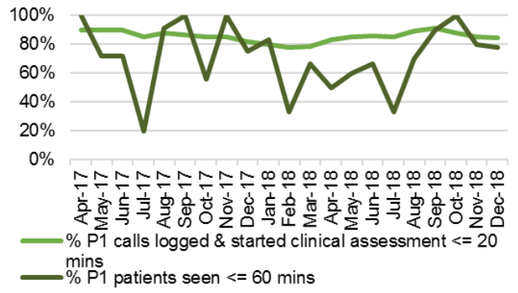


Chart 4: % red calls responded to within 8 minutes

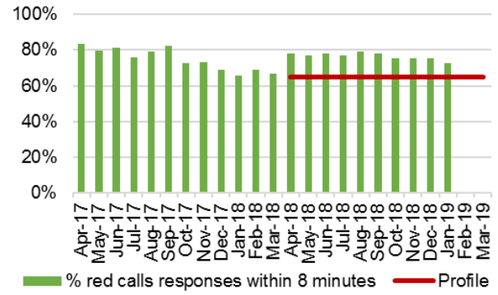


Chart 5: Number of ambulance handovers over 1 hour

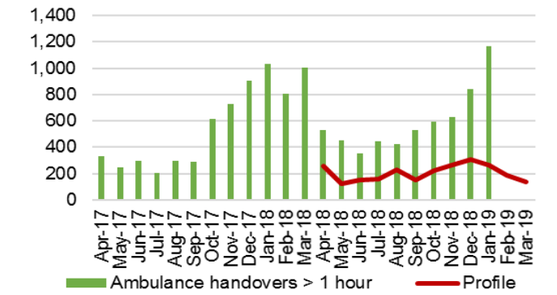


Chart 6: A&E Attendances

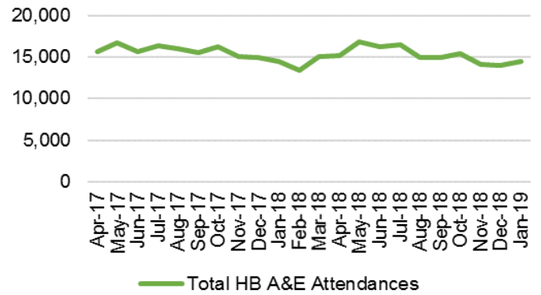


Chart 7: % patients who spend less than 4 hours in A&E

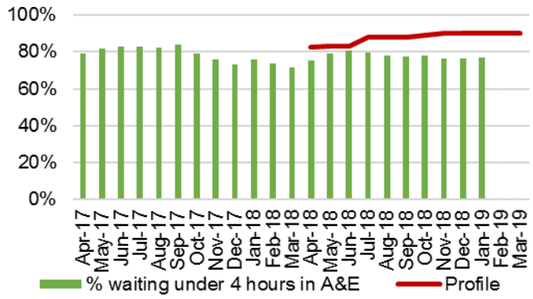


Chart 8: Number of patients waiting over 12 hours in A&E

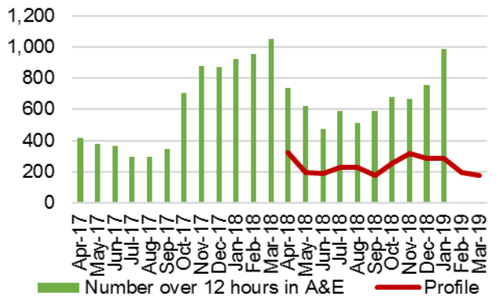


Chart 9: Number of emergency admissions

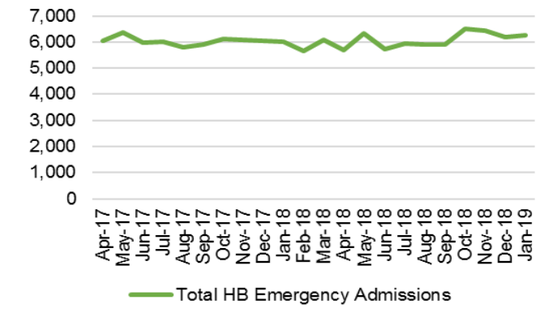


Chart 10: Elective procedures cancelled due to lack of beds

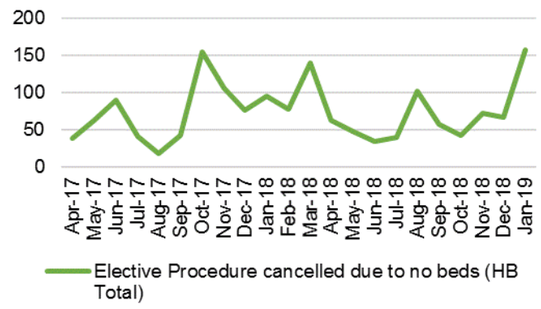


Chart 11: Number of mental health delayed transfers of care

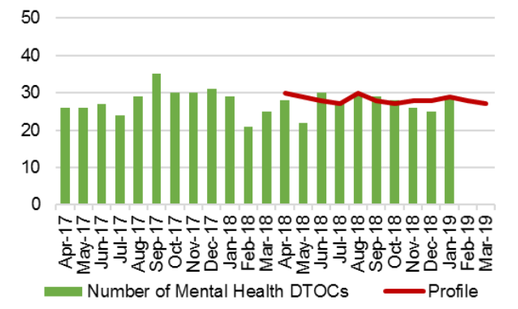


Chart 12: Number of non- mental health delayed transfers of care

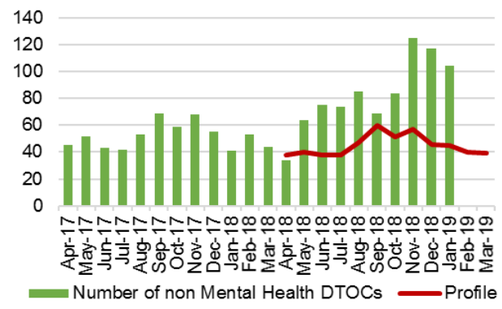


Chart 13: % of patients who have a direct admission to an acute stroke unit within 4 hours

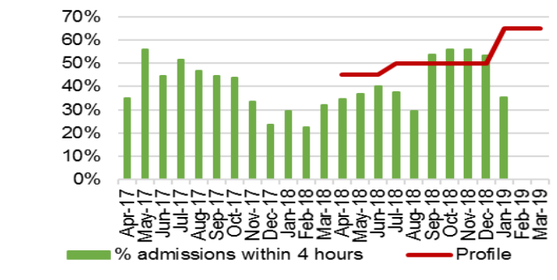


Chart 14: % of patients who receive a CT scan within 1 hour

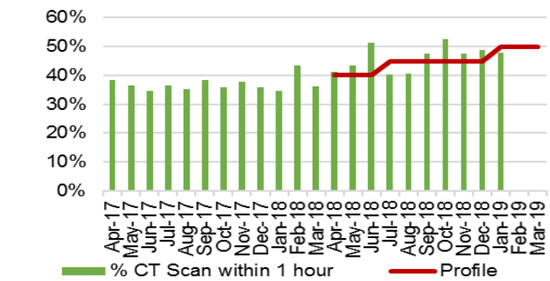


Chart 15: % of patients who are assessed by a stroke specialist consultant physician within 24 hours

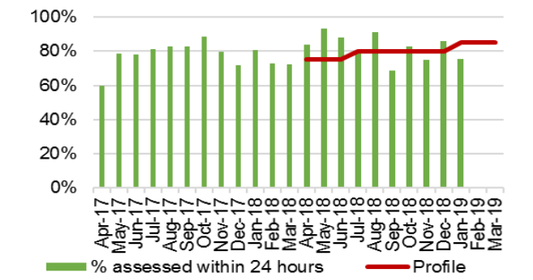
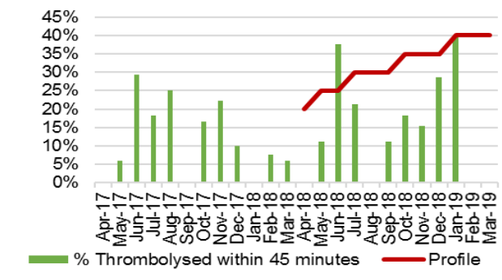


Chart 16: % of thrombolysed stroke patients with a door to door needle time of ≤45 minutes



Unscheduled Care Overview (January 2019)

Primary Care Access

95% (→)
GP practices open during daily core hours *(Dec-18)*

88% (→)
GP practices offering appointments between 5pm-6:30pm *(Dec-18)*

84% (1%↓)
P1 calls started assessment within 20 minutes *(Dec-18)*

78% (2%↓)
P1 calls seen within 60 minutes *(Dec-18)*

Ambulance

72.7% (3%↓)
Red calls responded to with 8 minutes

1,164 (38%↑)
Ambulance handovers over 1 hour

4,641 (5%↓)
Amber calls

390 (22%↓)
Red calls

Emergency Department

14,499 (4%↑)
A&E attendances

76.9% (0.4%↑)
Waits in A&E under 4 hours

986 (30%↑)
Waits in A&E over 12 hours

2,360 (2%↓)
Patients admitted from A&E

Emergency Activity

6,268 (1%↑)
Emergency Inpatient Admissions

438 (1%↓)
Emergency Theatre Cases

435 (6%↑)
Trauma theatre cases

157 (138%↑)
Elective procedures cancelled due to no beds

Patient Flow

29 (16%↑)
Mental Health DTOCs

104 (11%↓)
Non-Mental Health DTOCs

262 (13%↓)
Medically fit patients

2,195 (23%↑)
Days lost due to medically fit *(Morriston only)*

1,910 (10%↑)
Medical outliers

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

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

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

21.5% (Wales= 19%)
Adults who smoke

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

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

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

**RAG status and trend is based on in month-movement*

4.2 Winter Plan Dashboard

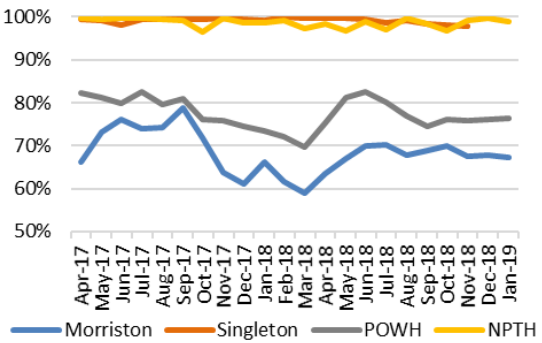
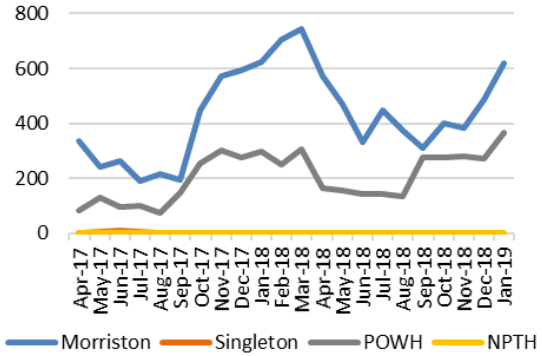
Quality & Performance Indicator	Measure	Report Period	Current Performance	In-month trend	Annual Comparison	Performance Trend	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Impact on unscheduled care standards	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	Jan-19	76.9%				76.1%	73.8%	71.4%	75.6%	78.9%	81.0%	79.9%	77.9%	77.5%	78.0%	76.7%	76.5%	76.9%
	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	Jan-19	986				924	957	1,051	737	624	476	590	511	588	680	665	756	986
	Number of ambulance handovers over one hour	Jan-19	1,164				1,030	805	1,006	526	452	351	443	420	526	590	628	842	1,164
	% of emergency responses to red calls arriving within (up to and including) 8 minutes	Jan-19	72.7%				65.7%	68.9%	66.7%	78.0%	77.2%	78.0%	77.0%	79.2%	78.3%	75.4%	75.2%	75.4%	72.7%
Delayed Transfers of care and medically fit for discharge numbers	Number of mental health HB DToCs	Jan-19	29				29	21	25	28	22	30	27	30	29	28	26	25	29
	Number of mental health HB DToCS (12 month rolling)	Jan-19	320				340	334	333	335	331	334	337	338	332	330	326	320	320
	Number of non-mental health HB DToCs	Jan-19	104				41	53	44	34	64	75	74	85	69	84	125	117	104
	Number of non-mental health HB DToCs (12 month rolling)	Jan-19	928				615	625	624	613	625	657	689	721	721	746	803	865	928
	Number of medically fit for discharge patients	Jan-19	262				233	187	184	285	276	260	254	230	285	276	268	300	262
Cancellations of operations for bed reasons	Number of elective procedures cancelled due to lack of beds	Jan-18	157				95	77	140	62	48	34	39	102	57	42	72	66	157
Medical Outliers on non medical wards	Number of medical outliers on non-medical wards	Dec-18	1,910				2,327	1,665	2,004	1,831	1,067	938	1,037	1,090	1,141	1,403	1,736	1,910	
Bed days lost due to delays in patient repatriation outside of the health board	Number of days lost where repatriation is the main reason for delay of discharge fit patient (Morriston Hospital only)	Jan-19	173				34	72	69	81	58	169	72	159	230	298	270	97	173
Flu uptake rates	% uptake of influenza among 65 year olds and over	Jan-19	67.5%				68.0%	68.0%	68.0%							42.5%	59.3%	66.1%	67.5%
	% uptake of influenza among under 65s in risk groups	Jan-19	41.7%				46.0%	47.0%	47.0%							25.3%	34.0%	40.4%	41.7%
	% uptake of influenza among pregnant women								93.3%										
	% uptake of influenza among children 2 to 3 years old	Jan-19	47.2%				48.4%	49.1%	49.1%							20.4%	35.9%	46.0%	47.2%
	% uptake of influenza among healthcare workers	Jan-19	53.8%				57.2%	58.1%	58.3%							43.2%	50.4%	52.3%	53.8%

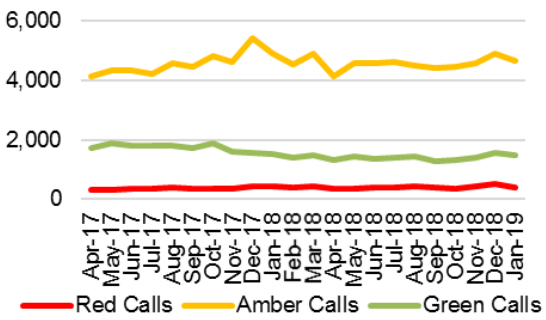
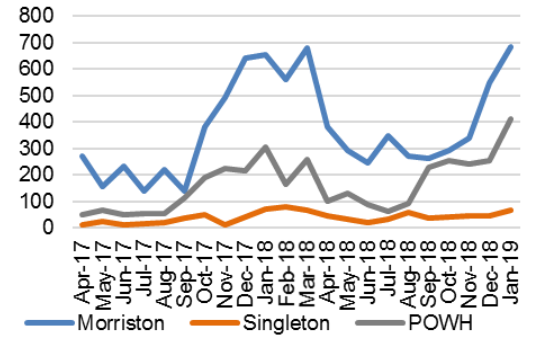
The following measures will be reported as soon as data is available/ validated:

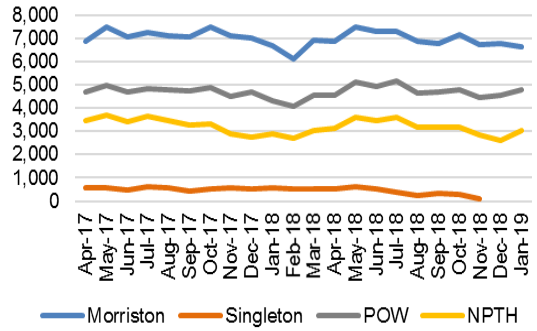
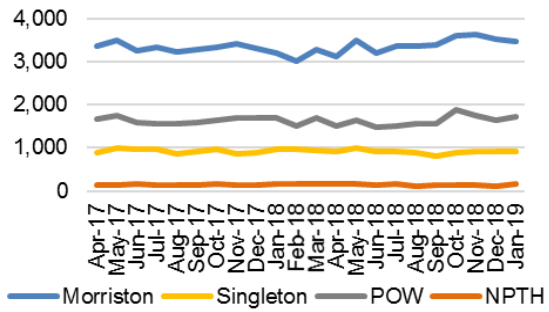
- Critical care utilisation and delayed discharges
- Use of pre-emptive/ boarding policy to place additional patients on wards
- Transfer times between hospitals within the health board
- Home before lunch metrics
- Serious incidents in ED
- Datix reports on 12 hour waits in ED/ delayed patient handover from WAST
- Patient and staff experience (e.g. Friends and Family test)

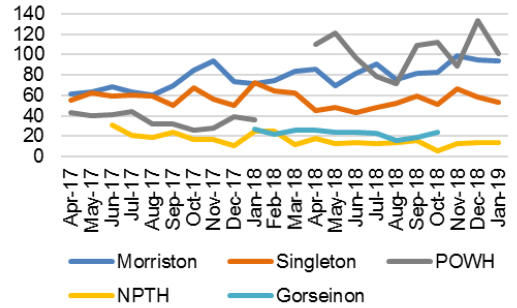
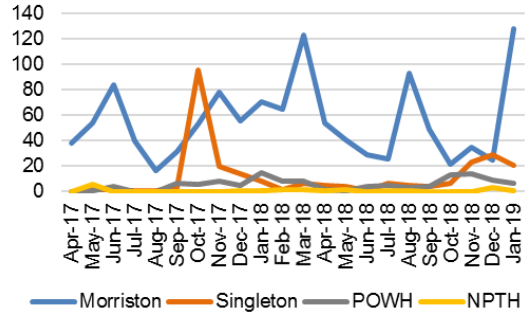
4.3 Unscheduled Care- Updates and Actions

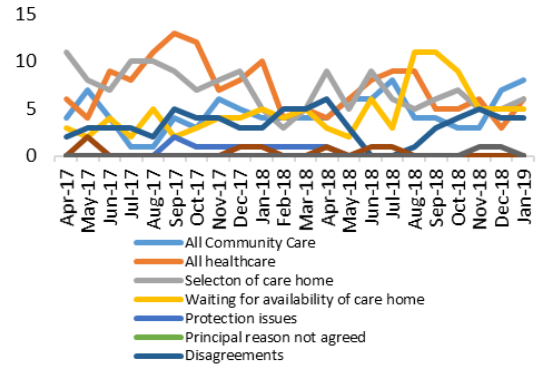
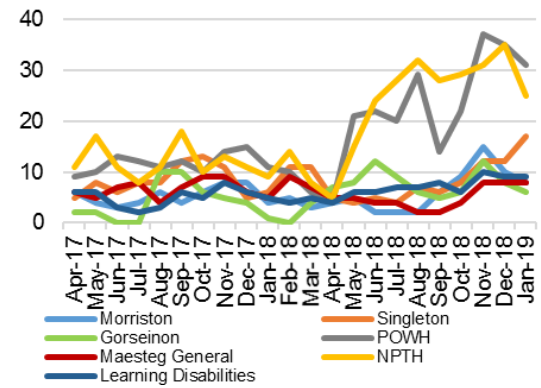
This section of the report provides further detail on key unscheduled care measures.

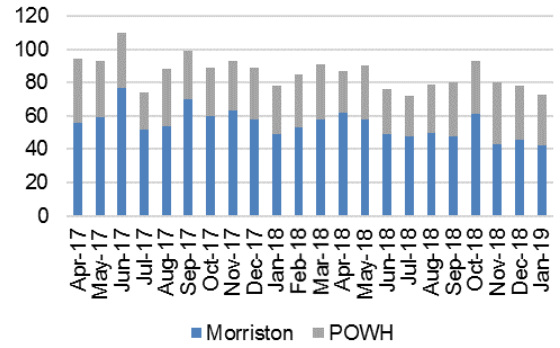
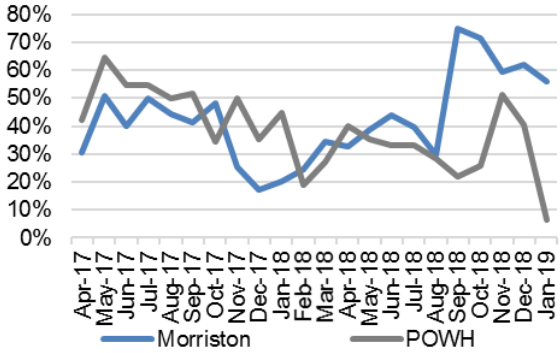
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr><td>A&E waiting times
The percentage of patients who spend less than 4 hours in all major and minor emergency care facilities from arrival until admission, transfer or discharge</td><td>Performance against the 4 hour metric in January 2019 improved by 0.4% from the December position and improved by 0.83% when compared with the reported performance for January 2018. However, performance was below the internal profile of 90.1%. Neath Port Talbot Hospital continues to exceed the national target of 95% but Morriston and Princess of Wales Hospitals were below profile, achieving 67.2% and 76.3% respectively.</td><td>% patients waiting under 4 hours in A&E
 
</td><td rowspan="2">• Full implementation of the Health Board and Welsh Government’s winter assurance funding to increase system support, resilience and patient safety. This includes:
○ Additional medical, nursing and therapy staff within our emergency departments (ED) and in key inpatient services.
○ Enhanced capacity in our frailty services in ED.
○ Increased capacity in support services to improve access to diagnostic tests, results and the movement and discharge of patients
○ Funding to continue to support inpatient winter ‘surge’ capacity – circa 60 additional beds are being used as surge capacity.
○ British Red Cross Home from Hospital service at Morriston and Princess of Wales hospitals
○ Care and Repair Wales to support at Morriston and NPT through a targeted Hospital to Home Assessment Service up until 31 March ‘19.
• In Morriston service delivery unit, recruitment to some posts supported via winter monies is ongoing – i.e. OPAS + recruitment of final band 7 still to be completed, HCSW pool, and the Respiratory CNS post.</td></tr>
<tr><td>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</td><td>Performance against this measure in January 2019 deteriorated when compared with January 2018, with 62 more patients waiting over 12 hours. In January 2019, there were 986 12 hour breaches of which 621 were attributed to Morriston Hospital and 365 to Princess of Wales Hospital.</td><td>Number of patients waiting over 12 hours in A&E
 
</td></tr>
</table>

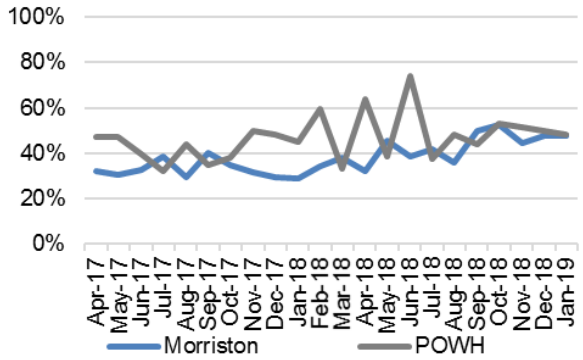
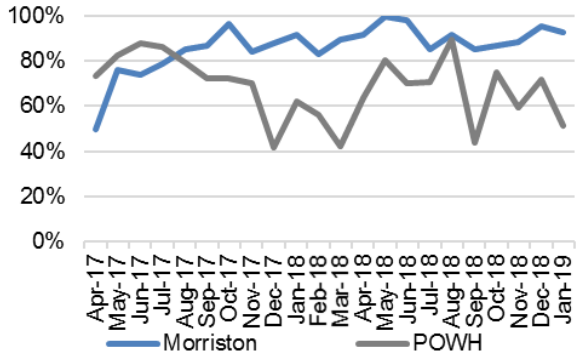
Description	Current Performance	Trend	Actions planned for next period
Ambulance responses The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes. The number of responses to ambulance calls.	Ambulance response times are consistently above the national target and local profile of 65%, reporting 72.7% at the end of January 2019.	**Number of ambulance call responses** 	• Working with WAST to direct patients to appropriate services or pathways, ensuring emergency ambulance capacity is utilised appropriately. Overall patients conveyed by ambulance reduced by 136 (4.1%) compared with January 2018, and by 309 (9% compared with December 2018. Red conveyances reduced by 54 (16%), and amber conveyances reduced by 122 patients (4.7%) in January 2019 compared with January 2018. Green call conveyances increased by 40 (11%). • Implement the recommendations of the WAST internal audit report on hospital handover that are applicable to ABMU. Further update provided to Audit Committee in January. • The Health Board has jointly funded a patient Hospital Ambulance Liaison Officer (HALO) role with WAST to assist with hospital handover during the winter months. • Two St Johns falls response vehicles have been commissioned in the HB area to reduce the number of falls patients conveyed to hospital and to release WAST ambulances to respond to higher acuity calls. Early indications are that this service has a 63% non-conveyance rate. • Increased liaison between our acute care teams and WAST to maximise opportunities to redirect, and where appropriate, manage patients in alternative settings to hospital. • Plan to implement pilot for the Acute GP in Singleton to have access to the ambulance stack to intercept, assess and manage HCP calls through alternative pathways.
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 wider unscheduled care system. In January 2019, Morriston Hospital saw an increase of 31 compared with January 2018 (653 to 684). Princess of Wales Hospital (POWH) saw an increase of 106 (306 to 412) and Singleton Hospital saw a reduction of 3 (71 to 68).	**Number of ambulance handovers over one hour** 	

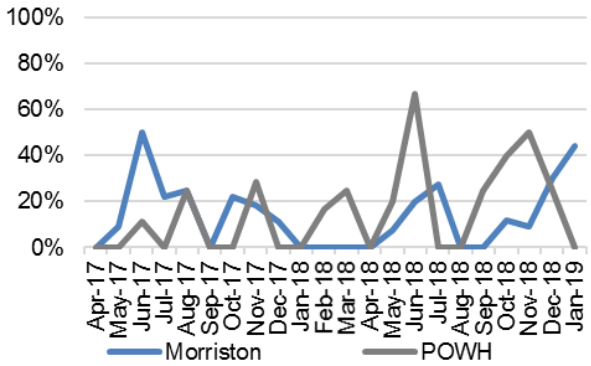
Description	Current Performance	Trend	Actions planned for next period
A&E Attendances The number of attendances at emergency departments in the Health Board	Attendances at our ED and Minor injuries units increased by 501 patients from 13,998 in January 2018 to 14,499 in January 2019. There were 7 fewer attendances in January 2019 than in January 2018. Singleton MIU remained closed during January as a result of refurbishment work. 550 patients were managed by this service in January 2018.	**Number of A&E attendances** 	• Additional 111 awareness campaign communication programme underway as part of the winter planning arrangements and communication of Choose Well pathways. • Encourage and promote the use of ABMU community pharmacies, 95% of whom are now in a position to offer the Common Ailment Service. • Maximise use of telephone first model to support practices to manage patient demand. • Implement the Cwmtawe cluster pilot to test a cluster led integrated health & social care system. • Promote attendance at MIU in NPTH for minor illness and injury.
Emergency Admissions The number of emergency admissions across the Health Board by site	In January 2019, there were a total of 6,268 emergency admissions across the HB which is 250 more than January 2018. Paediatric admissions largely accounted for the increase experienced between Jan-18 and Jan-19, whilst medical emergency demand reduced by 15. The number of emergency admissions in the over 75 age group has reduced by 110 (6.3%) to 1622 in January 2019, which is a reflection of the impact of the enhanced frailty services in the HB.	**Number of emergency admissions** 	• Rolling out the *I fell down* tool in the care homes with highest call demand on WAST in Swansea and NPT. This tool supports a reduction in the number of 'long lie' residents in care homes following a fall. • Maximise the benefit of the 2 falls vehicles in ABMU HB to support a reduction in the number of patients who have fallen, to be conveyed to hospital. (63% non-conveyance rate) • Acute Care Teams working in close liaison with WAST to redirect and manage patients in the community where capacity allows as opposed to a conveyance to hospital. • Maximise alternative models to admission that have been developed in Q1-3 such as ambulatory and day unit facilities, hot clinics and direct to speciality admission pathways. • Ongoing promotion of flu vaccine in vulnerable groups to reduce admissions to hospital.

Description	Current Performance	Trend	Actions planned for next period
Medically Fit The number of patients waiting at each site in the Health Board that are deemed discharge/ medically fit	In January 2019, there were on average 262 patients who were deemed medically/ discharge fit but were still occupying a bed in one of the Health Board's Hospitals. This is a 12% increase when compared with January 2018. 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. * Data for Gorseinon Hospital has not been available since November and December 2018.	• Ongoing implementation and embedding the models of care to provide more timely discharge and value based care for frail older people. This includes the ICOP service at Singleton, the OPAS service at Morriston, the frailty service at POWH and the enabling ward and early supported discharge service at NPTH. • Promote and implement the SAFER flow principles. Embedding the safety huddle approach to managing flow with the support of the NHS Wales Delivery Unit across all units. Clinically led programme of work reporting into USC board to ensure senior review is undertaken in a consistent way to ensure the provision of an agreed clinical management plan which is an essential to inform the estimated discharge date. • Roll out the electronic solution to capture live information on medically fit for discharge patients to improve communication and management of patient flow. • Implement the actions outlined in the section on delayed transfers of care below.
Elective procedures cancelled due to lack of beds The number of elective procedure cancelled across the hospital where the main cancellation reasons was	In January 2019 2018, there were 62 more elective procedures cancelled due to lack of beds on the day of surgery when compared with January 2018 (95 to 157). In January 2019, 128 of the 157 cancelled procedures were attributed to Morriston Hospital.	**Total number of elective procedures cancelled due to lack of beds** 	• Implementation of models of care that mitigate the impact of unscheduled care pressures on elective capacity – such as ambulatory emergency care models and enhanced day of surgery models. • Maximise utilisation of surgical unit at NPTH hospital which is not affected by emergency pressures.

Description	Current Performance	Trend	Actions planned for next period
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board- Mental Health (all ages)	The number of mental health related delayed transfers of care in January 2019 was 29 which is the same as January 2018.	**Number of Mental Health DToCs** 	• Maintain expanded capacity of early supported discharge service in NPT to increase the number of discharges with the support of this service. • Maximise use of reablement capacity in Bonymaen house in Swansea. • Additional investment from local British Red Cross services to support hospital to home services from January 2019. • Following a discharge workshop on 14/01/19 it was agreed that there will be a specific improvement programme focussing on reducing delayed transfers of care within our HB. This is a clinically led programme and the key aims are to: ○ Standardise the approach taken across all Units to weekly stranded patient meetings ○ Undertake centralised monthly DTOC validation scrutiny meeting and monthly debrief meeting ○ Improve and quicken the assessment process between organisations ○ Improve communication between organisations ○ Implement new pathways of care to support discharge, e.g. home from hospital models. ○ Continue investment in additional community capacity to reduce admissions ○ Document all cases on the DTOC system ○ Benchmark with other Health Boards • Whilst the majority of the improvements reflect changes to process and communication, a significant factor underpinning the expected reduction in reported numbers will be the development of a Hospital 2 Home model of care during 2019/20. A joint transformation bid is being developed between the HB and local authority partners with the aim of discussion with WG during March 2019.
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board - Non Mental Health (age 75+)	In January 2019, the number of non-mental health and Learning disability delayed transfers of care was 104, which is 63 more than in January 2018. However there was an in month reduction of 13 reported delays from the 117 delayed transfers reported in December 2018.	**Number of Non Mental Health DToCs** 	

Description	Current Performance	Trend	Actions planned for next period
Stroke Admissions The total number of stroke admissions into the Health Board	In January 2019, there were 73 confirmed stroke admissions across the Health Board; 42 in Morriston and 31 in Princess of Wales. This is 6% less when compared with January 2018 (78 to 73).	**Total number of stroke admissions** 	• Roll out and support impact of the Directed Enhanced Service for INR and Direct-Acting Oral Anticoagulants (DOAC) service. • Plan for the introduction of the revised QIMs f—Stroke measures to commence reporting against in April. • Although additional middle tier Medical staff appointed into Morriston – pressures from other vacancies are requiring them to act down on occasions. Unit to continue to try and recruit into vacant posts to address rota and service pressures. • Stroke Champion discussions held with key medical staff – but impact of vacancies reducing abilities to introduce change. Need to fill vacant posts.
Stroke 4 hour access target % of patients who have a direct admission to an acute stroke unit within 4 hours	In January 2019 only 25 out of 71 patients had a direct admission to an acute stroke unit within 4 hours (35.21%). January 2019 was an extremely challenging month for POWH as only 2 out of 30 patients were admitted within 4 hours (6.67%). The 4 hour target appears to be a challenge across Wales. The all-Wales data for December 2018 confirms that performance ranged from 39.7% to 64.6%. ABMU was the third best performing Health Board in December 2018.	**Percentage of patients admitted to stroke unit within 4 hours** 	• Monitor impact of additional training to improve swallow screening compliance within the Emergency department staff. • Actions to improve 4 hour target has seen improvements on both sites during the period – but increasing unscheduled care pressures are having an impact on this performance – need to continue with improvement actions. • Speech Language Therapy (SLT) recruitment in POWH – continuing. • Thrombolysis Review recommendations have been shared with the Health Board and action plans to improve service delivery in a number of areas are being compiled. This includes the need for decisions to be made around dedicated OOH consultants stroke rotas, changes to access to thrombolysis pathways and access to protected stroke beds.

Description	Current Performance	Trend	Actions planned for next period
Stroke CT scan Percentage of patients who receive a CT scan within 1 hour	In January 2019, ABMU achieved 48% which was below the internal profile of 50%.	**Percentage of patients receiving CT scan within 1 hour** 	• Morriston to review pathway for accessing CT within 1 hour for all stroke patients. Multi-Disciplinary meeting being arranged. • IBG has considered the case for the development of an Early Supportive Discharge service at Morriston / Singleton hospitals. Delivery Unit meetings to take place to update and agree next steps. • POWH have updated Clerking arrangements – process to be monitored to assess effectiveness. • The stroke team at POWH to continue working closely with the patient flow team to ensure a focus on stroke flow and a prioritisation for creating assessment capacity. • At Singleton the team continues to examine all processes including senior review / early discharge / effective Board rounds on ward 7. • Assessments and criteria between Ward F and ward 7 to continue.
Stroke assessment within 24 hours Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours	In January 2019, ABMU achieved 75% which was below the internal profile of 85%.	**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 January 2019 2018, 100% of eligible patients were thrombolysed and 4 one of the 10 patients were thrombolysed within the 45 minutes (door to needle) standard.	**Thrombolysed patients within 45 minutes** 	• As above

5.1 Planned Care- Overview

Chart 1: Number of GP Referrals into secondary care

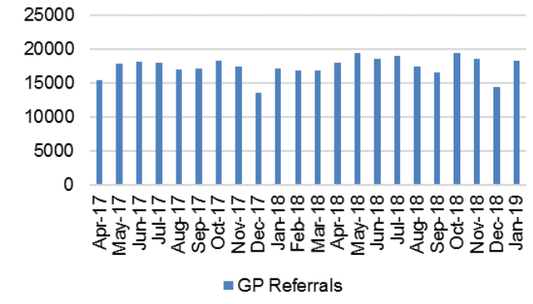


Chart 2: Number of patients waiting over 26 weeks for an outpatient appointment

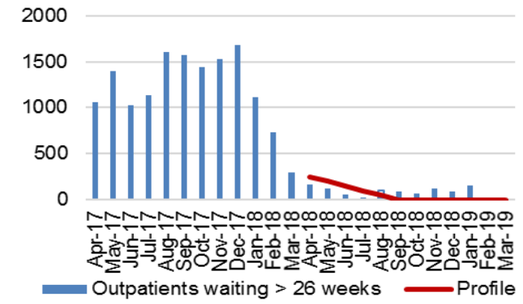


Chart 3: Number of patients waiting over 36 weeks for treatment

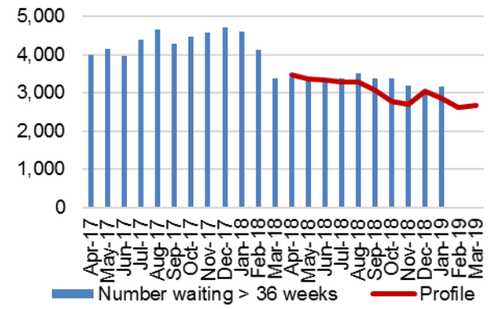


Chart 4: % patients waiting less than 26 weeks from referral to treatment

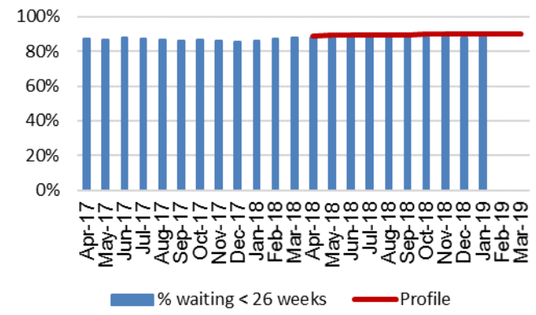


Chart 5: Number of patients waiting for reportable diagnostics over 8 weeks (excluding Cardiac)

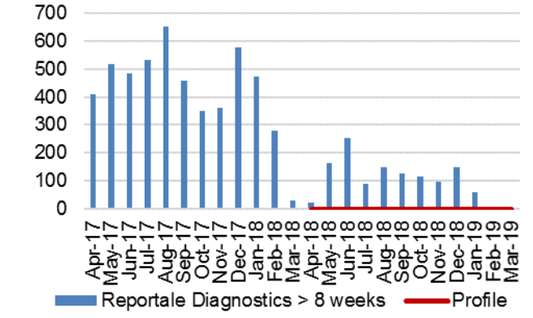


Chart 6: Number of patients waiting for reportable Cardiac diagnostics over 8 weeks

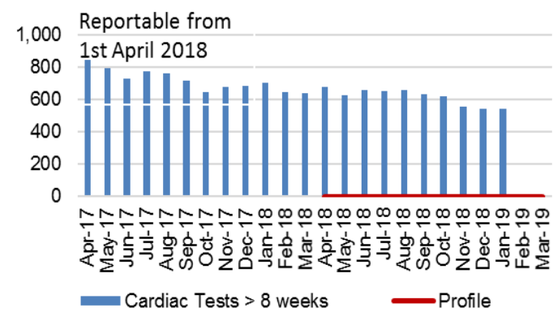


Chart 7: Therapies over 14 weeks

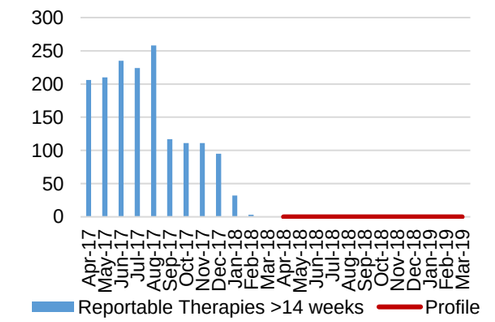


Chart 8: Cancer referrals

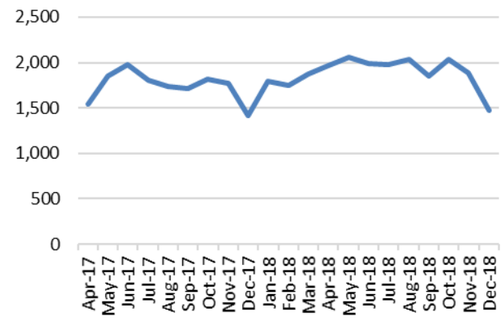


Chart 9: % patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days

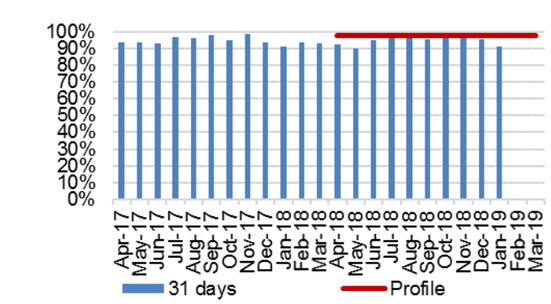


Chart 10: % patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to & including) 62 days of receipt of referral

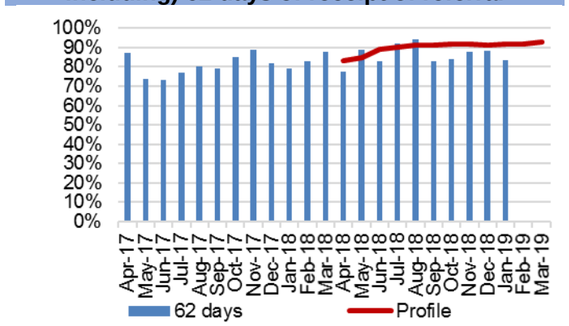


Chart 11: % of patients who did not attend a new outpatient appointment *(for selected specialties)*

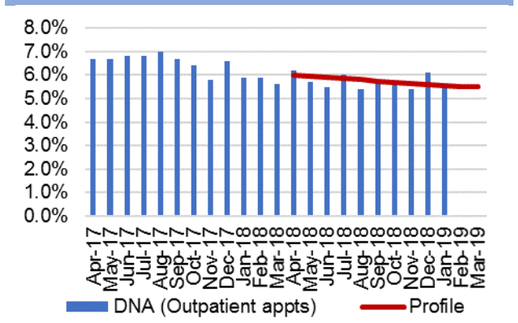
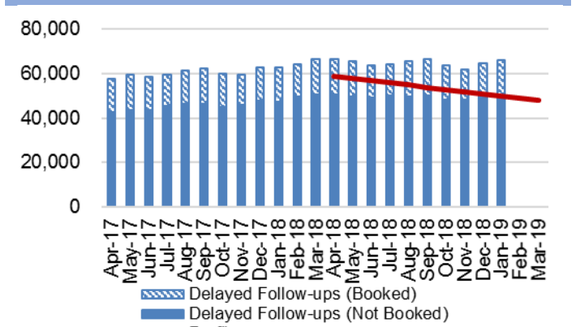


Chart 12: Number of patients waiting for an outpatient follow-up who are delayed past their target date



Planned Care- Overview (January 2019)

Demand

18,855 (31%↑)
Total GP referrals

11,565 (31%↑)
Routine GP referrals

7,290 (32%↑)
Urgent GP referrals

Waiting Times

153 (63%↑)
Patients waiting over 26 weeks for a new outpatient appointment

3,174 (5%↑)
Patients waiting over 36 weeks for treatment

1,349 (4%↓)
Patients waiting over 52 weeks for treatment

88.0% (0.7%↑)
Patients waiting under 26 weeks from referral to treatment

59 (60%↓)
Patients waiting over 8 weeks for reportable diagnostics

544 (→)
Patients waiting over 8 weeks for Cardiac diagnostics

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

65,743 (1.9%↑)
Patients waiting for an outpatient follow-up who are delayed past their target date

Outpatient Efficiencies

5.5% (0.6%↓)
% of patients who did not attend a new outpatient appointment (all specialties)

6.2% (0.2%↓)
% of patients who did not attend a follow-up outpatient appointment (all specialties)

Cancer

1,476 (22%↓)
Number of USC referrals received

123 (5%↓)
USC backlog over 52 days

91.3% (4.3%↓)
USC patients receiving treatment within 62 days

83.6% (4.5%↓)
NUSC patients receiving treatment within 31 days

Theatre Efficiencies

80% (13%↑)
Theatre utilisation rate

46% (2%↑)
% of theatres sessions starting late

40% (3%↓)
% of theatres sessions finishing early

39% (1%↑)
Operations cancelled on the day

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

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

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

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

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

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

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

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

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

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

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

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

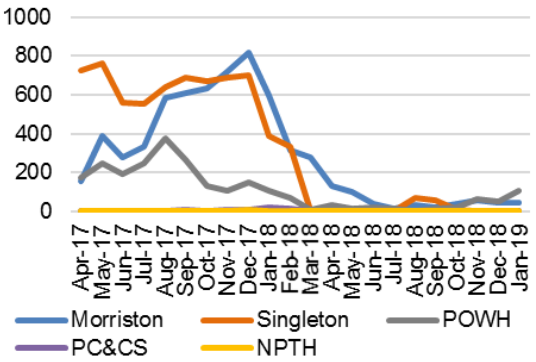
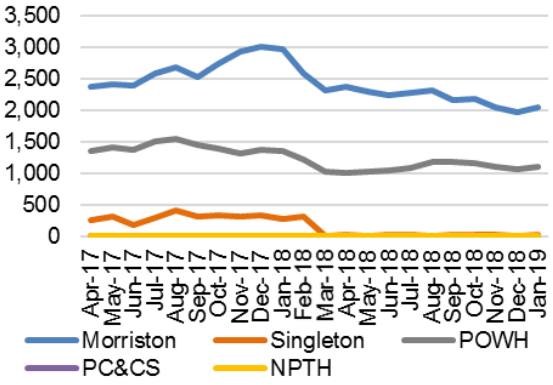
**RAG status and trend is based on in month-movement*

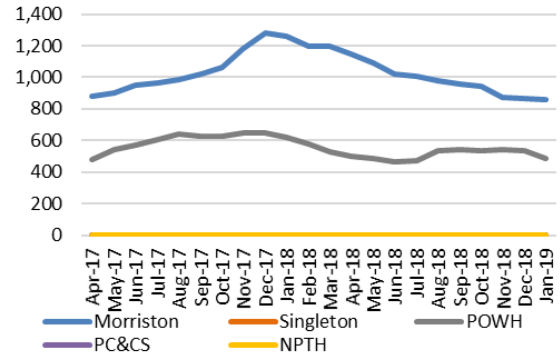
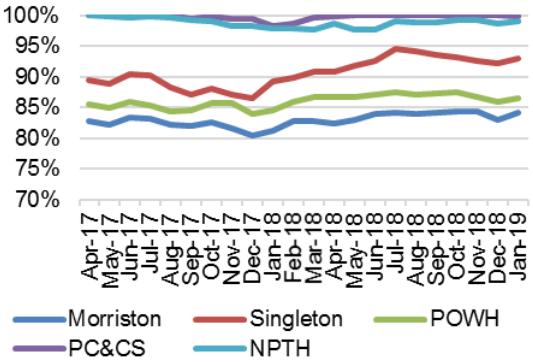
5.2 Theatre Efficiencies Dashboard

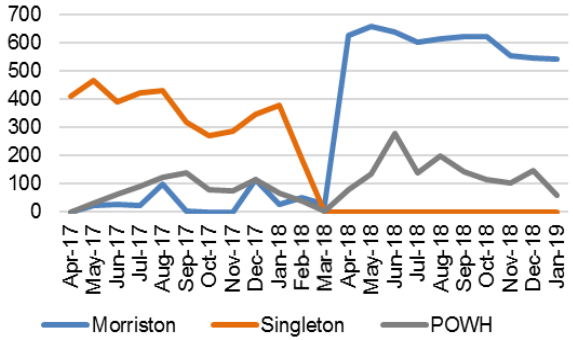
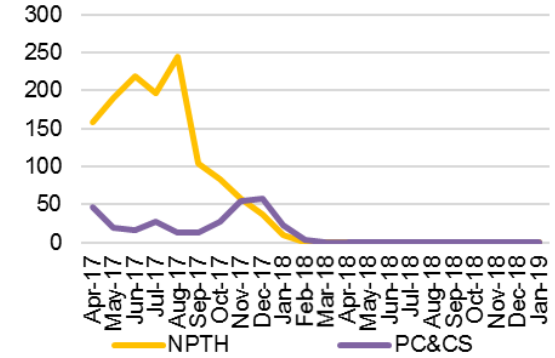
Measure			Report Period	Current Performance	Initial Target	Target Status	In-month trend	Annual Comparison	Performance Trend	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
Number of cancelled operations	Morriston		Jan-19	507						368	319	441	305	433	471	409	390	396	458	368	377	507
	NPTH		Jan-19	177						180	205	181	148	149	161	135	174	182	181	177	121	177
	POWH		Jan-19	301						320	321	396	336	323	399	376	287	322	363	322	364	301
	Singleton		Jan-19	222						173	159	214	161	202	169	170	217	158	223	235	193	222
	HB Total		Jan-19	1207						1041	1004	1232	950	1107	1200	1090	1068	1058	1225	1102	1055	1207
% of cancelled operations on the day	Morriston		Jan-19	41%	10%	✖				45%	51%	40%	40%	32%	28%	27%	35%	34%	44%	39%	40%	41%
	NPTH		Jan-19	23%		✖				26%	26%	24%	24%	29%	29%	24%	25%	21%	22%	32%	29%	23%
	POWH		Jan-19	36%		✖				33%	36%	43%	34%	31%	35%	33%	37%	28%	31%	32%	29%	36%
	Singleton		Jan-19	51%		✖				47%	45%	43%	50%	49%	41%	38%	31%	42%	48%	47%	57%	51%
	HB Total		Jan-19	39%		✖				38%	40%	39%	37%	34%	32%	31%	33%	31%	38%	37%	38%	39%
Reasons for cancellations on the day	Hospital Clinical		Jan-19	31%						35%	32%	31%	35%	30%	31%	32%	26%	32%	25%	29%	29%	31%
	Hospital Non-Clinical		Jan-19	39%						42%	40%	39%	34%	42%	42%	41%	49%	41%	46%	48%	49%	39%
	Other		Jan-19	0%						0%	0%	8%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%
	Patient		Jan-19	29%						24%	28%	21%	30%	28%	26%	27%	24%	26%	29%	22%	22%	29%
	Unknown		Jan-19	0%						0%	0%	0%	0%	1%	1%	0%	1%	1%	0%	0%	0%	0%
Late Starts	Morriston		Jan-19	45%	<25%	✖				43%	46%	50%	45%	37%	37%	37%	49%	38%	35%	35%	42%	45%
	NPTH		Jan-19	42%		✖				33%	35%	39%	39%	28%	30%	36%	20%	36%	36%	41%	43%	42%
	POWH		Jan-19	46%		✖				43%	35%	41%	38%	44%	40%	35%	38%	38%	42%	37%	37%	46%
	Singleton		Jan-19	52%		✖				47%	51%	46%	42%	52%	55%	43%	43%	45%	53%	54%	54%	52%
	HB Total		Jan-19	46%		✖				43%	43%	46%	41%	41%	41%	38%	42%	39%	41%	41%	44%	46%
Early Finishes	Morriston		Jan-19	42%	<20%	✖				31%	36%	41%	39%	33%	33%	34%	30%	25%	34%	37%	44%	42%
	NPTH		Jan-19	50%		✖				48%	54%	58%	39%	60%	58%	61%	59%	62%	62%	59%	66%	50%
	POWH		Jan-19	39%		✖				33%	37%	43%	37%	36%	44%	43%	35%	41%	38%	39%	39%	39%
	Singleton		Jan-19	29%		✖				32%	27%	36%	44%	34%	33%	36%	38%	34%	34%	36%	31%	29%
	HB Total		Jan-19	40%		✖				34%	36%	43%	39%	37%	39%	40%	36%	36%	39%	40%	43%	40%
Theatre Utilisation Rate	Morriston		Jan-19	89%	90%	✖				80%	79%	79%	78%	85%	79%	75%	70%	82%	80%	80%	69%	89%
	NPTH		Jan-19	65%		✖				70%	65%	58%	69%	63%	62%	63%	44%	67%	70%	66%	70%	65%
	POWH		Jan-19	77%		✖				69%	72%	70%	72%	76%	77%	71%	61%	72%	70%	74%	66%	77%
	Singleton		Jan-19	70%		✖				62%	63%	54%	60%	61%	63%	55%	53%	62%	62%	64%	61%	70%
	HB Total		Jan-19	80%		✖				73%	73%	70%	72%	76%	74%	69%	62%	74%	73%	74%	67%	80%
Theatre Activity Undertaken	Morriston	Day cases	Jan-19	373						284	299	321	312	269	310	302	368	272	371	339	300	373
		Emergency cases	Jan-19	276						346	324	335	354	387	374	375	391	373	335	310	286	276
		Inpatients	Jan-19	516						559	522	478	527	630	543	497	486	522	572	540	403	516
	NPTH	Day cases	Jan-19	295						261	285	257	267	240	214	234	190	290	347	297	202	295
		Emergency cases	Jan-19	2						15	1	7	3	5	9	6	5	8	5	9	6	2
		Inpatients	Jan-19	150						141	127	106	126	147	138	122	89	116	133	126	104	150
	POWH	Day cases	Jan-19	434						472	395	371	350	429	449	408	301	393	455	365	274	434
		Emergency cases	Jan-19	124						120	100	139	107	125	120	120	126	101	107	98	110	124
		Inpatients	Jan-19	259						162	225	234	262	238	252	251	236	223	264	263	172	259
	Singleton	Day cases	Jan-19	565						509	461	439	462	526	500	445	456	423	516	528	371	565
		Emergency cases	Jan-19	36						40	41	49	35	38	52	45	44	34	34	42	40	36
		Inpatients	Jan-19	129						118	123	91	124	127	120	90	102	98	141	132	94	129

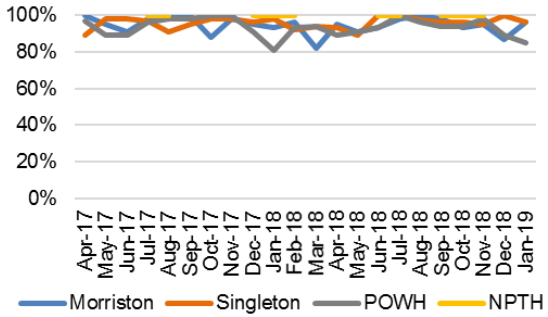
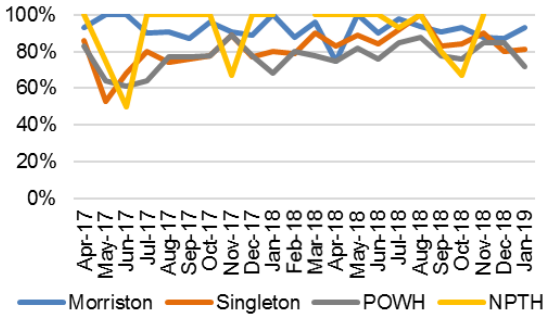
5.3 Planned Care Updates and Actions

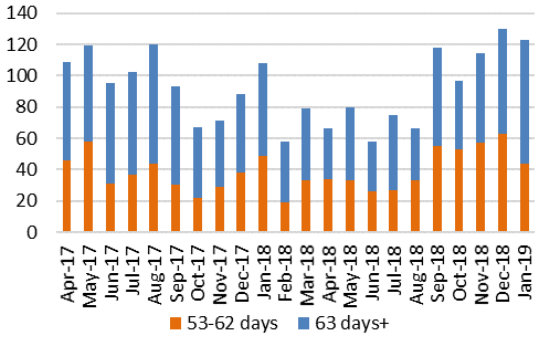
This section of the report provides further detail on key planned care measures.

Description	Current Performance	Trend	Actions planned for next period
Outpatient waiting times The number of patients waiting more than 26 weeks for an outpatient appointment (stage 1)	The number of patients waiting over 26 weeks for a first outpatient appointment continues to be significantly lower than in previous years. There was an increase in January 2019 with 153 patients waiting over 26 weeks compared with 94 in December 2018 and 958 less than January 2018. In January 2019, 74 breaches were in Urology, 40 were in Oral Maxillo Facial Surgery (OMFS), 35 in General Surgery, 2 in Restorative Dentistry and 1 in Orthopaedics and Paediatric Neurology.	**Number of stage 1 over 26 weeks** 	• Core capacity being maximised and additional clinics continue to be secured to maintain a Nil position across the majority of specialties. • Ongoing fragility of Urology service in POWH continues to be a challenge. Locum Consultant in place to support clearance of backlog before the end of March 2019. • Deterioration in General Surgery in Morriston due to redirection of capacity to cover rectal bleed clinics. Additional clinics planned to clear the backlog before the end of March 2019.
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 January 2019 there were 3,174 patients waiting over 36 weeks, therefore falling short of the internal profile of 2,854. 98% of patients are waiting in the treatment stage of the pathway and Orthopaedics accounts for 66% of the breaches, followed by General Surgery with 14%.	**Number of patients waiting longer than 36 weeks** 	• Significant outsourcing programme in place for the six main pressure specialties. Capacity secured and activity underway. All slots to be allocated by mid-February. • Clearance of all waits in stages 2 and 3. • Dedicated sessions in ENT for retired and returned Consultant. • Increase booking rates, general pooling, validation and additional lists in Plastic Surgery. • Recruitment programme for 10 theatre staff nurses at Singleton to support core and un-commissioned lists. • Time limited enhanced remuneration scheme for theatre staff nurses to support weekend working at POW in Orthopaedics.

Description	Current Performance	Trend	Actions planned for next period
Total waiting times The number of patients waiting more than 52 weeks for treatment	The number of patients waiting over 52 weeks mirrors that of the 36 week position with Orthopaedics and General Surgery accounting for the vast majority of breaches. In January 2019 the position has seen an in-month improvement of 50 and is 380 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 be an improvement on March 2018 and draft the January 2019 position shows an in-month improvement of 0.7%. This position is still the highest percentage since November 2013.	**Percentage of patient waiting less than 26 weeks** 	• Plans as outlined in previous tables.

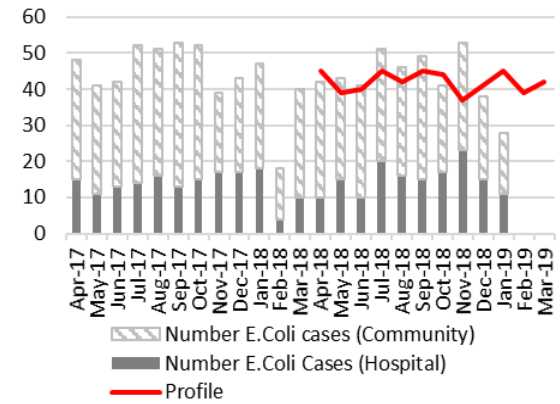
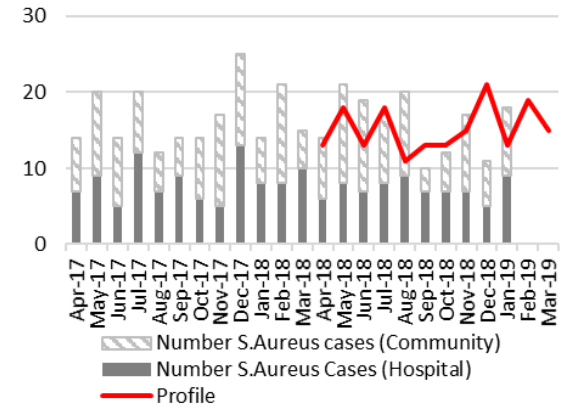
Description	Current Performance	Trend	Actions planned for next period
Diagnostics waiting times The number of patients waiting more than 8 weeks for specified diagnostics	In January 2019, there were 603 patients waiting over 8 weeks for specified diagnostics. The noticeable increase in breaches is due to the introduction of new Cardiac diagnostic tests in April 2018. The position is:- • Cardiac Diagnostics (544) • Cystoscopy (25) • Non Obstetric Ultrasound (25) • Radiology- MRI (9)	**Number of patients waiting longer than 8 weeks for diagnostics** 	• Sustain Nil position for Endoscopy by maximising backfill and WLIs. • Locum consultant to clear NOUS backlog by end of February 2019. • Additional lists and utilisation of mobile MRI unit at Morriston to clear backlog by February 2019. • Plan for additional Cardiac CT/MR capacity is implemented and working well with improvements being seen
Therapy waiting times The number of patients waiting more than 14 weeks for specified therapies	There has been significant improvement in Therapy waiting times over the last 12 months and there were no patients waiting over 14 weeks in April 2018. The January 2019 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.

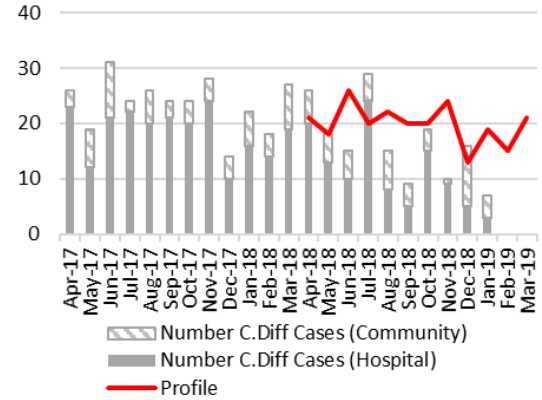
Description	Current Performance	Trend	Actions planned for next period
Cancer- NUSC waiting times- Percentage of patients newly diagnosed with cancer, not via urgent route that started definitive treatment within 31 days of diagnosis	January 2019 figures will be finalised on 28th February. Draft figures indicate projected achievement of 94% of patients' starting treatment within 31 days. At the time of writing this report there are 8 breaches across the Health Board in January 2019: • Breast: 4 • Urological: 2 • Skin: 1 • Gynaecological: 1	**Percentage of NUSC patients starting treatment within 31 days of diagnosis** 	• New Consultant Oncologist appointed for Urology and Lung tumour sites. To commence in post March 2019. • Gynaecology team working with Hywel Dda to consider options of utilising theatre capacity in Hywel Dda. • Singleton DU provided SBAR regarding delivery of chemotherapy services at Singleton. • Breast consultant surgeon returns from LTS/phased return in February.
Cancer- USC waiting times- Percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within 62 days of receipt of referral	January 2019 figures will be finalised on 28th February. Draft figures indicate a projected achievement of 84% of patients starting treatment within 62 days. At the time of writing this report there are 22 breaches in total across the Health Board in January 2019: • Breast: 7 • Gynaecological: 4 • Lower Gastrointestinal: 4 • Urological: 3 • Head & Neck: 2 • Upper Gastrointestinal: 2	**Percentage of USC patients starting treatment within 62 days of receipt of referral** 	• Morriston to progress Upper GI pathway review to identify possible bundling of diagnostic requests. • Re-advertising for 4th Gynae-oncology Consultant post. • Locum consultant in ENT to commence at POW 4/2/19. • Head and Neck Lump pathway to commence – date tbc that will streamline time to diagnosis where patients meets set criteria. • Detailed Radiology Demand and Capacity plan including reporting time requirements is being finalised. Informatics to include priority flags within data warehouse by the end of February in order to develop this further.

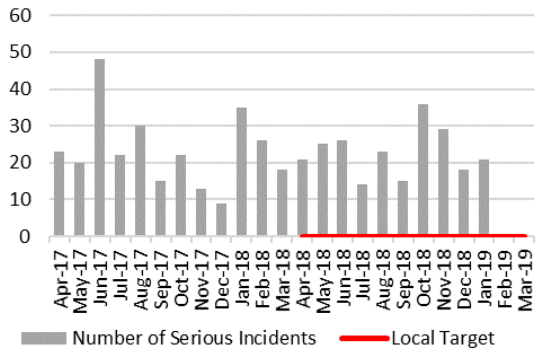
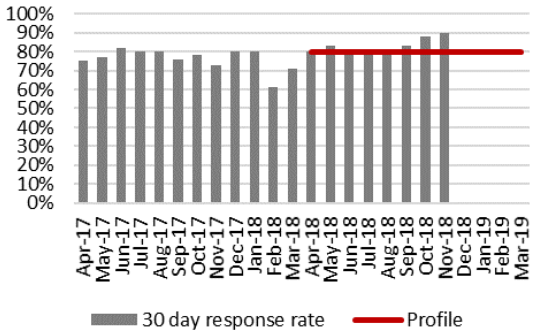
<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>USC backlog
The number of patients with an active wait status of more than 53 days</td>
<td>End of January 2019 backlog by tumour site:
<table>
<tr><th>Tumour Site</th><th>53 - 62 days</th><th>63 ></th></tr>
<tr><td>Breast</td><td>5</td><td>4</td></tr>
<tr><td>Gynaecological</td><td>10</td><td>15</td></tr>
<tr><td>Haematological</td><td>0</td><td>2</td></tr>
<tr><td>Head and Neck</td><td>7</td><td>3</td></tr>
<tr><td>Lower GI</td><td>6</td><td>7</td></tr>
<tr><td>Lung</td><td>0</td><td>0</td></tr>
<tr><td>Other</td><td>2</td><td>5</td></tr>
<tr><td>Skin</td><td>4</td><td>6</td></tr>
<tr><td>Upper GI</td><td>1</td><td>9</td></tr>
<tr><td>Urological</td><td>9</td><td>28</td></tr>
<tr><td>Grand Total</td><td>44</td><td>79</td></tr>
</table>
</td>
<td>Number of patients with a wait status of more than 53 days
 
</td>
<td>• New surgical cancer tracker appointed in POWH commenced in post, training arranged in February.
• Increased focus on tracking across units (indications backlog is reducing from early February).</td>
</tr>
<tr>
<td>USC First Outpatient Appointments
The number of patients at first outpatient appointment stage by days waiting</td>
<td>Week to week through January 2019 the percentage of patients seen within 14 days to first appointment/assessment ranged between 29% and 46%.</td>
<td>The number of patients waiting for a first outpatient appointment (by total days waiting) - End of January 2019
<table>
<tr><th></th><th>≤10</th><th>11-20</th><th>21-30</th><th>>31</th><th>Total</th></tr>
<tr><td>Breast</td><td>5</td><td>10</td><td>47</td><td>97</td><td>159</td></tr>
<tr><td>Gynaecological</td><td>7</td><td>20</td><td>52</td><td>2</td><td>81</td></tr>
<tr><td>Head and Neck</td><td>12</td><td>28</td><td>22</td><td>2</td><td>64</td></tr>
<tr><td>Lower GI</td><td>2</td><td>6</td><td>2</td><td>1</td><td>11</td></tr>
<tr><td>Lung</td><td>3</td><td>5</td><td>3</td><td>0</td><td>11</td></tr>
<tr><td>Other</td><td>5</td><td>42</td><td>28</td><td>8</td><td>83</td></tr>
<tr><td>Skin</td><td>3</td><td>56</td><td>8</td><td>0</td><td>67</td></tr>
<tr><td>Upper GI</td><td>0</td><td>2</td><td>0</td><td>2</td><td>4</td></tr>
<tr><td>Urological</td><td>2</td><td>4</td><td>16</td><td>16</td><td>38</td></tr>
<tr><td>Total</td><td>39</td><td>173</td><td>178</td><td>128</td><td>518</td></tr>
</table>
</td>
<td>• New first outpatient OMFS pathway stage agreed and taken forward with Primary Care with a plan to commence in April.
• Breast consultant radiographer post to be progressed via Morriston DU.
• Cancer Improvement Team have developed Demand & Capacity analysis for first outpatient appointment across most specialties managing suspected cancer referrals; these have been made available via the Cancer Dashboard.</td>
</tr>
</table>

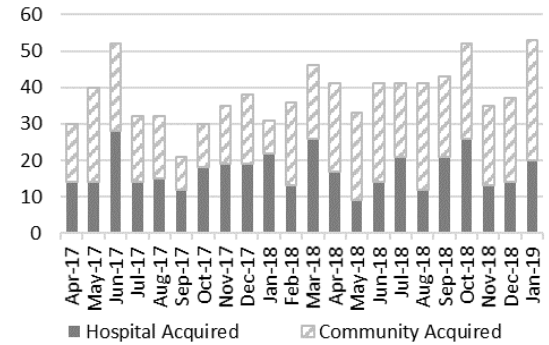
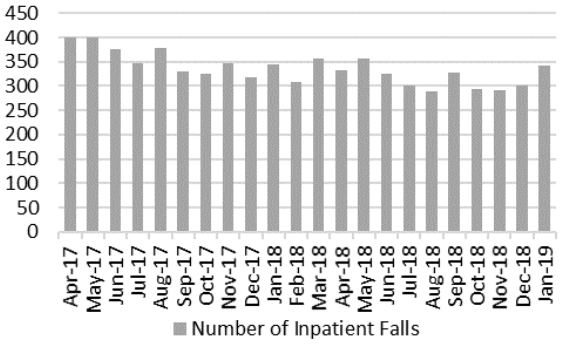
6.1 QUALITY AND SAFETY INDICATORS

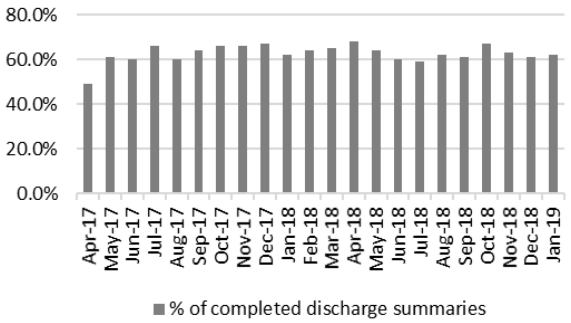
This section of the report provides further detail on key quality and safety measures.

Description	Current Performance	Trend	Actions planned for next period
Healthcare Acquired Infections- E.coli bacteraemia- Number of laboratory confirmed E.coli bacteraemia cases	• The number of cases in January 2019 decreased to 28 cases. The cumulative number of cases (Apr-Jan 2018/19) is approximately 8% less than the cumulative number of cases for the same period in 2017/18. Ratio: 35% hospital acquired to 65% community acquired. *High bed occupancy is a risk to achieving infection reduction.*	**Number of *healthcare acquired E.coli* bacteraemia cases** 	• Delivery Units to progress PDSA style quality improvement activities, with a focus on urinary catheters, across acute sites. • Progress plans for posters promoting the importance of good hydration as a measure to reduce urinary tract infection designed for use in public and patient toilets in healthcare facilities across the Health Board. Once funding has been approved, the posters will be disseminated across the Health Board once printed. • Improvement activities will continue to focus on the risk associated with the presence of invasive devices.
Healthcare Acquired Infections- S.aureus bacteraemia- Number of laboratory confirmed S.aureus bacteraemias (MRSA & MSSA) cases	• The number of cases in January 2019 increased to 18 cases. 50% were hospital acquired - majority associated with Singleton Hospital. • The cumulative number of cases (Apr-Jan 2018/19) approx. 3% less than the cumulative number of cases for the same period in 2017/18. Ratio: 45% hospital acquired to 55% community acquired. • Line associated infection remains a significant causative factor.	**Number of healthcare acquired S.aureus bacteraemias cases** 	• Delivery Units, with support from Infection Prevention & Control, to undertake a deep dive into the hospital acquired cases in January to understand contributory factors and identify improvement actions. • Public Health Wales Laboratory has been asked to send for typing *Staph. aureus* isolates (from various specimens, including blood cultures) from unit with increased incidence. • Observations of practice to be undertaken in clinical areas with increased incidence, with feedback of results to Delivery Unit. • Improvement activities will continue to focus on the risk associated with the presence of invasive devices.

Description	Current Performance	Trend	Actions planned for next period
Healthcare Acquired Infections- C.*difficile*- Number of laboratory confirmed C.difficile cases	• The number of cases of *Clostridium difficile* infection decreased further in January to 7 cases. The number of hospital acquired cases had decreased for the third consecutive month. The number of community acquired cases reduced from 10 in December to 4 in January. • The cumulative number of cases (Apr-Jan 2018/19) approx. 32% less than the cumulative number of cases for the same period in 2017/18. Ratio: 69% hospital acquired to 31% community acquired. *High bed occupancy is a risk to achieving infection reduction.*	**Number of healthcare acquired C.difficile cases** 	• Continue to monitor compliance with restriction of Co-amoxiclav, with feedback to Delivery Units. **Impact: 50% reduction in annual Co-amoxiclav use by 31.03.19.** • Primary Care antimicrobial guidelines review commenced. Restricting use of Co-amoxiclav more complex in Primary Care than in Secondary Care as limited oral antibiotic alternatives available. Lesser impact on community *Clostridium difficile* cases anticipated. • Launch deep cleaning & decontamination standards for *Clostridium difficile* ***source rooms/bays by 31.03.2019.*** **Impact: reduction in Periods of Increased Incidence and outbreaks of *Clostridium difficile* toxin positive cases in Quarters 1 and 2** (2019/20) compared with Quarters 1 and 2 (2018/19). Service demands and pressures will present a challenge to achievement.

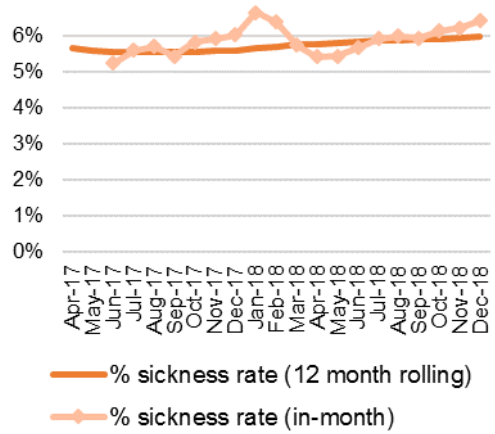
Description	Current Performance	Trend	Actions planned for next period
Number of Serious Incidents- Number of new Serious Incidents reported to Welsh Government	• The Health Board reported 22 Serious Incidents for the month of January 2019 to Welsh Government. • Last Never Event reported was on 21st March 2018. • In January 2019, the performance against the 80% target of submitting closure forms within 60 working days was 80%.	**Number of Serious Incidents** 	• Health Board are supporting the Mental Health & Learning Disabilities Unit to roll out the Serious Incidents Toolkit to ensure consistency of investigation and timeliness of investigations. • The Welsh Risk Pool have suggested that the Pressure Ulcer Improvement methodology be applied to the Falls Improvement work and will coincide with the upcoming relaunch of the Health Board's Fall Prevention and Management Policy.
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 90% in November 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 6 months of this financial year the Health Board has achieved 80% in responses for the 30 day target. • Ombudsman's Officer to present to Consultant Development Day.

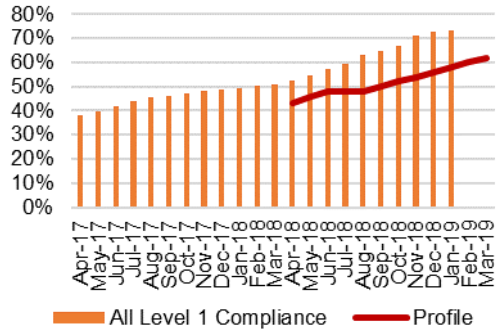
Description	Current Performance	Trend	Actions planned for next period
Number of pressure ulcers The number of grade 3, 4 suspected deep tissue injury and unstageable pressure ulcers	• The number of Grade 3+ pressure ulcers increased between December 2018 and January 2019 from 37 to 53. The in-patient cases deteriorated from 14 in December 2018 to 20 in January 2019, and similarly the number of community cases deteriorated from 23 in December to 33 in January 2019.	**Total number of grade 3+ hospital and community acquired Pressure Ulcers (PU)** 	• The Pressure Ulcer Prevention Strategic Group (PUPSG) is to meet on 11th February and receive the completed Serious Incident Analysis Report to agree the report's recommendations • Service Delivery Units Pressure Ulcer Quality Improvement reports are submitted quarterly to PUPSG for review and sharing of learning from pressure ulcer scrutiny. An exemplar of a new report format, linking work streams to causal factors, will be presented by Singleton SDU. • Local arrangements for ABMU have been circulated in response to the Welsh Health Circular Changes to the serious incident reporting of pressure ulcers • There is a new Tissue Viability Nurse in post for POWH.
Inpatient Falls The total number of inpatient falls	• The number of Falls reported via Datix web reduced from 344 in January 2018 to 341 in January 2019. • The Health Board has agreed a targeted action to reduce Falls causing harm by 10%.	**Number of inpatient Falls** 	• A Task & Finish Group has been established to implement the falls policy and provide training on the new Falls and Healthy Bones Multifactorial Risk Assessment / Care Plan across the Health Board. • Falls Injury Prevention Strategic Group will hold its 1st meeting in April 2019.

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 January 2019 the percentage of electronic discharge summaries signed and sent via eToC was 62% which is in line with January 2018. • Performance varies between Service Delivery Units (range was 58% to 88% in January 2019) 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. Delivery Units' performance in providing discharge information to GPs <24hrs and <5days after discharge. • Unit Medical Directors' are working with Clinical Directors and Clinical Leads to address variation between teams • The Health Board piloted Medicines Transcribing and e-Discharge (MTeD) from August – October 2018.

7. WORKFORCE UPDATES AND ACTIONS

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

Description	Current Performance	Trend	Actions planned for next period
Staff sickness rates- *Percentage of sickness absence rate of staff*	• The 12 month rolling performance to the end of December 2018 is 5.99% (up 0.03% on November 2018). Our in month performance in December 2018 was 6.43%, an increase of 0.2% on the previous month	**% of full time equivalent (FTE) days lost to sickness absence (12 month rolling)** 	• Outputs of a best practise case study conducted in three areas of good sickness performance have been shared with DU's and learnings are to be implemented via local sickness improvement plans. • Development of a pilot has commenced within a selected area in order to address high absence some of which will apply learning from the above best practise case study. • Further training sessions for managers regarding the new all Wales Managing Attendance policy. • Development of a full training plan to support implementation of the new Attendance policy. • OH Improvement Plan completed with targets for reductions in waiting times approved by Exec Board. Key developments include commencing the scanning of all OH records to enable a digital record and reduce inefficiencies (to be completed October 2019) and increasing OH resource with AHP's from TI monies. This has resulted in waiting lists for management referrals initially reducing from 4 to 2 weeks. Currently implementing digital dictation software for clinicians to reduce waits for OH reports to be sent to managers. Evaluation to be completed July 2019. • Plans to develop a more multidisciplinary approach within OH during 2019. • Flu Champions trained across the health board and Winter Flu Immunisation programme ends March 2019. 8522 staff have received the vaccination as 5/2/18 and 54.1% of frontline

			staff have now been vaccinated – the WG Tier 1 target is 60% of frontline staff. • Over 300 Staff Wellbeing Champions now trained to support their teams health and wellbeing and signpost to HB support services, promoting a prevention/early intervention approach. This model accepted as Bevan Exemplar 2018/19. • A draft Attendance plan has been developed as part of the R and S work and is due to be shared with Workforce and OD Committee for final sign off
Description	**Current Performance**	**Trend**	**Actions planned for next period**
Mandatory & Statutory Training- *Percentage compliance for all completed Level 1 competencies within the Core Skills and Training Framework by organisation*	• Januarys 2019 compliance against the 13 core competencies is 73.22%. This is a 0.41 % increase from December 2018 and an 18.65% rise since April 2018. Since April 2018, just over 46,600 competencies have been completed. • First two weeks in January ESR e-learning was not available. This was a national issue, which resulted in no new competencies being completed. Furthermore, staff were advised to not complete e-learning during this period of time. ESR e-learning system came back into use in the 3rd week of January.	**% of compliance with Core Skills and Training Framework** 	• E-learning drop in sessions at all sites conducted bi-weekly, including staff group specific training undertaken. • Review of Mandatory Framework planned • An internal audit of M&S Training commenced in December 2018. Recommendations from this audit are due in late February. • Work is underway reorganising position numbers in ESR in order to make secondary training more reportable. • All-Wales ESR audit has been completed. The report has been published and recommendations are currently being worked through. Another visit by NWSSP will happen in April. • There is a new e-learning facility on ESR, which will make accessing e-learning quicker. A user guide will be made available by the end of February.

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

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

</td>
<td>
Vacancies as at 31st Jan 2019
<table>
<tr><th>Grade - Medical & Dental</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th></tr>
<tr><td>21000-Consultant (M&D)</td><td>-83.65</td><td>-82.61</td><td>-78.61</td></tr>
<tr><td>21100-Locum Consultant (M&D)</td><td>7.20</td><td>7.45</td><td>6.65</td></tr>
<tr><td>22110-Associate Specialist (M&D)</td><td>-12.79</td><td>-12.69</td><td>-12.69</td></tr>
<tr><td>22200-Locum Associate Specialist (M&D)</td><td>0.45</td><td>0.45</td><td>0.45</td></tr>
<tr><td>22250-Specialist Dental Officer</td><td>-0.60</td><td>0.42</td><td>0.42</td></tr>
<tr><td>22260-Senior Dental Officer</td><td>-1.80</td><td>-1.80</td><td>-1.80</td></tr>
<tr><td>22270-Dental Officer</td><td>-2.19</td><td>-1.99</td><td>-1.99</td></tr>
<tr><td>22310-Speciality Doctor (M&D)</td><td>-25.36</td><td>-27.01</td><td>-27.92</td></tr>
<tr><td>22320-Locum Speciality Doctor (M&D)</td><td>-1.00</td><td>-1.00</td><td>-1.00</td></tr>
<tr><td>23100-Specialty Registrar (M&D)</td><td>-126.84</td><td>-129.48</td><td>-137.17</td></tr>
<tr><td>23120-Locum Specialty Registrar (M&D)</td><td>19.20</td><td>21.20</td><td>26.20</td></tr>
<tr><td>23200-Specialist Registrar (M&D)</td><td>-6.60</td><td>-6.60</td><td>-6.60</td></tr>
<tr><td>23300-Locum Specialist Registrar (M&D)</td><td>-0.20</td><td>-1.20</td><td>-1.20</td></tr>
<tr><td>24100-F2 foundation year 2 (M&D)</td><td>-2.97</td><td>0.03</td><td>0.08</td></tr>
<tr><td>24110-Locum F2 Foundation year 2 (M&D)</td><td>1.00</td><td>2.00</td><td>2.00</td></tr>
<tr><td>24400-F1 foundation year 1 (M&D)</td><td>-6.46</td><td>-8.37</td><td>-7.37</td></tr>
<tr><td>24900-Dental Trainees in Hosp Post</td><td>3.96</td><td>3.96</td><td>3.96</td></tr>
<tr><td>25000-Clinical Assistant (M&D)</td><td>-0.37</td><td>-0.37</td><td>-0.37</td></tr>
<tr><td>25100-Senior Lecturer (M&D)</td><td>-1.90</td><td>-1.90</td><td>-1.90</td></tr>
<tr><td>25300-G.P.Sessions / Staff Fund</td><td>0.76</td><td>1.21</td><td>0.59</td></tr>
<tr><td>Total</td><td>-240.16</td><td>-238.30</td><td>-238.28</td></tr>
</table>
<table>
<tr><th>Grade - Nursing & Midwifery</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th></tr>
<tr><td>2A182-Nurse Consultant Band 8B</td><td>-0.31</td><td>-0.31</td><td>-0.31</td></tr>
<tr><td>2A281-Nurse Manager Band 8A</td><td>5.23</td><td>6.53</td><td>6.10</td></tr>
<tr><td>2A282-Nurse Manager Band 8B</td><td>6.34</td><td>3.76</td><td>4.76</td></tr>
<tr><td>2A283-Nurse Manager Band 8C</td><td>3.00</td><td>4.00</td><td>4.00</td></tr>
<tr><td>2A284-Nurse Manager Band 8D</td><td>-2.00</td><td>-2.60</td><td>-1.60</td></tr>
<tr><td>2A451-Registered Nurse Band 5</td><td>-308.05</td><td>-338.05</td><td>-344.04</td></tr>
<tr><td>2A461-Registered Nurse Band 6</td><td>-26.92</td><td>-19.34</td><td>-17.62</td></tr>
<tr><td>2A471-Registered Nurse Band 7</td><td>-37.19</td><td>-26.91</td><td>-33.56</td></tr>
<tr><td>2A481-Registered Nurse Band 8A</td><td>3.11</td><td>-0.89</td><td>-1.84</td></tr>
<tr><td>2A482-Registered Nurse Band 8B</td><td>0.00</td><td>0.00</td><td>0.00</td></tr>
<tr><td>Total</td><td>-356.79</td><td>-373.81</td><td>-384.11</td></tr>
</table>
<table>
<tr><th>Grade - Health Care Support Workers</th><th>Nov-18</th><th>Dec-18</th><th>Jan-19</th></tr>
<tr><td>2AA11-Nursing HCA/HCSW Band 1</td><td>2.00</td><td>2.00</td><td>2.00</td></tr>
<tr><td>2AA21-Nursing HCA/HCSW Band 2</td><td>-92.96</td><td>-86.87</td><td>-60.39</td></tr>
<tr><td>2AA31-Nursing HCA/HCSW Band 3</td><td>-27.62</td><td>-28.58</td><td>-30.86</td></tr>
<tr><td>2AA41-Nursing HCA/HCSW Band 4</td><td>-6.43</td><td>-5.17</td><td>-1.52</td></tr>
<tr><td>Total</td><td>-125.01</td><td>-118.62</td><td>-90.77</td></tr>
</table>
</td>
<td>

Joint Cwm Taf / ABMU recruitment protocol to begin to address boundary change issues is in draft and will be implemented through the period up to transfer.
We are also currently exploring further options of nurses from Dubai and India. We are in the process of preparing a mini tendering exercise which will be aimed at suppliers who are able to provide overseas qualified nurses who already have the requisite English language requirements as this has been the time delay to date in our recruitment timeline.
Work is underway to develop a medical recruitment strategy in partnership with the Medical Director/ Deputy Medical Director team. The initial plans will be presented to the Workforce and OD committee in February.

</td>
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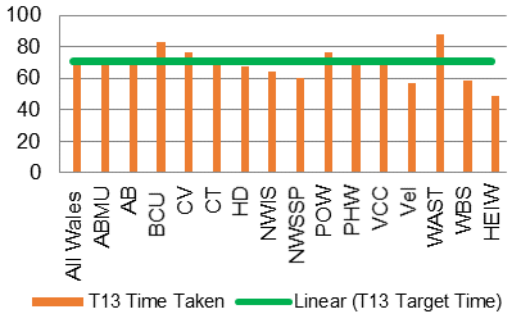
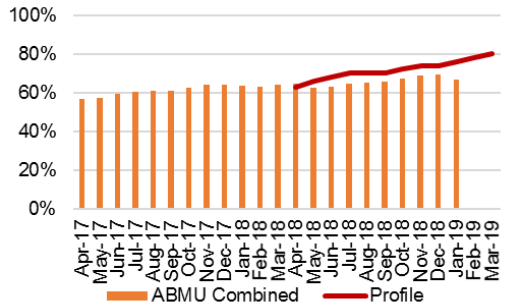
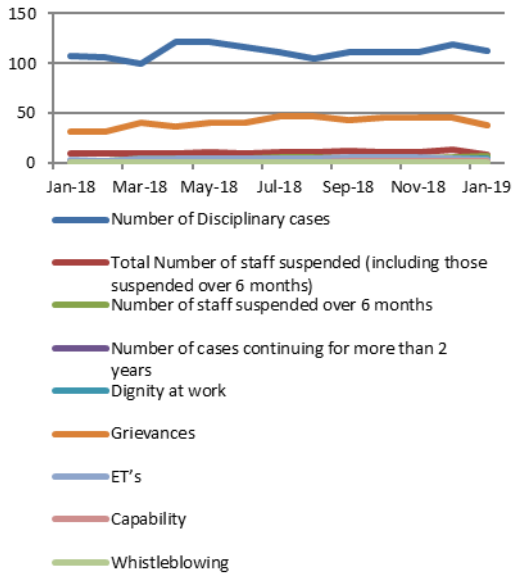
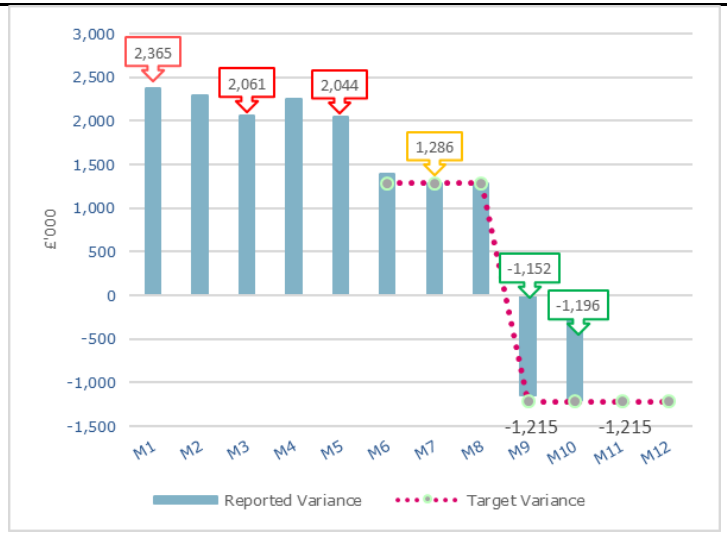
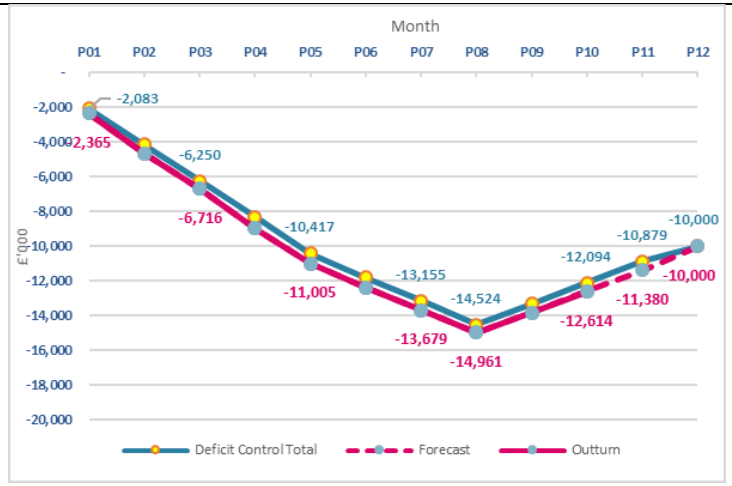
</table>

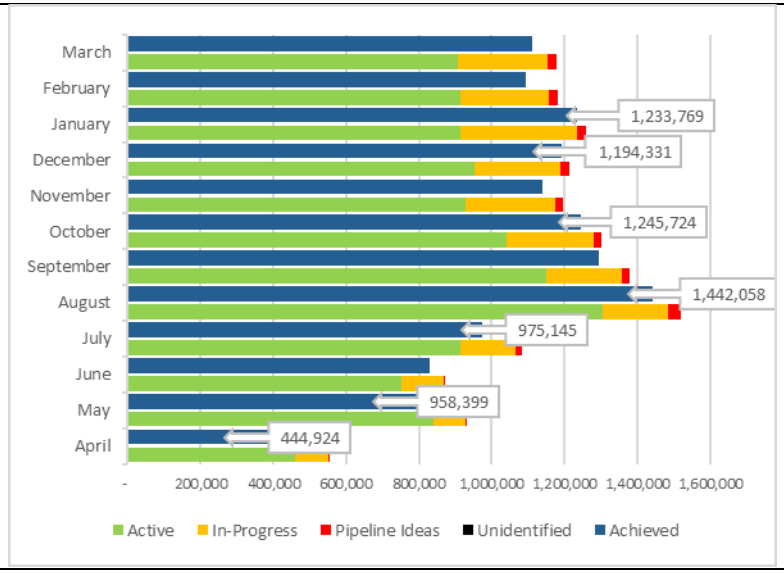
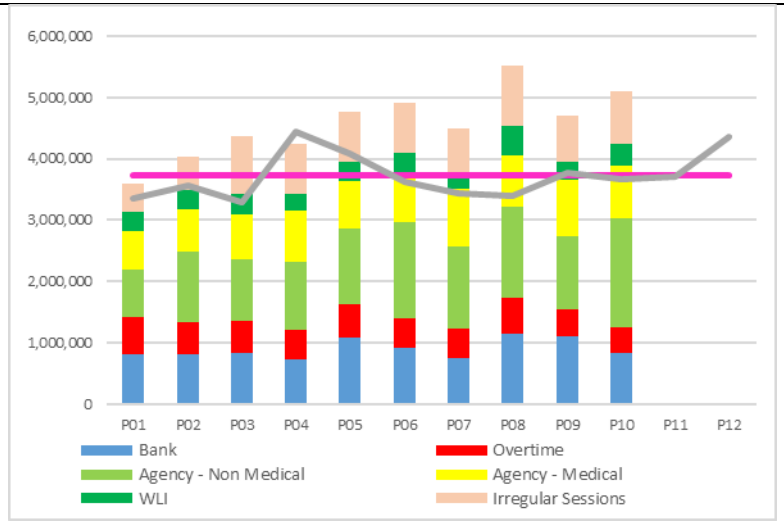
Description	Current Performance	Trend	Actions planned for next period
Recruitment *Metrics provided by NWSSP. ABMU comparison with All wales benchmarking*	• ABMU overall performance is just above the target level for NHS Wales Internal controls may have contributed to this. • Of the key ABMU measures where we are not yet at target - time to complete sifting has steadily improved towards the three day target and is at seven days.	**Vacancy Creation to Unconditional Offer October 2018 (working days: including outliers) T13** 	• Outlier data is passed to Delivery Units for review. • If Outliers (activity well outside the normal expected timescale) are excluded ABMU is well under the 71 day target. Action to sanitise the data will improve accuracy of the reports.
Turnover *% turnover by occupational group*	• Overall Turnover has reduced over the last six but increased slightly across most staff groups in January The overall FTE rate still stands below 8% (FTE)	Period Turnover 1st February 2018 – 31st January 2019 Staff Group / FTE / Headcount / Change Headcount Add Prof Scientific and Technic 9.00% 8.93% ↑ Additional Clinical Services 7.48% 8.08% ↑ Administrative and Clerical 7.60% 7.81% ↑ Allied Health Professionals 10.23% 10.50% ↑ Estates and Ancillary 4.96% 5.43% ↑ Healthcare Scientists 7.21% 7.69% ↓ Medical and Dental 10.73% 12.18% ↑ Nursing and Midwifery Registered 8.22% 8.54% ↑ Overall Rate / FTE / Headcount Overall Rate 7.91% 8.30% ↑	• Roll out of exit interviews across the Health Board following the pilot in Nursing is being looked into as well as the use of ESR exit interview functionality. This is being managed on an all-Wales basis.

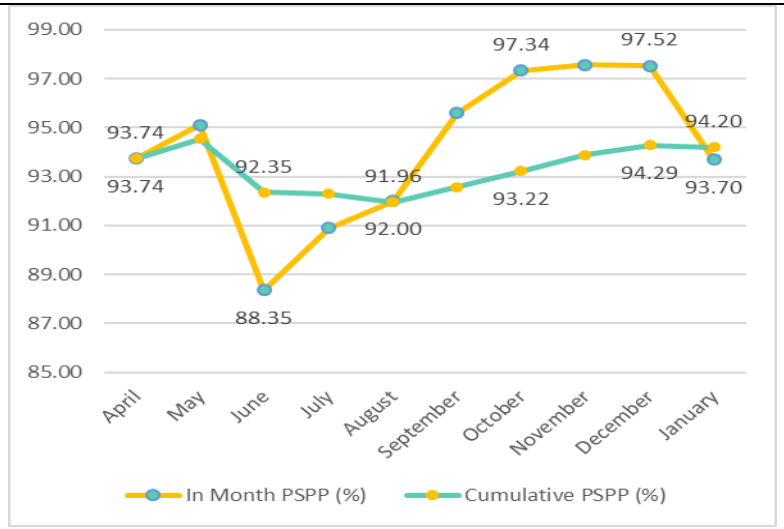
Description	Current Performance	Trend	Actions planned for next period
PADR *% staff who have a current PADR review recorded*	The combined percentage of staff who have had a Personal Appraisal and Development Review (PADR) as of January 2019 stands at 66.71%. This is a slight decrease of 0.42% from the combined percentage of appraisals undertaken in December which stood at 67.13% Medical and Dentals results have seen a significant improvement from 47.99% in December 2018 to 68.57% in January 2019. This is an increase of 20.58%	**% 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. Schedule in place from November 2018 to December 2019 at all sites. • Additionally, bespoke PADR training delivered as requested by teams and units. • Explore implications of NHS Pay Deal and links with PADR. • An internal audit of the PADR process commenced in December 2018. Recommendations from this audit are due in late February. • Director of WF&OD has asked for action plans from each Delivery Unit on how they will reach the tier 1 target of 85%. This is still an on-going process and will hear from this in due course.
Operational Casework *Number of current operational cases by category.*	• Some fluctuation in live cases over the last three months but volume of activity is still significantly increased on averages pre Mid 2016.	**Number of Operational Cases** 	• Procurement issues have been resolved and an order placed for the ER Tracker system. Full implementation in place around beginning of Q1 2019/2020. System configuration meetings started and will be completed end Feb 2019. Following testing phase and training in March system will require a post BBC data download – go-live anticipated second week of April • Case for investigating officer team 3 x band 6 1 x band 3 approved by IGB. Recruitment and establishment of team underway with first appointment to the team expected Q1 2018/19. • ACAS supported training looking at improving partnership working and a programme of work with managers to look at bullying and harassment (targeted on hot spots identified in the 2018 staff survey) has been agreed all events completed as at 4th Feb. ACAS summary post vents is being prepared.

8. FINANCE UPDATES AND ACTIONS

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

Description	Current Performance	Trend	Actions planned for next period
Revenue Financial Position – expenditure incurred against revenue resource limit	• The cumulative revenue financial position at January 2019 is an overspend of £12.614m. • The in-month performance produced an underspend of £1.196m against a target profile of £1.215m. • Key pressures are savings not delivering in full and premium workforce cost.		• Review of opportunities and risks within the delegated financial positions. • Ensure robust management of costs through the remaining 2 months of the financial year.
Forecast Position – delivery of the £10m forecast deficit	• The financial plan initially set out a planned deficit of £25m. • WG then set a £20m Deficit Control Total. • Following the provision of £10m additional WG support in recognition of operational and performance pressures, the forecast deficit has been reduced to £10m. • The Health Board is on track to achieve this forecast. Within this position a number of risks and opportunities are being managed to ensure delivery		• Review all opportunities and risks to ensure delivery of £10m forecast deficit.

Description	Current Performance	Trend	Actions planned for next period
Savings Delivery – Performance against the £21.2m savings requirement	• The Health Board financial plan set out a requirement to identify and deliver £21.2m. • To date savings of £16.2m have been identified, however only £14.6m are classified as Green or Amber for delivery. • To date savings of £10.8m have been delivered against a planned delivery of £12.8m. • The forecast delivery is £13.5m against the £21.2m target.		• Identify areas of potential further slippage and consider the impact of scheme slippage on future year delivery.
Workforce Spend – workforce expenditure profile	• Workforce expenditure is around £2.4m per month higher this year than in previous year. Around £1.5m of this relates to 18/19 pay inflation. The remainder reflects increased variable pay. • The key areas of increase are Medical staffing through agency and internal locum cover and nursing agency.		• Analysis of the key factors driving the use of variable pay outside of planned budget

Description	Current Performance	Trend	Actions planned for next period
PSPP – pay 95% of Non-NHS invoices within 30 days of receipt of goods or valid invoice	• In-month performance in January was 93.7%. • Cumulative position is 94.2% which does not achieve the target. • Significant improvements have been made in last 4 months, however in January there were over 2300 invoices processed outside the 30 day target. This is linked to clearing invoices on hold due to the implementation of the No PO No Pay policy.		• Closely monitor performance and identify impacts of No PO No pay to enable further awareness and training to be undertaken

9. KEY PERFORMANCE MEASURES BY DELIVERY UNIT

9.1 Morriston Delivery Unit- Performance Dashboard

			Quarter 1			Quarter 2			Quarter 3			Quarter 4		
			Apr-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%	67.9%	68.8%	70.0%	67.5%	67.7%	67.2%		
		Profile	*71%*	*76%*	*76%*	*83%*	*81%*	*81%*	*85%*	*87%*	*87%*	*86%*	*86%*	*86%*
	12 hour A&E waits	Actual	574	468	333	447	373	311	402	383	485	621		
		Profile	*259*	*124*	*125*	*148*	*168*	*101*	*162*	*206*	*239*	*198*	*143*	*135*
	1 hour ambulance handover	Actual	380	291	245	348	270	261	294	340	546	684		
		Profile	*210*	*79*	*120*	*107*	*171*	*72*	*137*	*177*	*239*	*194*	*139*	*104*
Stroke	Direct admission within 4 hours	Actual	32.8%	38.6%	43.8%	39.6%	29.8%	75.0%	71.7%	59.5%	62.2%	56.1%		
		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%	45.8%	38.8%	41.7%	36.0%	50.0%	52.5%	44.2%	47.8%	47.6%		
		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%	92.0%	85.4%	86.9%	88.4%	95.7%	92.9%		
		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%	7.7%	20.0%	27.3%	0.0%	0.0%	11.8%	9.0%	30.0%	44.4%		
		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	31	19	38	55	43	43		
		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	2,312	2,160	2,179	2,054	1,971	2,046		
		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	613	620	619	554	544	543		
		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%	98%	100%	98%	93%	95%	100%	96%		
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	75%	100%	90%	98%	94%	91%	93%	88%	90%	93%		
		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	4	2	5	2	2	1		
		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	3	3	4	3	3	2		
		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	5	5	8	11	7	3		
		Profile	*8*	*3*	*6*	*4*	*6*	*4*	*4*	*6*	*7*	*10*	*4*	*5*
Quality & Safety Measures	Discharge Summaries	Actual	63%	58%	59%	53%	61%	59%	66%	60%	61%	58%		
		Profile	*69%*	*72%*	*75%*	*77%*	*80%*	*83%*	*86%*	*89%*	*92%*	*94%*	*97%*	*100%*
	Concerns responded to within 30 days	Actual	93%	83%	90%	87%	84%	92%	95%	100%				
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.94%	5.94%	5.97%	5.94%	5.98%	6.01%	6.04%	6.07%	6.12%			
		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%	63%	64%	65%	68%	68%	70%		
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	50%	52%	55%	57%	60%	61%	62%	66%	68%	68%		
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

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

9.1 Morriston Delivery Unit- Overview

Successes	Priorities
• ED 4-hr performance improved to >70% daily 16-21 Jan 2019 despite high acuity and capacity issues across the site. • Sustained improvement in 4-hr stroke care bundle since Sept 2018. • 12-hr 24-hr and 72-hr stroke performance indicators consistently high • Thrombolysis rate in Morriston is second highest in Wales (January performance is 21.4% against an all-Wales average of 14.5%). • Successful KPMG 10-wk programme complete reports being finalised • Continued reduction in 52-wks. RTT 26-wks waiting times improved. • Significant waiting time improvement for TAVI patients – 13 patients currently on TAVI pathway (1>26 weeks) compared with 63 patients at 01/11/2018 (31 patients >36 weeks). • Continued strong unit-wide cancer performance – focus maintained on early first outpatient consultation and treatment within target. • Training for and register of Disciplinary Investigating Officers resulting in matching skillset of the investigating officer with the case. Aim to improve staff experience and management outcomes of ER process. • Reduction in Disciplinary cases from 23 to 16 in one month period. • No cases of C.Diff in Morriston Hospital in January 2019.	• Sickness absence is being addressed through hot spot meetings and training sessions on the new All-Wales Managing Attendance At Work policy and ACAS People Management training. • Continued improvement in PADR compliance. 85% target to be met by 31/3/19. • Kendall Bluck are reviewing the ED medical workforce, reviewing medical staff rotas across service areas. • Improve thrombolysis timeliness (in line with key recommendations of the DU Thombolysis Review) • Assigning additional theatre capacity to address key RTT and cancer priorities • Improve the uptake of straight to test in Lower GI cancers • Engage with the Renal Network to explore opportunities to increase dialysis capacity East of Swansea. • Financially, Morriston cumulative spend is £1,439k above Budget, focus currently on Non Pay pressures and income shortfalls through the weekly FRG group. • Working with IT and NWIS to resolve WPAS issues • Plastic Surgery remains a significant risk to the Qtr4 RTT delivery for MDU. Weekly meetings to mitigate the risk around this specialty.
Opportunities	**Risks & Threats**
• Ongoing development of a local electronic system to streamline the agency cap request process. • ED have agreed a full time Physicians Associate post from April 2019 as part of the integrated workforce plan. • Four new ED Consultant job descriptions are being written to offer a wider scope of opportunity for potential applicants such as Paediatric Emergency Medicine, a joint role with EMRTS, and an academic role. • Focus on reducing lead time to CT head following WG thrombolysis review. • Pathway review of out of area sarcoma patients. • Continue to develop stronger working relationships with the third sector e.g. MS Trust, MacMillan.	• Significant issues escalated to IT with the Zylab system • Medicine beds remain 41 beds short of required capacity. • Winter bed availability represents a threat to ASU access times. • Clinical transfer delays to Singleton Hospital and NPTH • Reduction in cancer tracking capacity due to staffing issues (turnover and sickness) • Introduction of single cancer pathway • Late cancer referrals from other Delivery Units and Health Boards • Despite a slight improvement delivery of Orthopaedic and Spinal elective cases through Qtr4 at risk due to theatre staffing levels and increased cancellations due to trauma.

9.2 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%	99.7%	98.4%	96.8%	99.3%	99.8%	98.8%		
		Profile	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*
	12 hour A&E waits	Actual	0	0	0	0	0	0	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*	*0*	*0*	*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*	*0*	*0*	*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*	*0*	*0*	*0*	*0*	*0*	*0*		
		Profile	*0*	*0*	*0*		*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Cancer	NUSC patients starting treatment in 31 days	Actual			100%	100%		100%	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%	93%	100%	80%	67%	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	0	0	0	1	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	0	0	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	4	0	0	2	0	0		
		Profile	*0*	*2*	*1*	*2*	*1*	*1*	*3*	*1*	*3*	*3*	*1*	*1*
Quality & Safety Measures	Discharge Summaries	Actual	81%	77%	82%	77%	90%	76%	83%	83%	70%	80%		
		Profile	68%	71%	74%	77%	80%	83%	85%	88%	91%	94%	97%	100%
	Concerns responded to within 30 days	Actual	100%	100%	100%	88%	75%	83%	44%	100%				
		Profile	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.00%	5.06%	5.24%	5.35%	5.48%	5.48%	5.47%	5.52%	5.51%			
		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%	70%	70%	77%	80%	83%	84%		
		Profile	63%	66%	68%	70%	70%	70%	72%	74%	74%	76%	78%	80%
	Mandatory Training	Actual	61%	65%	67%	70%	73%	74%	75%	80%	82%	82%		
		Profile	43%	46%	48%	48%	48%	50%	52%	54%	56%	58%	60%	62%

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

9.2 Neath Port Talbot Delivery Unit- Overview

Successes	Priorities
• Waiting times targets achieved in all medical specialties. Rheumatology waiting times for new patients under 18 weeks. • MIU attendance at 98.94%. • Cancer 100%. • All Nurse Practitioner posts filled. • RDC – £100k funding approved for 19/20 from Cancer Network. • Critical Care funding from Network for Nutrition and Dietetics and Physiotherapy for 19/20. • Maintaining performance of reduced number of falls causing harm. • Therapy led ESD average case load of 15 patients and has been expanded to early evening to increase support short term winter funding. • Centralisation of booking office for medical specialties operational from January 2019	• Support staff and services through boundary changes. • Develop primary care services for therapies. • Increase triage staffing in MIU to meet 99% 4hr target – recruiting. • Consultant Antimicrobial Pharmacist and Antimicrobial Stewardship IMTP • MHRA licence for Singleton PTS and replacement air handling plant for Morriston PTS. • Recruitment of Registered Nurses. • Support the development and establishment of a stroke ESD service. • Increasing elective surgical activity to support RTT. • Secure agency therapists to support winter plans – majority recruited. • Support Plas Bryn Rhosyn Winter Plan to alleviate pressures within wards. • Secure agency physiotherapist to support MSK waiting times. • ALN report to Executive Directors. • Establish extended hours within Pharmacy and support Winter pressures.
Opportunities	**Risks & Threats**
• Strategic Review of MIU, Afan Nedd and rheumatology infusion unit, linking with Singleton Unit re chemotherapy infusions. • Remodelling of therapy management and financial structures to one structure. • Further development of pharmacy specialty teams to support inpatients and specialist clinics. • Develop primary care OT posts to address the preventative and early intervention needs of our population. • Develop R&D within OT /physio/ N&D to support clinically effective service delivery for our patients. • Re-structure of primary care pharmacy team (due to staff loss) to support long term work agenda & pharmacy contract with PCCS. • Work with our communities to develop sustainable solutions to well-being by developing social enterprise opportunities. • Development of long term posts in therapies and pharmacy to support winter plans in a sustainable format. • Potential new income stream from private surgical activity. • Bridgend boundary changes– e.g. theatre management transfer	• Capacity within the Community for discharges. • DTOC continuing to increase – 34 in December. • Winter pressures – staffing challenges to support surge capacity. • Loss of pharmacists to cluster & practice based roles. • Increased workload from NICE / New Treatment Fund appraisals specifically cancer drugs requiring infrastructure changes. • Nurse recruitment challenges. • Bridgend boundary changes. • Devolved management and financial therapy budgets leads to governance issues and the reduces ability of therapy services to remodel, flex and respond to patients/ service needs. • Brexit – increased equipment costs, risk to pharmaceutical products etc. • WFI WHSCC activity underperforming. • MIU staffing pressures awaiting recruitment.

9.3 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%	76.9%	74.5%	76.2%	75.8%	76.1%	76.3%		
		Profile	*85%*	*85%*	*85%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*	*88%*
	12 hour A&E waits	Actual	163	155	141	141	136	274	275	282	271	365		
		Profile	*63*	*68*	*49*	*78*	*57*	*77*	*92*	*109*	*49*	*85*	*53*	*43*
	1 hour ambulance handover	Actual	101	130	88	61	90	227	253	241	252	412		
		Profile	*38*	*34*	*26*	*40*	*42*	*58*	*68*	*81*	*35*	*55*	*41*	*28*
Stroke	Direct admission within 4 hours	Actual	40.0%	35.5%	33.3%	33.3%	28.6%	21.9%	25.8%	51.4%	40.6%	6.7%		
		Profile	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*	*50%*	*50%*	*50%*	*65%*	*65%*	*65%*
	CT scan within 1 hour	Actual	64.0%	38.7%	74.1%	37.5%	48.3%	43.8%	53.1%	51.4%	50.0%	48.4%		
		Profile	*40%*	*40%*	*40%*	*45%*	*45%*	*45%*	*45%*	*45%*	*45%*	*50%*	*50%*	*50%*
	Assessed by Stroke Specialist within 24 hours	Actual	64.0%	80.6%	70.4%	70.8%	89.7%	43.8%	75.0%	59.5%	71.9%	51.6%		
		Profile	*75%*	*75%*	*75%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*85%*	*85%*	*85%*
	Thrombolysis door to needle within 45 minutes	Actual	0.0%	20.0%	66.7%	0.0%	0.0%	25.0%	40.0%	50.0%	25.0%	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	2	15	21	66	51	107		
		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	1,175	1,191	1,159	1,111	1,057	1,097		
		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	79	135	277	138	198	142	116	104	149	60		
		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%	96%	94%	94%	98%	90%	85%		
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	75%	82%	76%	85%	88%	78%	76%	85%	87%	75%		
		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	2	2	6	4	2	0		
		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	2	2	1	3	2	1		
		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	4	3	4	5	2	3		
		Profile	*1*	*2*	*2*	*3*	*2*	*3*	*3*	*5*	*4*	*3*	*1*	*3*
Quality & Safety Measures	Discharge Summaries	Actual	72%	64%	60%	64%	68%	59%	65%	67%	62%	64%		
		Profile	*55%*	*59%*	*63%*	*67%*	*71%*	*76%*	*80%*	*84%*	*88%*	*92%*	*96%*	*100%*
	Concerns responded to within 30 days	Actual	75%	90%	64%	90%	88%	83%	100%	82%				
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.23%	5.18%	5.25%	5.25%	5.26%	5.30%	5.32%	5.36%	5.38%			
		Profile			*5.20%*			*5.15%*			*5.08%*			*5.00%*
	Personal Appraisal Development Review	Actual	61%	59%	58%	60%	61%	63%	68%	68%	68%	67%		
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	52%	54%	55%	58%	63%	66%	68%	72%	73%	73%		
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

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

9.3 Princess of Wales Delivery Unit- Overview

Successes	Priorities
• Implementation of wide ranging winter plan (funded by ABMUHB) including recruitment of locum respiratory consultant to support winter pressure Achievement of January 2019 profiles for C.*difficile,* Staph. Aureus Bacteraemia and E.*Coli.* • Identification of additional registrar for each Saturday and Sunday to the end of February to support the ward patients and any patients suitable for discharge. • Transfer of patient to Morriston on ACS Treat and Repatriate pathway – reducing waiting times • Arrival of Cancer trackers in post • First Accredited Colonoscopy training course agreed for February 2019 in POW Endoscopy suite. • Successful capital replacement bids approved and awaiting delivery of equipment.	• Preparing for transfer into CTM UHB – supporting staff and services • Ensure clarity on the transition/boundary work across all workstreams • Continue to manage winter pressures and demand, supporting staff throughout this period • Frailty at the front door service • Management of interim ENT consultant on call model at weekends with Morriston colleagues • Agree Emergency on-call model for ENT services for Quarter 4 • Ensure capacity for outsourcing is maximised and that March 2019 cohort patients are treated to deliver the required Q4 long wait target • Apply solutions to reduce waiting times in diagnostics below 8 weeks in quarter 4. • Continue work to administratively review FUNB lists • Continue to drive theatre efficiencies through reduction of cancellations on the day, and reducing late starts and early finishes. • Cancer Performance and scoping of impact of Single Cancer pathway. • Improvement in PADR and Mandatory training compliance across all disciplines.
Opportunities	**Risks & Threats**
• Developing engagement with current Cwm Taf team to develop working arrangements as part of new CTMUHB from April 1st 2019 • Frailty at the front door service commencing 7th January 2019 • IBG bid approval to recruit Parkinson's nurse • Continue to reduce elective waiting times by maximising routine capacity through outsourcing • Proceeding with further consultant radiologist advert in January 2019. • Continued head & neck radiology support from specialist to reduce backlog and waiting times in ultrasound.	• Boundary change preparation and workload • The impact of a No Deal Brexit • Medical workforce gaps in Q4 in ENT and continuing in Urology • 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). 2 consultants now on phased return. • Nursing workforce gaps • Winter demand and pressures due to flu will be in full effect in Q4. • Bed availability on stroke unit and delays in transfer to the unit • Patients being cared for in inappropriate areas due to capacity issues • Numbers of DTOCs continue across Unit.

9.4 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%	99.2%	98.5%	98.1%	97.8%				
		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	2	3	3	0				
		Profile	*1*	*2*	*5*	*3*	*2*	*2*	*1*	*0*	*0*	*0*	*0*	*1*
	1 hour ambulance handover	Actual	45	31	18	34	60	38	43	47	44	68		
		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*	*72*	*55*	*6*	*4*	*0*	*1*		
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*16*	*14*	*31*	*21*	*10*	*30*	*32*	*28*	*2*	*31*		
		Profile	*24*	*23*	*1*	*3*	*12*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Diagnostic waits over 8 weeks	Actual	*0*	*0*	*0*	*0*	*0*	*0*	*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%	97%	96%	96%	95%	100%	96%		
		Profile	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*	*98%*
	USC patients starting treatment in 62 days	Actual	83%	89%	84%	92%	100%	83%	84%	90%	80%	81%		
		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	1	1	4	2	1	2		
		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	4	2	2	1	0	6		
		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	3	5	4	5	6	5		
		Profile	*6*	*4*	*4*	*4*	*5*	*4*	*4*	*4*	*2*	*1*	*1*	*3*
Quality & Safety Measures	Discharge Summaries	Actual	73%	72%	61%	67%	61%	62%	69%	64%	59%	65%		
		Profile	*73%*	*76%*	*78%*	*81%*	*83%*	*86%*	*88%*	*90%*	*93%*	*95%*	*98%*	*100%*
	Concerns responded to within 30 days	Actual	60%	65%	88%	83%	94%	63%	100%	86%				
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.73%	5.79%	5.91%	5.95%	6.04%	6.13%	6.17%	6.16%	6.21%			
		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%	63%	64%	64%	71%	72%	72%		
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	49%	50%	53%	55%	60%	62%	65%	70%	72%	74%		
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

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

9.4 Singleton Delivery Unit- Overview

Successes	Priorities
• SAU environment improvements continue. • Continued achievement of RTT 26, 36 and 52-week target for all medical specialties in Quarter 1, 2 and 3 2018/19. • Singleton Assessment Unit patient list and handover system implemented successfully. Rollout to inpatient ward areas continues. • Full ICOP Team appointed - Initial analysis demonstrates that 48% patients assessed by the team discharged directly from SAU. • AWaRe (All Wales Early Phase Research Partnership), between Velindre Cancer Centre and the South West Wales Cancer Centre has been developed. • Rollout of RFID at Morriston into Main Theatre. • Formal opening of Radiopharmacy on 8 February 2019. • Laboratory Medicine has recently completed a UKAS assessment against ISO 15189 standards. • A new electronic request form for DXA has be designed, and liaising with WCCG for roll out to GPs.	• Manage RTT pressures in Ophthalmology and Gynaecology following recent workforce challenges. • Service Resign: Redesign Services Ward 4&7, embedding ICOPS model and inpatient capacity. • Integrated workforce planning. • Develop a plan to support Radiotherapies waiting times. • Improvement in PADR and Mandatory training compliance across all disciplines. • Cancer Performance and scoping of impact of Single Cancer pathway. • Business Cases - PET/CT & replacement Radiotherapy CT. • Brexit – assure the continued supply of laboratory reagents and consumables. • Developing capacity plans for Chemo-day unit • Embedding the COPD early supporting discharge team
Opportunities	**Risks & Threats**
• Delivery Unit to support Health Board case for Nerve centre. • Review Endoscopy Capacity & Demand to agree strategic direction. • Increase activity through Medical Day Unit to support patient flow and review opportunities to support flow from Morriston. • Regional collaboration with Hywel Dda for both Dermatology and Endoscopy Services. • Temporary urgent closure of MIU during winter allowing extended role of AGPU. • Piloting of Patient Knows Best (PKB) - high volume medical conditions - rollout will be in Gastroenterology (IBD), Dermatology and Diabetes. • Implementation of Treat & Extend service in wet-AMD to improve patient experience and reduce unnecessary appointments for stable patients. • Approval of FUNB validation proposal.	• Cwm Taf Boundary Remapping. • Cladding. • Availability of Staff/Loss of Consultant Histo-Pathologists • Under delivery of Waterfall elements. • Consultant retirement within Cardiology end of December and risk of not covering this post – discussions with Morriston DU ongoing. • Capacity issues within Dermatology including administration gaps and risk on RTT and Skin Cancer targets. • Approval of FUNB validation proposal. Capital requirement for Fibroscan. • Cancer tracking and lack of workforce to support. • New NICE drug implementation will stretch the existing chemotherapy infrastructure.

9.5 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 *(excluding CAMHS)*	% MH assessments undertaken within 28 days	Actual	90.0%	94.0%	91.2%	93.0%	93.0%	90.0%	93.0%	90.0%	97.0%			
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
	% therapeutic interventions started within 28 days	Actual	83%	81%	80%	84%	90%	93%	93%	87%	84%			
		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%			100%			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%	88%	90%	91%	92%	91%	91%			
		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%	100%	100%	100%	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	0	0	0	0	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	0	0	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	0	1	0	0	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%	85%	86%	88%	84%	75%	75%	88%		
		Profile	*77%*	*79%*	*81%*	*83%*	*85%*	*88%*	*90%*	*92%*	*94%*	*96%*	*98%*	*100%*
	Concerns responded to within 30 days	Actual	71%	100%	100%	83%	100%	100%	83%	91%				
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	6.07%	6.11%	6.11%	6.05%	5.98%	6.02%	6.08%	6.11%	6.12%			
		Profile			*6.03%*			*5.93%*			*5.83%*			*5.73%*
	Personal Appraisal Development Review	Actual	85%	77%	79%	77%	74%	77%	79%	79%	78%	75%		
		Profile			*80%*			*83%*			*85%*			*85%*
	Mandatory Training *(all staff- ESR data)*	Actual	64%	66%	68%	69%	70%	72%	73%	78%	79%	79%		
		Profile			*60%*			*70%*			*80%*			*85%*

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

9.5 Mental Health & Learning Disabilities Delivery Unit- Overview

Successes	Priorities
• The Delivery Unit regularly meets all requirements of sections 1,3 and 4 of the Mental Health Measure. Section 2 is being managed closely to ensure the small dips experienced in June and July are avoided in the future. • Maintaining low number of healthcare acquired infections, with each occurrence reviewed for lessons learnt. • Maintaining relatively high levels of compliance with the PADR measures. • Met new target for psychological therapies in January.	• 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 Delivery Unit Staff Counsellor; Pilot Performing Medicine Staff Wellbeing programme; Promote Well Being Champions roles (47). • Appoint to medical staffing vacancies or modernise service.
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 Delivery Unit report to be in line with the rest of the Health Board. A learning matrix has been developed to embed and share the learning identified from serious incidents. RCA Training needs to be provided for investigators. Appointment to training post being progressed. • 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. • Security issues in Cefn Coed and Garngoch Hospitals.

9.6 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*	*0*	*0*	*0*	*0*	*0*	*2*		
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
	Treatment waits over 36 weeks	Actual	*0*	*0*	*0*	*0*	*0*	*0*	*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*	*0*	*0*	*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%	94%	90%	95%	95%	95%	95%			
		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%	84%	78%	88%	88%	88%	88%			
		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			62.5%									
		Profile												
Healthcare Acquired Infections	Clostridium Difficile cases (Community acquired)	Actual	6	5	5	5	7	4	4	1	11	4		
		Profile	*3*	*6*	*9*	*2*	*5*	*3*	*3*	*3*	*3*	*5*	*3*	*6*
	Clostridium Difficile cases (Community Hospitals)	Actual	0	0	0	1	1	0	0	0	0	0		
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	*1*	*0*	*0*	*1*
	Staph.Aueurs bacteraemia cases - (Community acquired)	Actual	8	13	12	9	11	3	5	10	6	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	0	0	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	30	34	24	30	23	17		
		Profile	*30*	*28*	*27*	*31*	*28*	*33*	*30*	*21*	*25*	*28*	*32*	*30*
	E.Coli cases (Community Hospitals)	Actual	0	1	1	0	0	1	1	0	0	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%	55%	38%	76%	79%	50%				
		Profile	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*	*80%*
Workforce Measures	Sickness rate *(12 month rolling)*	Actual	5.76%	5.71%	5.73%	5.74%	5.68%	5.68%	5.64%	5.62%	5.58%			
		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%	78%	76%	77%	78%	78%	78%		
		Profile	*63%*	*66%*	*68%*	*70%*	*70%*	*70%*	*72%*	*74%*	*74%*	*76%*	*78%*	*80%*
	Mandatory Training	Actual	60%	62%	64%	67%	69%	72%	75%	80%	81%	83%		
		Profile	*43%*	*46%*	*48%*	*48%*	*48%*	*50%*	*52%*	*54%*	*56%*	*58%*	*60%*	*62%*

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

9.6 Primary Care & Community Services Delivery Unit- Overview

Successes	Priorities
• Confirmation that the findings of the Occupational Therapy Activity Management Group will be presented at the IMPACT conference in March 19 • Maintained compliance with internal 14 week Wait targets (Orthotics & Podiatry) • Transfer of Primary Care services at Portway Surgery from existing premises to new Porthcawl Primary Care Centre • Hearing Loss pathway established - reducing referrals to ENT by circa 1000 / year • Roll out of Paediatric GA Service to encompass urgent referrals commenced 24th January • Innovation SLA completed -this will feed into an All Wales health board meeting with the GDS reform national team for approval • Take Home Naloxone Service (THNS) delivered by 2 Community Pharmacies to support specialist treatment centres in reducing the number of drug related deaths across the ABMU footprint. • Implementation of the Heartburn Management Service to support GP colleagues in reducing Proton Pump Inhibitor (PPI) prescribing • Successful implementation of District Nursing Escalation Plan • Positive feedback received from Welsh Government following the desktop review of Clusters • Positive feedback received from Welsh Government Transformation team regarding the presentation to the Transforming Clusters All Wales event. Positive informal feedback re the Cluster Whole System roll out submission	• National Diabetes Foot Care audit data collection at Morrison Hospital – roll out to commence once feedback is received • First meeting of a Patient Participation Group for Managed Practice on 12/02/19 • Finalise Dental pathways for implementation of national e-referral project in ABM - due to go live in March. • Establish MDT Task and Finish Group to develop new Oral Medicine pathway. • Initiate EOI exercise for Dental contract reform, selection process to be complete by March 4th • Finalise pathway for Syrian Refugees to access General Dental services • Work with Singleton Opthalmology clinicians and managers to scope options for primary care Optometrists to help reduce FUNB backlog [Gold Command T&F Group] • Finalise requirements for Primary Care Optometrists to undertake extended eye tests for stroke patients (Cwmtawe) • Work with Swansea University to confirm the process for the 19/20 Community Pharmacists on the Independent Prescribing course. • Work with 111 and Hywel Dda to finalise the Community Pharmacy UTI service requested by Welsh Government • Implement extended public engagement re Maesteg Day Hospital in partnership with Cwm Taf University Health Board
Opportunities	**Risks & Threats**
• Knee Pain Bracing pathway – potential cost reduction • Development of sedation service within Dental Teaching Unit in PTRC. • Diabetic retinopathy screening in the community relieving Ophthalmology pressures in Singleton, providing opportunity at NPTH • Development of a community pharmacy Blood Bourne Virus (BBV) service to meet the WHO elimination agenda • Cluster Whole System transformation	• Bridgend Boundary Change • Removal of Reception service at Cwmbwrla – no admin staff to take care of Podiatry patients on arrival • Notification of a tribunal to lift a national GP disqualification • Delayed corporate approval for 8a CDS managerial post which is an existing/substantive role within the dental team structure

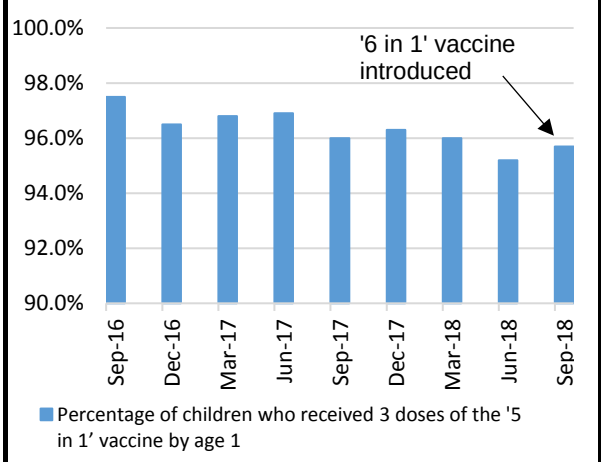
10. QUARTERLY PERFORMANCE REPORT CARDS
10.1 Staying Healthy

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

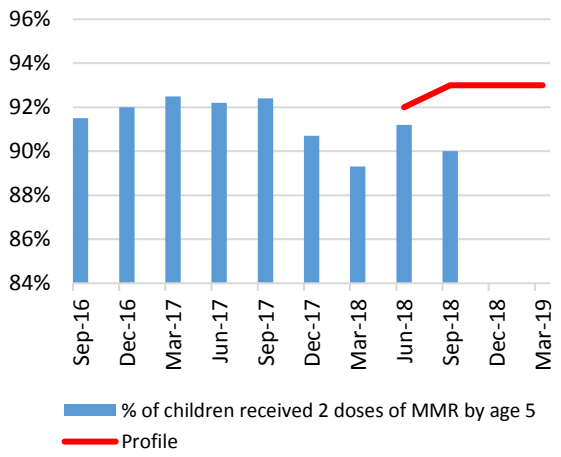
Measure 1: % of children who received 3 doses of the '5 in 1' vaccine by age 1
Measure 2: % of children who received 2 doses of the MMR vaccine by age 5

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 : September 18	**IMTP Profile Target :**	**WG Target:** 95%	**Current Status:** ✓	**Movement:** ↓ Worsening
Current Trend: Sep 16 - Sep 18				

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

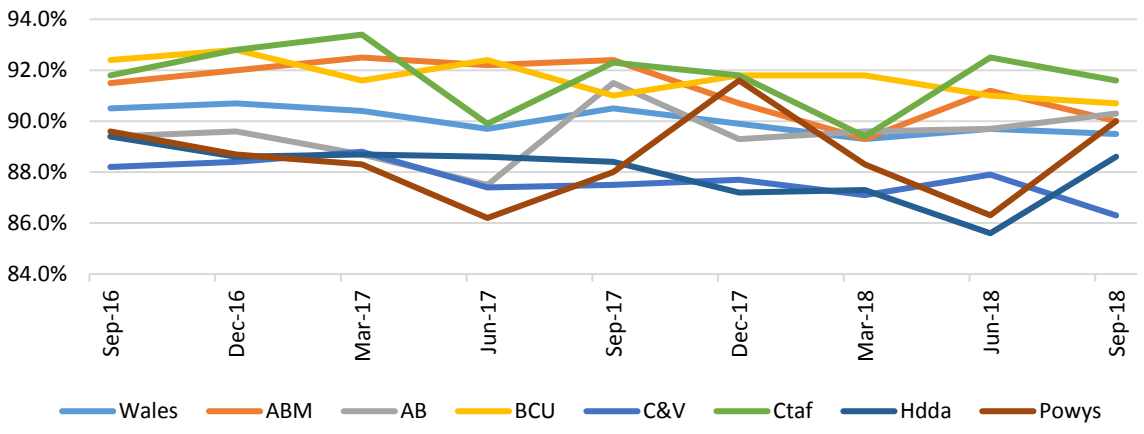


(2) % of children who received 2 doses of the MMR vaccine by age 5



Benchmarking

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



Source : Vaccine Uptake in Children in Wales April to September 2018 (COVER 128)

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

Measure 2: % of children who received 2 doses of the MMR vaccine by age 5

How are we doing?

- Measure 1 – Overall, during this quarter we continue to achieve the Welsh Government target in the percentage of resident children who have received 3 doses of the 6 in 1 vaccine by 1 year of age. However, during this reporting quarter one LA (Swansea) is below target with uptake rates of 94.8% (Bridgend 96.1%; NPT 96.8%)

- Measure 2 – during this reporting quarter there has been a slight decrease in the percentage of resident children who have received 2 doses of the MMR vaccine by age 5, with the COVER report indicating uptake rates of 90.0%. Again there is variance between the 3 LA areas Bridgend 91.9%; NPT 90.3%; Swansea 88.5%.

What actions are we taking?

- A task and finish group was convened to implement a consistent reporting mechanism to ensure all planned cancelled clinics were being accounted for by the primary care team. However, there has been a delay in the implementation of this process in the Child Health Department. There is an expectation that issues identified which has delayed its implementation will be resolved shortly.
- The current waiting lists and the number of cancelled immunisation clinics are being monitored by the primary care team. Practices displaying any waiting lists have been contacted by the primary care teams with discussions around various options around reducing waiting lists on-going.
- The Strategic Immunisation Group received an SBAR from the Child Health Department in relation to recommendations made following the internal audit in respect of additional resource to perform routine data cleansing to ensure data held on the Child Health Information System is the same as that on GP records. This will improve confidence in the COVER data, whilst enabling health care professionals to target areas with low uptake rates.

What are the main areas of risk?

- During this reporting quarter we are below 95% in the percentage of resident children who have received 2 doses of the MMR by 5 years which is needed for herd immunity.

- When uptake is below 95% the main area of risk is an outbreak of a vaccine preventable disease.

How do we compare with our peers?

- Measure 1 – ABM is ranked 3rd in comparison to the other Welsh Health Boards and above the Welsh average of 95.3%

- Measure 2 – ABM is ranked 4th in comparison to the other Welsh Health Boards and above the Welsh average of 89.5%

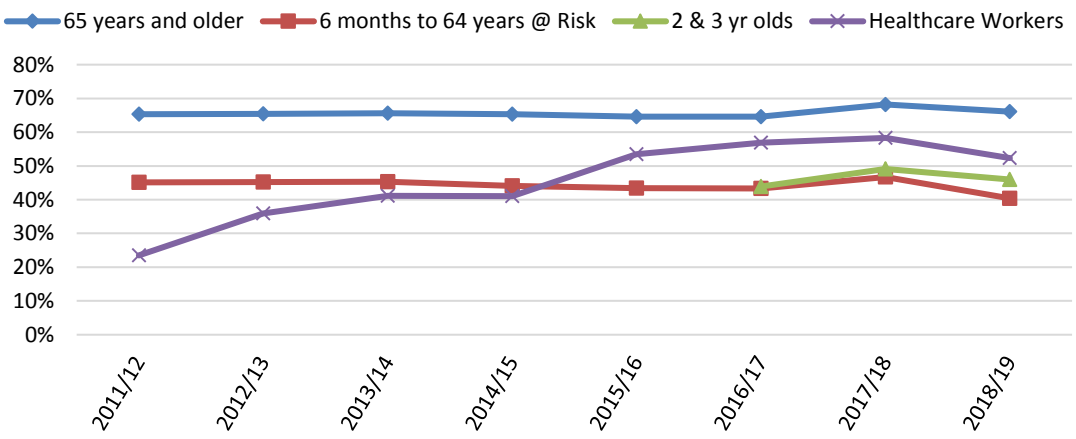
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

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

Corporate Objective : Promoting & Enabling Healthier Communities			**Executive Lead :** Sandra Husbands Director of Public Health	
Outcome Statement : I am healthy and active and do the things to keep myself healthy				
Period : December 2018	**IMTP Profile Target :** (1) 75%, (2) 55%, (46%), (4) 60%	**WG Target :** (1) 75%, (2) 55%	**Current Status :** ✗	**Movement :** ↓ ● Worsening

Current Trend: 2011/12 - 2018/19

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



** Data up to December 2018*

Benchmarking

% Uptake of Seasonal Flu Vaccine

2018/19	ABM	AB	BCU	C&V	CTaf	HDdA	Powys	Wales
(1) 65+	66.1%	69.20%	68.30%	67.70%	65.20%	60.60%	66.0%	66.0%
(2) 6 months to 64 years at risk	40.4%	42.90%	44.30%	40.70%	37.50%	35.40%	40.7%	40.7%
(3) 2 to 3 Year Olds	46.0%	42.00%	51.20%	43.00%	43.00%	42.60%	54.7%	45.2%
(4) Health Care Workers	52.3%	**Current uptake for other Health Boards not available*						

** Data up to December 2018*

Source: Public Health Wales Vaccine Preventable Disease Programme and Communicable Disease Surveillance Centre. IVOR (Influenza Vaccine Online Reporting) December 2018

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

How are we doing?

As of 16th Jan 2019 (IVOR)

- Measure 1. Uptake is 66.5%, which is the same as the uptake for Wales. Uptake by cluster ranges from 57.4% to 72.3%. Six practices have achieved the target of 75%.
- Measure 2. Uptake is 40.5%, slightly below the uptake for Wales 41.3%. Cluster uptake ranges from 32.8 to 45.9%. Five practices have achieved the 55% national target. The target has been achieved for patients with chronic diabetes (55.9%). 7 clusters have achieved the target for patients with chronic diabetes and 8 clusters for patients with COPD.
- Measure 3. Uptake is 45.7% comparable with the Welsh uptake of 45.9%. No national uptake target for 2 and 3 year olds. Uptake by cluster ranges from 35.8% to 53.8%.
- Measure 4. Uptake of frontline staff is 53.7%; uptake by delivery unit ranges from 45.8% to 62.8%

What actions are we taking?

The primary care flu planning group actions include:

- Weekly IVOR data and Public Health Wales (PHW) flu communication materials shared with practice flu leads
- Vaccine uptake monitored by the primary care flu planning group. Practices with lower uptake are contacted to identify and help resolve issues and offer support
- Letters funded by Public Health Wales (PHW) sent to parents of 2 year olds to inform of child eligibility and raise awareness of the childhood flu vaccine programme
- Health visitors are informed of practices with lower uptake for 2 and 3 year olds
- Support from ABM Public Health Team to develop cluster/ practice flu plans
- Cluster participation (three) in the PHW cluster support scheme.
- Development of local communications by the Health Board communication team
- Initial work with Swansea Mosque and Muslim community to promote the flu vaccine and to better understand the barriers to flu vaccine uptake in children
- Community pharmacy service commissioned including off site provision.

Staff campaign actions include:

- Flu champions were recruited and trained in accordance with minimum standards
- Weekly schedules for staff flu vaccination clinics (static and mobile) issued since October 2018.
- Additional resource used for mobile vaccinators supporting the campaign across the Health Board
- Delivery Unit Senior Team's engaged to support the campaign at local level
- Detailed weekly staff uptake reports shared widely across the Health Board.
- Weekly bulletins on the Health Board intranet site to encourage uptake, including myth busting and staff stories.

What are the main areas of risk?

- Uptake has been slower this season due the staggered and delayed delivery of the new flu vaccine (aTIV) for patients over 65 years.
- Uptake for patients under 65 at risk is lower compared to the same time last season, as is the uptake for Wales. The main strain of flu circulating is flu A (H1N1) pdm09 –affecting mainly the working age population.
- The Health Board denominator for patients under 65 at risk is currently being investigated by NWIS as it appears inflated compared to last season.
- Flu is now circulating and the Health Board should ensure that effective measures are in place to prevent further spread in health care settings.
- Vaccine availability for staff is now limited and several cases of flu have been confirmed across the Health Board

How do we compare with our peers?

Compared to other Welsh Health Boards ABMU is ranked:

- 4th for patients 65 years and older
- 4th for patients 6m to 64 years at risk
- 3rd for children 2 to 3 years
- 6th for staff with direct patient contact

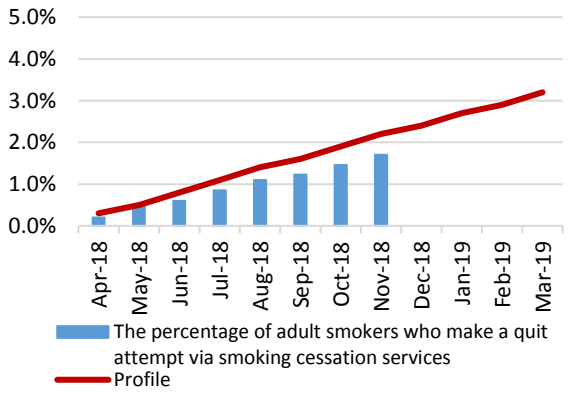
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

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)

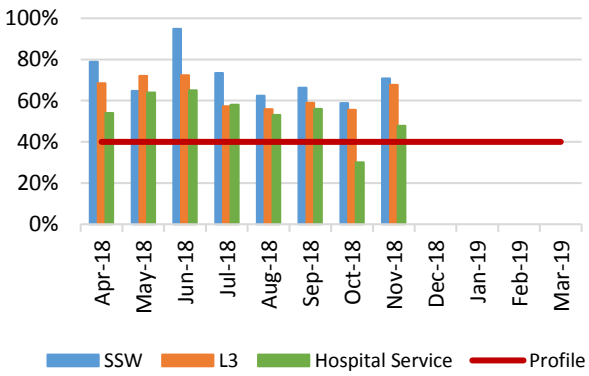
Corporate Objective : Promoting & Enabling Healthier Communities			**Executive Lead:** Sandra Husbands Director of Public Health	
Outcome Statement : I am healthy and active and do the things to keep myself healthy				
Period: November 18	**IMTP Profile Target:** (1) 2.2% (2) 40%	**WG Target:** (1) 5% (2) 40%	**Current Status:** ✗	**Movement:** ↑ ● Improving

Current Trend: 2018 - 2019 (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-Q2 18/19	Previous Q1-Q2 17/18
Wales	1.5%	↓ 1.6%
ABM	1.3%	↑ 1.2%
AB	1.6%	↓ 1.8%
BCU	1.8%	↓ 1.8%
C&V	0.8%	↓ 0.9%
CTaf	2.2%	↓ 2.6%
HDda	1.8%	↑ 1.3%
Powys	1.0%	↓ 1.1%

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

LHB	Current Q1-Q2 18/19	Previous Q1-Q2 17/18
Wales	44.6%	↑ 42.8%
ABM	56.9%	↑ 54.3%
AB	44.3%	↑ 40.5%
BCU	38.8%	↑ 32.2%
C&V	54.7%	↓ 57.4%
CTaf	35.5%	↓ 37.0%
HDda	47.7%	↓ 57.4%
Powys	39.7%	↓ 43.2%

Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (December 2018)

Measure 1: % Welsh resident smokers make a quit attempt via Smoking Cessation Services (numerator = set 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 4711 smokers need to be treated in ABM stop smoking services per year, with an average of 393 smokers treated per month. A target of 3.2% has been set for the ABM UHB Annual Plan, to achieve this 3.2% target approximately 3015 smokers need to be treated in ABM stop smoking services per year, with an average of 251 smokers treated per month. ABMU has treated 1613 smokers (monthly activity data) against the cumulative monthly target of 2008, achieving to November 2018 1.7% of the overall target. This is higher than the figure to November 2017 at 1.6%.
- All three smoking cessation services are exceeding the 40% target for CO Validated 4 week quitters, apart from one service for one month.
- The most recent data from the National Survey for Wales 2016/17 estimates that 21% of ABM ABMU's population (aged 16+) smoke. This is higher than the Wales average of 19%.

What actions are we taking?

- Stop Smoking Services are available in GP Practices and community venues (Stop Smoking Wales), pharmacies and in hospital for inpatients and outpatients. Primary care and secondary care staff referring patients to stop smoking services.
- Proposal to move Stop Smoking Wales (SSW) into Health Board (HB) from April 2019. National Project Board established. ABMU options being considered. Service review of hospital based service completed and recommendations being taken forward around management of service.
- Pilot project in progress to explore if sending out a letter to smokers from GP practice results in increased number of contacts to Help Me Quit.
- Successful training sessions delivered with pharmacy staff to develop knowledge about services and confidence to have conversations with customers about stopping smoking.
- Making Every Contact Count (includes brief advice on stopping smoking) Training Sessions delivered to 101 ABMU HB Employee Wellbeing Champions.
- Public Health Wales in conjunction with all HBs are facilitating the development of an implementation plan to deliver key components of the cessation system framework, as outlined in the tobacco control delivery plan for Wales. National integrated cessation system in place which involves ABMU services. Minimum service standards on all Wales basis have been drafted and consulted on.
- Maternal smoking priority as part of WG National improvement programme. ABM maternal smoking working group established. Work progressing to train all Midwives to support conversations about stopping smoking and referral to services.

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 which affect both uptake of smoking and relapse in those that had quit.
- The demand for ABM cessation services from smokers does not produce the required number of treated smokers. Commissioned pharmacies are now accredited, but not all are actively delivering the service. Inpatient referrals to the in house hospital service remain low despite a high level of training and awareness raising about service.
- Smoking on hospital grounds continues to be a widespread issue and visible problem despite Health Board smoke free site policy.
- National Improvement Programme Models for Access to Maternal Smoking Cessation Support (MAMSS) put on hold as a Prevention bid is with Welsh Government which includes the development of pregnancy smoking cessation service.
- The proposal to move the Stop Smoking Wales service to Health Boards is both an opportunity and a risk, including to quality of service.

How do we compare with our peers?

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

10.2 Safe Care

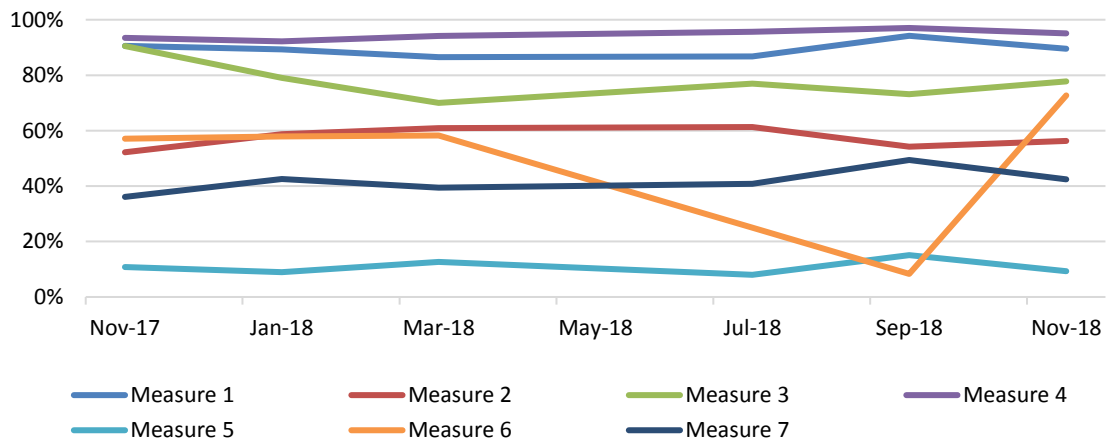
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period : November 2018	**IMTP Profile Target :**	**Local Target :** (1) >95% (2) >95% (3) >95% (4) >95% (5) ≤20% (6) ≤20% (7) ≤30%	**Current Status:** ✗	**Movement:** ↓ ● Worsening

Current Trend: Nov 17 - Nov 18

% compliance with Antimicrobial Audits (HB Total)



Nov-18	POWH	Morriston	Singleton	NPTH	MH & LD	HB Total
(1) % indication for antibiotic documented on medication chart	88.0%	91.1%	85.7%	100.0%	100.0%	89.5%
(2) % stop or review date documented on medication chart	45.6%	53.6%	67.7%	83.3%	90.9%	56.3%
(3) % of antibiotics prescribed on stickers	100.0%	-	57.1%	100.0%	75.0%	77.8%
(4) % appropriate antibiotic prescriptions choice	93.5%	95.4%	95.1%	83.3%	100.0%	95.1%
(5) % of patients receiving antibiotics for more than 7 days	7.3%	12.0%	6.1%	0.0%	0.0%	9.3%
(6) % of patients receiving surgical prophylaxis for more than 24 hours	0.0%	88.9%	-	-	-	72.7%
(7) % of patients receiving IV antibiotics > 72 hours	29.6%	47.8%	32.1%	100.0%	-	42.4%

Source : ABMU Pharmacy

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

How are we doing?

- Excellent compliance to the new guidelines continues to be observed and systems are in place to tackle episodes of non-compliance via co-amoxiclav authorisation forms and pharmacist exception reporting to the unit medical directors.
- Compliance with documentation of indications is also approaching target but documentation stop/review dates needs improvement.
- We continue to see a high proportion of patients remaining on IV antibiotics for longer than the recommended 48 - 72 hour period. An early switch to oral antibiotics has numerous benefits including removal of lines and expediting early discharge.
- Particularly high percentage of surgical prophylaxis over 24 hours observed this audit, guidelines recommend single pre-operative doses for the majority of procedures.

What actions are we taking?

- A planned rollout of the Public Health Wales “Start Smart the Focus audits”, which will be doctor led audit. This audit will raise awareness amongst junior doctors of the principles of SSTF 48 – 72 hour review which includes early IV to oral switch. Consultant champions within each speciality are being recruited to co-ordinate junior staff. Planned to introduce into pilot areas initially and then roll out. A new chair, Dr Phil Coles has been recruited for the Antimicrobial Stewardship Group and this work will be progressed via this group.
- Options for mandating review of prescriptions at 72 hours by adapting the medication charts are being scoped and considered.
- Guideline work is progressing with Burns and Plastics to further reduce co-amoxiclav usage within the Health Board.
- Antibiotic QIP are being undertaken by junior doctors, across a number of sites.
- An audit of surgical prophylaxis via theatre recovery in planned in Morriston

What are the main areas of risk?

- Audit results point to a need to improve the review of IV antibiotics and embed the principles of Start smart then focus and the 48 -72 hours review into all specialities.
- Lack of compliance to the recommended durations for surgical prophylaxis continue to be observed.

How do we compare with our peers?

- No national data available for comparison.

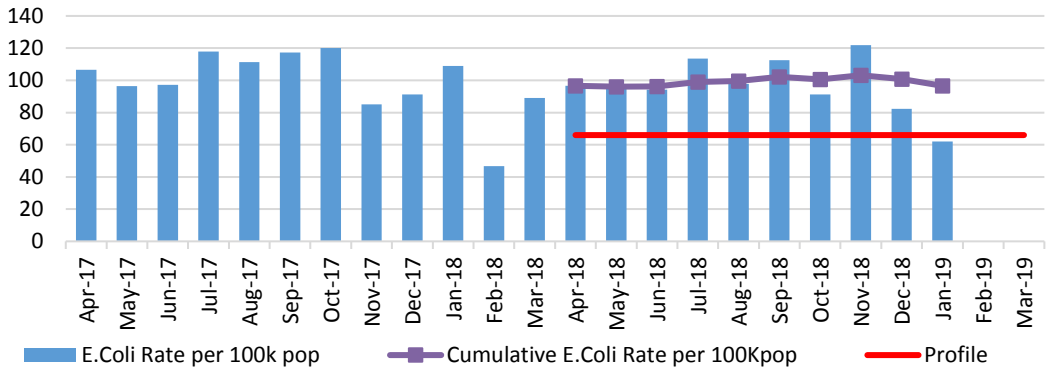
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

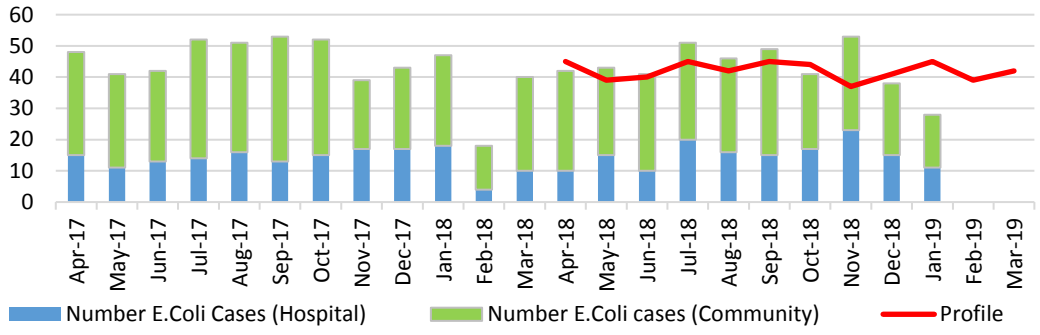
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : December 2018	**IMTP Profile Target:** (2) 41	**WG Target:**	**Current Status:** ✓	**Movement:** ↑ Worsening

Current Trend: Dec 17 - Dec 18

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



(2) Number of E.coli bacteraemia cases



Benchmarking

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

LHB	Cumulative Cases (Apr - Dec 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	1922	1563	+359
ABM	402	265	+137
AB	324	267	+57
BCU	441	349	+92
C&V	265	219	+46
Ctaf	211	149	+62
Hdda	268	192	+76

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

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

How are we doing?

- The number of cases in December 2018 decreased to 38 cases. Natural variation can be expected, with the number of cases fluctuating over months.
- The average number of cases over a period of time may provide an indication of trends. There has been little variation in the monthly average number of cases of infection in the three quarters of 2018/19.
- The proportion of the April to December 2018 cumulative E. coli bacteraemia cases that were hospital acquired was 35% (65% community acquired). The proportion of cases in December that were hospital acquired was 40%.
- Approximately 40% of all cases were considered to have a urinary source. Of these with a urinary source, approximately 22% of hospital acquired cases, and approximately 17% of community acquired cases, were associated with urinary catheters. Improvement activities will continue to focus on the risk associated with the presence of invasive devices.

What actions are we taking?

- Delivery Units to progress PDSA style quality improvement activities, with a focus on urinary catheters, across acute sites.
- Delivery Units to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.

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?

- The incidence of E. coli bacteraemia within ABMU for the month of December 2018 was the third highest in Wales.
- To date in 2018/19, the cumulative incidence of E. coli bacteraemia within ABMU was the second highest in Wales.

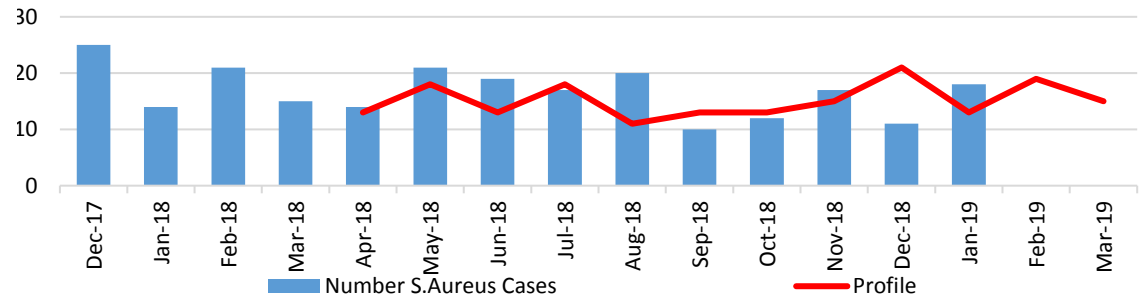
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

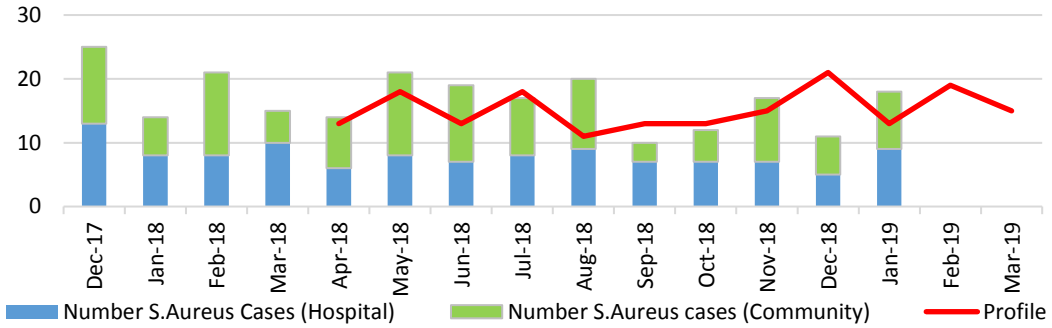
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from harm through high quality care, treatment and support				
Period : December 2018	**IMTP Profile Target:** (2) 21	**WG Target:**	**Current** Status: ✓	**Movement:** ↓ Improving

Current Trend: Dec 17 - Dec 18

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



(2) Number of S.*aureus* cases



Benchmarking

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

LHB	Cumulative Cases (Apr - Dec 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	683	466	+217
ABM	139	78	+61
AB	124	82	+42
BCU	124	104	+20
C&V	122	72	+50
Ctaf	76	44	+32
Hdda	96	56	+40

Source: Public Health Wales C.difficile, S.aureus and E.coli bacteraemia monthly dashboard (December 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?

- The number of cases in December 2018 decreased to 11 cases. Natural variation can be expected, with the number of cases fluctuating over months.
- The average number of cases over a period of time may provide an indication of trends. The monthly average number of cases of infection in Quarter 1 was 18 cases per month; this monthly average reduced to 16 cases per month in Quarter 2; the monthly average in Quarter 3 had reduced further to 15 cases per month.
- The proportion of the April to December 2018 cumulative Staph.aureus bacteraemia cases that were hospital acquired was 45% (55% community acquired). The proportion of cases in December that were hospital acquired was 45% also.
- Of the hospital acquired cases, line associated infection remains a significant causative factor; improvement activities must continue to focus on the risk associated with the presence of invasive devices.

What actions are we taking?

- Delivery Units to progress PDSA style quality improvement activities, with a focus on invasive vascular devices, across acute sites.
- Delivery Units to extend Aseptic Non-touch Technique training, with competence assessment, to medical staff.
- Delivery Units to focus improving ANTT competence assessment compliance in those clinical areas where patients undergo frequent vascular access (e.g. Haemodialysis Unit, Chemotherapy Unit, etc.).

What are the main areas of risk?

- 55% of Staph.aureus bacteraemia is community acquired, with many patient related contributory factors, such as recreational drug use, arthritis, chronic conditions, etc. As such, it is a challenge to prevent a significant proportion of these.
- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which frequently is close to, or exceeds, 90%. Analysis by the Department of Health, reported in Tackling Healthcare associated infections through effective policy action (BMA, June 2009), suggested that when all other variables are constant, an NHS organisation with an occupancy rate above 90 per cent could expect a 10.3% higher MRSA rate compared with an organisation with an occupancy levels below 85%.
- High bed turnover. In the same BMA report, the impact on MRSA rates of turnover intervals were suggested to have a greater impact on MRSA rates than bed occupancy levels.

How do we compare with our peers?

- The incidence of Staph.aureus bacteraemia within ABMU for the month of December 2018 was the third lowest in Wales.
- To date in 2018/19, the cumulative incidence of Staph.aureus bacteraemia within ABMU was the highest in Wales.

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

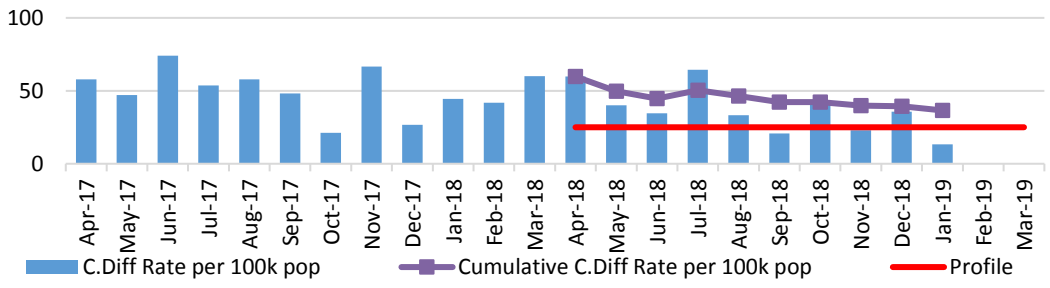
Measure 1: Rate of C.*difficile* cases per 100,000 of the population
Measure 2: Number of C.*difficile* cases
Measure 3: Number of cumulative cases of C.*difficile* against March 2019 reduction expectation

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	

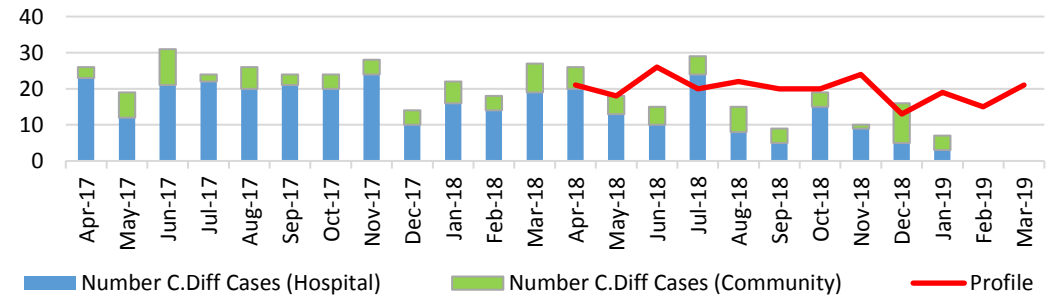
Period:	**IMTP Profile**	**WG Target:**	**Current Status:**	**Movement:**
December 2018	**Target:** (2) 13		✗	↓ ● Improving

Current Trend: Dec 17 - Dec 18

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



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



Benchmarking

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

LHB	Cumulative Cases (Apr - Dec 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	671	606	+65
ABM	157	102	+55
AB	119	109	+10
BCU	135	135	0
C&V	85	83	+2
Ctaf	43	39	+4
Hdda	115	74	+41

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (December 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?

- The number of cases of Clostridium difficile infection increased in December to 16 cases. However, the number of hospital acquired cases had decreased for the second consecutive month; there was a significant increase in the number of community acquired cases in December 2018, none of these was in a long-term care facility. However, the high number of community acquired cases seen in December highlights the additional infection prevention & control, microbiology and antimicrobial stewardship requirements of Primary Care.
- Natural variation can be expected, with the number of cases fluctuating over months. The average number of cases over a period of time may provide an indication of trends. The monthly average number of cases of infection in Quarter 1 was 20 cases per month; this monthly average reduced to 18 cases per month in Quarter 2; the monthly average in Quarter 3 had reduced further to 15 cases per month.
- The proportion of the April to December cumulative Clostridium difficile cases that were hospital acquired was 69% (31% community acquired).

What actions are we taking?

- Review compliance with restriction of Co-amoxiclav, with feedback to Delivery Units**. Impact: 50% reduction in annual Co-amoxiclav use by 31.03.19.**
- Review the use of Co-amoxiclav in Primary Care, with the aim of reducing total volume usage. This will require a review of Primary Care Guidelines.
- Further engagement with Primary Care leads to review the December cases, to better understand whether the increase was due to special causation, and to identify actions – **by 31.01.19**.
- Commence small scale quality improvement project relating to improving the clinical detail within documented daily reviews of patients with Clostridium difficile infection – **by 28.02.19**.
- Launch deep cleaning & decontamination standards for Clostridium difficile **source rooms/bays by 31.03.2019. Impact: reduction in Periods of Increased Incidence and outbreaks of Clostridium difficile toxin positive cases in Quarters 1 and 2** (2019/20) compared with Quarters 1 and 2 (2018/19). Service demands and pressures will present a challenge to achievement.

What are the main areas of risk?

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

How do we compare with our peers?

- The incidence of the incidence of Clostridium difficile infection within ABMU for the month of December 2018 was the highest in Wales.
- To date in 2018/19, the cumulative incidence of Clostridium difficile infection within ABMU was the second highest in Wales.

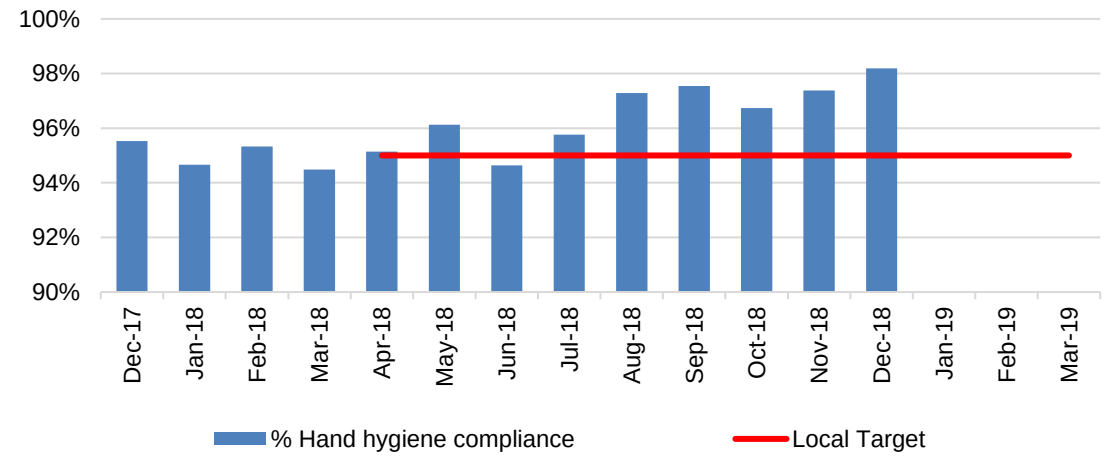
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % compliance with Hand Hygiene Audits

Corporate Objective : Delivering Excellent Patient Outcomes & Access			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period : December 2018	**IMTP Profile Target:** 95%	**WG Target:** N/A	**Current Status:** ✓	**Movement:** ↑ ● Improving

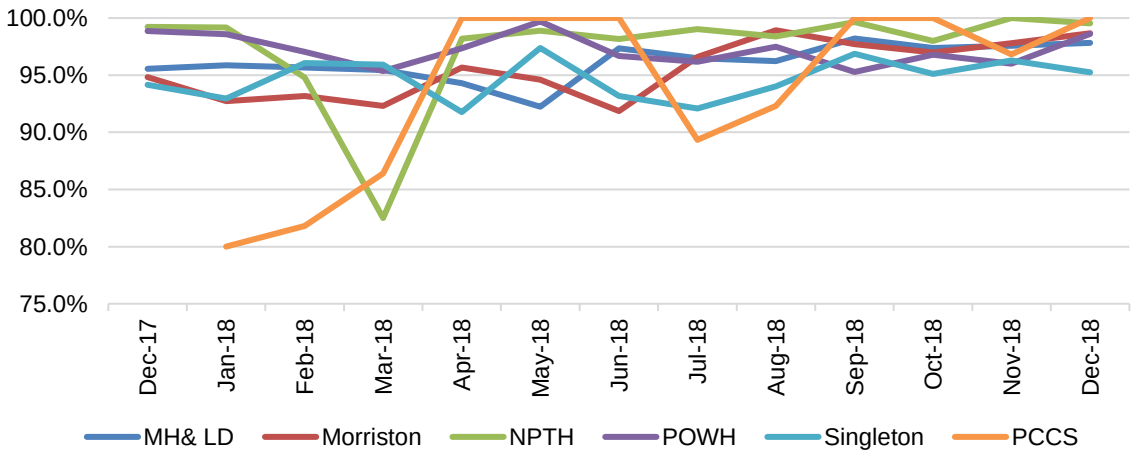
Current Trend: Dec 17 - Dec 18

(1) % compliance with Hand Hygiene Audits.



Benchmarking

(1) % compliance with Hand Hygiene Audits



Source : ABMU Care Matrix

Measure 1: % compliance with Hand Hygiene Audits

How are we doing?

- Compliance with hand hygiene (HH) for December 2018 was approximately 98%.
- For December 2018, 80 wards/units (58%) reported compliance ≥95%.
- 7 wards/departments (5%) reported compliance between 90% and 94%; 7 wards/units (5%) reported compliance of 89% or below.
- 43 wards/departments had not uploaded the results of their audits undertaken in December 2018 at the time of updating this report.
- All six Service Delivery Units (SDU) reported compliance ≥95% in December 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?

- Delivery Units can agree internal peer review audit programmes, undertaking these between wards, specialties or Delivery Units.
- The updated Hand Hygiene Training programme is being delivered.
- Training of ward Hand Hygiene Coaches continues and these continue to deliver approved training at ward level.

What are the main areas of risk?

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

How do we compare with our peers?

- The 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.

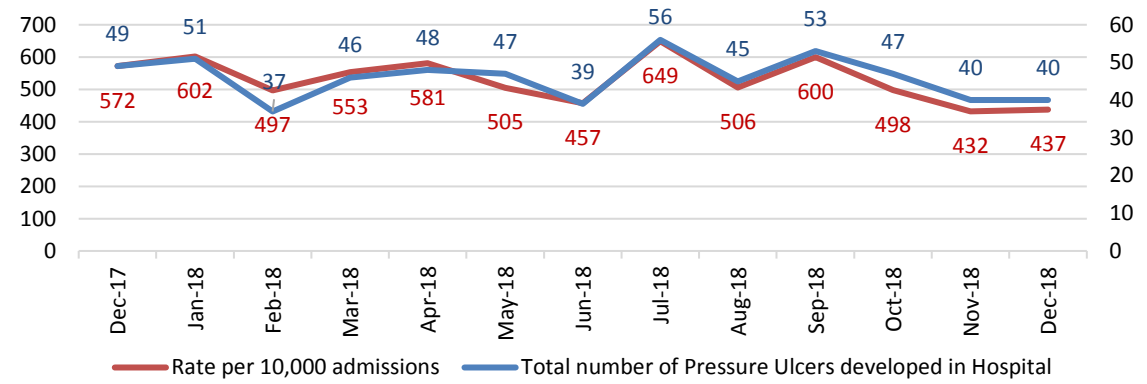
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: 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.

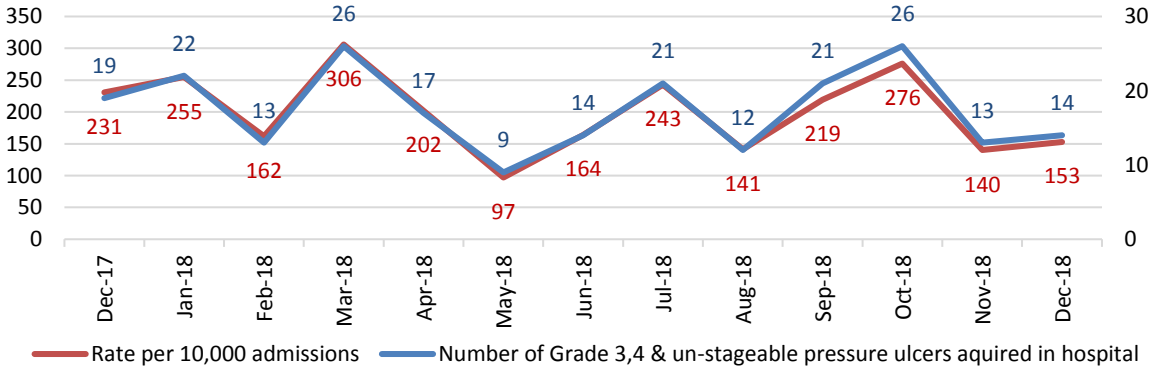
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period : December 2018	**IMTP Profile Target:** Reduce	**WG Target:** Reduce	**Current Status:** ✓	**Movement:** ↓ Improving

Current Trend: Dec 17 - Dec 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 small increase in the rate of pressure ulcer development for in-patients during December 2018. The rate per 100,000 admissions rose from 432 in November to 437 in December 2018. There was no change in the number of pressure ulcers developing in hospital: 40 in November 2018 and 40 in December 2018.
- Princess of Wales Hospital (POWH) continues to be a hotspot for pressure ulcer development and accounts for 65% of the hospital acquired pressure ulcers developing in December (26 out of 40).
- The rate of Grade 3+ pressure ulcers has increased from 140 per 100,000 admissions in November, to 153 per 100,000 admissions in December 2018. There were 13 Grade 3+ pressure ulcers in November compared to 14 in December 2018
- Of the 14 Grade 3+ pressure ulcer incidents reported in December 2018, 3 were classified as deep damage and met the criteria for Serious Incident reporting.
- No device related pressure ulcers were reported in December.

What actions are we taking?

- The Pressure Ulcer Prevention Strategic Group (PUPSG) continues to meet quarterly with a multi-disciplinary membership and representation from all Service Delivery Unit's (SDU's).
- PUPSG are working closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- The final report, with recommendations, of the Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 has been completed and is to be presented at PUPSG in February.
- The most common causal factor identified in the report for avoidable pressure ulcers was inadequate frequency of patient repositioning. The revised Prevention and Management of Pressure Ulcers Policy clearly identifies the minimum requirement for repositioning for in-patients and implementation of the policy is underway.
- Incomplete documentation continues to be a contributory factor. All Service Delivery Units have plans in place for pressure ulcer prevention documentation audit.
- A designated Matron has been identified to lead the POWH Scrutiny panels and the TVN post, vacant for 6 months, has recently been filled.
- Morriston Hospital has developed a Theatres Skin Integrity Project that has delivered improvements in care, resulting in zero pressure ulcers developing as a result of surgery since June 2018. The work was presented at November's PUPSG and is to be shared across the Health Board.
- A concordance policy has been written by Primary Community & Care and a training package has been developed with the aim of supporting staff to coproduce an acceptable plan of care for pressure ulcer prevention with the patient. This will be presented and shared at PUPSG in February.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all Service Delivery Unit's and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.

What are the main areas of risk?

- Continued difficulty with maintain nurse staffing levels on wards

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.

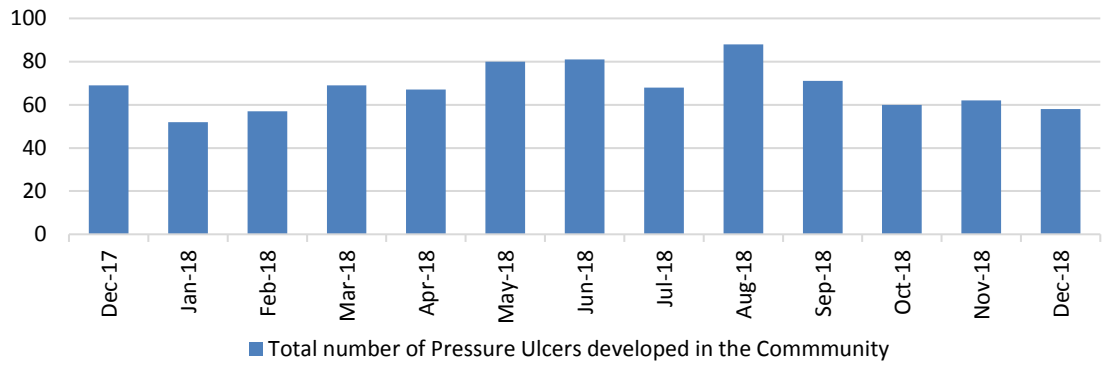
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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.

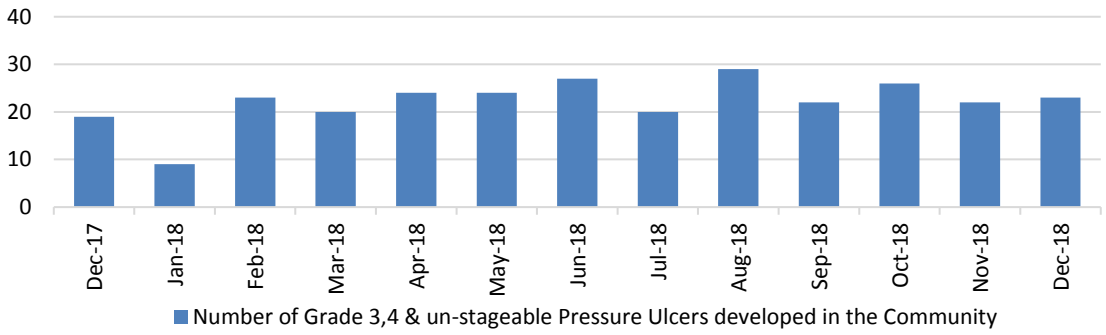
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period : December 2018	**IMTP Profile Target:** Reduce	**WG Target:** Reduce	**Current Status:** ✕	**Movement:** ↑ ● Worsening

Current Trend: Dec 17 - Dec 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 : Pressure 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 December 2018, 58 incidents of pressure ulceration were reported in the community, this is a decrease compared to the 62 incidents reported in November 2018.
- Comparing December 2017 to December 2018 shows a 16% reduction from 69 to 58 incidents
- Device related damage accounts for 3 pressure ulcers, of those 1 was caused by a device owned by the patient.
- There has been a small increase in the number of Grade 3+ pressure ulcers reported, from 22 in November to 23 in December 2018.
  Of the 22 Grade 3+ pressure ulcers reported in December, 12 were considered deep damage and met the criteria for Serious Incident (SI) reporting. This is no change from the 12 that met the criteria in November 2018.

What actions are we taking?

- The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) continues to meet quarterly. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
- The final report, with recommendations, of the Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 has been completed and is to be presented at PUPSG in February.
- Data on the number and grades of pressure ulcers occurring in NPT, Bridgend and Swansea community areas is produced monthly. A deep dive is planned to further map out the pressure ulcer data and equipment use for individual district nursing hubs to target interventions in hot spots.
- A concordance policy has been written by Primary Care & Community and a training package has been developed with the aim of supporting staff to coproduce an acceptable plan of care for pressure ulcer prevention with the patient. This will be presented at PUPSG in February.
- Using mobilisation has increased the timeliness of home visits when early pressure damage is identified enabling earlier intervention and treatment and avoiding delays in management.
- The community Pressure Ulcer Improvement Group meets quarterly to receive feedback and learning from the local community scrutiny panels.
- 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.
- Education for pressure ulcer prevention and classification of pressure ulcers remains an ongoing priority. Bespoke sessions are delivered by TVN's to community staff, carer organisations and care homes on a rolling programme.

What are the main areas of risk?

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

How do we compare with our peers?

- No benchmark data available.

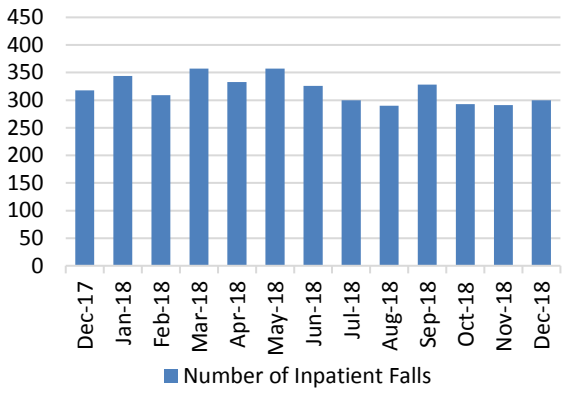
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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

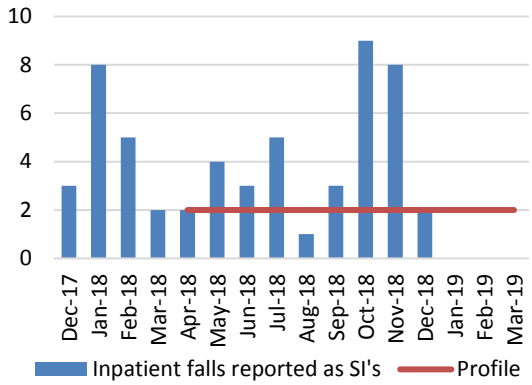
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Outcome Statement : I am safe and protected from abuse and neglect				
Period: December 2018	**IMTP Profile Target:** (2) 2	**WG Target:** (2) 12 month reduction trend	**Current Status:** ✓	**Movement:** ↑ Worsening

Current Trend: Dec 17- Dec 18

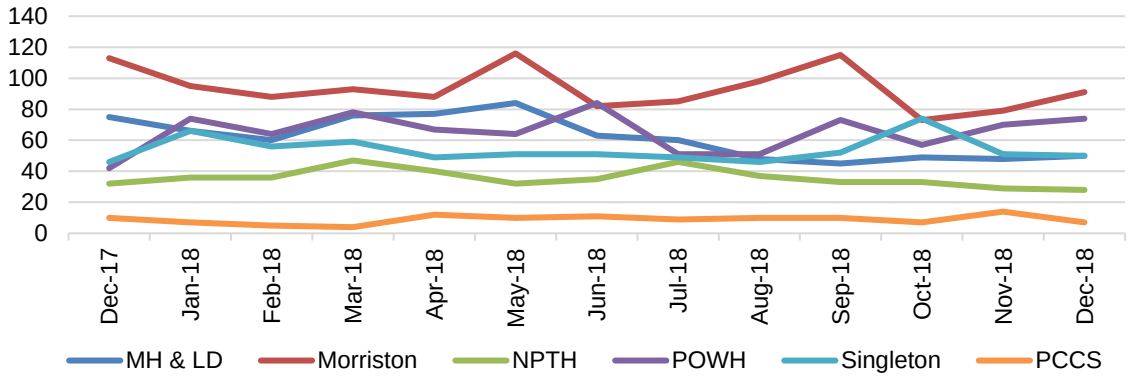
(1) Total number of Inpatient Falls



(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?

- November to December has shown an increase in the number of falls for Morriston and Princess of Wales. Mental Health & LD, Singleton and NPTH maintained their position between November and December, and PCCS Unit saw a reduction of 7 (from 14 to 7). There are a number of Serious Incident's recorded for the Health Board, 9 in October, 8 in November and 2 in December (awaiting verification from SDU's).

What actions are we taking?

- A Falls Injury Prevention Strategic Group Meeting will take place on April 11th 2019. Terms of Reference will be revised as part of the revised meeting.
- The updated Health Board's Falls Prevention & Management Policy was ratified in September 2018. The policy has not yet been adopted as training is required.
- A Multidisciplinary Task and finish group has been set up to devise a training and implementation plan, to support the policy.

What are the main areas of risk?

- The Health Board (HB) policy has not yet been implemented.
- A training and implementation plan is being developed.

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 Management Group (FPMG).

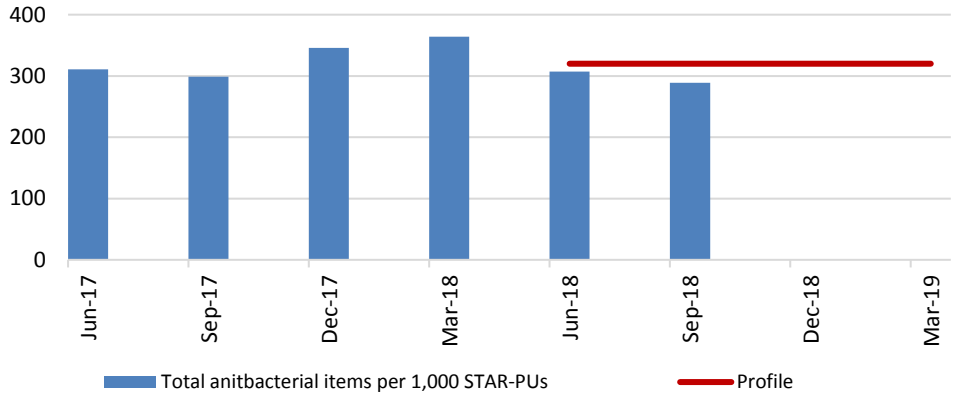
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : September 2018	**IMTP Profile Target:** 320	**WG Target:** 4 quarter reduction trend	**Current Status:** ✓	**Movement:** ↓ ● Improving

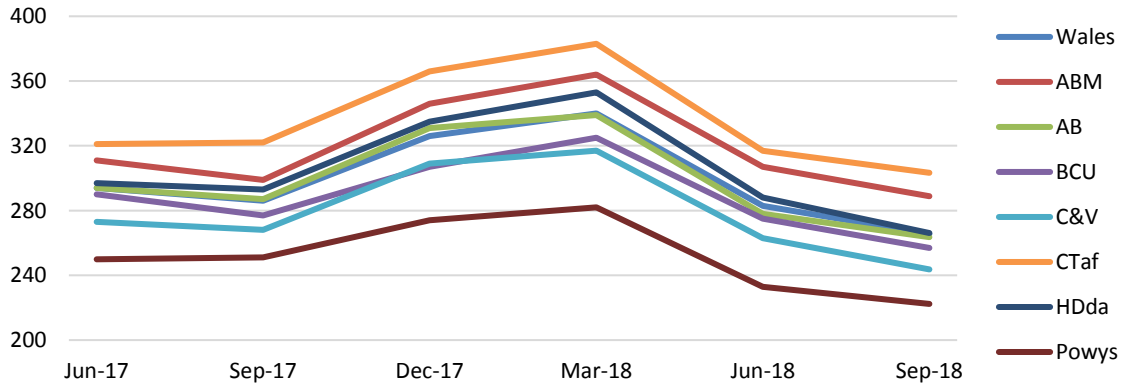
Current Trend: Jun 17 – Sep 18

(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 : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

- While the long term trend is down, this has seen some slowing and reversal that requires close monitoring.

What actions are we taking?

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

- Included in the 2018-19 Prescribing Management Scheme including a co-amoxiclav audit
- Highlighted in every practice's annual prescribing visit
- Supported additional audits in target practices
- Regular guideline updates
- Regular updates via prescribing leads meetings including presentation from microbiologist
- Highlighting links and resources to national campaigns
- Links with Primary Care & Community Services work with care homes and other projects

What are the main areas of risk?

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

How do we compare with our peers?

- 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.

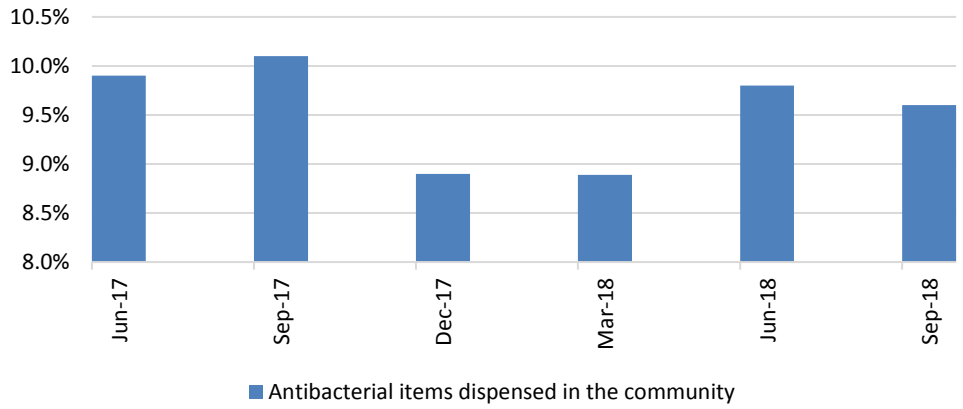
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : September 2018	**IMTP Profile Target:**	**WG Target:** Quarter on quarter improvement	**Current Status:** ✓	**Movement:** ↓ ● Improving

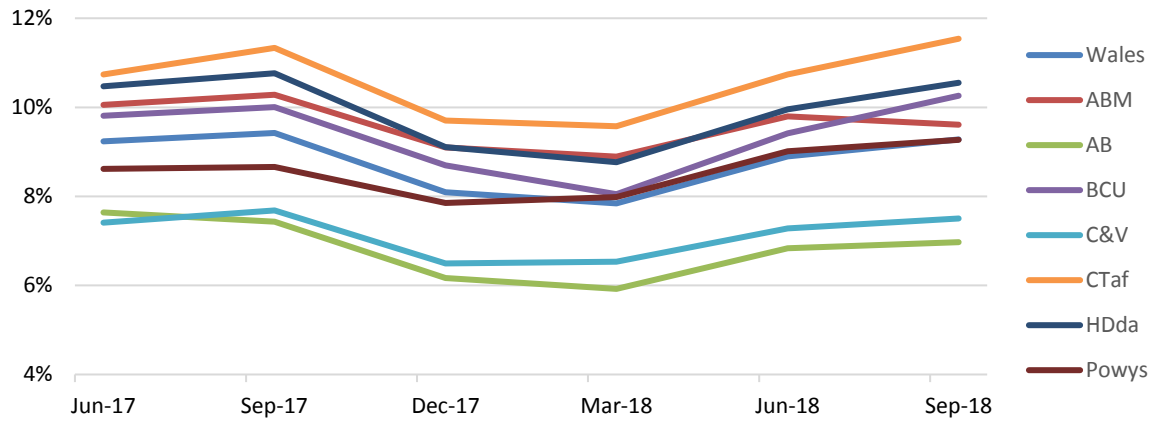
Current Trend: Jun 17 - Sep 18

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



Benchmarking

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



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

- After an initial significant reduction 2-3 years ago, these antibiotics have shown some increases, which are being monitored and targeted.

What actions are we taking?

To maintain focus, the following are in place:

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

What are the main areas of risk?

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

How do we compare with our peers?

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

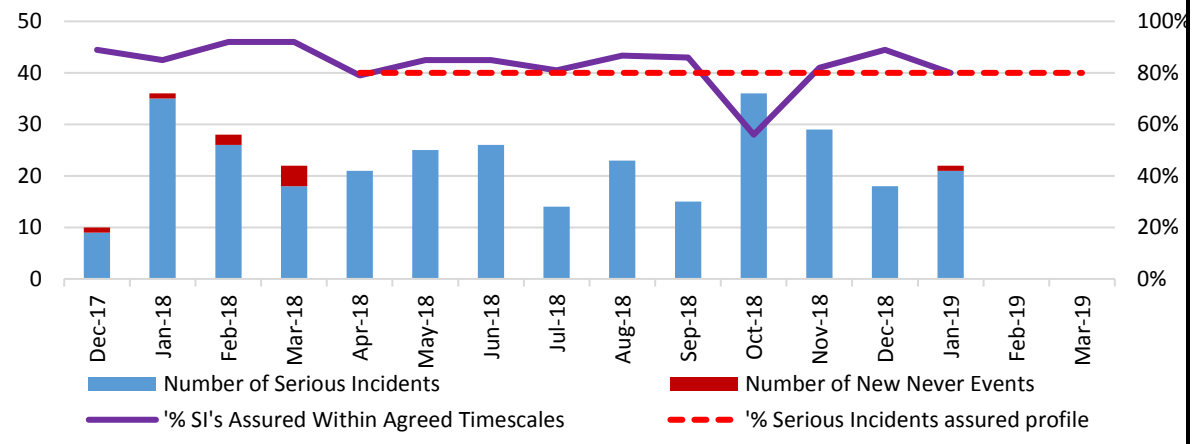
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of 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 : December 2018	**IMTP Profile Target:** (1) 0, (2) 0, (3) 80%	**WG Target:** (1) 0, (3) 90%	**Current Status:** ✕	**Movement:** ↓ ● Improving

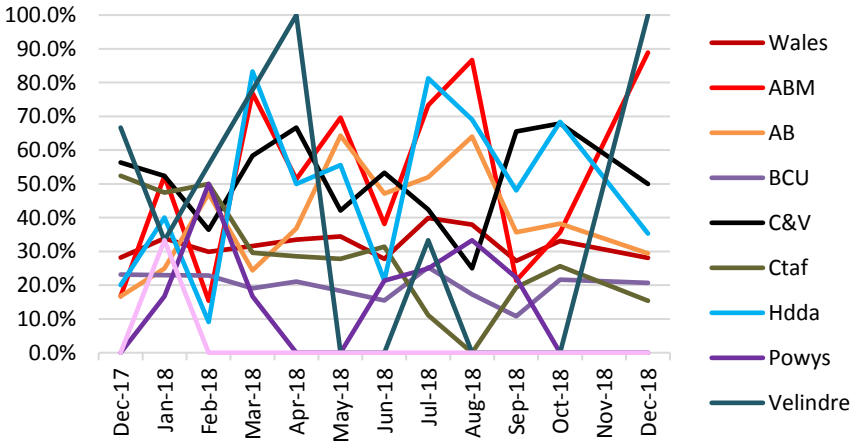
Current Trend: Dec 17 - Dec 18

(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

Dec-18	
Wales	1
ABM	0
AB	0
BCU	1
C&V	0
Ctaf	0
Hdda	0
Powys	0
Velindre	0
WAST	0

Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

SI Scorecard – completed on 24 January 2019.

- Total number of incidents reported in December 2018 was 2,198. This compares to 2,155 incidents reported in September 2017, an increase of 43 incidents for the month of December (increase of 2%).
- 20 Serious Incidents (SI's) were reported to Welsh Government (WG) in December 2018. In comparison, 9 SI's were reported to WG in December 2017, an increase of 11 incidents (increase of 122%). Of the 20 new serious incidents reported to WG in December 2018, 12 (60%) related to pressure ulcer incidents (grade 3 and above), 2 (10%) related to patient falls and 1 (5%) was an unexpected death, 1 (5%) related to an absconder, 1 (5%) related to administrative processes and 2 (10%) related to diagnostic processes/procedures.
- In terms of severity of incidents, the percentage of incidents resulting in severe harm for December 2018 was 0.5% (total incidents reported 2,198). 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 December 2018.
- Performance against the WG target of closing SI's within 60 working days for September 2018 was 89% against the WG target of 80%.

What actions are we taking?

- The SI Team continues to trial the new reflective methodology approach to review serious incidents managed by the SI Team. Presentations promoting the approach are being undertaken across the Health Board to help promote an organisational learning culture.
- A new toolbox supporting the revised approach to SI investigations is set to be approved at Quality and Safety in February following which will be rolled-out across the Health Board
- 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.
- In addition, recruitment to a new Concerns Quality Improvement Manager are progressing with appointment to the new post anticipated for mid-March 2019.

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 HB 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 FPMG

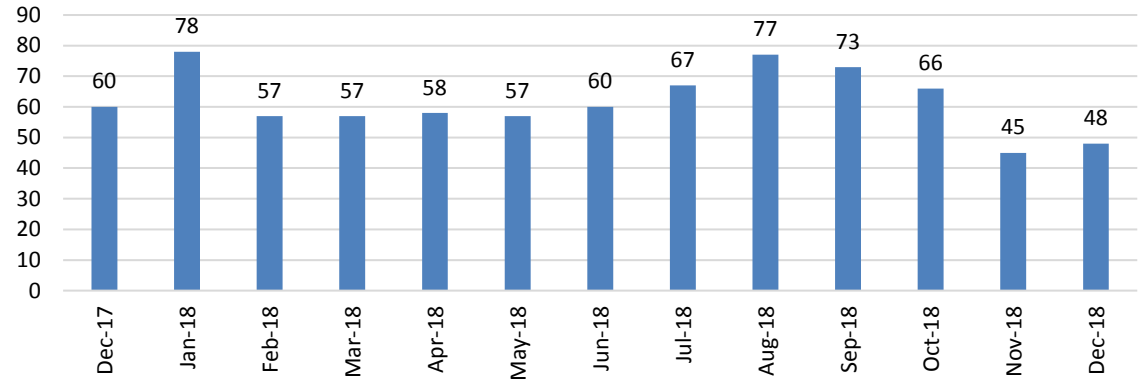
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of risks with score ≥ 20

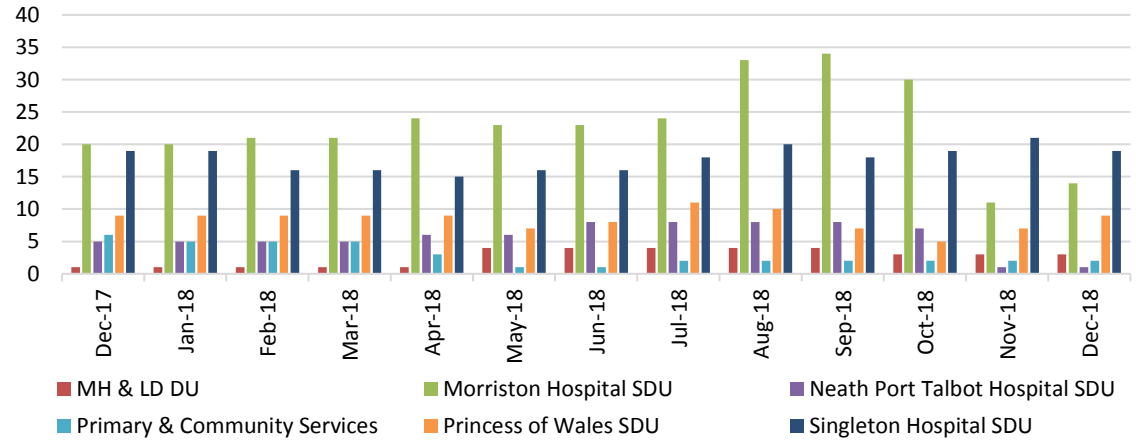
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead :** Gareth Howells Director of Nursing & Patient Experience	
Period : December 2018	**IMTP Profile Target:** Reduce	**Local Target:** Reduce	**Current Status:** ✓	**Movement:** ↓ Improving

Current Trend: Dec 17 - Dec 18

(1) Number of risks with score ≥ 20



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



Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of risks with score ≥ 20

How are we doing?

- 48 operational risks, rated 20 or above. A decrease of 12 from December 2017.
- Singleton Unit has the highest number of risks rated at 20 or above, 22.

What actions are we taking?

- The Corporate Risk has been renamed the Health Board Risk register.
- A work plan for the Health Board Risk Management Group has been agreed.
- Service Delivery Units will be invited to future meetings of the Risk Management Group to review their Unit Risk Registers.
- An SOP has been developed to give guidance on how to escalate a risk to the Health Board Risk Register (HBRR).
- The Health Board Risk Management Strategy and Policy is to be reviewed in line with the newly formatted Health Board Risk Register.

What are the main areas of risk?

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

How do we compare with our peers?

- No comparable data available.

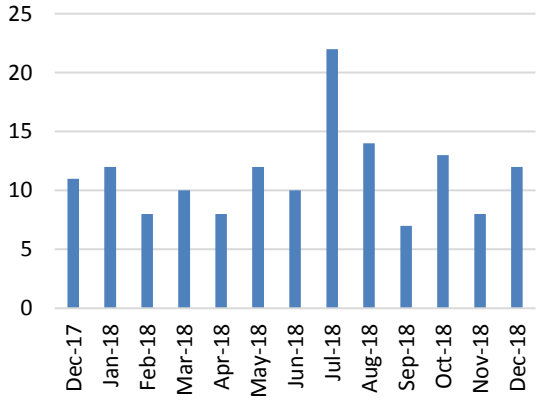
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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

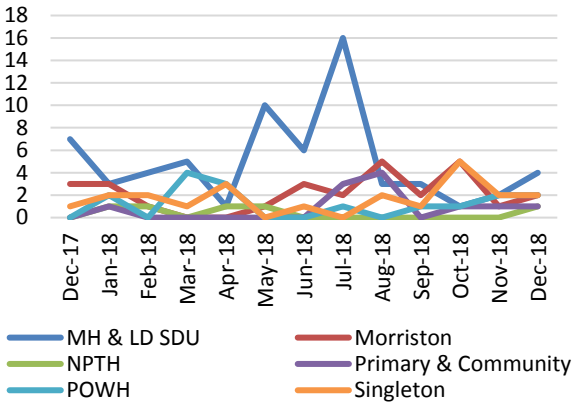
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period : December 2018	**IMTP Profile Target:** N/A	**Local Target:** (1) (2) Reduce (3) (4) Monitor	**Current Status:** ✗	**Movement:** ↑ ● Worsening

Current Trend: Dec 17 - Dec 18

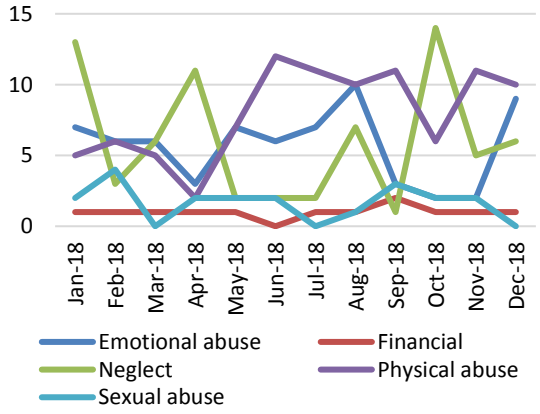
(1) Number of Safeguarding Adult referrals relating to Health Board staff/services (HB Total)



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



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



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

Dec-18						
	Emotional abuse	Financial	Neglect	Physical abuse	Sexual abuse	Total
MH & LD SDU	7	1		9		17
Morriston Hospital SDU			2			2
NPT Hospital SDU			1			1
Princess of Wales SDU			2			2
Singleton Hospital SDU			1	1		2
P & CC SDU	2					2
Total	9	1	6	10	0	26

Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

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

How are we doing?

- (1) The number of safeguarding adult at risk referrals relating to Health Board (HB) staff or services continue to vary each month, with a peak noted in July. The level of referrals for December 18 is consistent with that of December 2017.
- (2) The trend indicates a maintenance of an overall reduced level of referrals since October 2018.
- (3/4) Mental Health & Learning Disabilities Service Delivery Unit (SDU) consistently have the highest number of adult at risk referrals. This is expected due to the complexities and vulnerabilities of their client group. Most of referrals managed by the SDU relate to allegations of abuse of a patient by another patient. The most common theme across all SDUs is that of physical abuse, closely followed by emotional abuse.

What actions are we taking?

- Service Delivery Units report on lessons identified from closed safeguarding cases in their unit performance reports to the Safeguarding Committee. This allows learning from specific cases to be shared across the Health Board.
- The themes and trends of adult safeguarding cases across the Health Board are being reported and analysed by the Corporate Safeguarding team. This information is presented to both the Safeguarding Committee and Quality and Safety Committee in the Bi-annual Safeguarding Report

What are the main areas of risk?

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

How do we compare with our peers?

- Peer information is not available for comparison

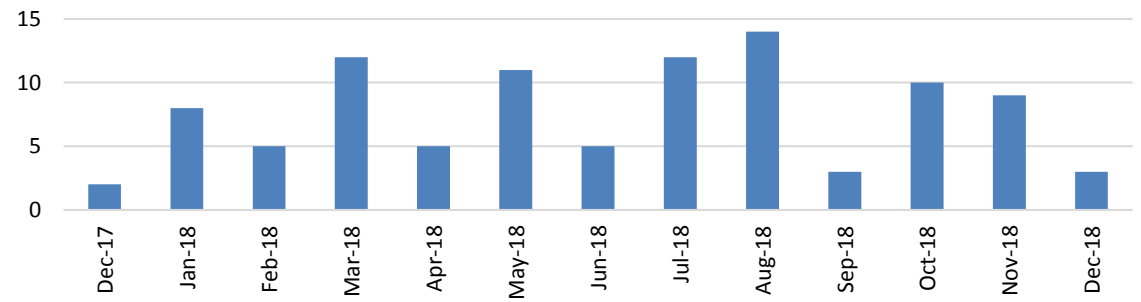
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of Safeguarding Children Incidents

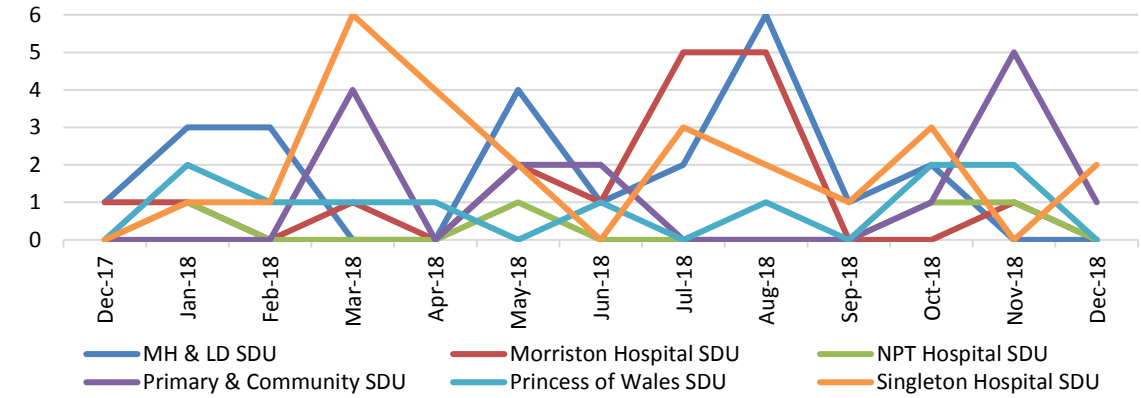
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period : December 2018	**IMTP Profile Target:** N/A	**Local Target:** 0	**Current Status:** ✗	**Movement:** ↓ ● Improving

Current Trend: Dec 17 - Dec 18

(1) Number of Safeguarding Children Incidents



(1) Number of Safe guarding Children Incidents



Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Children Incidents

How are we doing?

- After a peak in October 2018, children's incident reporting has reduced. The numbers are still relatively low and so recognising themes and trends are difficult to identify however there has been a noticeable increase in the reporting of Children being nursed on Adult wards. This is in part attributable to Service Delivery Units (SDUs) being reminded to incident report any child that has been admitted to an adult ward, and to complete the Risk Assessment Tool for Children admitted to Adult Ward Environments to ensure that Safeguarding has been considered and put in place by ward staff.
- The Health Board (HB) does not capture any Health Board Safeguarding Children referrals to Children's Services in the Local Authority and so this activity is not visible on the Report Cards. The data is currently collated by contacting the Local Authority.

What actions are we taking?

- The Children's Trigger list has been revised, and was presented to the Safeguarding Committee in November 2018. A link has been added on Datix giving guidance for Safeguarding Children Incident alerts.
- The Risk Assessment Tool has been revised to make it more user-friendly to promote wider use and is available on the Clinical Online Information Network (COIN).
- Safeguarding Children referrals made by HB staff are sent directly to the Local Authority and as such the HB does not have an accurate record of Children's safeguarding referrals that have been made. The Corporate Safeguarding team are working with the Datix team to design a data collection tool that will capture this information. Anticipated date of completion March 2019
- The Safeguarding Team are planning to undertake an audit in 2019 (in partnership with the DATIX Team) to identify whether there is a discrepancy between incidents that are triggered for review and those that should have been triggered but were not.

What are the main areas of risk?

- The data reporting tool for Children's safeguarding referrals is currently under development, until this is complete there is no robust method to capture all Safeguarding Children activity across ABMU HB. The Service Delivery Units report on any Safeguarding Children's referrals within their bi-monthly performance reports to the Safeguarding Committee but these are not reflective of all activity.

How do we compare with our peers?

- Comparison data from peer organisations not available

10.3 Effective Care

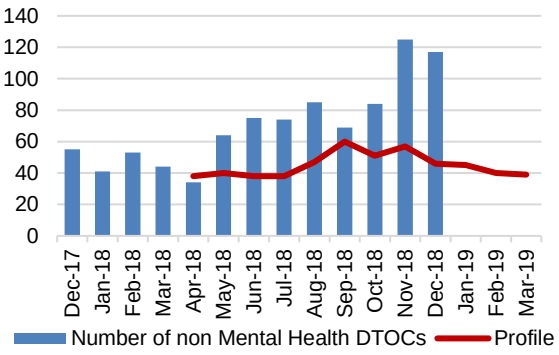
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

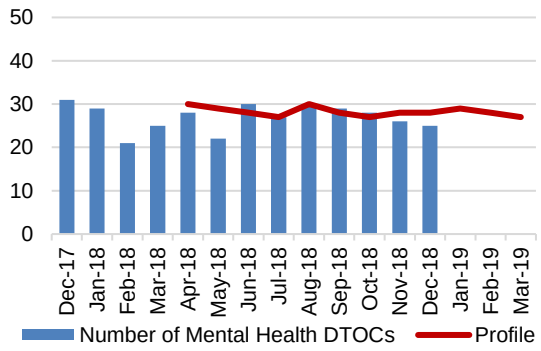
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : Health care and support are delivered at or as close to my home as possible				
Period : December 2018	**IMTP Profile Target:** (1) 46 (2) 28	**WG Target:** (3) Reduce by 10% (4) Reduce by 5%	**Current Status:** ✗	**Movement:** ↑ ● Worsening

Current Trend: Dec 17 - Dec 18

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

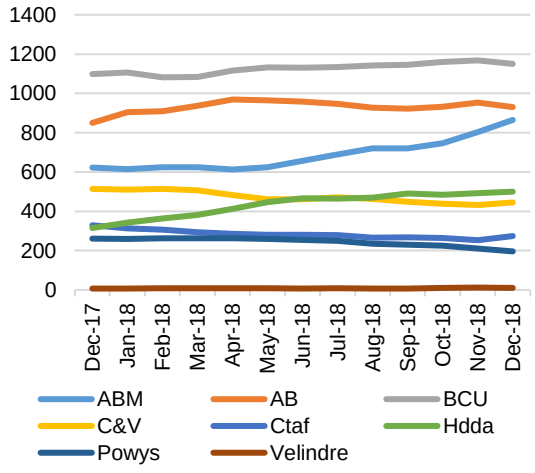


Measure 2: Number of Delayed Transfers of Care (DTOCs) for mental health (All ages)

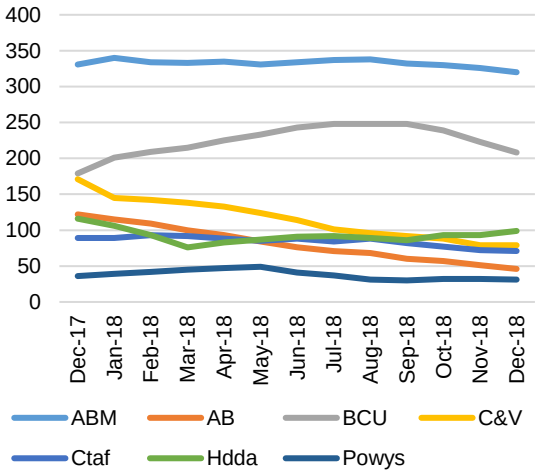


Benchmarking

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



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



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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 a delayed discharge at a Health Board site in December 2018 was 142. This was a reduction when compared with the 151 patients reported in November, but a marked increase when compared with the 86 delayed transfers of care reported in December 2017.
- The overall bed days associated with delayed transfers of care in December 2018 increased by 107% compared with December 2017, rising from 3076 bed days to 6389 bed days.

What actions are we taking?

- An agreed prioritised work programme is being implemented to deliver systematic improvement in our patient flow and discharge processes, which is being overseen by the unscheduled care delivery board. The detail of these programmes will be signed off by the February USC board. The focus of the clinically led work streams will be to:
  - Reduce variation in our patient discharge process against the SAFER patient flow bundle.
  - Improve communication, and to strengthen and streamline processes across the USC discharge pathway ensuring consistency and to reduce avoidable delays in the discharge process and maximising discharge capacity. This includes benchmarking our processes with other Health boards.
- In conjunction with Local Authority colleagues, ensuring the robust design of the Hospital to Home service to support more timely patient discharge. The development of a transformation bid to Welsh Government to support the provision of this service model during 2019/20 will be developed by March 2019.
- The Health Board's patient flow and discharge policy will be finalised following the redirection of Health Board resources to support this programme of work in February.
- Ensuring full benefit is achieved from the additional winter pressures funding allocated to increase discharge capacity in Quarter 4 of the current financial year.

What are the main areas of risk?

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

How do we compare with our peers?

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

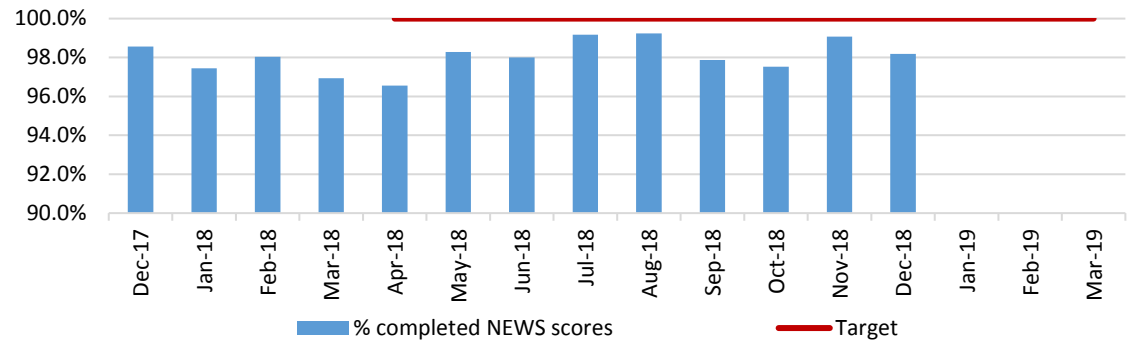
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % patients with completed NEWS score and appropriate responses actioned

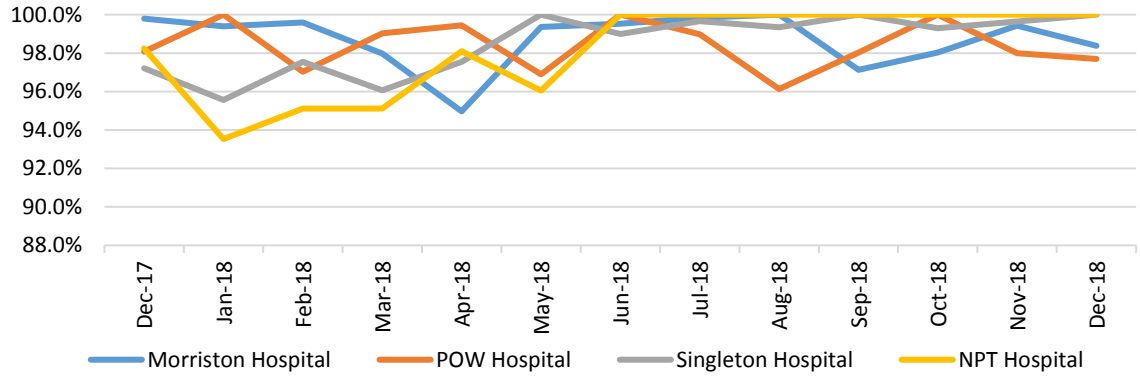
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Richard Evans Executive Medical Director	
Period: December 2018	**IMTP Profile Target:** N/A	**Local Target:** 100%	**Current Status:** ✗	**Movement:** ↑ Improving

Current Trend: Dec 17 - Dec 18

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



(1) % patients with completed NEWS score and appropriate responses actioned (By Service Delivery Unit).



Benchmarking

No Benchmarking Data Available.

Source : ABMU Care Matrix

Measure 1: % patients with completed NEWS score and appropriate responses actioned

How are we doing?

- The overall Health Board percentage of patients with a completed NEWS Score in December 2018 was 98.2% compared with 99.1% in November and 98.6% in December 2017.
- Neath Port Talbot (NPT) has sustained 100% since June 2018.
- Singleton improved from 99.7% in November to achieve 100% in December.
- Performance at both Morriston and Princess of Wales Hospital's (POWH) dropped in December 2018.

What actions are we taking?

- Delivery Unit Quality & Safety groups continue to regularly review the percentage of patients with a completed NEWS score.
- The Recognising Acute Deterioration and Resuscitation (RADAR) Group has received and considered the draft Peer Review Report and will agree an action plan that will focus on identifying a single lead for the Health Board as recommended within the report. The group has already made good progress with agreeing meaningful metrics and they continue to monitor progress on training.
- Funding for the Sepsis work at Morriston and Singleton Units has ceased. This has resulted in no Welsh Government performance data being provided since September 2018 at Morriston. Singleton were unable to provide data for the first time in January 2019. Interim deputy Medical Director to discuss the issue with key individuals and explore solutions on a Health Board-wide basis, including the potential for use of optical readers, palm devices etc.
- Work continues at NPTH with Acute Kidney injury alert stickers and will be monitored by the RADAR Group for the potential to roll out the approach.
- POWH continues to use NEWs stickers as a prompt for staff.
- No updates received from Unit Medical Directors.

What are the main areas of risk?

- Sepsis forms not currently being entered for Morriston and Singleton – funding ended.
- Timeliness of rollout given the operational pressures.

How do we compare with our peers?

- No comparable data available.

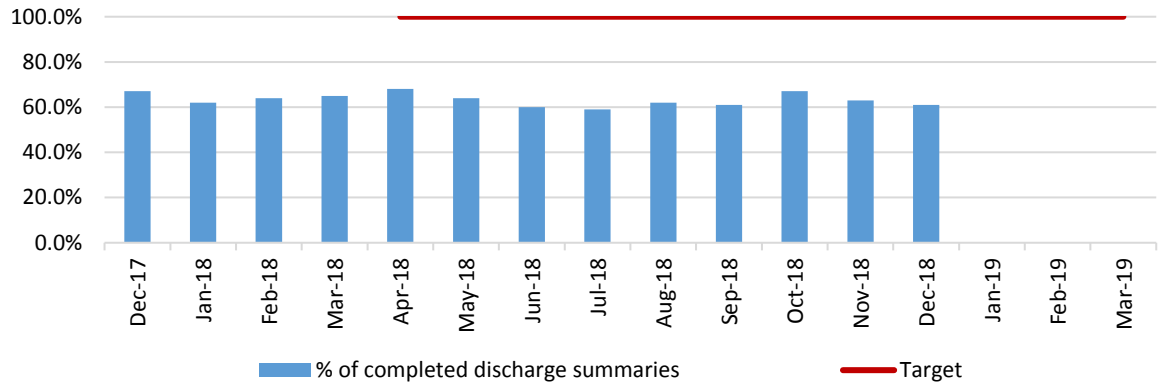
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: % of completed discharge summaries

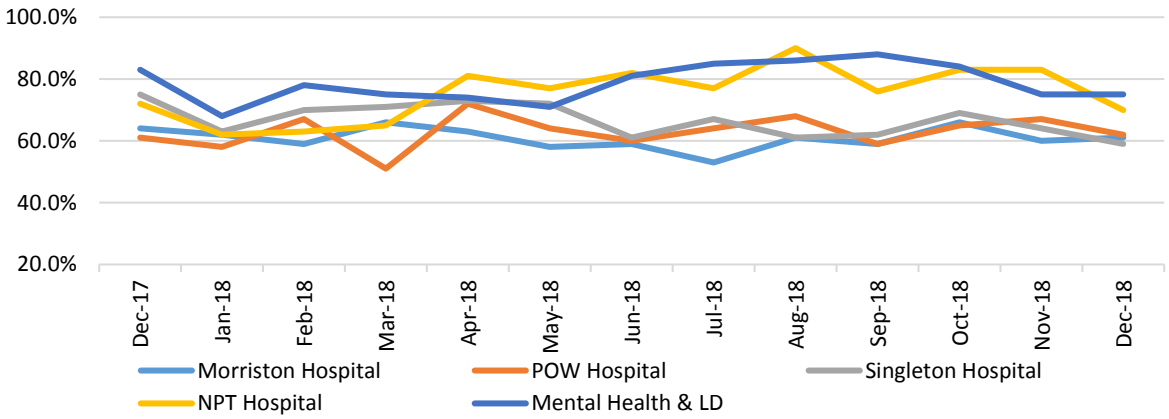
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Richard Evans Executive Medical Director	
Period : December 2018	**IMTP Profile Target:** Improve	**Local Target:** 100%	**Current Status:** ✗	**Movement:** ↓ Worsening

Current Trend: Dec 17 - Dec 18

(1) % of completed discharge summaries ABMU



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



Benchmarking

Benchmarking data not available

Source : ETOC Dashboard

Measure 1: % of completed discharge summaries

How are we doing?

- The overall Health Board performance in December 2018 was 59%
- There is considerable variation between Delivery Units (61% - 90%)
- Morriston, Neath Port Talbot (NPT) and Princess of Wales (POW) all achieved 90%
- Mental Health & Learning Disabilities (MH & LD) achieved 86%
- Singleton achieved 61%

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. CNSs' are completing eToCs to a high standard in many specialties.
- E-Discharge - this is on the Work Programme for Morriston's Clinical Cabinet and Quality & Safety Meetings. It is hoped that the MTeD functionality due to be rolled out from Welsh Clinical Portal will support E-Discharges for Medicine.
- The Executive MD and the relevant UMDs met with Trauma & Orthopeadics Leads at Morriston and POWH to emphasise the need to prioritise discharge summaries.
- Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician' 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.
- MH&LD report that they have identified areas that have not been trained in completing eTOCs and are arranging training. The areas where there is little medical cover to complete will receive training allowing ward managers to complete. The Business and Performance Manager now regularly checks compliance and chases up inpatient areas as required. Oversight of the process and action plan is provided by the UMD and Service Director.

What are the main areas of risk?

- Risk to patient care and the need for readmission.

How do we compare with our peers?

- ABMU is the only health board to publish its performance

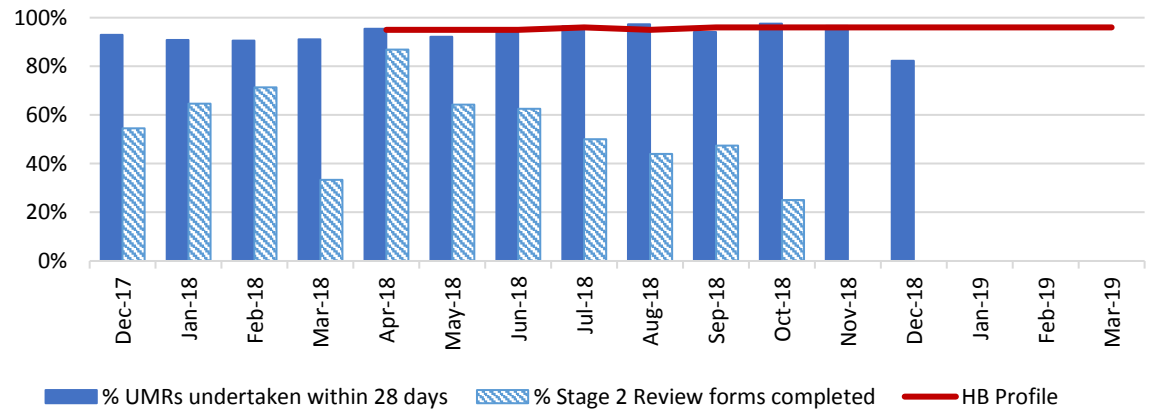
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Richard Evans Executive Medical Director	
Outcome Statement : Interventions to improve my health are based on good quality and timely research and best practice				
Period : December 2018	**IMTP Profile Target:** (1) 95%	**WG Target:** (1) 95%	**Current Status:** ✗	**Movement:** ↑ Improving

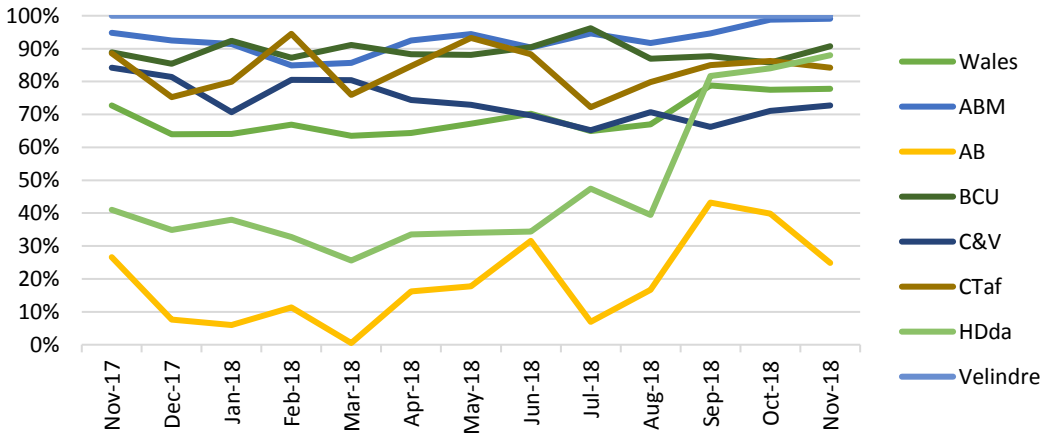
Current Trend: Dec 17 - Dec 18

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



Benchmarking

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



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

- Welsh Government Mortality Review Performance - ABMU achieved 98.8% completion of UMRs within 28 days of death in October 2018. The overall Wales compliance was 77.5%
- The Health Board UMR rate reported in December 2018 was 82%, a fall from 96% in November. Performance figures have been affected by capacity within the Clinical Audit Department, which has had to prioritise work in another area. *(Performance for December 2018 as at 23rd January 2019 is 93%).*
- Singleton and Neath Port Talbot Hospital (NPTH) maintained 100%, Princess of Wales Hospital (POWH) 77% and Morriston 91%.
- There were 33 missing UMR forms, 11 in Morriston and 22 in POWH.
- Completion of Stage 2 reviews for September 2018 deaths is currently at 47%. There are a total of 72 outstanding Stage 2 reviews accumulated from April 2018.
- Mental Health and Community data remains unavailable via the eMRA application at present. This is being addressed by Informatics.
- There have been recent reports of issues with eMRA from users which have been escalated to IT support as necessary.

What actions are we taking?

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

What are the main areas of risk?

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

How do we compare with our peers?

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

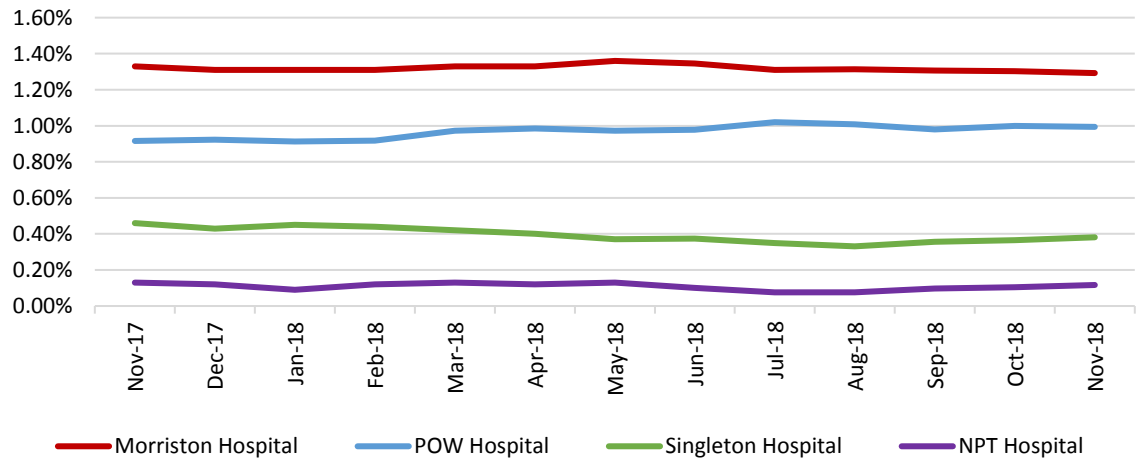
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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:** Richard Evans Executive Medical Director	
Period : November 2018	**IMTP Profile Target :**	**WG Target:** 12 month reduction trend	**Current Status:** ✕	**Movement:** ↑ ● Worsening

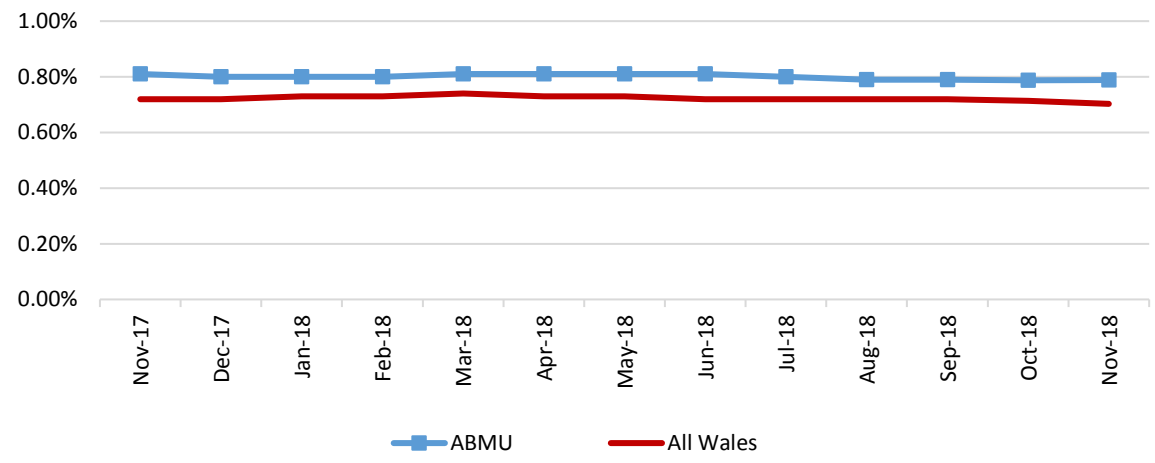
Current Trend: Nov 17 – Nov 18

(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 DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

Measure 1: Crude hospital mortality rate (less than 75 years of age)
How are we doing?
• The ABMU Crude Mortality Rate for under 75s in the 12 months to November 2018 was 0.79%, compared with 0.81% for the same period last year. • Site level performance is as follows: (previous year in brackets) Morriston 1.29% (1.33%), Princess of Wales 0.99% (0.92%), Neath Port Talbot 0.12% (0.13%), Singleton 0.38% (0.46%). Site comparison is not possible due to different service models being in place. • There were 88 in-hospital Deaths in this age group in December 2018 and 95 in December 2017: Morriston 46 (53), Princess of Wales Hospital 33 (25), Neath Port Talbot Hospital 1 (0), and Singleton 7 (16). • The number of deaths for Surgical and Elective cases remains consistently low for this age group.
What actions are we taking?
• All Unit Medical Directors have access to the Mortality Dashboard to enable them to review mortality data and mortality review performance and learning. • Reporting and assurance arrangements for mortality review performance and learning will be reviewed by the incoming Executive Medical Director.
What are the main areas of risk?
• There is a risk of harm going undetected resulting in lessons not being learned. Our approach is designed to mitigate this risk and ensure effective monitoring, learning and assurance mechanisms are in place.
How do we compare with our peers?
• ABMU are above the all-Wales Mortality rate for the 12 months to November 18 – 0.79% compared with 0.70%. • ABMU is the best Performing Health Board in respect of UMRs completed within 28 days of the patient's death

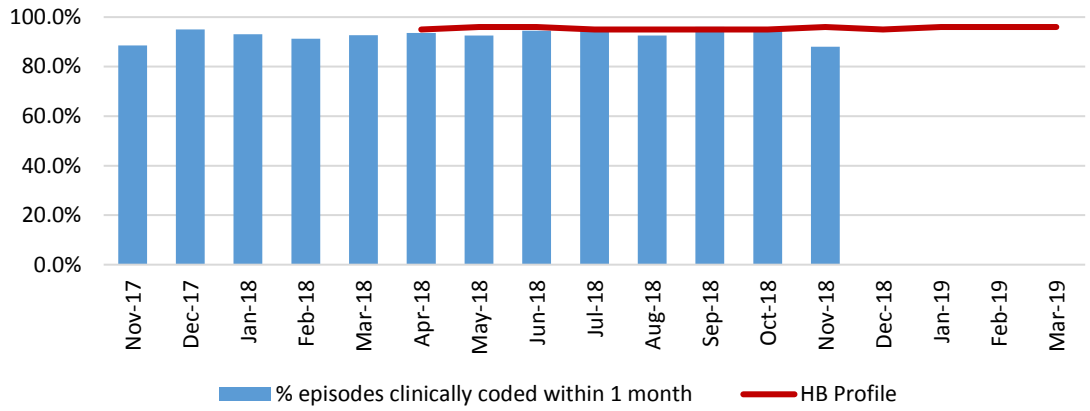
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access **Outcome Statement :** Interventions to improve my health are based on good quality and timely research and best practice			**Executive Lead:** Matt John Interim Chief Information Officer	
Period : November 2018	**IMTP Profile Target:** 95%	**WG Target:** 95%	**Current Status:** ✗	**Movement:** ↓ ● Worsening

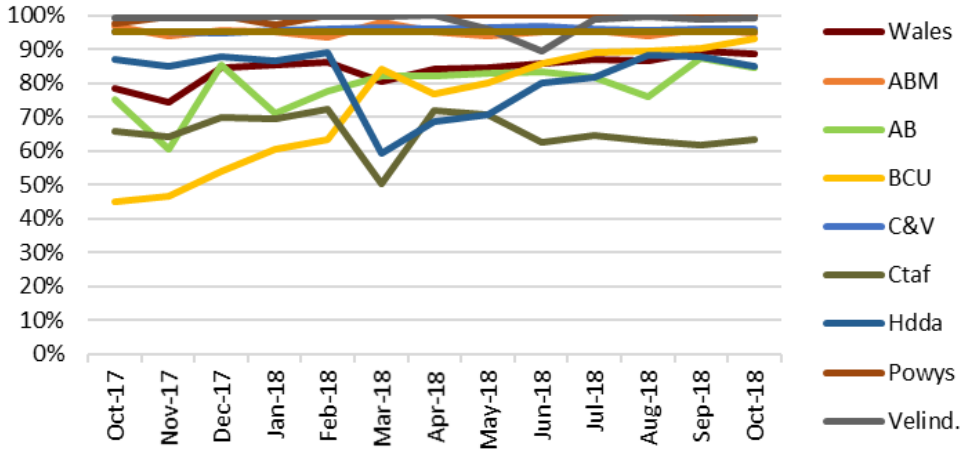
Current Trend: Nov 17 - Nov 18

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



Benchmarking

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



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

The completeness within 30 days for 2018/19 (snapshot positon) was, April 94%, May 93%, June 94%, July 95%, August 92%, September 92%, October 95%, November 88%.

The department has achieved overall cumulative coding completeness for 2018/2019 as follows: April - 98%, May 98%, June 98%, July 98%, August 97%, September 98%, and 97% for November.

The 88% completeness for November was due to multiple factors; increased sickness levels, Christmas bank holidays, increase in annual leave being taken over the Christmas period and decrease in overtime being done. Rotas are now being reviewed

The 88% completeness for November was also due to an increase in the amount of episodes generated this year which is having a knock on effect with us trying to reach target. There has been an increase of 4500 extra episodes this financial year so far compared to the last financial year.

Therefore, despite missing the 'in month' (30 day) compliance by a number of days the cumulative position is exceeding the required performance levels and is performing amongst the best in Wales. An internal renal coding accuracy audit carried out this autumn confirmed that the clinical coding team achieved above the recommended accuracy for al diagnostic and procedure fields and draft audit report containing the findings and recommendations have been received. Further coding accuracy audits are due to be completed for the stroke and obstetrics specialty across the four sites.

What actions are we taking?

- Review of roles and responsibilities in the department to ensure that processes are performing at optimum levels.
- Continued training of the 6.5 WTE permanent staff which will address the completeness in month once staff are trained and competent.
- Overtime undertaken by staff who have completed their training in specific specialties to support the experienced coder's also undertaking overtime to support the overall performance and effectiveness of the clinical coding service.
- Detailed audit and improvement plans being proactively managed.

What are the main areas of risk?

- Maintaining the productivity levels in 2018/19 whilst the trainee Coders are still training and the contract coders are no longer employed and the availability of the Health Records in a timely manner.

How do we compare with our peers?

- The indicator above is now showing performance against the new target introduced for 2016/17 - 95% complete within 30 days (shown as a snapshot). ABMU is one of the top performing Health Boards. Currently Welsh Government cannot identify the date coded field in the Admitted Patient Care (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.

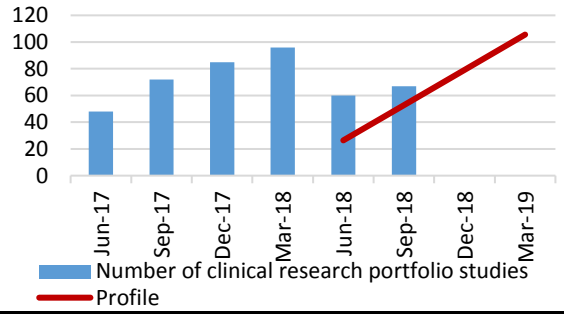
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

Measure 1: Number of Health and Care Research Wales clinical research portfolio studies.
Measure 2: Number of Health and Care Research Wales commercially sponsored studies.
Measure 3: Number of patients recruited in Health and Care Research Wales clinical research portfolio studies.
Measure 4: Number of patients recruited in Health and Care Research Wales commercially sponsored studies.

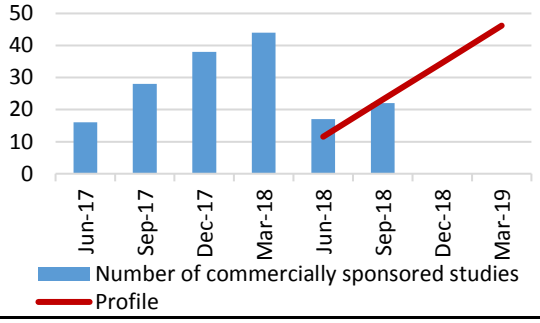
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Richard Evans Executive Medical Director	
Period : September 2018	**IMTP Profile Target :**	**WG Target:** Annual Improvement	**Current Status:** ✗	**Movement:** ↓ ● Worsening

Current Trend: Jun 17 – Sep 18

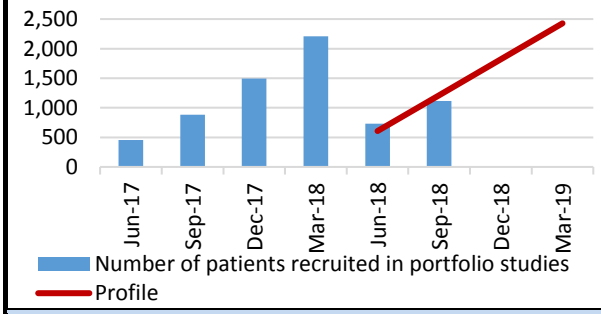
(1) Number of Health and Care Research Wales clinic al research portfolio studies



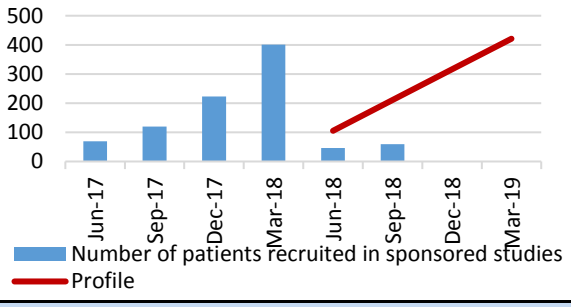
(2) Number of Health and Care Research Wales commercially sponsored studies.



(3) Number of patients recruited in Health and Care Research Wales clinical research portfolio studies.



(4) Number of patients recruited in Health and Care Research Wales commercially sponsored studies.



Benchmarking

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

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

Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

Measure 1: Number of Health and Care Research Wales clinical research portfolio studies.
Measure 2: Number of Health and Care Research Wales commercially sponsored studies.
Measure 3: Number of patients recruited in Health and Care Research Wales clinical research portfolio studies.
Measure 4: Number of patients recruited in Health and Care Research Wales commercially sponsored studies.

How are we doing?

- For measures 1 & 3, we have 73 studies open & recruiting and 1,116 patients recruited into portfolio studies – this is 68% and 45% of respective targets achieved. We need to ensure this trend is maintained during the year for the portfolio study targets to be comfortably achieved.
- For measures 2 & 4, relating to number of commercial studies and the number of patients recruited into commercially sponsored studies, we have 25 studies open and recruiting and 71 patients recruited. Therefore, we are at 54% and 16% of target achieved for measures 2 & 4 respectively.
- The impact of Brexit cannot be ignored as we have seen global pharma choosing not to be place studies in the UK due to the potential pending regulatory system differences however we will continue to use our strengths as UK preferred site and centre of excellence status (JCRF) to continue to open new commercial studies and recruit patients accordingly. The enthusiasm and time commitment of local clinicians to work with pharma will be essential to enable an upward trend.

What actions are we taking?

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

What are the main areas of risk?

- Impact of UK losing studies in globally competitive environment.
- Slow responses – time for clinicians to respond to expressions of interest and feasibility.

How do we compare with our peers?

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

10.4 Dignified Care

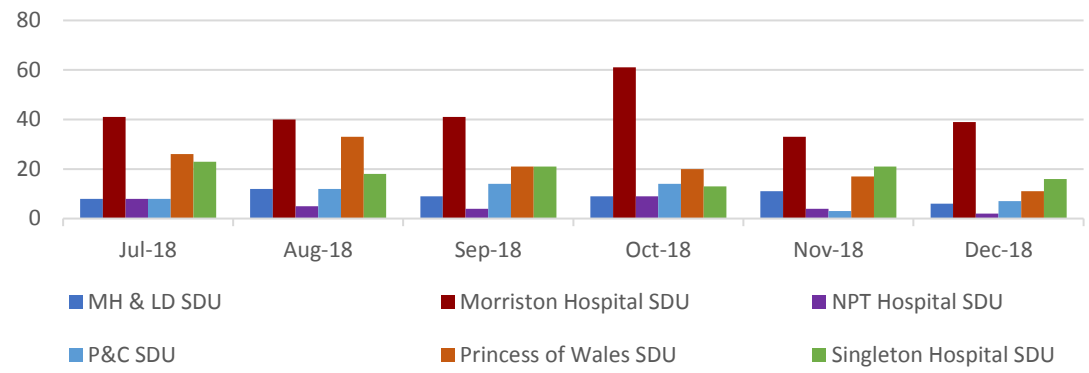
DIGNIFIED CARE: PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

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

Corporate Objective : Embedding Effective Governance and Partnerships **Outcome Statement :** My voice is heard and listened to			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period: December 2018	**IMTP Profile Target:** (1) Reduce, (2) 80%	**WG Target:** (1) Monitor, (2) 80%	**Current Status:** ✓	**Movement:** ↑ ● Improving

Current Trend: (1) July 18 – Dec 18 (2) Nov 17 – Nov 18 (3) Dec 17 – Dec 18

(1) Number of new formal complaints received.



(2) % of responses sent within 30 working days

	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
MH & LD SDU	71%	88%	60%	50%	33%	71%	100%	100%	83%	100%	100%	83%	91%
Morriston Hospital SDU	75%	88%	76%	58%	76%	93%	83%	90%	87%	84%	92%	95%	100%
NPT Hospital SDU	83%	67%	100%	100%	67%	100%	100%	100%	88%	75%	83%	44%	100%
Princess of Wales SDU	62%	64%	93%	60%	74%	75%	90%	64%	90%	88%	83%	100%	82%
P&C SDU	82%	100%	75%	88%	67%	57%	63%	63%	55%	38%	76%	79%	50%
Singleton Hospital SDU	72%	73%	75%	53%	64%	60%	65%	88%	83%	94%	63%	100%	86%
Health Board Total	73%	80%	80%	61%	71%	80%	83%	80%	81%	81%	83%	88%	90%

(3) % of acknowledgements sent within 2 working days

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

Benchmarking

Benchmarking data is not available.

Source : COMPLAINTS MODULE FROM DATIX

Measure 1: Number of new formal complaints received

Measure 2: % of responses sent within 30 working days

Measure 3: % of acknowledgements sent within 2 working days

How are we doing?

- The Health Board received 85 formal complaints in December 2018, this is a decrease of 7 formal complaints compared to 92 for December 2017.
- The overall Health Board response rate for responding to concerns within 30 working days was 90% for December 2018, which is above the Welsh Government target of 80%.
- The Health Board continues to consistently maintain the 2 day acknowledgement target at 100%.
- Patient Advice Liaison Service (PALS) activity for the period April 2018 - December 2018, identified 2626 contacts of which 1.7% (45) converted to formalised complaints.

What actions are we taking?

- Performance of the 30 day response target is addressed consistently at all Service Delivery Unit (SDU) performance reviews. December performance for the Health Board was 90%
- Service Delivery Unit's (SDU) identify trends and themes from their formal complaints for discussion at each local Quality and Safety meeting and formal reporting through the Health Boards' Assurance and Learning Group where themes, trends and Health Board actions can be identified and shared for learning. A recurring theme in complaints received continues to be communication. A training programme for communication for all staff grades continues in all SDU's by the Patient Experience Training officer, with further SDU discussions during attendance at Concerns and Redress Group (CRAG)
- Currently there are 42 open Ombudsman investigation cases; Morriston 13, Princess of Wales 10, Singleton 7, Mental Health & Learning Disabilities 3, NPT 2 and; Primary Care and Community Service 7. Recurring themes from the Ombudsman investigations are discharge process, communication, record keeping and poor complaint handling. The Corporate Concerns function has recently embarked on a re-structure. One of the aims of the re structure is to support improvement in the Units and ensure consistency across all of the SDU's in terms of the way the Health Board investigates and responds to complaints. In addition, the Health Board continues to liaise closely with the Ombudsman Improvement Officer and the Community Health Council to discuss on-going investigations. Trends and themes deriving from these interactions will be developed into training and awareness sessions to improve across the Health Board. A new 2019/2020 work plan for Ombudsman referrals has been developed which will be implemented by the newly appointed Ombudsman's Referrals Manager and overseen by the Assistant Head for Concerns Assurance. A key focus on the annual plan will be to demonstrate better learning from the process to help improve future concerns processes.

What are the main areas of risk?

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

How do we compare with our peers?

- No monthly all-Wales data to compare.

10.5 Timely Care

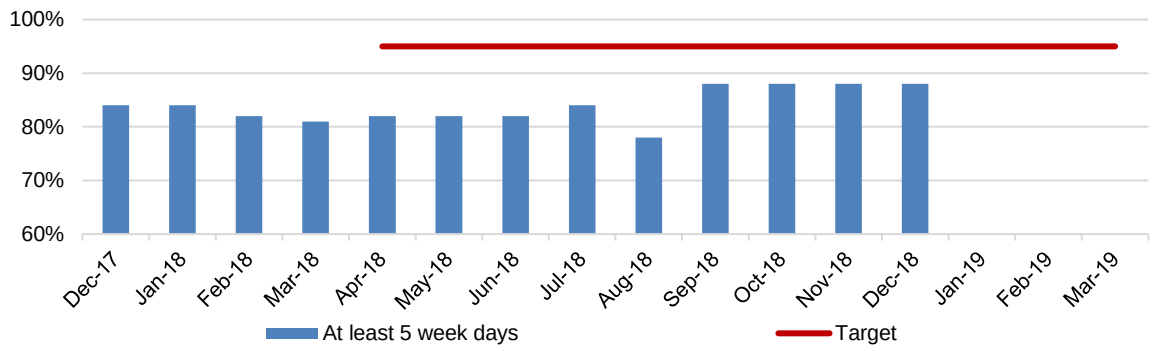
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

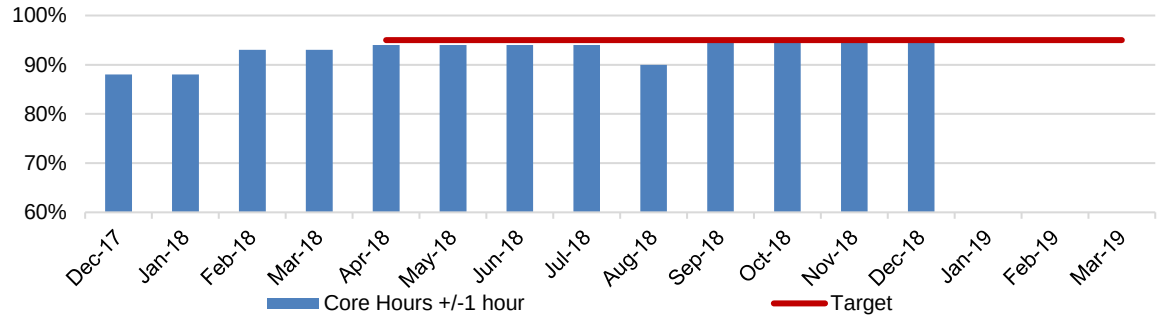
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : I have easy and timely access to primary care services				
Period: December 2018	**IMTP Profile Target:** (1) 95% (2) 95%	**WG Target:** (1) 95% (2) 95%	**Current Status:** ✗	**Movement:** ↑ Improving

Current Trend: Dec 17 - Dec 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 DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

Measure 1: % GP practices offering appointments between 17:00 & 18:30 at least 5 week days
Measure 2: % GP practices open during the daily core hours or within 1 hour of daily core hours

How are we doing?

- As at December 2018 57/65 (88%) practices are offering appointments between 17.00 and 18.30 at least 5 nights per week. This is an improved position. 62/65 (95%) practices are now open during daily core hours or within 1 hour of daily core hours. This now meets the Welsh Government target and is an improved position.

What actions are we taking?

- To inform the unit's access and sustainability forum in March of the improved access position. Continue to monitor improvement in meeting standards/targets in line with the agreed access action plan on a bi monthly basis.
- Continue to support and be provided with assurance of reasonable access to more sustainable General Medical Services, through the use of the discretionary framework to merge and monitoring sustainability scores on a bi monthly basis.
- Formally writing to the practices still not meeting the level 1 standards as agreed with the local medical committee. Discussing with practices as part of the GMS governance arrangements.
- Continue to support clusters to discuss access and sustainability as part of their cluster development plans. This will focus on beginning to introduce the new model of primary care and promote a range of wellbeing services.
- Devising and implementing a telephone first self-assessment tool.

What are the main areas of risk?

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

How do we compare with our peers?

- The Access returns were submitted to Welsh Government across Wales in January 2019. The statistical bulletin will provide an updated all Wales picture to benchmark against.

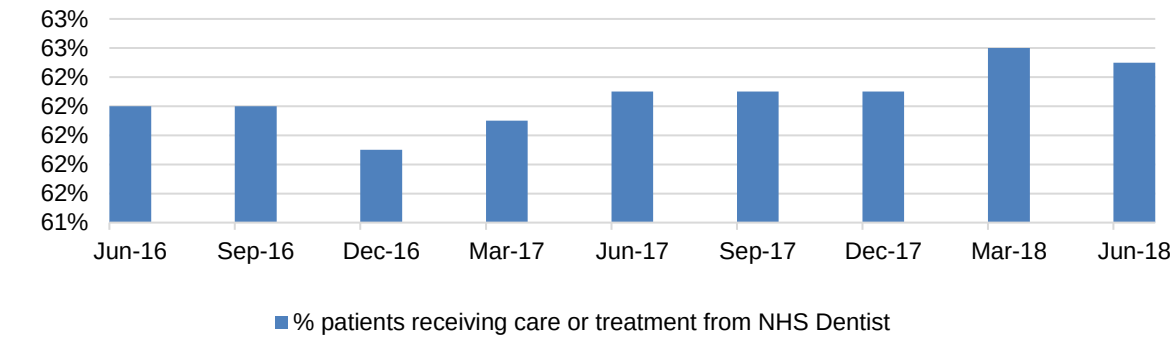
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

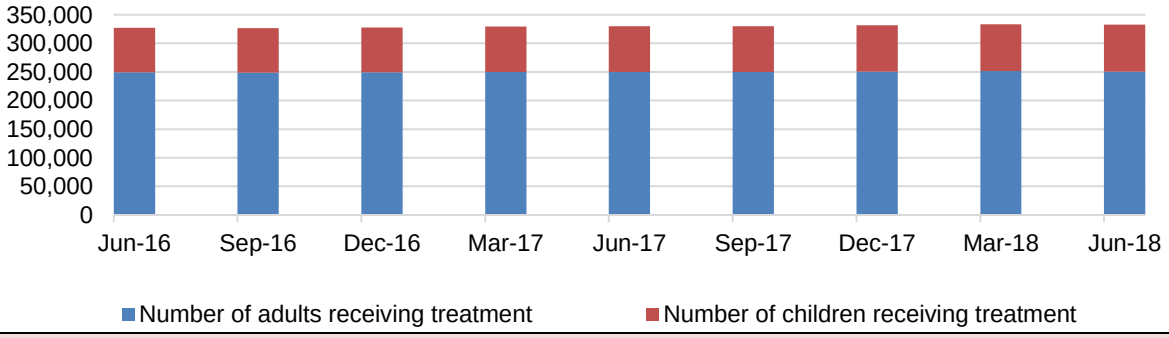
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : I have easy and timely access to primary care services				
Period : June 2018	**IMTP Profile Target:** N/A	**WG Target:** Improve	**Current Status:** ✓	**Movement:** ↑ Improving

Current Trend: Jun 16 – Jun 18

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



Number of Patients receiving NHS treatment



Benchmarking

LHB	Current	Same Period Comparison		
	Jun-18	Jun-17	Jun-16	Jun-15
Wales	55.0%	⇧ 54.9%	⇧ 54.8%	⇧ 54.8%
ABM	62.5%	⇧ 62.3%	⇧ 62.2%	⇧ 62.5%
AB	57.5%	⇧ 57.0%	⇧ 56.9%	⇧ 56.5%
BCU	49.3%	⇩ 49.6%	⇩ 50.0%	⇩ 50.3%
C&V	55.9%	⇩ 56.2%	⇩ 55.9%	⇧ 55.3%
CTaf	59.9%	⇧ 58.3%	⇧ 57.3%	⇧ 57.2%
HDda	45.5%	⇩ 46.0%	⇩ 45.9%	⇧ 45.4%
Powys	56.6%	⇩ 57.3%	⇩ 58.7%	⇩ 60.3%

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

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

How are we doing?

- NHSBSA June 2018 data above confirms a steady (+) 0.2% increase in the total number of patients (adults and children) who received NHS dental treatment in ABMU in comparison to 2017 data.
- Demand on the urgent dental care services continued to remain high in 2018: usage of dental OOH increased by +3% in Apr.-June 2018 compared to 2017/ significant rise [+5.9%] in usage of In Hours Urgent Access 2018, however additional sessions commissioned to meet constant demand for urgent care. NB this figure includes repeat visits by patients who choose to access dental care through this service rather than access routine dentistry.
- Previous reports advised that a new dental contract for 12,500 UDAs (£300,000) has been commissioned in the Sandfields area of Port Talbot, an area of high deprivation and need. The practice was due to open in December 2018 but issues with a restricted covenant on the building (by Local Authority), delayed the opening. It's anticipated the practice will open 1 March 19 and provide a significant increase to NHS dental care within the area. The HB and practice will develop a patient base for opening and the practice will automatically join the GDS reform programme.
- As part of the General Dental Practitioner (GDP) Fellowship scheme commenced in October 2018: the practice will provide enhanced access sessions which will focus on offering full courses of treatment to patients accessing urgent care to prevent continual usage of urgent care service. Figures will follow pending review.
- Paediatric GA Pathway continued to reduce number of children receiving GA for dental treatment, historically 100% of patients referred into service received GA: since introduction of new pathway in June 2017: June-Dec 2017- only 43% of referrals received GA compared to 54% in June-Dec 2018.
- 10% of ABM practices on National GDS Reform Programme meeting WG guidance target.

What actions are we taking?

- Supporting new practice to open by March '19, - agreed funds released to support refurbishment. Regular meetings in place to review progress.
- Signposting/encouraging patients to use mainstream dental service rather than making unnecessary use of the urgent care services to ensure the latter can focus on those who need it
- Providing additional in-hours access sessions through the Educational Supervisors at the Dental Teaching Unit, maintaining clinical skills and increasing access to NHS dental care. Exploring possibilities to extend services at DTU utilising skills of ES trainers i.e. sedation/complex extractions.
- Paediatric GA pathway rolled out in January 2018 to include urgent referrals, anticipated further reduction in GAs provided. 3 month review due April '19.
- Successfully supported 5/9 contract reform bids awarded additional WG funds to support skill mix in dental practice (170k). Further roll out of programme due April 19 to meet WG target of 20%.
- Monitoring compliance against the quality indicators with those practices (43) who received a performance based UDA uplift: the scheme should secure improved access over a 2-year period.
- Review of GDS/CDS domiciliary services completed (Dec'19). New integrated model/service spec being developed for housebound patients to receive timely access to oral health care treatment.
- New pathway being developed to ensure Syrian refuges have timely access to routine and urgent care. Service to be in place by March '19.
- HMP Swansea- 3 monthly review of service – 7% increase in banded treatment provided in Q3 compared with Q2.
- Monitoring continues against quality indicators associated with UDA uplift provided to 43 GDS contractors: i.e. 100% practices submitting claims electronically/93% improvement on referral info to HDS/RMC/71% compliant with QI on opening times/only 32% applied to join GDS reform programme

What are the main areas of risk?

- Continued delays in the new practice opening in Port Talbot.

How do we compare with our peers?

- ABM Health Board continues to maintain its positon as provider to the highest percentage of patients receiving dental care compared to all other HB's and is significantly higher than the Welsh average.
- Only HB to successfully implement new service pathway to manage and reduce % of paediatric dental GA provided.
- ABM early adopter of national dental e-referral system which will improve quality/processing of GDP referrals/collation of referral data /waiting times/outcomes

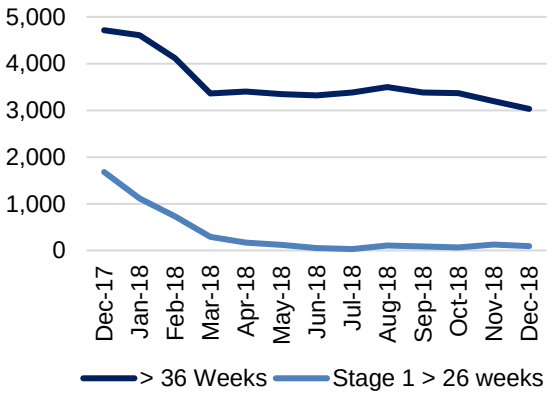
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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)

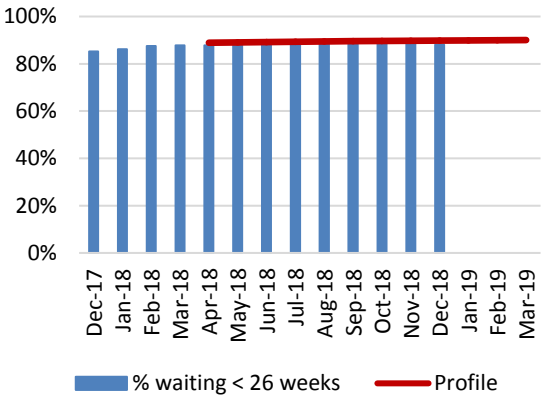
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period: December 2018	**IMTP Profile Target:** (1) 3,045 (2) 0 (3) 89.8	**WG Target:** (1) 0 (2) 0 (3) 95%	**Current Status:** ✗	**Movement:** ↓ ● Improving

Current Trend: Dec 17 - Dec 18

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

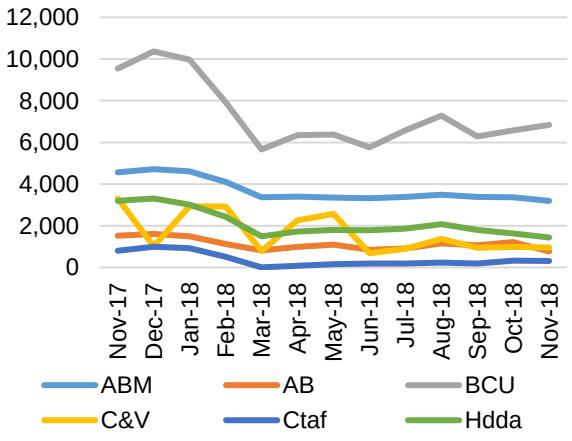


(2) % patients waiting less than 26 weeks for referral to treatment (RTT)

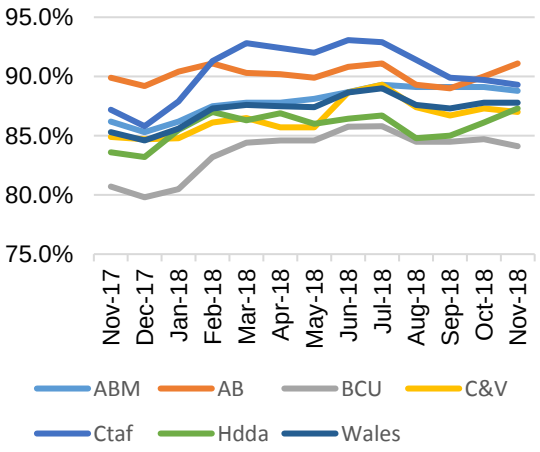


Benchmarking

(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 : StatsWales (data extracted 01.02.2019)

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

How are we doing?

- In December 2018 there are 94 patients waiting over 26 weeks for a new outpatient appointment. This was an in-month reduction of 31 compared with November 2018 (125 to 94) and is mainly contained within Urology (45%) and Oral Maxillo Facial Surgery (41%).
- There are 3,030 patients waiting over 36 weeks for treatment in December 2018 compared with 4,716 in December 2017, this is an improvement of 1,686 and the best position since June 2014. The Health Board achieved and bettered its target of 3,043. There was also an in-month reduction of 163 compared with November 2018. ENT, General Surgery, Plastic Surgery and Orthopaedics collectively account for 2,828 of the 3,030 over 36 weeks at December 2018. 99% of the patients waiting over 36 weeks are in the treatment stage of their pathway.
- 1,399 patients are waiting over 52 weeks in December 2018 which is 28% less than in December 2017 and 1% less patients than November 2018.
- The overall Health Board RTT target remained stable in December 2018 at 88.0%.

What actions are we taking?

Following achievement of the 36 week target at the end of December the focus at the Executive led weekly RTT meetings is now on Quarter 4 delivery. In addition to the solutions identified within Unit plans to deliver the end of March 2019 position, a range of additional actions to maintain continued improvement have been agreed and are being implemented. A high level summary of these include:-

- Enhanced outsourcing programme of 821 cases across the range of specialties under pressure. Capacity has been secured and being utilised with four Providers
- List established at NPTH for joints, reviewing potential to increase
- Focus on clearance of the diagnostic and follow up stages in the pathway, targeting middle grade doctors to undertake this work
- Targeted administrative and clinical validation in Orthopaedics and General Surgery
- Dedicated sessions in ENT for retired and returning Consultant
- Principle of a time-limited enhanced remuneration system for Orthopaedic theatre nursing staff to enable additional working outside core hours agreed. Further paper to Executive Team with implementation approach due in January
- Flexibility to undertake a recruitment programme for 10 theatre staff nurses to strengthen cover for core lists and support un-commissioned lists at Singleton agreed
- Target all opportunity to displace non-cohort patients to maximise capacity for cohort patients

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 November 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) (88.8% compared with 87.8%) however, was the second worst Health Board in Wales for the number of patients waiting over 36 weeks.

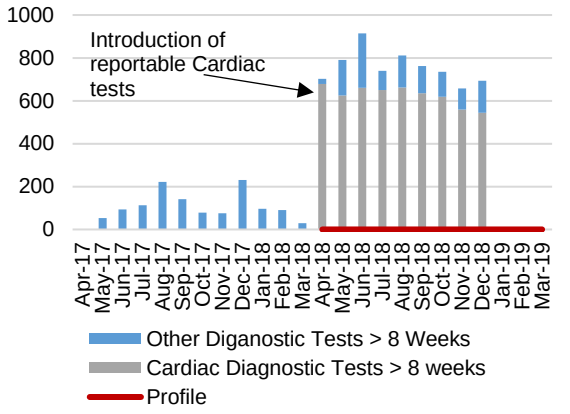
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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)

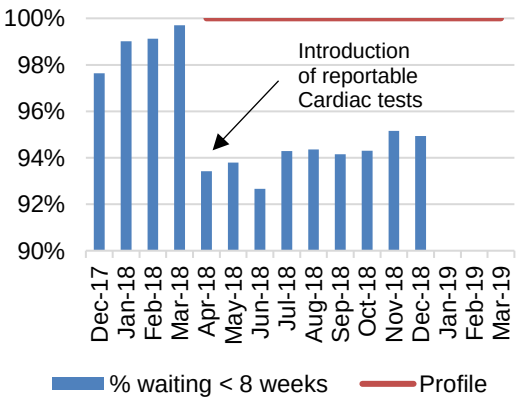
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : December 2018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

Current Trend: Dec 17 - Dec 18

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

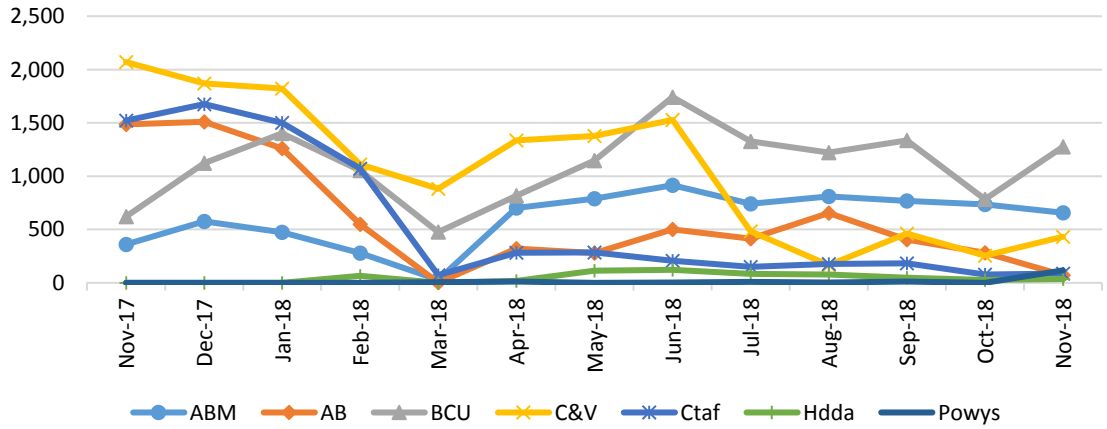


Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy



Benchmarking

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



Source : StatsWales (extracted data 01.02.2019)

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

How are we doing?

- There were 693 patients waiting over 8 weeks for reportable diagnostics as at the end of December 2018. 82 breaches are for Non-Obstetric Ultrasounds (NOUS), 61 breaches are for MRIs and 6 breaches for Cystoscopy in Princess of Wales Hospital. The remaining 635 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:
  - Diagnostic Angiography = 12
  - Cardiac Magnetic Resonance Imaging (Cardiac MRI)= 203
  - Cardiac Computed Tomography (Cardiac CT)= 329
- All other diagnostic areas maintained a zero breach position in March 2018.

What actions are we taking?

- The 82 NOUS patients at the end of December was an improved position on the last six months and continues to recover. The sub-specialty Consultant has returned from planned sick leave and is back to full scanning capacity. A locum Consultant has been supporting additional lists over weekend working in addition to small cohort of outsourced cases. It is anticipated that the breach position will recover to Nil in February and maintain the position through to March.
- Due to equipment failure, MRI encountered 61 breaches in December. Additional lists have been secured and Sunday operating is being scoped in addition to the utilisation of the mobile MRI unit based at Morriston. It is anticipated that the breach position will recover to Nil in February and maintain the position through to March.
- There is an ongoing cohort of Cystoscopy breaches in Princess of Wales as a result of significant sickness absenteeism amongst the small consultant body. A Locum Consultant is in place however planned leave impacted on the position in December. Two extra cases are being booked per list to increase throughput. It is anticipated that the breach position will recover to Nil in February and maintain the position through to March.
- The plan for increasing Cardiac CT and MRI capacity has been agreed and implemented. Small improvement is being seen although further testing of the plan will take place at the weekly RTT meetings to drive this further.

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 November 2018, which is the latest published data available at the time of writing this report, ABMU was the second worst performing Health Board.

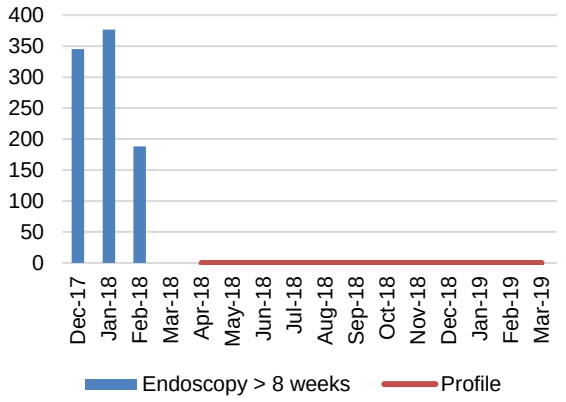
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

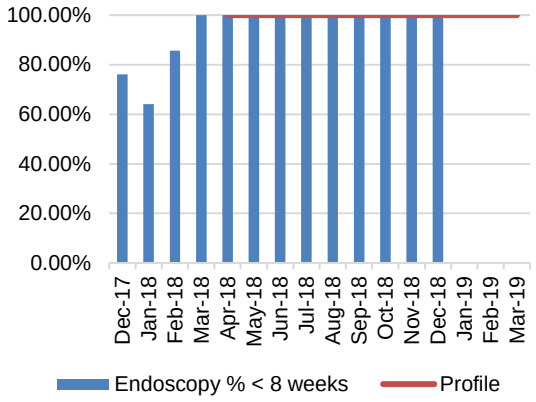
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access				**Executive Lead:** Chris White Chief Operating Officer
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : December 2018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

Current Trend: Dec 17 - Dec 18

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

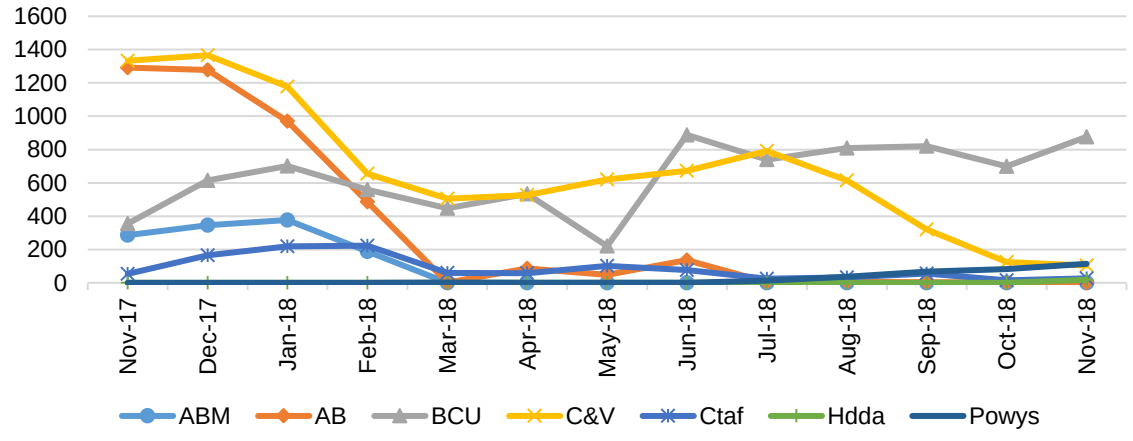


(2) % patients waiting less than 8 weeks for Endoscopy



Benchmarking

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



Source: StatsWales (extracted data 01.02.2019)

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

How are we doing?

- ABMU Health Board has achieved zero position for patients waiting over 8 weeks for endoscopy as of the end of December 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 the end of March 2019.
- 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 confirmed until the end of March 2019 from Medinet to maintain the zero position.
- Development of alternative diagnostic pathway in partnership with Radiology (CT colonography)
- 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?

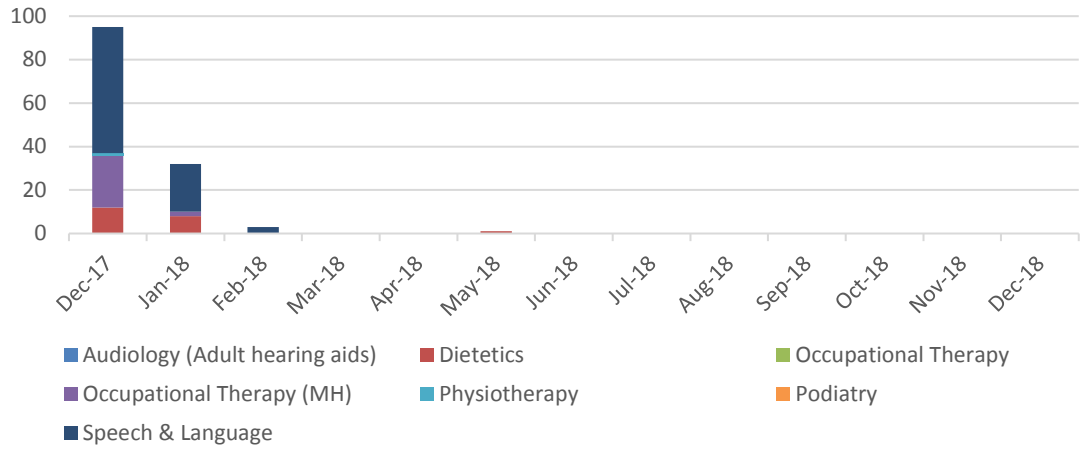
- Routine activity being displaced by cancer, urgent and RTT patients with significant pressures in Gastroenterology and an increase in USC referrals.
- Ability to maintain the number of additional sessions undertaken with a very small group of Endoscopists.

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 HBs.

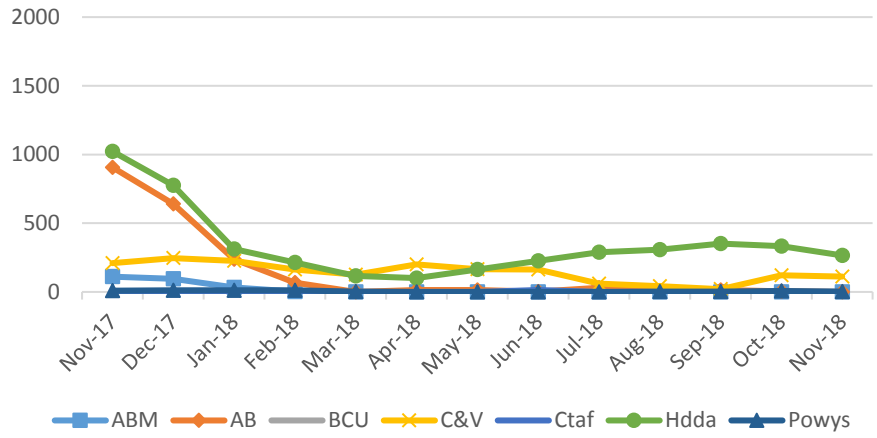
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE				
Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & 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 : December 2018	**IMTP Profile Target:** (1) 0	**WG Target:** (1) 0	**Current Status:** ✓	**Movement:** ↓ Improving
Current Trend: Dec 17 - Dec 18				

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



Benchmarking

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



	Nov-18
ABM	0
AB	0
BCU	0
C&V	112
Ctaf	0
Hdda	265
Powys	3

Source: StatsWales (extracted data 01.02.2019)

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

How are we doing?

- Waiting times targets achieved a nil position at the end of March 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 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

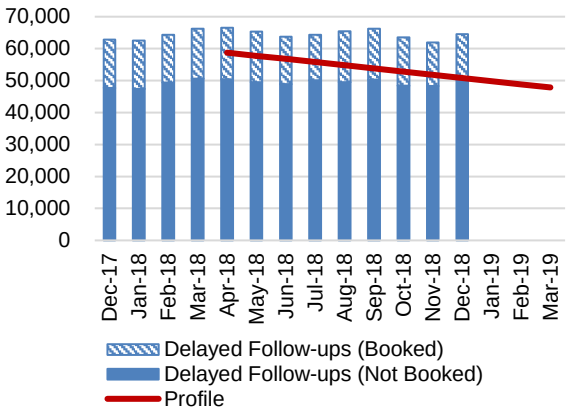
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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)

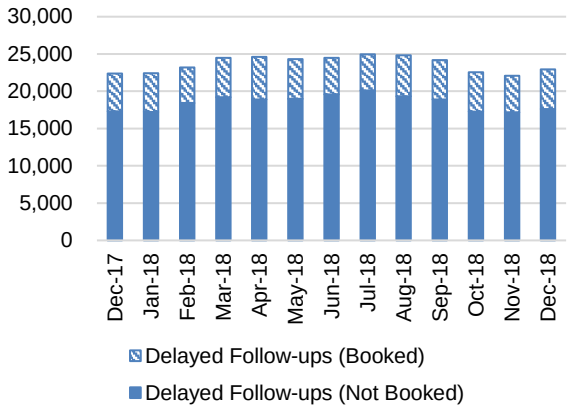
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : December 2018	**IMTP Profile Target:** (1) 50,832	**WG Target:** Reduction	**Current Status:** ✗	**Movement:** ↓ Improving

Current Trend: Dec 17 - Dec 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

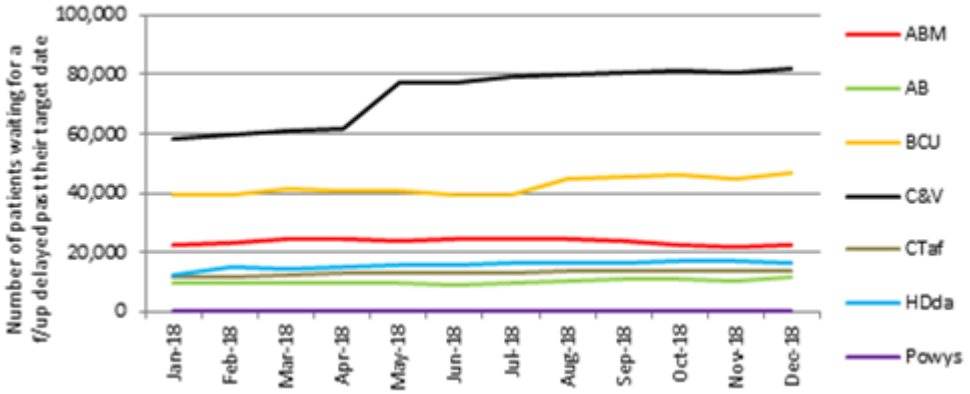


(2) Number of patients waiting for an outpatient follow-up (booked & not booked) who are delayed past their agreed target date for planned care specialties



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 WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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 non-booked) has increased from 62,797 (Dec 2017) to 64,535 (Dec 2018).
- Delayed Follow Up (Not Booked): In-month performance has deteriorated with an increase in the number of not booked patients waiting for a follow up appointment delayed past their target date from 48,303 to 50,279. There has been a further increase in delayed follow up not booked when compared with the same period 12 months ago (47,710 to 50,279).
- Delayed Follow Up (Booked): In-month performance has slightly deteriorated with an increase in the number of booked patients waiting for a follow up appointment delayed past their target date from 13,586 to 14,256. There has been small reduction in the number of delayed follow ups booked with the same period 12 months ago (15,087 to 14,256).
- In Dec 2018 the Health Board continues to be above trajectory / IMTP profile.

What actions are we taking?

- Each Delivery Unit has developed a quarterly plan to address their Delayed Follow up Not Booked / Delayed Follow up Booked position as per the planned trajectory identified above. These plans are overseen by the Outpatient Improvement Group which in turn reports to the Planned Care Supporting Delivery Board. Each Plan has a Managerial lead for each delivery unit and who will regularly monitored through local delivery mechanisms and the Outpatient Improvement Group.
- Updated quarterly action plans have been received from all Delivery Units.
- Additional funding is being released to support short term validation reviews of the FunB lists – these are being led by the managerial delivery unit lead. Each Unit outpatient lead will have been allocated some funds during quarter 4 to address validation issues and to reduce erroneous / update current entries by approx. 6,000 entries by the end of March 19.
- An SBAR for medium to long term sustainability solution to this reduction has been completed and submitted to the IBG for investment consideration. It is expected that this will be considered by the IBG at its meeting in January 2019.
- A Status report has been considered at the November Finance and Performance Committee.
- Internal Audit have completed their review of progress against the WAO recommendations. Their report has been received – an action plan has been agreed and is being implemented through delivery unit action plans.
- The National Outpatient Modernisation Working Group has been refreshed and actively taking forward new measures to address these pressures which are being seen across Wales. Actions include improved coding, clarification of virtual clinic patients, shared learning, and stronger information reporting by specialty – actions arising from this group will be taken forward through the HB's Outpatient Modernisation group during 19 / 20. The aim being to reduce all delayed follow up patients waiting 100%+ beyond their target date.
- A "Gold Command" group has been established under the joint Chairmanship of Dr Alastair Roeves and Christine Morrell to address concerns within the Ophthalmology Service. The group will be making recommendations in February to address issues.

What are the main areas of risk?

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

How do we compare with our peers?

- All Health Boards have experienced a deteriorating position in the number of patients waiting for an outpatient follow up (booked and not booked) who are delayed past their target date for planned care specialties from December 2017 to December 2018.

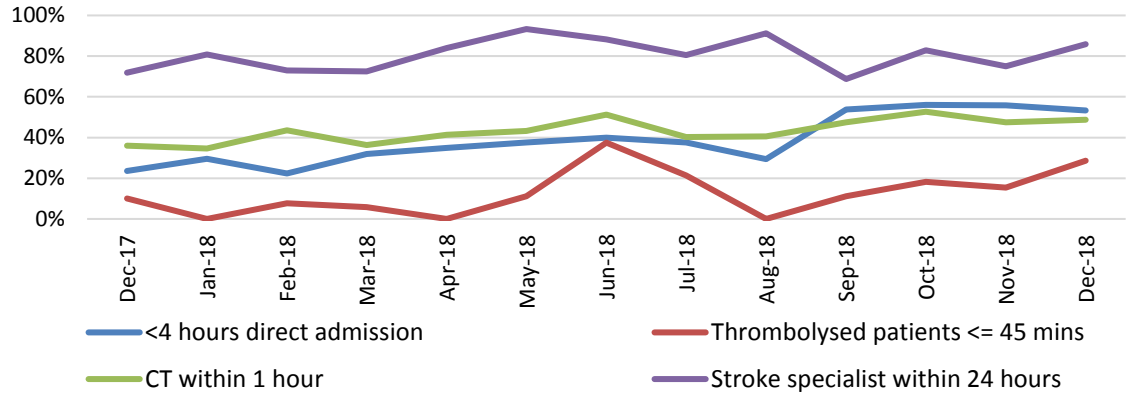
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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: December 2018	**IMTP Profile Target:** (1)50% (2)35% (3)45% (4)80%	**WG Target:** 95%	**Current Status:** ✗	**Movement:** ↑ ● Improving

Current Trend: Dec 17 - Dec 18

Acute Stroke Quality Improvement Measures



Benchmarking

Thrombolysis Quality Improvement Measures (Dec-18)	AB	ABM	BCU	C&V	Cwm Taf	Hywel Dda
1a - Percentage of All Strokes Thrombolsyed - H16.3	10.3%	17.9%	8.9%	22.6%	16.0%	19.6%
2b - Percentage of Eligible Patients Thrombolsyed - H16.55	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%
1a - Thrombolysed Patients with Door-to-Needle <= 30 mins	0.0%	0.0%	0.0%	8.3%	0.0%	9.1%
2b - Thrombolysed Patients with Door-to-Needle <= 45 mins	28.6%	28.6%	25.0%	16.7%	12.5%	36.4%
3c - Thrombolysed Patients with Onset to-Needle <= 90 mins	14.3%	7.1%	0.0%	16.7%	0.0%	18.2%
4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score	100.0%	92.9%	100.0%	91.7%	100.0%	100.0%
72 Hour Pathway Quality Improvement Measures (Dec-18)	**AB**	**ABM**	**BCU**	**C&V**	**Cwm Taf**	**Hywel Dda**
1. < 4 Hours Care Performance Indicator	38.2%	52.6%	38.9%	56.6%	46.0%	67.9%
1a - Direct Admission to Acute Stroke Unit - H7.18	39.7%	53.2%	40.0%	64.6%	44.9%	59.5%
2. < 12 Hours Care Performance Indicator	97.1%	97.4%	96.7%	98.1%	100.0%	96.4%
2a - CT Scan - H6.12	97.1%	97.4%	96.7%	98.1%	100.0%	96.4%
3. < 24 Hours Care Performance Indicator	80.9%	80.8%	71.1%	77.4%	60.0%	71.4%
3a - Assessed by Stroke Consultant - H9.3	98.5%	85.9%	72.2%	83.0%	62.0%	87.5%
3b - Assessed by Stroke Nurse - H8.3	98.5%	94.9%	96.7%	92.5%	86.0%	92.9%
3c - Assessed by One of OT, PT, SALT	82.4%	94.9%	94.4%	90.6%	62.0%	83.9%
4. < 72 Hours Care Performance Indicators	97.1%	93.6%	94.4%	94.3%	88.0%	91.1%
4a - Formal Swallow Assessment - H15.24	100.0%	92.0%	97.0%	100.0%	83.3%	100.0%
4b - OT Assessment - H10.24	98.4%	96.9%	96.2%	95.7%	87.2%	95.7%
4d - SALT Communication Assessment - H12.24	100.0%	97.0%	98.8%	100.0%	87.5%	96.2%
5. < 1 Hour Care Performance Indicator	52.9%	48.7%	35.6%	67.9%	60.0%	78.6%
5a - CT Scan	52.9%	48.7%	35.6%	67.9%	60.0%	78.6%

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

Source : ALL WALES PERFORMANCE SUMMARY (JANUARY 2019) + 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 within 24 hours

How are we doing?

- Over the last 4 weeks – Eligible Patients requiring Thrombolysis has remained positive. Direct admissions to a stroke unit bed within 4 hours continues to be under target on both sites - Morriston with 67.4% - POW to 41% which is mainly due to unscheduled care pressures on these stroke beds. Assessment by a Consultant has improved with 93.2% in Morriston, and 72% in POW. CT scanning within 12 hours improved to 100% in both Morriston and POW sites – however our access to CT scanning within 1 hour remains low at 47.5% overall.
- Additional Medical appointments have taken up post during August and September – although there remain gaps in overall out of hours cover which has impacted on our ability to make the desired improvements.

What actions are we taking?

- Weekly multi-disciplinary meetings are held in Morriston and Princess of Wales hospitals and led by the Clinical leads for the service to review individual patient pathways and to identify opportunities for improvement. Actions being progressed in Quarter 4 include:

Morriston • The additional medical staffing reported previously has allowed some improvement to service but it cannot be sustained as there are gaps at lower grades which these colleagues have to cover, therefore not allowing them sufficient time to commit to improved stroke performance. The units continue to look to cover the junior gaps in rota and look to sustainable recruitment in a difficult to recruit area. This work is ongoing and led by the Medical Directorate management team.

- Business cases for a Stroke Retrieval team and an Early Supported Discharge team have been included for consideration within the IMTP / IBG for investment. Investment decisions will be made by the Executive team by the end of Q4 / start of Q1.
- A meeting with the Radiology Consultant team and Medical Team is planned for early February to address the access to 1 hour scanning time – with a view to change the current arrangements. Remedial action to be implemented as soon as possible thereafter and ideally before the end of Q4.

Princess of Wales • The five Task and Finish groups continue to undertake actions to improve their performance with a reporting improvements in Q1 of 19 / 20.

- Clerking procedures in ED have changed with patient transfers now not being delayed because of clerking arrangements – where necessary clerking is undertaking on the ward and the patient transferred in a more timely fashion. Performance in accessing a Stroke bed should therefore improve and not delayed because they were awaiting a clerking in procedure to be completed in ED.
- The Unit is developing a case for an early Supported Discharge service as part of their IMTP with Cwm Taf HB – a decision on investment will be made in Q1 of 19 / 20.

ABMU wide • 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. A Business Case to be completed by Q1 of 19 / 20.

- The all-Wales Thrombolysis Review has been completed by the Delivery Unit and a full report is anticipated in February.
- A review of TIA service arrangements is planned over the next quarter to address availability/cover arrangements in Neath Port Talbot hospital. Service Directors from NPT and Morriston are leading this work with support from their management and clinical teams – with a view to recommend a way forward by the end of Q4.

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. The Health Board thrombolysis rates for eligible patients were amongst the highest, Access to specialist assessment within 24 hours compares well with the majority of HB's. CT scanning time within 1 hour is improving but requires further work to match the best performing HB's.

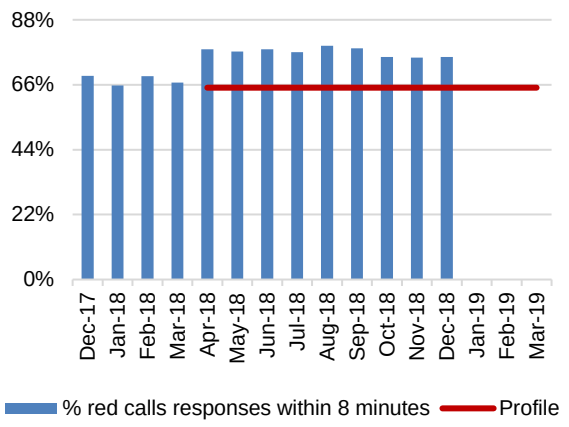
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % 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

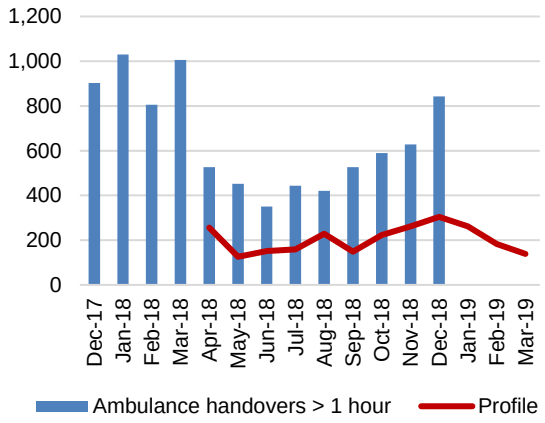
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : December 2018	**IMTP Profile Target:** (1) 65% (2)304	**WG Target:** (1)65% (2) 0	**Current Status :** ✗	**Movement:** ↓ ● Worsening

Current Trend: Dec 17 - Dec 18

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

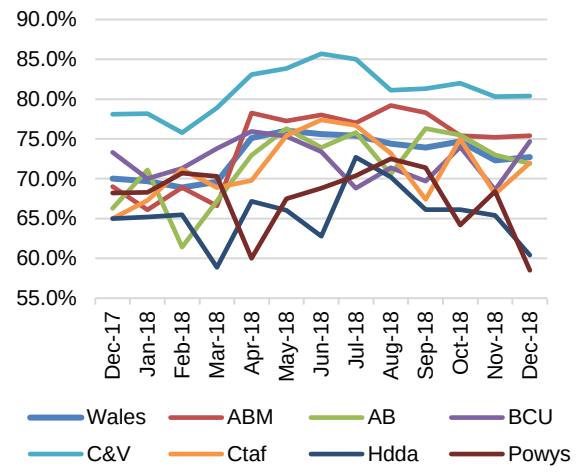


(2) Number of patients waiting more than 1 hour for an ambulance handover

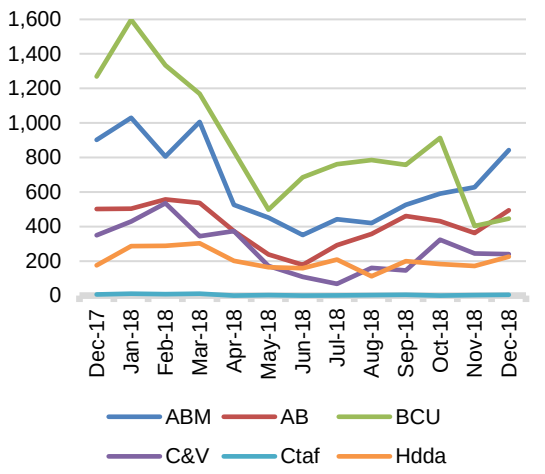


Benchmarking

(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 (January 2019)

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

How are we doing?

- The Health Board's Category A (Red response) was 75.4% in December 2018, which exceeded the National shared target of 65%. When compared with December 2017, whilst red call conveyances increased by 10%, performance against this measure improved by 6.4%.
- 1 hour ambulance handover performance has deteriorated during Quarter 3 with an increase in the number of reported delays from 541 patients in September to 855 in December. When compared with December 2017 however the number of handover delays reduced by 58 (6%)
- 96 fewer patients (a 2.7% reduction) were conveyed to our hospital front doors by ambulance in December 2018 when compared with December 2017. This is a reflection of the 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 is working closely with WAST to ensure that patients are directed to the most appropriate service or pathway of care that best meets their needs, and as a result the number of patients conveyed to hospital by ambulance is reducing (2.7% fewer conveyances in December 2018 compared with 2017).
- Implementation of the management recommendations provided in response to the WAST internal audit report on hospital handover. A progress update has been provided to the Audit Committee in January 2019 and the majority of recommendations applicable to ABMU HB have been implemented in line with the agreed plan.
- The Health Board has jointly funded a patient liaison role with WAST to support hospital handover at Morriston and Princess of Wales hospitals at periods of high demand over the winter months.
- A falls response service has been commissioned by WAST over the winter months to improve response times for this group of patients who are predominantly elderly and to reduce the number of patients who need to be conveyed to hospital as a result of the intervention of this service.

What are the main areas of risk?

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

How do we compare with our peers?

- The Health Board delivered the 2nd highest Category A response time performance in Wales in December, achieving 75.4% against the all-Wales performance of 72.7%.
- The Health Board continues to experience a higher number of delayed handover than the majority of other Health Boards in Wales.

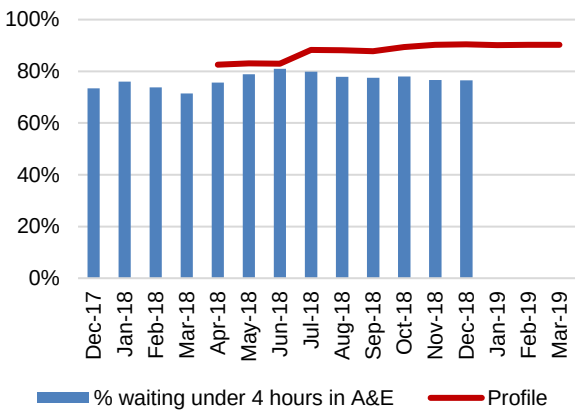
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % 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

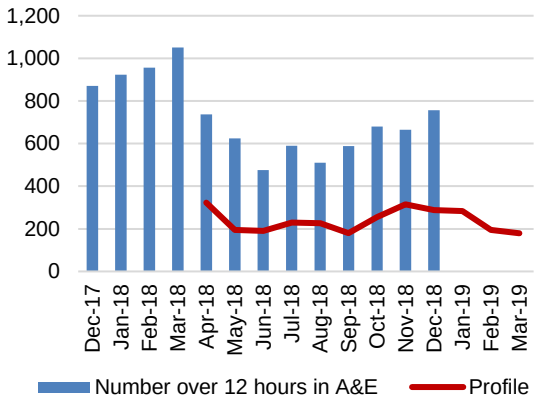
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period: December 2018	**IMTP Profile Target:** (1) 90.4% (2) 288	**WG Target:** (1) 95% (2) 0	**Current Status:** ✗	**Movement:** → Stable

Current Trend: Dec 17- Dec 18

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

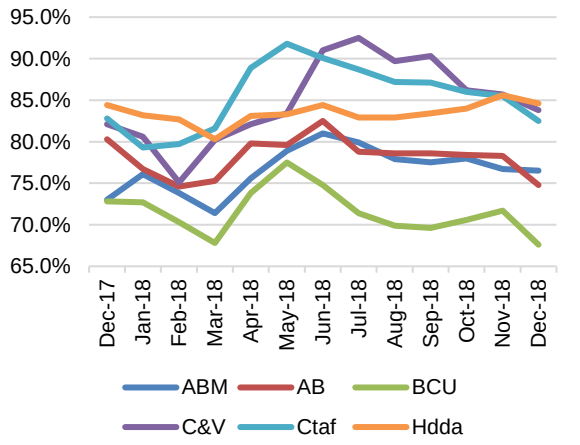


(2) Number of patients spending more than or equal to 12 hours in A&E

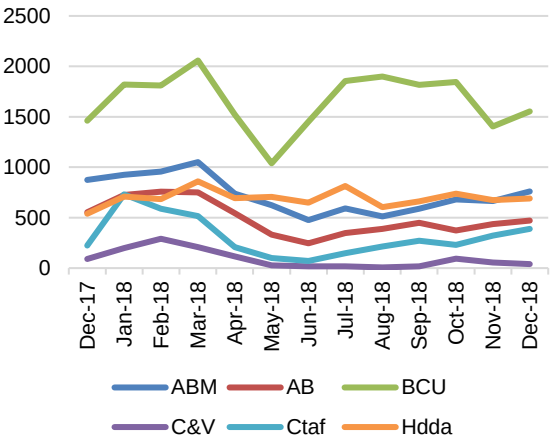


Benchmarking

(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 : StatsWales (data extracted 29.01.19)

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 December 2018 was 76.5%, against the all-Wales performance of 77.8%.
- In December 2018, 94.6% of patients were admitted, discharged or transferred from our ED's within 12 hours. 759 patients stayed longer than 12 hours in our Emergency Departments (ED's) during December 2018, which represented a 14% increase when compared with November 2018, but a 13% reduction when compared with December 2017.
- The overall number of patients attending the Emergency Departments and minor injuries units in December 2018 reduced by 958 attendances or 6.3% compared with December 2017. Whilst the temporary closure of the minor injuries unit in Singleton hospital contributed towards this reduction in attendances all sites experienced a lower demand when compared with December 2017.

What actions are we taking?

Between January and March 2019 we are:

- Implementing our Unscheduled Care improvement plans and embedding the improvement actions from previous quarters.
- Fully implementing our winter assurance plans for 2018/19 to ensure patient safety and improved system resilience including:
    - Additional medical, nursing and therapy staff within our emergency departments
    - Enhanced capacity in our frailty services in our Emergency Departments and front door services
    - Increased capacity in support services to improve access to diagnostic tests, results and the movement and discharge of patients
    - Providing additional inpatient winter 'surge' capacity - as at 7th January 60 additional spaces were being used as surge capacity.
- Increasing the focus of attention to clinically led improvements in our discharge processes and in reducing variation in our SAFER flow processes following a discharge workshop held on 14th January 2019. The main aspects of this improvement plan and outline implementation plans will be confirmed by the end of January, and finalised for approval by the USC board in February.
- In conjunction with Local Authority colleagues, ensuring the robust design of the Hospital to Home recovery service to support more timely patient discharge. The development of a transformation bid to WG to support the provision of this service model during 2019/20 will be developed by March 2019.

What are the main areas of risk?

- Capacity gaps in Care Homes, Community Resource Teams and capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit'.
- Workforce - with ongoing challenges in general nursing and medical roles in some key specialities and service areas such as the Emergency Department (ED).
- 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 76.5% in December 2018, which was just below the all-Wales 4 hour performance of 77.8% for this period.
- In ABMU Health Board in December 2018, 94.6% of all patients were assessed, treated and transferred from the Emergency Department within 12 hours, which was also just below the all-Wales position of 95.2%.

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

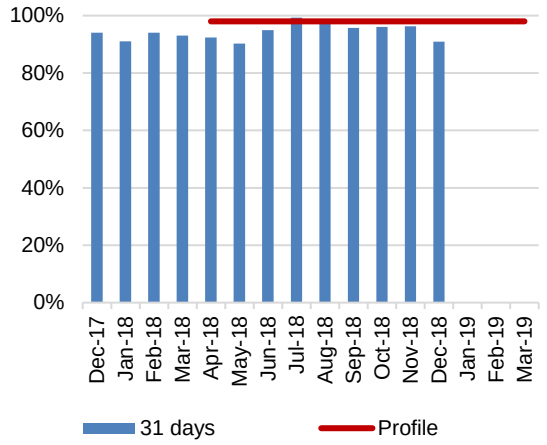
Measure 1: % of patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days
Measure 2: % of patients newly diagnosed with cancer via the urgent suspected route that started definitive treatment within 62 days

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

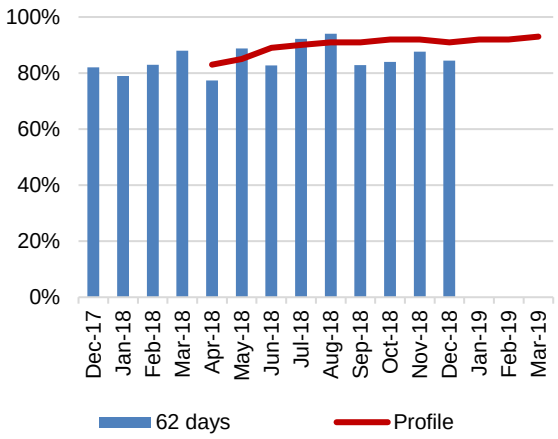
Period:	**IMTP Profile Target:**	**WG Target:**	**Current Status:**	**Movement:**
December 2018	(1) 98% (2) 91%	(1) 98% (2) 95%	✗	↑ ● Improving

Current Trend: Dec 17 - Dec 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

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

	Quarter ending Sept 2018	October 2018	November 2018
Wales USC	85.6	86.6	85.3
Betsi Cadwaladr University Health Board (1)	83.5	85.8	80.9
Hywel Dda University Health Board	90.0	93.5	85.5
Abertawe Bro Morgannwg University Health Board	89.8	84.3	87.6
Cwm Taf University Health Board	81.9	80.8	91.4
Aneurin Bevan University Health Board	84.8	89.9	86.1
Cardiff and Vale University Health Board (2)	81.7	84.5	81.0

Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

- NUSC performance for December 2018 is 94% (5 breaches).
- USC performance for December 2018 is 87% (15 breaches).
- USC referrals received by the Health Board remain high. The monthly average during the 13 months November 17 to November 18 is 1975. 1887 referrals were received in November 2018.
- Patients waiting over 62 days in backlog has been on an upwards trend throughout since early December with 67 patients reported in the 30th December PTL waiting over 62 days. This increase in backlog demonstrates difficulties within Urological and Gynaecological specialties in particular, lost capacity during the Holiday period coupled with a lack of tracking due to the holiday period and vacancies.

What actions are we taking?

- New Consultant Oncologist appointed for Urology and Lung tumour sites. To commence in post March 2019.
- Work to be completed by the end of January to allow the Urology single-handed template clinician to increase dedicated DSU weekly list.
- Chemotherapy Day Unit reviewing options for delivering some treatments outside of day unit by utilising the Tenovus bus and possibly utilising chair facilities at Neath Port Talbot Delivery Unit.
- New Endoscopy live dashboard released on the 18th December 2018.
- Upper GI pathway review and discussions to identify where bundling of diagnostic requests will be progressed following retire and return.
- Gynaecology team working with Hywel Dda to look at options of utilising theatre capacity there.
- Detailed Radiology Demand and Capacity plan including reporting time requirements is being finalised. Informatics to include priority flags within data warehouse by the end of January in order to develop this further.
- Pathway review of out of area sarcoma patients.
- New surgical cancer tracker appointed in Princess of Wales. To commence in post in January.
- Breast radiologist post to be re-advertised.
- New gynaecological clinic timetable to be implemented alongside one-stop PMB clinics to increase capacity. To be fully operational in January.
- Gynaecological Rapid Access Clinic capacity to be increased following return of consultant from long term sick leave in December, which will help reduce waiting times
- New first outpatient OMFS pathway stage agreed and taken forward with Primary Care with a plan to commence in April.
- New neck lump pathway agreed with a plan to implement at the end of January.
- Cancer Improvement Team have developed Demand & Capacity analysis for first outpatient appointment across most specialties managing suspected cancer referrals; these will be developed into live dashboard views by Informatics with timeframes to be determined.

What are the main areas of risk?

- Unscheduled Care pressures through winter on bed capacity, although site management processes aim to minimise impact on cancer cases.
- Continued growth in demand and therefore the backlog.
- Challenges to appoint to vacant posts and time lag in developing new workforce models.
- 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 (POW).
- Ongoing issues with delivery of Breast services.
- Delays due to lack of Gynaecological surgical capacity.
- Lack of tracking capacity until new staff are in post at POW and through sickness elsewhere.

How do we compare with our peers?

- USC Performance for the quarter ending September 2018 demonstrates ABMU HB has the second best performance of all Welsh Health Boards. Performance so far this quarter has been more challenging however and anticipated to deteriorate into quarter 4.

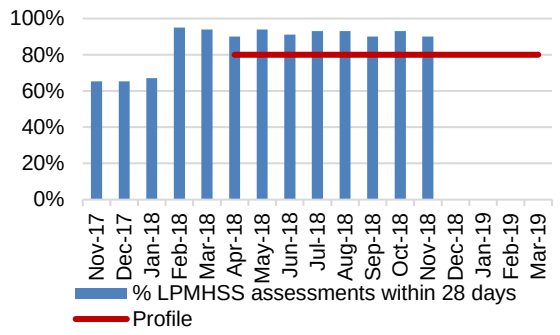
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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 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

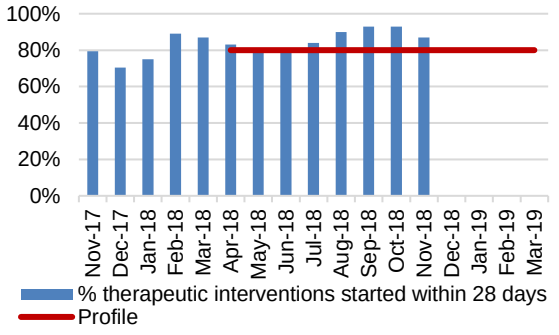
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need				
Period : November 2018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

Current Trend: Nov 17 – Nov 18

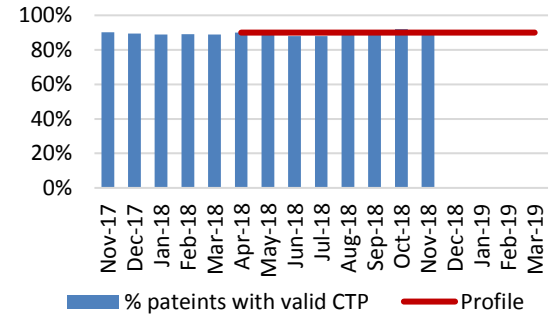
Measure 1



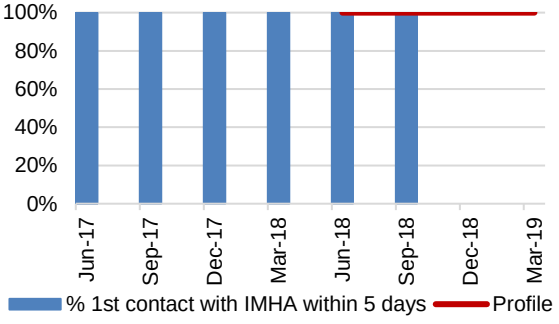
Measure 2



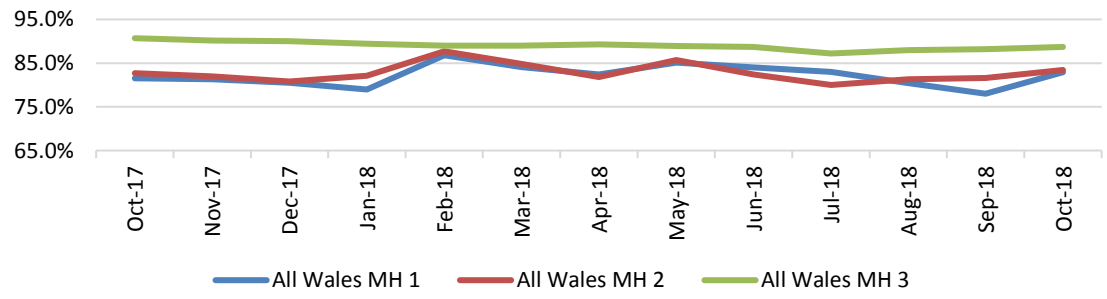
Measure 3



Measure 4



Benchmarking



Source : ALL WALES PERFORMANCE SUMMARY (December 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 10 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 10 of 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 7 of the 13 months shown. There was a slight dip in June and July but we have sustained compliance since August.

What actions are we taking?

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

What are the main areas of risk?

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

How do we compare with our peers?

October 2018

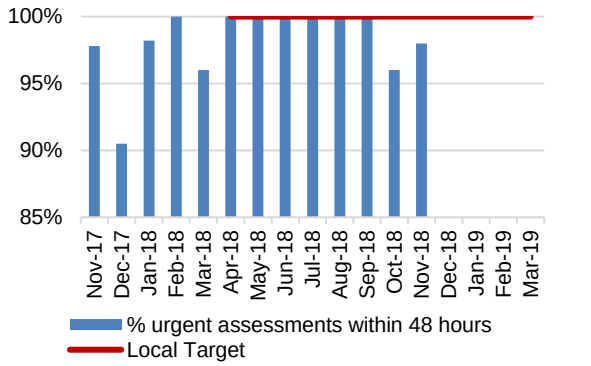
- All-Wales MH1 measure ranged from 69% to 96% 84% ABMU
- All-Wales MH2 measure ranged from 65% to 99% 92% ABMU
- All-Wales MH3 measure ranged from 84% to 92% 92% ABMU

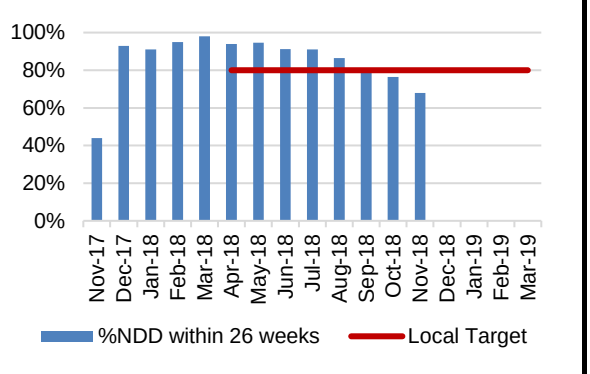
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

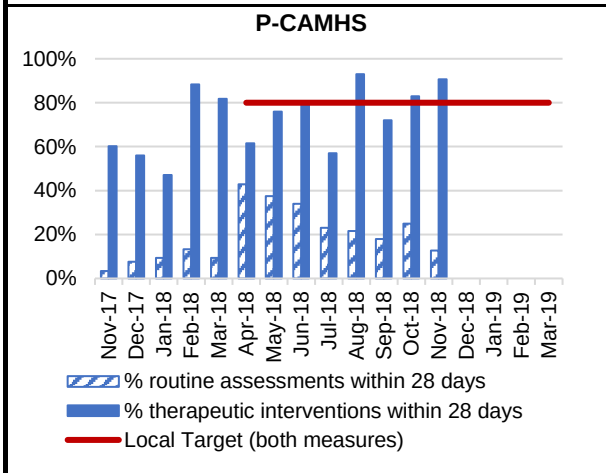
(1)Crisis - % Urgent Assessment by CAMHS undertaken within 48 Hours from receipt of referral
(2)NDD - % Neurodevelopmental Disorder patients receiving a Diagnostic Assessment within 26 wks
(3)P-CAHMS - % Routine Assessment by CAMHS undertaken within 28 days from receipt of referral
(4)P-CAHMS - % Therapeutic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

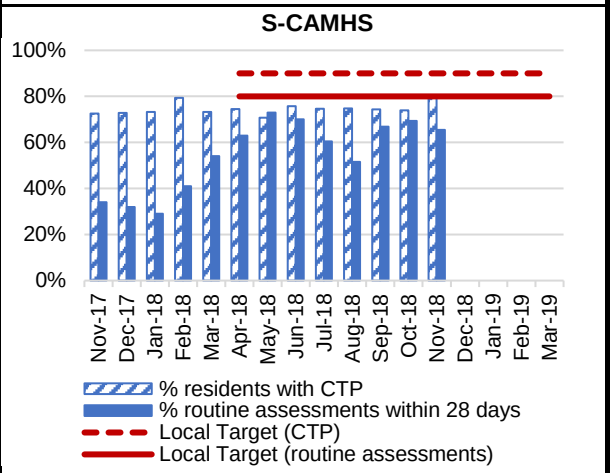
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Siân Harrop-Griffiths Director of Strategy	
Period: November 2018	**IMTP Profile Target:** N/A	**Local Target:** (1) 100% (5) 90% (2,3,4,6) 80%	**Current Status:** ✗	**Movement:** ↑ ● Improving

Current Trend: Nov 17 - Nov 18









Benchmarking (SCAMHS)

Position as at 22 January 2019	Bridgend	Neath Port Talbot	Swansea	ABM overall	Cardiff & Vale	Cwm Taf
Total WL	61	42	88	**191**	**177**	**144**
> 4 Weeks	28	23	39	**90**	**126**	**77**
Compliance	54.1%	45.2%	55.7%	**52.9%**	**29.2%**	**46.5%**
Average Weeks	3.1	3.9	3.0	**3.1**	**5.0**	**3.9**

Source : Cwm Taf LHB

(1) Crisis - % Urgent Assessment by CAMHS undertaken within 48 Hours from receipt of referral
(2) NDD - % Neurodevelopmental Disorder patients receiving a Diagnostic Assessment within 26 wks
(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 - % ABMU residents in receipt of CAMHS to have a valid Care and Treatment Plan
(6)S-CAHMS - % Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral

How are we doing?

- Measure 1: Crisis - Service now operates 7 days a week, and until October 2018, when compliance dipped to 96%, the 100% target had consistently been achieved. Performance in November recovered slightly to 98%, this position remains under review via the commissioning arrangements in place. Where 100% has not been achieved this has been because of staff absences.
- Measure 2: NDD - Compliance against this measure has deteriorated to 68% in November. Until August 2018 compliance against this target had been good, however a dip in performance has been seen following a significant increase in referrals. The increase has been experienced across Wales, due to increased awareness of the service available and unmet demand.
- Measure 3: P-CAMHS – Compliance against the assessment within 28 days has deteriorated, however the number of patients waiting still remains significantly lower compared to 12 months ago. The longest wait for an assessment in December 2018 was 12 weeks compared to January 2018 when the longest wait was 47 weeks. The service remains fragile due to a number of vacancies within a small service, and whilst agency staff are being utilised, the availability of appropriate staff is limited and a continued risk.
- Measure 4: P-CAMHS – Compliance against the 80% target for therapeutic interventions has improved and was achieved in November. The service prioritises this target since it is seen as a key quality indicator that once young people start their interaction with CAMHS, they receive their intervention quickly without waiting for this.
- Measure 5: S-CAMHS – Compliance against the Care and Treatment Plan target was achieved.
- Measure 6: S-CAMHS - Compliance against the 80% target in November was at 68%, as a result of a number of vacancies in the service. The Christmas and New Year holidays has also had an effect on activity by the service in addition to vacancies.

What actions are we taking?

- NDD – The significant increase in referrals remains a concern, and the Singleton Hospital Delivery Unit are mitigating the implications of this increase in the short term by providing additional waiting list initiatives. Funding has been identified and agreed through Integrated Autism Service slippage monies for the 18/19 financial year. However indications are that unmet need for NDD assessment has not yet been satisfied with referrals still increasing and the SH Delivery Unit is developing a proposal regarding how these services need to change and expand to meet need in the future.
- CAMHS –The variation in performance experienced is consistently related to the number of vacancies across the services, with a number of staff on maternity leave, and shortages in suitable staff leading to vacancies having to be re-advertised. ABMU has agreed to utilise the vacancy underspend to fund waiting list initiatives to improve the position. Cwm Taf have also secured additional funds for waiting list initiatives to deliver the targets from the Welsh Government, however there has been limited agency staff available to do this work. The results of the Demand & Capacity modelling for CAMHS have been shared with ABMU which shows that there is a marginal shortfall in capacity for SCAMHS. ABMU and Cwm Taf are finalising a three year plan to develop a single integrated PCAMHS and SCAMHS service for the whole of Swansea and Neath Port Talbot with a single office base, a single referral centre to manage all referrals and access to a widened range of services and with clinics in community settings such as GP surgeries and community schools.
- The NHS Delivery Unit are in the process of reviewing P-CAMHS across Wales, and the ABMU review is currently underway.

What are the main areas of risk?

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

How do we compare with our peers?

- There is limited data available to undertake peer review across CAMHS, however there is some data available against the SCAMHS target which is shown in the benchmarking section above.

10.6 Individual Care

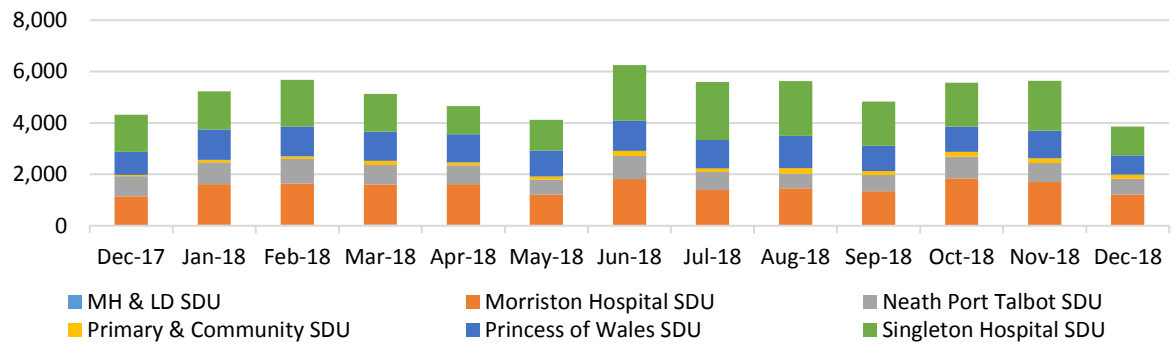
INDIVIDUAL CARE – PEOPLE IN WALES ARE TREATED AS INDIVIDUALS WITH THIE RIWN NEEDS AND RESPONSIBILITIES

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Gareth Howells Director of Nursing & Patient Experience	
Period : December 18	**IMTP Profile Target :**	**Local Target:** (1) Increase, (2) 90%, (3) 90%	**Current Status:** ✗	**Movement:** ↓ ● Worsening

Current Trend: Dec 17 – Dec 18

(1) Number of friends and family surveys completed



(2) % of who would recommend and highly recommend

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
MH & LD SDU	65%	73%	91%	76%	72%	52%	79%	31%	65%	90%	93%	80%	75%
Morriston Hospital SDU	92%	93%	94%	93%	94%	94%	94%	94%	92%	93%	95%	95%	91%
Neath Port Talbot SDU	99%	98%	98%	99%	99%	98%	99%	99%	98%	98%	98%	99%	99%
Primary & Community SDU	90%	90%	91%	90%	89%	94%	94%	93%	93%	94%	96%	95%	92%
Princess of Wales SDU	94%	95%	94%	94%	95%	95%	96%	96%	95%	95%	94%	95%	95%
Singleton Hospital SDU	96%	96%	96%	95%	94%	94%	97%	96%	97%	97%	96%	95%	96%
HB Total	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**96%**	**96%**	**95%**	**96%**	**96%**	**96%**	**94%**

(3) % of All Wales surveys scoring 9 or 10 on overall satisfaction

	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
MH & LD SDU	100%	NS	NS	0%	-	-							0%
Morriston Hospital SDU	94%	77%	87%	91%	93%	96%	74%	87%	83%	92%	83%	91%	74%
Neath Port Talbot SDU	76%	91%	88%	80%	62%	80%	84%	93%	87%	100%	94%	100%	80%
Primary & Community SDU		95%	100%	93%	92%	97%	-	-	91%	87%	95%	88%	90%
Princess of Wales SDU	77%	79%	69%	79%	87%	82%	86%	77%	63%	88%	83%	96%	84%
Singleton Hospital SDU	85%	79%	84%	79%	85%	86%	90%	84%	95%	79%	88%	83%	90%
HB Total	**84%**	**83%**	**87%**	**84%**	**87%**	**89%**	**85%**	**85%**	**87%**	**89%**	**86%**	**88%**	**82%**

NS= No Surveys Target = 90%

Benchmarking

	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
ABMU Response %	28.9%	20.0%	22.1%	25.0%	23.3%	19.4%	16.9%	30.1%	26.1%	26.8%	21.8%	22.9%	24.1%
ABMU Recommendation %	96.0%	95.0%	95.7%	95.5%	95.7%	95.1%	95.4%	97.2%	96.5%	96.2%	96.3%	96.5%	96.3%
Top Equivalent Organisation Response %	17.0%	14.1%	14.6%	21.3%	27.7%	17.6%	27.3%	27.0%	19.3%	19.8%	17.0%	18.3%	20.3%
Top Equivalent Organisation Recommendation %	98.1%	97.0%	97.5%	95.0%	93.7%	97.4%	94.2%	92.0%	94.1%	97.1%	92.9%	93.2%	95.5%
NHS England Benchmark Response %	25.1%	21.4%	22.7%	23.9%	22.6%	24.4%	25.1%	24.8%	24.8%	24.6%	24.2%	24.5%	24.2%
NHS England Benchmark Recommendation %	95.6%	95.0%	95.5%	95.5%	95.3%	95.6%	95.8%	95.7%	95.6%	95.5%	95.5%	95.5%	95.5%

Source : ABMU Datix System

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

How are we doing?

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

- Health Board Friends & Family patient satisfaction level in December was 94%.
- Neath Port Talbot Hospital completed 616 surveys for December, with a recommended score of 99%.
- Singleton Hospital completed 1,125 surveys for December, with a recommended score of 96%.
- Morriston Hospital completed 1,198 surveys for December, with a recommended score of 91%.
- Princess of Wales Hospital completed 743 surveys for December, with a recommended score of 95%.
- Mental Health & Learning Disabilities completed 12 surveys for December, with a recommended score of 75%
- Primary & Community Care completed 171 surveys for December, with a recommended score of 92%

What actions are we taking?

- Third workshop to take place during February to strengthen Datix knowledge and coding of complaints, discuss the new PALS policy, etc.
- ABMU Patient Story Policy, guide, toolkit and SharePoint site is now ratified and presented to each DSU Quality and Assurance Meetings. First cohort of training to take place in January and the second cohort takes place during March 2019.
- Pilot of SMS text messaging the F&F surveys to patients/service users (retrospectively) undertaken and early indications show this could be a good method of gaining further feedback. Further 'testing' is required, to provide proof of concept.

What are the main areas of risk?

- New Welsh Government Validated Patient Survey questions sent to all Chief Executives across Wales. Changes to the survey questions required. Snap System update with the new questions will need to take place during March 2019, to coincide with the financial year and annual archiving of the Snap system.
- Removal of the Bridgend area from the Snap systems and reports.

How do we compare with our peers?

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

10.7 Our Staff & Resources

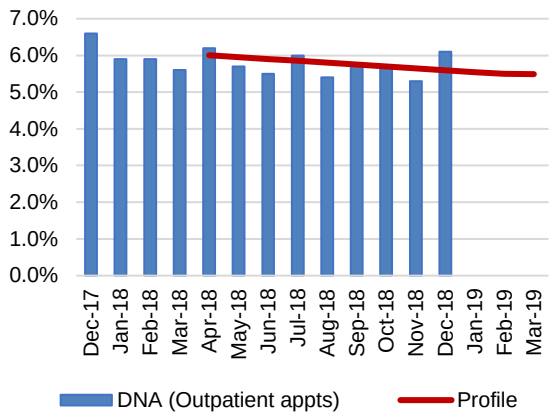
OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

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

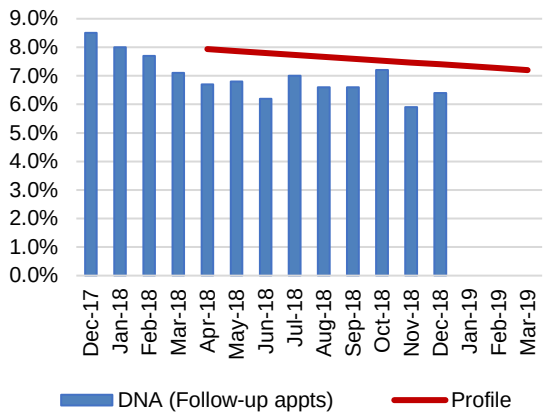
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead:** Chris White Chief Operating Officer	
Outcome Statement : I work with the NHS to improve the use of resources				
Period: December 2018	**IMTP Profile Target:** (1) 5.60% (2) 7.4%	**WG Target:** 12 month reduction trend	**Current Status:** ✗	**Movement:** ↓ ● Improving

Current Trend: Dec 17 - Dec 18

(1) % New Outpatient that Did Not Attend

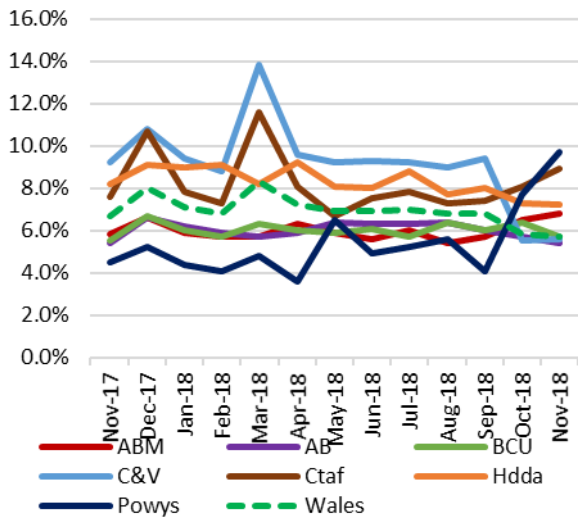


(2)% Follow Up Outpatient that Did Not Attend

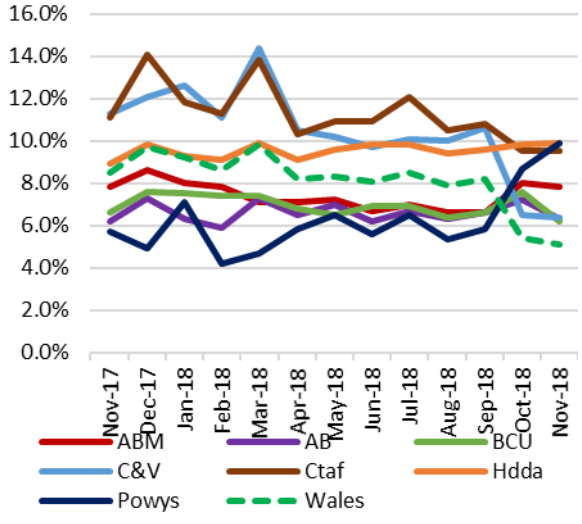


Benchmarking

(1) % New Outpatient that Did Not Attend



(2) % Follow Up Outpatient that Did Not Attend



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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 Sept 2017 - Nov 2018 performance has improved from 6.7% to 5.3%. There was an increase in December which may be due to the Christmas period with patients reluctant to attend and notify the Hospital.

- Follow-Up DNA: From Sept 2017 - Dec 2018 performance has continued to improve from 8.6% to 6.4%.

What actions are we taking?

- Outpatient appointment text reminder service implementation - review of current arrangements underway by Information / Service Improvement team – recommendation by the end of February 2019.
- Work continues with GP clusters and patients to inform the development of alternative methods of service delivery to support patients in the most appropriate setting including nurse led / advanced practitioner led clinics. Each Delivery Unit has developed a plan to address their DNA position. These plans, overseen by the Outpatient Improvement Group and led by nominated managerial leads from each delivery unit, 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 by each delivery unit lead in Q4 include:

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

What are the main areas of risk?

- The Wales Audit Office identified, in a review of ABMU Outpatients in 2015 and 2018, the need to ensure patients receive appointment letters in a timely manner in order to reduce DNAs. The Outpatient 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 Nov 2018, ABMU performance continues to be comparable with the all-Wales average on New and Follow Up DNA performance.
- New DNA: ABMU, C&V, CT and Powys have experienced a slight deterioration in their performance during November; AB, BCU and HD position has seen improvements.
- Follow Up DNA: HD experienced a slight deterioration in performance during November; ABM, AB, BCU,and C&V have seen improvements.

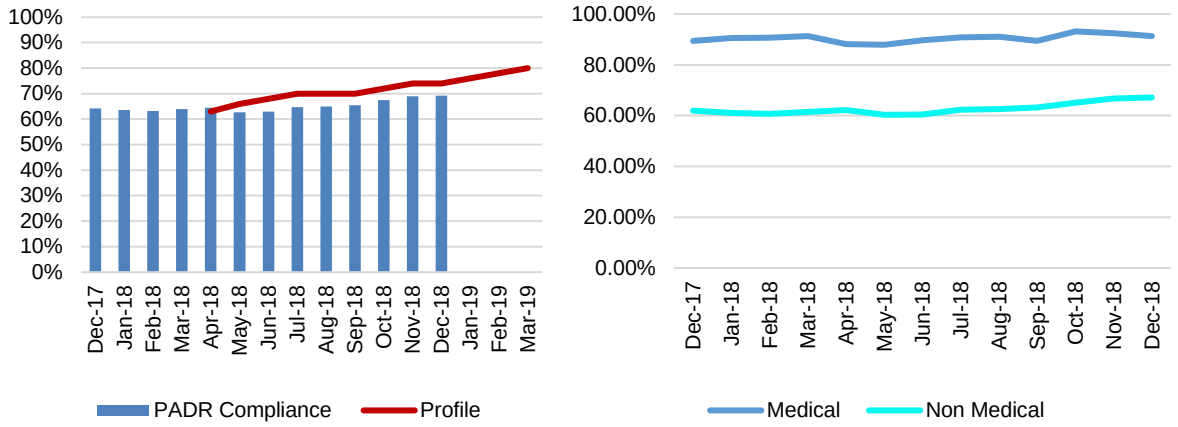
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Securing a Fully Engaged and Skilled Workforce			**Executive Lead:** Hazel Robinson Director of Workforce & OD	
Outcome Statement : Quality trained staff who are fully engaged in delivering excellent care and support to me and my family				
Period : December 2018	**IMTP Profile Target:** 74%	**WG Target:** 85%	**Current Status:** ✗	**Movement:** ↑ ● Improving

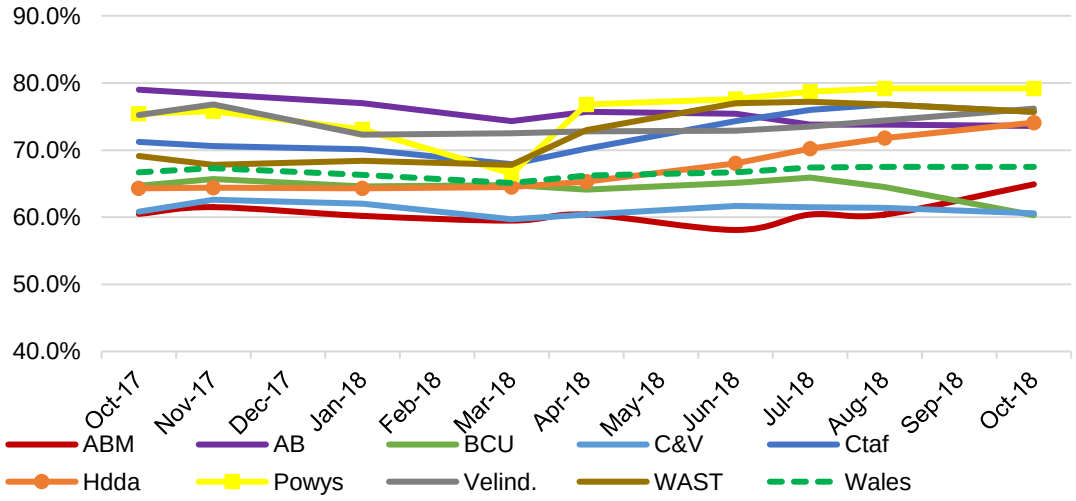
Current Trend: Dec 17 - Dec 18

(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 (January 2019)

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

How are we doing?

Medical:

- Excluding any exemptions (new starters, absences e.g. long term sickness, maternity leave etc.) the appraisal rate for the rolling period to December 2018 is 91.3%.
- 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 1335 to 1369. This varies throughout the year but for consistency, the statistics are based on numbers at the beginning of April each year.
- **Medical:**
- Reporting figures demonstrate an increase in PADR compliance- September 2018 63.17% to January 2019 67.13%, This has been an increase in compliance from September 2018 – January 2019 by 3.96%
- From the 6 Service Delivery Units (SDUs): Mental Health & Learning Disabilities (MHLD) 77.80% an increase of 0.92% on the last results, Morriston Delivery Unit (MSDU) 68.35% an increase of 4.76%, Neath Port Talbot (NPT) 84.54% an increase of 14.47%, Primary & Community Care (PCC) 77.54% a decrease of 1.42%, Princess of Wales (POW) 67.80% an increase of 4.52%, Singleton Delivery Unit (SSDU) 72.47% an increase of 8.68% on the last results.

What actions are we taking?

Medical:

- Maintain current performance levels through continuing engagement with Unit Medical Directors, GP Appraisal Co-ordinators and Medical Appraisal Leads - undertake quarterly exception management process, providing doctors with training and advice.
- Further and ongoing enhancements to MARS (Medical Appraisal and Revalidation System) continue to improve functionality in line with identified changes/developments.
- Unit based Appraisal Leads driving appraisal quality forward and maximise delivery of appraisal benefits, providing support for appraisers.

Non-Medical:

- There is a continuation of focus on training Managers to complete Values Based PADR/use ESR to improve reporting figures on a request basis with bespoke sessions for teams/units when requested. 46 managers have been trained since September 2018.
- All Delivery Units have been asked to provide a plan to achieve compliance with the 85% target.

What are the main areas of risk?

Medical:

- 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).
- Whole Practice Appraisal (WPA) – ensuring doctors declare work undertaken outside their NHS role within their annual appraisals for revalidation. Revalidation recommendations to the GMC are based on WPA.

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
- Individual perspectives of the validity and necessity of having a PADR in line with the requirements of the job role i.e. what's the point?

How do we compare with our peers?

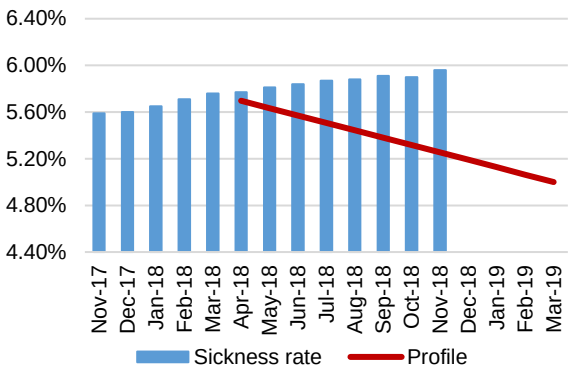
- **Medical:** Stats from the RSU (Revalidation Support Unit) show appraisals undertaken from 1st April 2018 – 31st January 2019 in ABMU as 73.7% of the baseline total number of doctors (based on appraisals completed) this is in line with other Health Boards within Wales. Awaiting benchmark information for 1st April 2018 to date.
- **Non-Medical:** There have been slight variations in performance of ABMU in line with other Health Boards across Wales throughout the later months of 2018. We will continue look and scope actions taken by other Health Boards in relation to their PADR compliance.

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

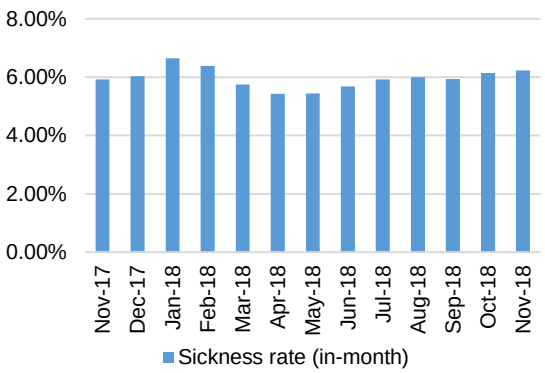
Measure 1: % workforce sickness absence (Rolling 12 months)
Measure 2: % workforce sickness absence (In-month)

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 : November 2018	**IMTP Profile Target:** (1) 5.25%	**WG Target:** Reduction	**(2) Current Status:** ✓	**(2) Movement:** ↓ Improving
Current Trend: Nov 17 – Nov 18				

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

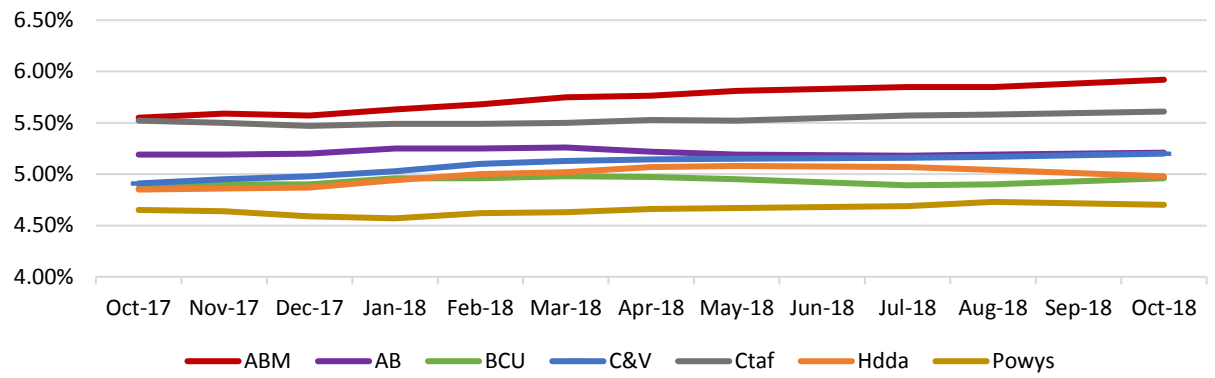


(2) % workforce sickness absence (In-Month)



Benchmarking

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



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

Rolling 12 month performance:

- Dec 16 - Nov 17 = 5.58%
- Nov 17 - Oct 18 = 5.91%
- Dec 17 - Nov 18 = 5.93%

In Month performance:

- Oct 18 = 6.21%
- Nov 18 = 6.20% (was 6.01% in Nov 17)

- Three of the six units saw their in month performance improve in November 18 compared to the previous month with MH and LD seeing an improvement of 0.46% in month. Cumulative 12 month performance also improved in 3 of the six Delivery Units.
- Short term sickness for November was 2.22% down from 2.30% the previous month.
- Long term sickness rates in Nov 18 were below 4% at 3.97% which is the second consecutive month that in month reported long term sick (LTS) levels have been sub 4%
- Our highest reason for absence continues to be stress related absence, which remained static compared to the previous month.

What actions are we taking?

- Commence training sessions for managers regarding the new all-Wales Managing Attendance policy.
- Development of a pilot within a selected area in order to address high absence, which will apply learning from the above best practise case study.
- Occupational Health improvement plan complete and being implemented – this includes increasing capacity for management referrals in occupational health using AHP workforce and scanning of 35,000 staff records to enable efficiency savings related to e-records and E-systems.
- Continue delivery of Mental Health awareness sessions to managers. To date 16 sessions have been delivered to 132 managers.
- Continue delivery of Work related stress risk assessment training for managers. To date 24 sessions have been delivered to 210 managers in total
- Development of a pilot focusing on early communication and support to aid early return to work (RTW) for Short Term Absences.
- Development of a pilot within Facilities to test and exploit the benefits of using ESR Manager Self-Serve in managing absence more effectively.

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 0.56%.
- The latest differential between our monthly sickness absence rates and the all-Wales average is 0.68%.

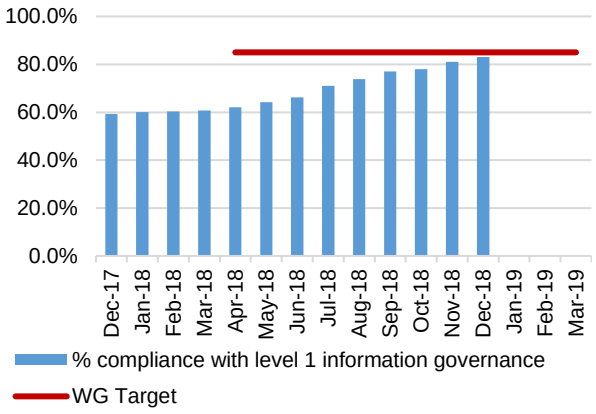
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

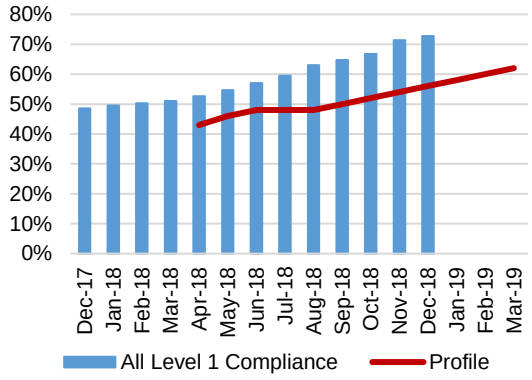
Corporate Objective : Securing a Fully Engaged and Skilled Workforce				**Executive Lead:** Hazel Robinson Director of Workforce & OD
Outcome Statement: Quality trained staff who are fully engaged in delivering excellent care and support to me and family				
Period : December 2018	**IMTP Profile Target:** (2) 56%	**WG Target:** (2) 85%	**Current Status:** ✓	**Movement:** ↑ Improving

Current Trend: Dec 17 - Dec 18

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

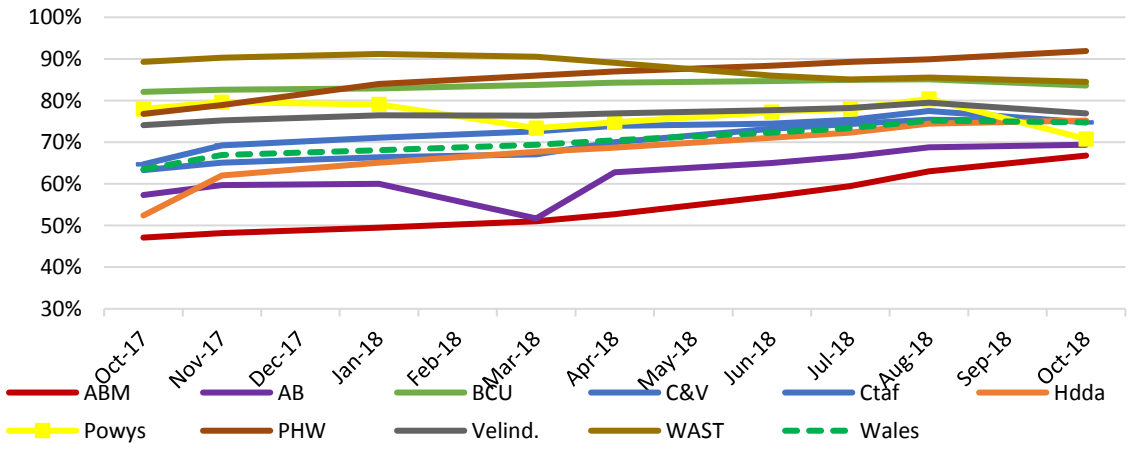


Measure 2: % compliance for all completed Level 1 competencies within the Core Skills and Training Framework



Benchmarking

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



Source : NHS WALES DELIVERY FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (January 2019)

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

How are we doing?

Information Governance

- The Current Compliance for IG Level 1 training is 83%, an increase of 23.7% since December 2017. This is a result of continued IG training delivery and IG compliance monitoring by a dedicated IG Training Lead and awareness raising via the Information Governance Board Leads, bulletins, IG intranet pages, continued support with e-learning sessions, train the trainer sessions and open access/departmental face to face sessions held across the Health Board. Proactive targeting of non-compliant staff has continued to take place via monthly checks on all staff, complemented by mailshot to all non-compliant staff. A supplementary ESR user guide specific for accessing IG e-learning has been continually distributed.

All Level 1 Competencies

- The current level of compliance for Mandatory and Statutory stands at 72.81%. This is an improvement on the last reported compliance level of 66.27% by 6.55%. This is an equivalent of 16,250 compliances being completed. A continuation of proactive targeting of non-compliant staff has worked since October 2018 to ensure the compliance level has risen. The support that the health board lead for ESR & M&S compliance has provided, through e-learning workshops and over the phone trouble shooting has been attributable to the percentage increase.

What actions are we taking?

Information Governance

- Continue to send compliance lists for IG Training compliance to directorates and service delivery units.
- Continue to report IG training compliance formally to the Information Governance Board and to Audit Committee, as well as include it in the annual public facing SIRO Report.
- Continue to proactively contact all IG training non-compliant staff individually.
- Finalise the production of an IG training video as an alternative to e-learning or face to face sessions.
- Continue to deliver open access and departmental IG Training and Train the Trainer (if required).

All Level 1 Competencies

- Investigate Inter Authority Transfer Process to ensure records transfer with employees.
- Update outstanding individual records from Action Point.
- Use additional resources such as apprentices to reduce the backlog on Action Point.
- Continue to deliver e-learning workshops across the Health Board.
- Investigate where compliance in higher level training mitigates the need for level 1 training and implement automatic sign off of competencies.
- Ensure everyone is aware of the new and updated ESR related email address that will go live as of the 1st February 2019.

What are the main areas of risk?

All level 1 Competencies

- ESR self-service and supervisor self-service roll out and usage.
- IT infrastructures.
- Potential changes to pay progression and increments.
- Lack of resources (highlighted at Audit Committee).
- Lack of computer literacy amongst staff
- Time and access to computers for community based staff
- Priorities of completing M&S training in relation to completing day to day job related tasks.
- As of the 1st February there will be a new updated email address for all ESR, e-learning & training records related queries.
- Delay in updating competencies onto ESR following face to face training.

How do we compare with our peers?

All Level 1 Competencies

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

11. LIST OF ABBREVIATIONS

ABMU	Abertawe Bro Morgannwg University
AOS	Acute Oncology Service
CAMHS	Child and Adolescent Mental Health
CBC	County Borough Council
CNS	Clinical Nurse Specialist
COPD	Chronic Obstructive Pulmonary Disease
CRT	Community Resource Team
CT	Computerised Tomography
DEXA	Dual Energy X-Ray Absorptiometry
DNA	Did Not Attend
DU	Delivery Unit
ECHO	Emergency Care and Hospital Operations
ED	Emergency Department
ESD	Early Supported Discharge
ESR	Electronic Staff Record
eTOC	Electronic Transfer of Care
EU	European Union
FTE	Full Time Equivalent
FUNB	Follow Up Not Booked
GA	General Anaesthetic
GMC	General Medical Council
GMS	General Medical Services
HB	Health Board
HCA	Healthcare acquired
HCSW	Healthcare Support Worker
HYM	Hafan Y Mor
IBG	Investments and Benefits Group
ICOP	Integrated Care of Older People
IMTP	Integrated Medium term Plan
IPC	Infection Prevention and Control
IV	Intravenous
JCRF	Joint Clinical Research Facility
LA	Local Authority
M&S training	Mandatory and Statutory training
MIU	Minor Injuries Unit
MMR	Measles, Mumps and Rubella
MSK	Musculoskeletal
NDD	Neurodevelopmental disorder
NEWS	National Early Warning Score
NICE	National Institute of Clinical Excellence
NMB	Nursing Midwifery Board
NPTH	Neath Port Talbot Hospital
NUSC	Non Urgent Suspected Cancer
NWIS	NHS Wales Informatics Service

OD	Organisational Development
OH	Occupational Health
OPAS	Older Persons Assessment Service
OT	Occupational Therapy
PA	Physician Associate
PALS	Patient Advisory Liaison Service
P-CAMHS	Primary Child and Adolescent Mental Health
PCCS	Primary Care and Community Services
PDSA	Plan, Do, Study, Act
PEAS	Patient Experience and Advice Service
PHW	Public Health Wales
PMB	Post-Menopausal Bleeding
POVA	Protection of Vulnerable Adults
POWH	Princess of Wales Hospital
PTS	Patient Transport Service
Q&S	Quality and Safety
R&S	Recovery and Sustainability
RCA	Root Cause Analysis
RDC	Rapid Diagnostic Centre
RMO	Resident Medical Officer
RRAILS	Rapid Response to Acute Illness Learning Set
RRP	Recruitment Retention Premium
RTT	Referral to Treatment Time
SAFER	Senior review, All patients, Flow, Early discharge, Review
SARC	Sexual Abuse Referral Centre
SBAR	Situation, Background, Analysis, Recommendations
S-CAMHS	Specialist Child and Adolescent Mental Health
SDU	Service Delivery Unit
SI	Serious Incidents
SLA	Service Level Agreement
SLT	Speech and Language Therapy
SMART	Specific, Measurable, Agreed upon, Realistic, Time-based
StSP	Spot The Sick Patient
TAVI	Transcatheter aortic valve implantation
UDA	Unit of Dental Activity
UMR	Universal Mortality Review
USC	Urgent Suspected Cancer
WAST	Welsh Ambulance Service Trust
WFI	Welsh Fertility Institute
WG	Welsh Government
WHSSC	Welsh Heath Specialised Services Committee
WLI	Waiting List Initiative
WPAS	Welsh Patient Administration System