Meeting Date	**25th May 2021**	**Agenda Item**	**4.6**
Report Title	**Quality & Safety Performance Report**		
Report Author	Darren Griffiths, Director of Finance and Performance (interim)		
Report Sponsor	Darren Griffiths, Director of Finance and Performance (interim)		
Presented by	Darren Griffiths, Director of Finance and Performance (interim)		
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 local performance measures as well as the national measures outlined in the 2020/21 NHS Wales Delivery Framework. **For the May Committee the report has been extended to give the full year report pack for the Committee's consideration. This is a more detailed one off report and a similar presentation will be provided to the Performance and Finance Committee.**		
Key Issues	The Integrated Performance Report is a routine report that provides an overview of how the Health Board is performing against the National Delivery measures and key local quality and safety measures. The key issues set out in this report are: - • **Emergency Department (E**D) attendances in March 2021 were 32% higher than February 2021 and this increasing trend continued into April 2021. • **ED 4-hour** performance improved to 76.9% in March 2021 compared to 71.3% in February 2021. • **12-hour waits** in March 2021 reduced by 77 (-14.4%) on February 2021 however 1-hour hand over delays remained broadly static (219 in February 2021 and 231 in March 2021). • **GP referrals into the RTT** system have steadily increased since the first wave of the pandemic, but are not yet at pre-pandemic levels. As a consequence, length of wait and overall list size across the RTT system continues to increase (total list size now 73,238 from 54,307 in February 2020). This excludes 8 week diagnostic waits. • **Single Cancer Pathway (SCP) backlog** has reduced in total from its peak at the end of January 2021, but the backlog has		

<table>
<tr><td></td><td colspan="4">increased for the last four weeks and now stands at 356 patients over 63 days as opposed to 285 four weeks ago.
• SCP performance fell between January 2021 and February 2021 by 12% but was forecast to recover by at least 6% in March 2021 (unvalidated figure) to 61.8%. Further work is required to reduce backlog to a sustainably deliverable level.
• Sickness absence levels have improved considerably since the December 2020 in-month peak.
• Mental Health- performance against the Mental Health Measures continues to be maintained. All targets were achieved in March 2021. Psychological therapies access times achieved 100% within target access levels
• Serious Incidents closures- Performance against the 80% target was 0% in March 2021 as none of the eleven closure forms due to be submitted to Welsh Government were submitted on time.</td></tr>
<tr><td rowspan="2">Specific Action Required</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
<tr><td>✓</td><td></td><td>✓</td><td></td></tr>
<tr><td>Recommendations</td><td colspan="4">Members are asked to:
• NOTE the current Health Board performance against key measures and targets as set out in this year end report.</td></tr>
</table>

QUALITY & SAFETY PERFORMANCE REPORT

1. INTRODUCTION

The purpose of this report is to provide an update on current performance of the Health Board at the end of the most recent reporting window in delivering key performance measures outlined in the 2020/21 NHS Wales Delivery Framework and local quality & safety measures.

2. BACKGROUND

The 2020/21 NHS Wales Delivery Framework sets out the 78 measures under the quadruple aims which the performance of the Health Board is measured. The aims within the NHS Delivery Framework are:

- **Quadruple Aim 1**: People in Wales have improved health and well-being with better prevention and self-management
- **Quadruple Aim 2**: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement
- **Quadruple Aim 3**: The health and social care workforce in Wales is motivated and sustainable
- **Quadruple Aim 4:** Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes

The Health Board's performance reports have traditionally been structured according to the aims within the NHS Delivery Framework however, the focus for NHS Wales reporting has shifted to harm management as a consequence of the COVID-19 pandemic. In order to improve the Health Board's visibility of measuring and managing harm, the structure of this report has been aligned with the four quadrants of harm as set out in the NHS Wales COVID-19 Operating Framework and the Health Board's Q2 Operational Plan. The harm quadrants are illustrated in the following diagram.

Harm from Covid itself	**Harm from overwhelmed NHS and social care system**
Harm from reduction in non-Covid activity	**Harm from wider societal actions/lockdown**

Appendix 1 provides an overview of the Health Board's latest performance against the Delivery Framework measures along with key local quality and safety measures. A number of local COVID-19 specific measures have been included in this iteration of the performance report and further work will be undertaken over the next quarter to introduce additional measures that will aid in measuring harm in the system.

The traditional format for the report includes identifying actions where performance is not compliant with national or local targets as well as highlighting both short term and

long terms risks to delivery. However, due to the operational pressures within the Health Board relating to the COVID-19 pandemic, it was agreed that the narrative update would be omitted from this performance report until operational pressures significantly ease. Despite a reduction in the narrative contained within this report, considerable work has been undertaken to include additional measures that aid in describing how the healthcare systems has changed as a result of the pandemic.

3. GOVERNANCE AND RISK ISSUES

Appendix 1 of this report provides an overview of how the Health Board is performing against the National Delivery measures and key local measures. Mitigating 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.

4. 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.

5. RECOMMENDATION

Members are asked to:

- **NOTE** the current Health Board performance against key measures and targets as set out in this year end report.

Governance and Assurance		
Link to Enabling Objectives *(please choose)*	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

The performance report outlines performance over the domains of quality and safety and patient experience, and outlines areas and actions for improvement. Quality, safety and patient experience are central principles underpinning the National Delivery Framework and this report is aligned to the domains within that framework.

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

Financial Implications

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

Legal Implications (including equality and diversity assessment)

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

Staffing Implications

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

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
The '5 Ways of Working' are demonstrated in the report as follows: • **Long term** – Actions within this report are both long and short term in order to balance the immediate service issues with long term objectives. In addition, profiles have been included for the Targeted Intervention Priorities for 2019/20 which provides focus on the expected delivery for every month as well as the year end position in March 2020. • **Prevention** – the NHS Wales Delivery framework provides a measureable mechanism to evidence how the NHS is positively influencing the health and well-being of the citizens of Wales with a particular focus upon maximising people's physical and mental well-being. • **Integration** – this integrated performance report brings together key performance measures across the seven domains of the NHS Wales Delivery Framework, which identify the priority areas that patients, clinicians and stakeholders wanted the NHS to be measured against. The framework covers a wide spectrum of measures that are aligned with the Well-being of Future Generations (Wales) Act 2015. • **Collaboration** – in order to manage performance, the Corporate Functions within the Health Board liaise with leads from the Service Groups 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 Service Groups leads are key in identifying performance issues and identifying actions to take forward.

Report History	The last iteration of the Quality & Safety Performance Report was presented to Quality & Safety committee in March 2021. This is a routine monthly report.
Appendices	Appendix 1: Quality & Safety performance report

Appendix 1- Quality & Safety Performance Report

May 2021

CONTENTS PAGE

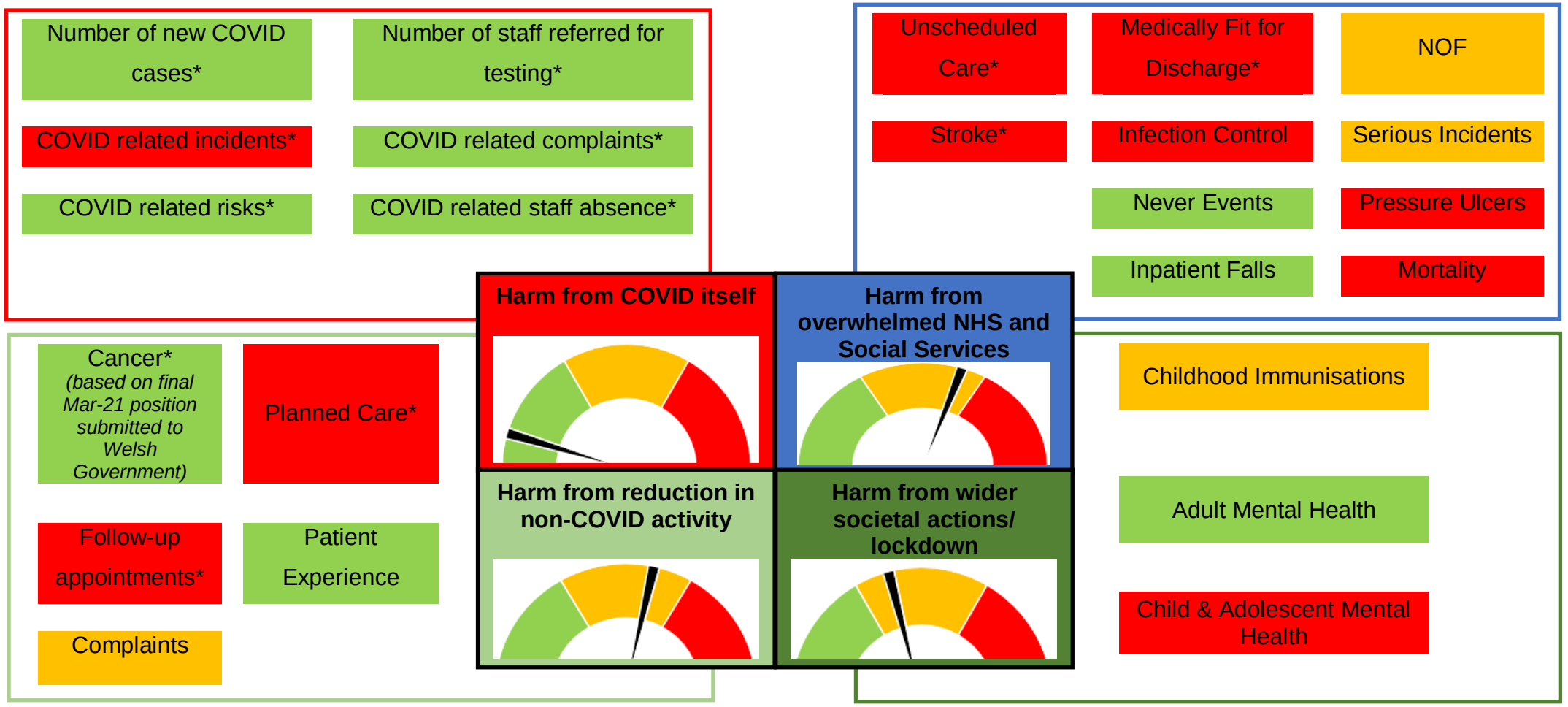
1. OVERVIEW- KEY PERFORMANCE INDICATORS SUMMARY

Key messages for consideration of the committee arising from the detail in this report below are: -

- Q&S report detail has been enhanced at the year end to give the committee a more comprehensive performance report with additional narrative detail.
- Adult Mental health access performance remains excellent and Psychological Therapy performance continues to be over target, achieving 100% in March 2021. CAMHS access to assessments within 28 days significantly improved from 29% in January 2021 to 97% in February 2021, Access levels have decreased slightly in March 2021 and are currently under review by the service team.
- Despite an increase in demand on the unscheduled care system in March 2021, performance against the 4 and 12 hour A&E access targets improved.
- Planned care system is still challenging, especially for treatment within 36 weeks. The rate at which the size of the waiting list is increasing was slowing down however, referrals and additions to the waiting list both increased in March 2021. Although there are a significant number of patients waiting over target for diagnostics and therapies, the number of breaches continues to reduce month on month.
- Performance against the Single Cancer Pathway measure of patients receiving definitive treatment within 62 days, deteriorated in February 2021 however, the draft March 2021 shows an improving position.
- All categories of healthcare acquired infections were above target in March 2021 with the exception of Pseudomonas aerginosa which was on target.
- Concerns response performance did not achieve the internal profile of 80% or the national target of 75% in January 2021. The number of formal complaints received increased in March 2021 to pre-COVID levels.
- The number of Friends & Family surveys completed increased in March 2021 and the overall recommendation rate was 87% against an internal target of 90%.
- Serious Incident (SI) numbers have reduced. SI closure performance remained poor in March 2021 (0%)
- The last new Never Event was recorded in November 2020.
- Fractured neck of femur performance in January 2020 continues to be broadly at Welsh National levels (see detail below) and showing an improved position compared with January 2019 for most indicators.

2. QUADRANTS OF HARM SUMMARY

The following is a summary of all the key performance indicators included in this report.



NB- RAG status is against national or local target
** Data not available

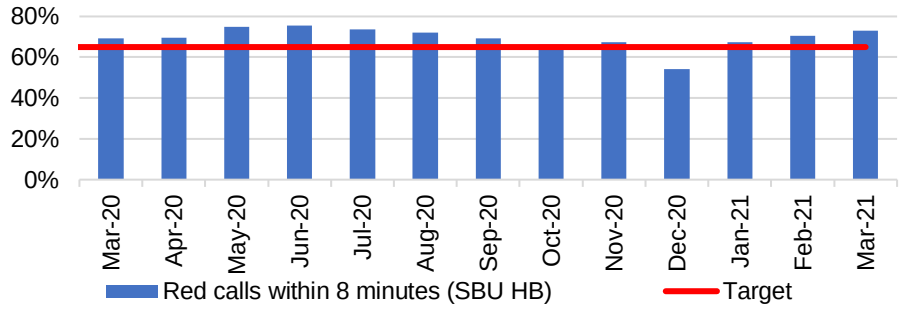
*RAG status based on in-month movement in the absence of local profiles

3. REPORT CARDS

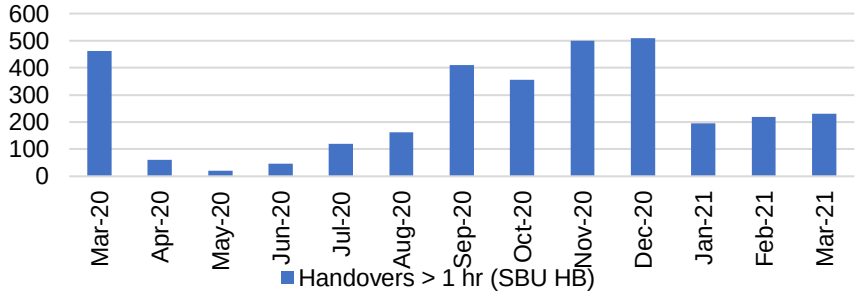
3.1 HARM FROM OVERWHELMED NHS AND SOCIAL CARE

AMBULANCE RESPONSE TIMES AND HANDOVERS					
Quadrant Of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % of emergency responses to red calls arriving within (up to and including) 8 minutes		65%	65%	✓	↓
Measure 2: Number of patients waiting more than 1 hour for an ambulance handover		N/A	0	✗	↑

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

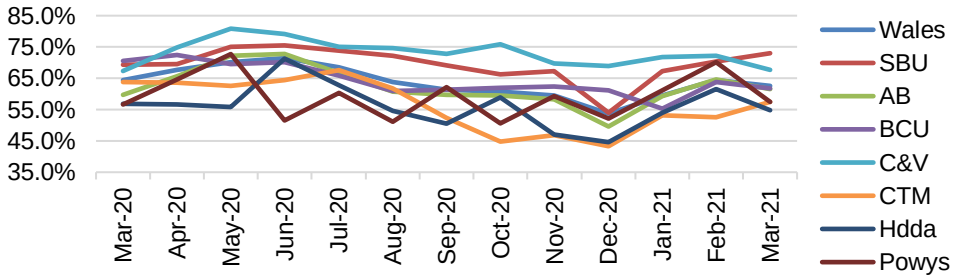


(2) patients waiting more than 1 hour for an ambulance handover

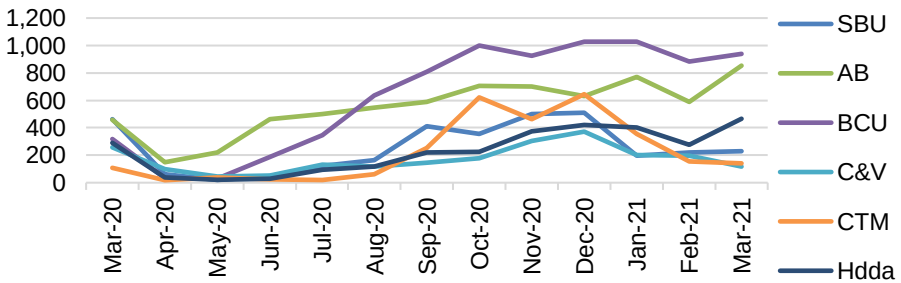


Benchmarking

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



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



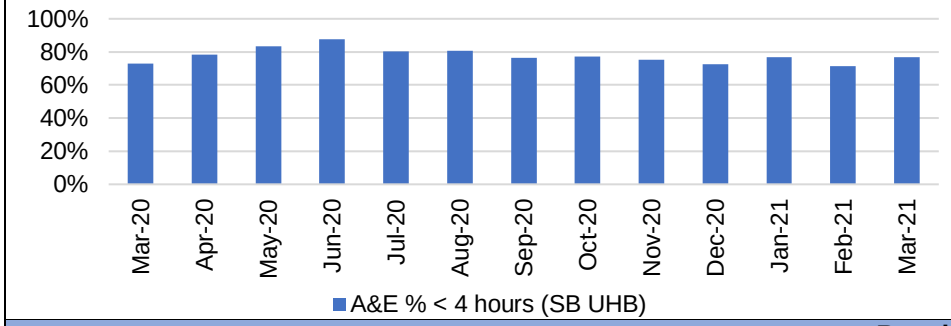
Source : StatsWales (09.04.2021)

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 73% in March 2021, which exceeds the National shared target of 65% and represents an improvement of circa 3 % per month since January 2021. Red call demand was 321, an increase of 34 red calls compared to February. • 1 hour ambulance handover performance has seen a marginal deterioration versus the February position, though still better than the large number of >1 hr handover delays reported Sept – Dec 2020. The total number of ambulance delays > 1 hr was 231, this equates to 5% of patients experiencing a delay at the front door of greater than 1 hour. • Ambulance demand for March 2021 was 4413, an increase of 144 when compared to February activity. Demand has ranged between 3918 and 4778 over the last 10 month period.
What actions are we taking?
• Implementing an OPAS service adjacent to Morriston Emergency Department (ED) and thus improve care for frail elderly patients and release ED trolley capacity to support timely patient handover. • Surge capacity open in all hospital sites to support urgent care flows and ambulance handover. • Improved focus, reporting and escalation of the clinically optimised patient group that impacts capacity and flow on all of the sites. • Implementation of the full time Patient Flow Co-ordinators role in Morriston Hospital to work in partnership with the ambulance triage nurse in respect of handover, monitoring of patients and staffing of ambulance handover capacity within the Emergency Department. • More consistent application of the 'Fit to Sit' policy with the above roles in place. • Adoption of good communication and escalation of flow/handover challenges with the Operational Delivery Unit. • Continuation of the Level 1 falls vehicle with St Johns' to reduce the conveyance of patients to hospital following a fall. • Falls rapid response car with the Welsh Ambulance Service Trust (WAST) Health Board Clinical Lead and Physiotherapist to respond to falls at home-aimed at admission avoidance. • Daily review of the ambulance stack by GP's to reduce ambulance conveyance demand and seek alternative pathways for patients. • Singleton hospital to provide the downgraded 999 and treat and transfer pathways to redirect appropriate demand. • Promotion of the GP advice for ambulance paramedics linked to the Acute GP Unit (AGPU) based in Singleton Hospital.
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 results in increased risk to patients in the community and at hospital if there are prolonged ambulance handover times. • Reduced acute capacity due to COVID outbreaks, particularly on the Morriston site and the impact of this on ED outflow and ambulance handover.
How do we compare with our peers?
• The Health Board achieved 73% Category A performance response in March 2021, the best performing Health Board area in Wales. • The Health Board performance for >1 hour handover delays is exceeded only by Cwm Taf Morgannwg and Cardiff and Vale, with markedly poorer performance in the remaining Health Board areas.

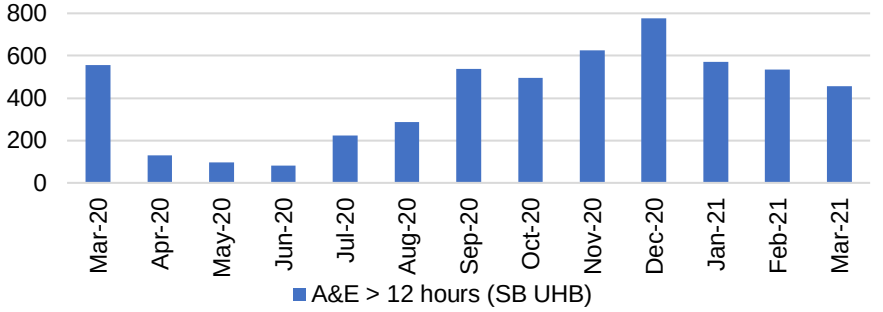
A&E WAITING TIMES

Quadrant Of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % new patients spending no longer than 4 hours in an Emergency Department		N/A	95%	✗	↓ ●
Measure 2: Number of patients spending more than or equal to 12 hours in A&E		N/A	0	✗	↑ ●

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

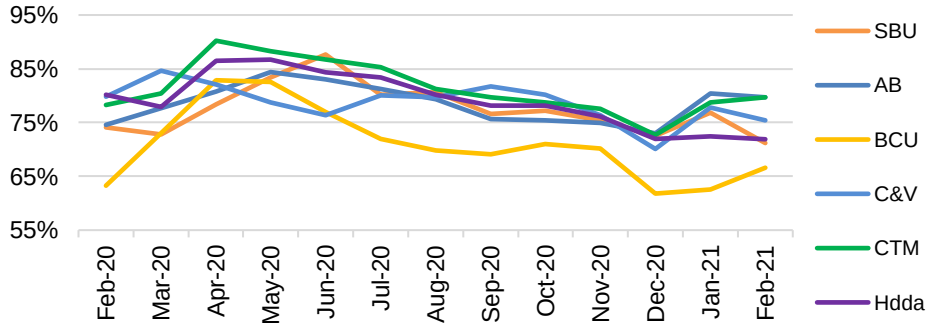


Number of patients spending more than or equal to 12 hours in A&E

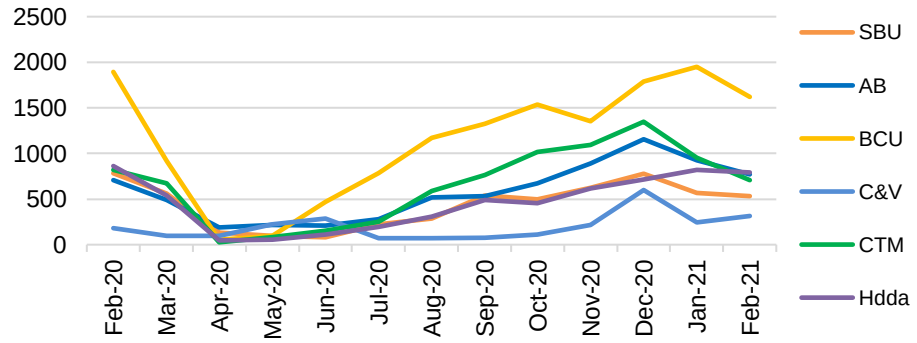


Benchmarking

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



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

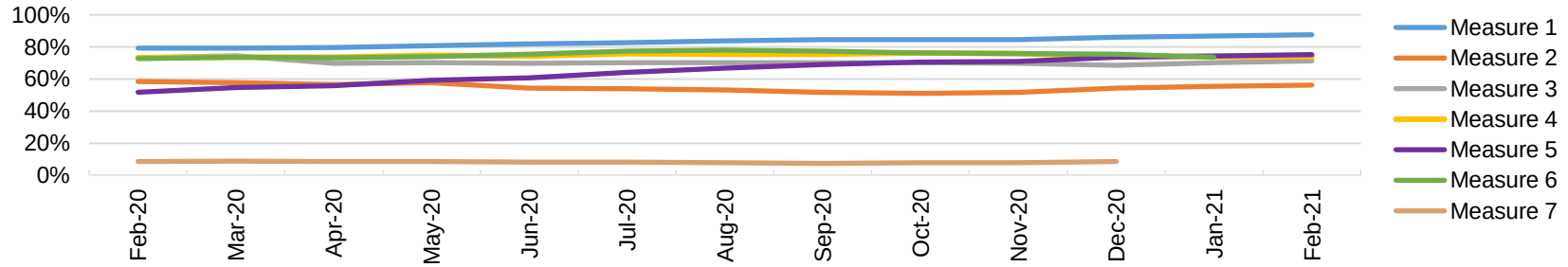


Source : Stats Wales (data extracted 16.04.2021)

Measure 1: % new patients spending no longer than 4 hours in an Emergency Department Measure 2: Number of patients spending more than or equal to 12 hours in A&E
How are we doing?
• Unscheduled care performance against the 4 hour target in March 2021 was 76.9%, >5% improvement on the February position. • 4 hr performance over the past 6 month period has been relatively static at 71-77%. • There has been a sustained reduction in the number of patients spending more than 12 hours in the Emergency Department with a reported March position of 457, 77 less patients than the February position. • During March 2021 4hr and 12hr performance improved compared to the previous reporting period, against a background of increasing activity. • There is marked increase in activity in March 2021, with total attendances of 8839 between NPT Minor Injury Unit (MIU) and Morriston Emergency Department (ED), an increase of 24% compared to the February activity of 6677 attendances.
What actions are we taking?
• Introduction of revised system escalation processes to ensure risk balanced approach to demand management. • Surge capacity open and staffed across all hospital sites to support urgent care flows. • Ongoing recruitment to vacancies critical to delivery of unscheduled care services across the Health Board – in progress. • Improved focus on the clinically optimised patient group, improved reporting and escalation processes in place. • Securing additional medical and nursing workforce to support front door services- combination of block booking and ad hoc cover requests - in place. • Ring-fenced planned care pathways with complete separation from the unscheduled care bed pool. • Emergency Care Manager of the Day model introduced in Morriston to support the Patient Flow function. • '111 First' step 1 launched in February 2021 to redirect patients into appropriate pathways of care, thus avoiding ED attendance. • Improved 'direct to specialty pathways' being developed with clinical and managerial leads.
What are the main areas of risk?
• Closed beds for Infection Prevention Control. • Capacity gaps in Care Homes, Community Resource Teams and capacity and fragility of private domiciliary care providers, leading to an increase in the number and length of wait of patients in hospital who are 'discharge fit'. The increasing number of discharge fit patients is impacting the outflow from the ED and thus ability to support timely ambulance handover. • Sustainably staffing the high level of surge beds in the system remains a key operational challenge. • Workforce - with ongoing challenges in general nursing and medical roles in some key specialities and service areas such as the Emergency Department. • Loss of in-patient capacity on the Morriston site due to COVID ward outbreaks continues to further impact patient flow on site.
How do we compare with our peers?
• Of the 6 Welsh peers, SBUHB rate 5th in relation to 4 hr performance however significant opportunity exists in relation to the development of wrap around unscheduled care services and 7 day working which feature in the annual plan. • SBUHB are the second best performing HB in relation to 12 hour waits in Wales despite an increasing clinically optimised patient position.

FRACTURED NECK OF FEMUR (NOF)				
Quadrant Of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Richard Evans, Executive Medical Director	
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	**Annual Plan Profile**	**Period:** February 2021	
			Current Status *(against target):*	**Movement:** *(12 month trend)*
(1) Prompt orthogeriatric assessment- % patients receiving an assessment by a senior geriatrician within 72 hours of presentation				↑
(2) Prompt surgery - % patients undergoing surgery the day following presentation with hip fracture				↓
(3) NICE compliant surgery - % of operations consistent with the recommendations of NICE CG124				↓
(4) Prompt mobilisation after surgery - % patients out of bed (standing or hoisted) by the day after operation				↑
(5) Not delirious when tested- % patients (<4 on 4AT test) when tested in the week after operation				↑
(6)Return to original residence- % patients discharged back to original residence, or in that residence at 120 day follow-up				↑
(7) 30 day mortality rate				↓

Morriston Hospital compliance against NOF measures



Benchmarking

Measure	Period	Morriston	All-Wales	England, Wales & N. Ireland
(1) Prompt orthogeriatric assessment	Feb-21	87.6%	59.9%	86.3%
(2) Prompt surgery	Feb-21	56.3%	67.6%	68.7%
(3) NICE compliant surgery	Feb-21	71.2%	73.0%	70.6%
(4) Prompt mobilisation after surgery	Feb-21	74.1%	75.5%	80.8%
(5) Not delirious when tested-	Feb-21	75.2%	55.4%	57.7%
(6)Return to original residence	Jan-21	73.7%	73.6%	69.8%
(7) 30 day mortality	Dec-20	8.4%	7.3%	8.2%

Source: National Hip Fracture Database

Measure 1 Prompt orthogeriatric assessment Measure 2 Prompt surgery Measure 3 NICE compliant surgery Measure 4 Prompt mobilisation after surgery Measure 5 Not delirious when tested Measure 6 Return to original residence. Measure 7 30 day mortality rate

How are we doing?

1. The current orthogeriatric medical establishment <1 WTE equivalent split between: 1 Consultant, 1 Associate Specialist and 1 Specialty Doctor. Specialty Doctor is retiring Aug 2021. Frailty Business Case has been developed to support the recommended Orthogeri staffing model further.
2. Hip fracture patients are operated on as a priority over fitter and younger trauma patients that are stable, but the lack of trauma capacity restricts doing all in a timely fashion - particularly the inability to upscale when there is a spike in activity. There is a trauma list running 8am-8pm every day (incl. weekends and bank holidays). Additional Trauma theatre capacity has been provided which has assisted in meeting the target and can be seen in the figures below. However, the additional Trauma theatre capacity has is shared between Orthoplastics and Spines which on occasions results in #NOF patients not getting to theatre within the NHFD target.
3. Surgical procedure consistent with the recommendations of NICE CG124.
4. All patients receive a physio assessment within 24hours of surgery Mon-Fri. Data is captured for all patients who do not sit out of bed Mon-Fri e.g. low haemoglobin, low blood pressure.
5. The overall performance has improved in the last twelve months with significant improvement on the not delirious post-op.

What actions are we taking?

1. Part time orthogeriatric Associate Specialist's contract has been increased by 2 sessions per week.
2. NICE compliant surgery - process being monitored through monthly audit/governance meetings – performance is improving which is encouraging.
3. Funding secured to appoint additional weekend physio cover for #NOF patients; service commenced in Jan 20 and impact is being monitored. Additional weekend support is required and will be covered in the IMTP bid for 2020-21. Work being undertaken to train nursing staff in mobilising patients and provide additional resources for physiotherapy to support the early mobilisation of patients, particularly on the weekend.
4. Further improvement is required in relation to greater involvement of rehabilitation sites in pathway discussions and planning. Ensuring that a conversation about home circumstances, improved use of discharge planning sheets to capture family / patient discussions about expected destination on discharge and involving social workers (when appropriate) at an early stage, are priorities.
5. GIRFT recommendations are included in the Frailty Business Case, which is in discussion with Morriston Unit and Executive team.
6. Regular #NOF multi-disciplinary meetings are in place so that performance and service improvement is monitored in detail.

- Bi monthly ●Audit meetings Bi Monthly Business meetings ●Monthly Exec meetings ●Fortnightly performance 'look back' meetings ●Monthly Meeting held with Emergency Dept. stakeholders

7. Regular audits are undertaken in all elements of the pathway and presented to the Unit so that service improvement is monitored and promoted.
8. Detailed data is now collected in house so that every patients journey is not only captured but also analysed at the fortnightly 'look back' meetings.
9. All #NOF patients are discussed as a matter of priority at the 7:30 trauma meeting.
10. MDT working is encouraged in the fortnightly and monthly #NOF meetings. Meetings include a wide invitation of stakeholders who are encouraged to attend the regular meetings as well as specific service improvements events and discussions
11. The case for increasing the number of Orthogeriatrician by 2 posts is being made through the Frailty Business Case.

What are the main areas of risk?

30-day mortality has improved but remains a key issue and the outcomes and mortality data are reviewed at the departmental arthroplasty meetings. All cases of mortality are cross-referenced with the department's morbidity and mortality database and presented at the monthly meeting to review any points for learning. The case for increasing the number of Orthogeriatrician by 2 posts is being made through the Frailty Business Case.

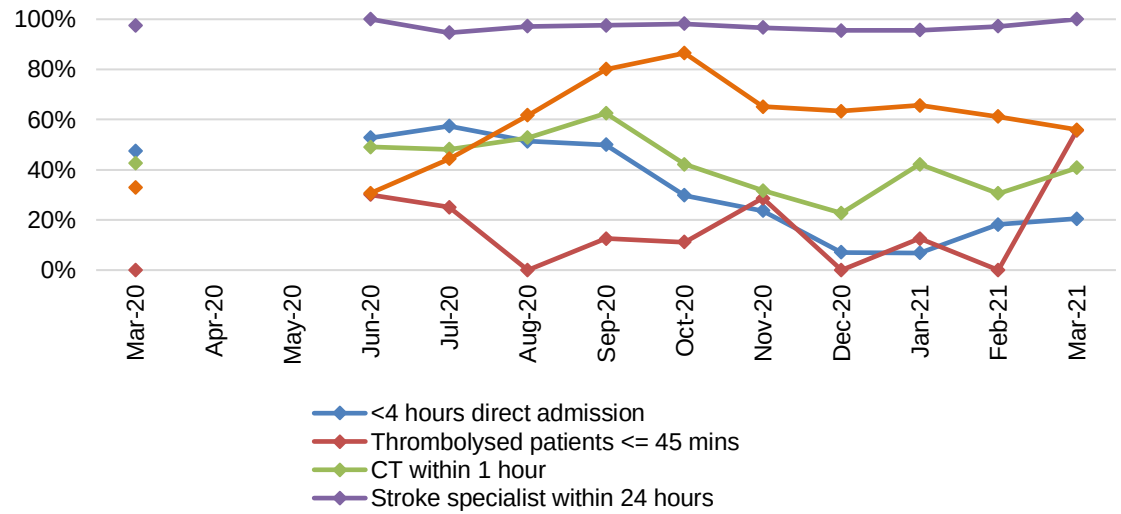
How do we compare with our peers?

- Included within the benchmarking table above.

STROKE

Quadrant Of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement	**Annual Plan Profile**	**WG Target**	**Period:** March 2021	
				Current Status *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours		N/A	59%	✗	↓
Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes		N/A	12 ↑ trend	✓	↑
Measure 3: % of patients who receive a CT scan within 1 hour		N/A	55%	✗	↓
Measure 4: % of patients who are assessed by a stroke specialist consultant physician within 24 hours		N/A	95%	✓	↑
Measure 5: % of patients receiving the required minutes for speech and language therapy		N/A	12 ↑ trend	✓	↑

Acute Stroke Quality Improvement Measures



N.B. Data for Apr-20 and May-20 not available.

Benchmarking

March 2021			
Quality Improvement Measures	1. Direct Admission to Acute Stroke Unit < 4 hours	4. Assessed by Stroke consultant < 24 hours	5. Patients receiving minutes for SALT
AB	40.0%	97.2%	58.0%
BCU	21.1%	83.0%	42.3%
C&V	4.5%	75.0%	63.7%
CTM	12.0%	79.8%	32.4%
Hywel Dda	38.3%	96.4%	40.0%
SBU	20.4%	100.0%	55.9%
All-Wales	22.6%	87.6%	43.7%

Source : All-Wales performance summary (April 2021) & Acute stroke quality improvement measures Delivery Unit report

Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours. Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes. Measure 3: % of patients who receive a CT scan within 1 hour. Measure 4: % of patients who are assessed by a stroke specialist consultant within 24 hours. Measure 5: % of patients receiving the required minutes for speech and language therapy

How are we doing?

- Our door to needle time within 45 minutes has improved to 55.6% in March 2021 (target 59%), following a drop in performance due to Covid pressures. Direct admissions over the last 4 weeks to a stroke unit bed within 4 hours continues to be under target at 20.4%, which is mainly due to unscheduled care pressures and Covid. 100% was achieved for the end of March 2021 for assessment by a Consultant and 93.9% compliance achieved for Physio, OT and SALT assessment. Our access to CT scanning within 1 hour has improved to 40.8% in March 2021, from 30.6% in February 2021, despite the ongoing pressures due to Covid, however there is still room for improvement.
- Gaps in overall out of hours medical cover has impacted on our ability to make the desired improvements, and unscheduled care pressures/Covid have also impacted on our delivery against these targets.

What actions are we taking?

- Weekly multi-disciplinary meetings are held in Morriston Hospital - the Clinical leads and managers for the service review individual patient pathways to identify opportunities for improvement.
- Medical cover for Stroke patients is provided by the General Medical team out of hours – there is currently no dedicated stroke medical team that covers 24 hours. The additional medical staffing reported previously has allowed some improvement to service but it cannot be sustained due to gaps at lower grades which these colleagues have to cover, therefore not allowing them time to commit to improved stroke performance. The Unit makes best endeavours to cover the junior gaps in rota and looks to sustainable recruitment in a difficult to recruit area. The creation of a dedicated Stroke rota is key and needs to be agreed as part of the Hyper-acute Stroke Unit (HASU) business case development as below.
- An Early Supported Discharge team has been developed and implemented recently, however, it has limited therapies cover and lack of support staff, as well as lack of 7 day working. A business case has been developed by the lead therapist to be considered in the near future.
- A Business Case for a local “Hyper-acute Stroke Unit” model for Swansea Bay University Health Board (SBUHB) is currently being developed for consideration in line with Annual plan for expected delivery in Qtr 4 2021/22. This work is led by the Medical Directorate management team, in conjunction with strategy.

What are the main areas of risk?

- Insufficient capacity and workforce resilience to support 7 day working, which will ultimately require a strategic change to centralise acute stroke services.
- Not having a dedicated Stroke Consultant out of hour’s rota.
- High volumes of work in Emergency Department preventing timely assessment and management of patients.
- Medicine bed deficit equates to approximately 50 beds which prevents ring fencing of ASU beds to facilitate timely admissions.
- Unscheduled care pressures and increasing waits for transfers of care affecting stroke care capacity.
- Limited availability to the thrombectomy pathway represents a risk to patient mortality as it is not available out of hours.

How do we compare with our peers?

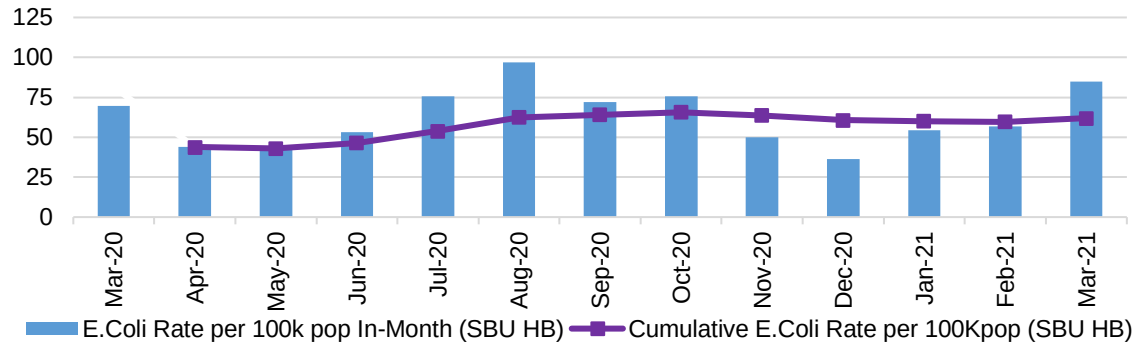
- SBUHB is one of the main acute stroke care providers in Wales which allocates general medicine workload to Stroke Physicians – detracting from acute stroke work.
- SSNAP report for March 2021 shows Morriston with comparative stroke performance in some domains to most Welsh hospitals, but not others (cat C).
- The Health Board needs to develop dedicated Consultant Stroke out of hours cover and improved ring fenced / dedicated stroke beds in order to deliver further improvements.

E. COLI Bacteraemia

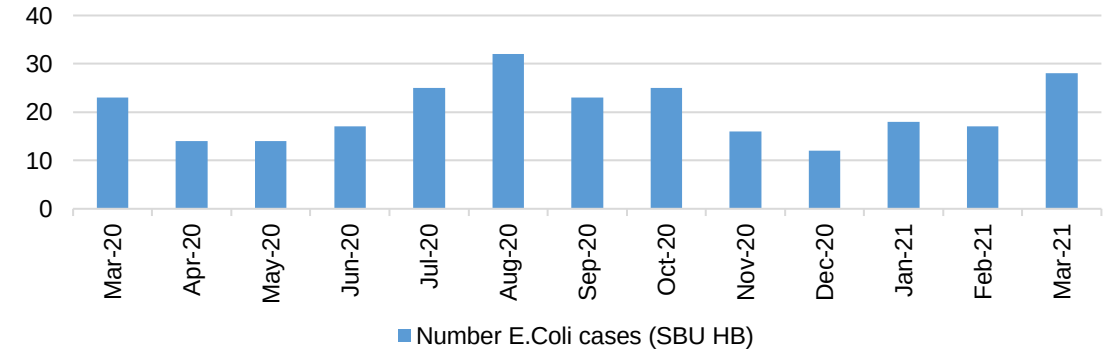
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.		

	Annual Plan Profile	**WG Target**	**Period:** March 2021	
			Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Cumulative rate of E.*coli* bacteraemia cases per 100,000 of the population	N/A	N/A		↑
Measure 2: Number of E.*coli* bacteraemia cases	N/A	N/A		↑

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



(2) Number of E.coli bacteraemia cases



Benchmarking

LHB	Cumulative Cases (Apr 20 - Mar-21)	Cumulative Rate (Apr 20 - Mar 21)	Rank (Cumulative Rate)
Wales	1882	59.9	-
SBU	241	61.89	3
AB	295	49.9	1
BCU	440	63	4
C&V	280	56.4	2
CTM	316	70.53	5
Hdda	299	77.54	6

Source : Public Health Wales: Healthcare Acquired Infections Dashboard (April 2021)

Measure 1: Rate of E.coli bacteraemia cases per 100,00 of the population
Measure 2: Number of E.coli bacteraemia cases

How are we doing?

- In 2020/21, there had been 241 cases of *E. coli* bacteraemia within the Health Board. This was 24% fewer than the number of cases in the previous year. The cumulative cases for 2020/21 was 59 cases below the projected IMTP profile and 11 cases below the Welsh Government infection reduction expectation for the Health Board.
- There were 28 cases of *E. coli* bacteraemia in March 2021; this was 5 cases above the IMTP monthly profile and 4 cases above the Welsh Government monthly infection reduction expectation.
- 66% of the cases in 2020/21 were considered community acquired; 34% were considered hospital acquired. Of the latter, 52% were associated with Morriston Hospital, 30% with Singleton Hospital, and 16% with Neath Port Talbot Hospital.
- In March 2021, 32% of cases were considered hospital acquired; of these, 56% were associated with Morriston Hospital, 33% with Singleton Hospital, and 11% with Neath Port Talbot Hospital.

What actions are we taking?

- Service Delivery Groups are monitoring staff training in relation to Standard Infection Control Precautions and ANTT training.
- Morriston Service Delivery Group has established a Consultant-led bacteraemia review group. Neath Port Talbot & Singleton Hospital Service Delivery Group is establishing a Service Group IPC Group, plus a Divisional Ward Manager IPC group, which feeds into the main IPC Group, which will monitor Tier 1 hospital acquired infections.

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.
- Use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which is frequently close to, or exceeds, 90% is associated with an increased risk of hospital acquired infections.
- Reduction initiatives are compromised by high levels of service activity, staffing vacancies, and reliance on temporary staff.

How do we compare with our peers?

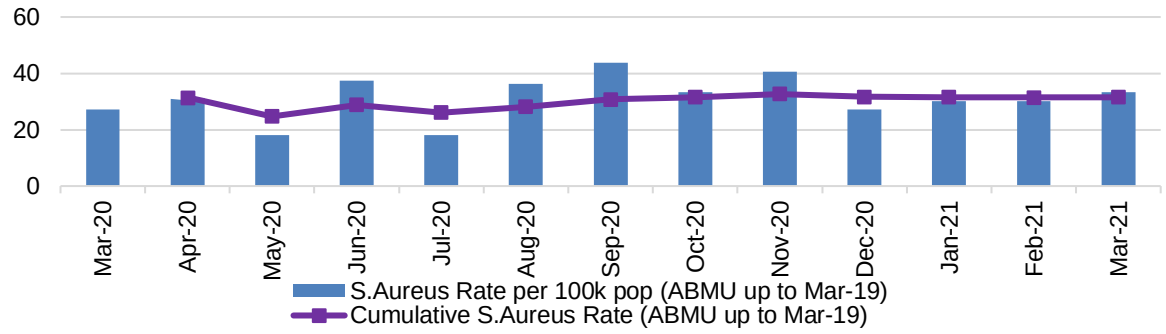
- The Health Board cumulative incidence of *E. coli* bacteraemia per 100,000 population for 2020/21 was 61.89, the third lowest incidence in NHS Wales.
- The incidence in March 2021 was 84.67/100,000 population; this was the third highest monthly incidence for the major acute Health Boards in Wales.

S. AUREUS Bacteraemia

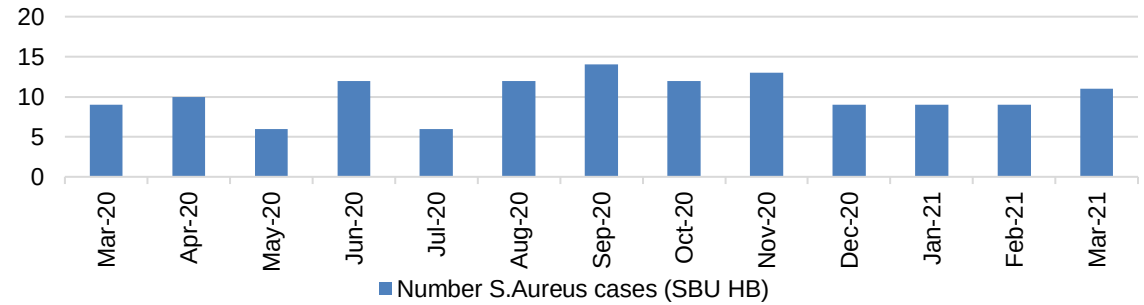
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.		

	Annual Plan Profile	**WG Target**	**Period:** March 2021	
			Current Status *(against profile)*:	**Movement:** *(12 month trend)*
Measure 1: Cumulative rate of *S.aureus* bacteraemia cases per 100,000 of the population	N/A	N/A		↑
Measure 2: Number of *S. aureus bacteraemia* cases	N/A	N/A		↑

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



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



Benchmarking

LHB	Cumulative Cases (Apr 20 - Mar-21)	Cumulative Rate (Apr 20 - Mar 21)	Rank (Cumulative Rate)
Wales	780	24.85	-
SBU	123	31.59	6
AB	157	26.56	5
BCU	157	22.48	1
C&V	130	26.19	4
CTM	116	26.06	3
Hdda	94	24.38	2

Source : Public Health Wales: Healthcare Acquired Infections Dashboard (April 2021)

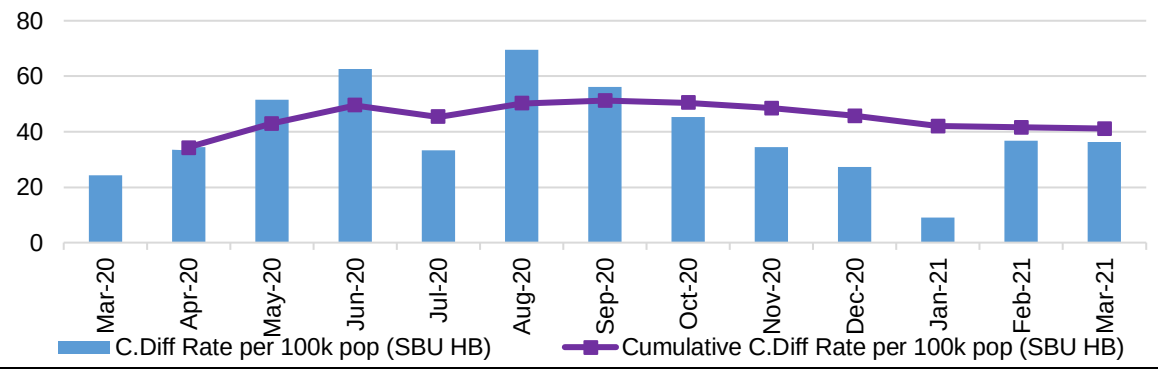
Measure 1: Rate of S.aureus cases per 100,00 of the population Measure 2: Number of S.aureus cases
How are we doing?
• In 2020/21, there had been 122 cases of *Staph. aureus* bacteraemia within the Health Board. This was 8% fewer than the number of cases in the previous year. The cumulative cases for 2020/21 was 2 cases above the projected IMTP profile and 50 cases above the Welsh Government infection reduction expectation for the Health Board. Three of these cases were MRSA bacteraemia, of which two were identified in Morriston and one was a community-acquired infection. There had been an 81% reduction in the number of MRSA bacteraemia cases in 2020/21 compared with the preceding financial year. This is a significant achievement, with the lowest incidence of MRSA bacteraemia in NHS Wales. • There were 11 cases of *Staph. aureus* bacteraemia in March 2021; this was 5 cases above the IMTP monthly profile and the Welsh Government monthly infection reduction expectation. • 52% of the cases in 2020/21 were considered community acquired; 48% were considered hospital acquired. Of the latter, 61% were associated with Morriston Hospital, and 36% with Singleton Hospital. • In March 2021, 36% of cases were considered hospital acquired; of these, 50% were associated with Morriston Hospital, and 50% with Singleton Hospital.
What actions are we taking?
• Service Delivery Groups are monitoring staff training in relation to Standard Infection Control Precautions and ANTT training. • Morriston Service Delivery Group has established a Consultant-led bacteraemia review group. Neath Port Talbot & Singleton Hospital Service Delivery Group is establishing a Service Group IPC Group, plus a Divisional Ward Manager IPC group, which feeds into the main IPC Group, which will monitor Tier 1 hospital acquired infections.
What are the main areas of risk?
• A significant proportion 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. • 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 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. • Reduction initiatives are compromised by high activity levels, staffing vacancies, and reliance on temporary staff.
How do we compare with our peers?
• The Health Board cumulative incidence of *Staph. aureus* bacteraemia per 100,000 population for 2020/21 was 31.59, the highest incidence in NHS Wales, despite the incidence of MRSA bacteraemia being the lowest in Wales. • The incidence in March 2021 was 33.26/100,000 population; this was the highest monthly incidence in Wales.

C.DIFFICILE

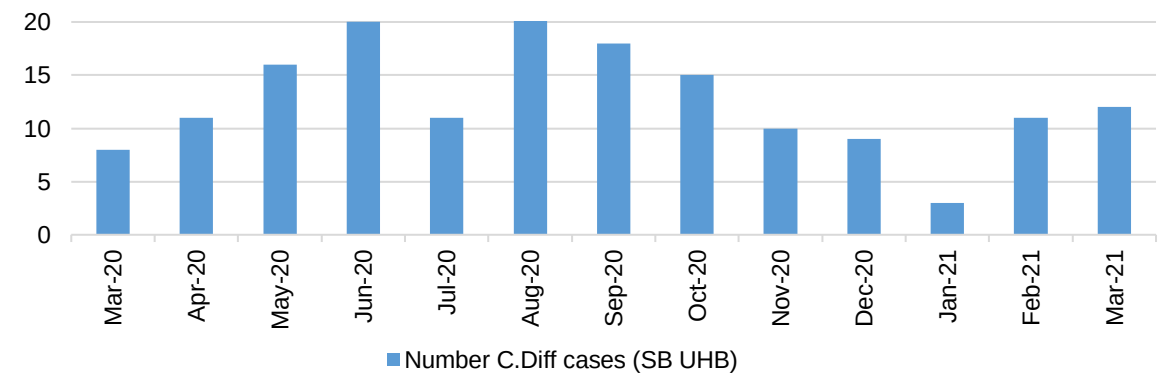
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.		

	Annual Plan Profile	**WG Target**	**Period:** March 2021	
			Current Status *(against profile)*:	**Movement:** *(12 month trend)*
Measure 1: Cumulative rate of *C. difficile* cases per 100,00 of the population	N/A	N/A		↑
Measure 2: Number of *C. difficile* cases	N/A	N/A		↓

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



(2) **Number of *C. difficile cases***



Benchmarking

LHB	Cumulative Cases (Apr 20 - Mar-21)	Cumulative Rate (Apr 20 - Mar 21)	Rank (Cumulative Rate)
Wales	880	28.04	-
SBU	160	41.09	6
AB	146	24.69	2
BCU	212	30.36	4
C&V	99	19.94	1
CTM	112	25.16	3
Hdda	138	35.79	5

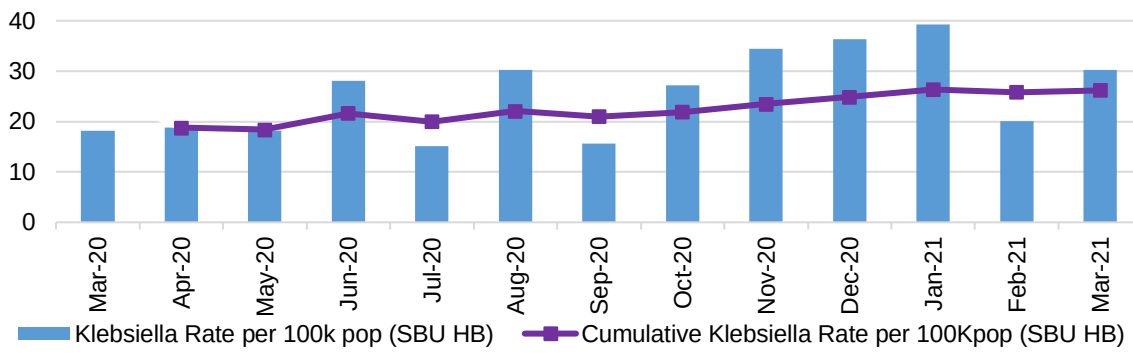
Source : Public Health Wales: Healthcare Acquired Infections Dashboard (April 2021)

Measure 1: Rate of *C. difficile* cases per 100,00 of the population Measure 2: Number of *C. difficile* cases
How are we doing?
• In 2020/21, there had been 160 cases of *C. difficile* within the Health Board. This was 16% higher than the number of cases in the previous year. The cumulative cases for 2020/21 was 43 cases above to projected IMTP profile and 64 cases above the Welsh Government infection reduction expectation for the Health Board. There were few episodes during the year of confirmed transmission of infection. The increase is cases may have been related to antimicrobial prescribing due to COVID-19. • There were 12 *Clostridioides difficile* toxin positive cases in March 2021; this was 7 cases above the IMTP monthly profile and 4 cases more than the Welsh Government monthly infection reduction expectation. • 65% of the cases in 2020/21 were considered hospital acquired. Of these, 59% were associated with Morriston Hospital, 26% with Singleton Hospital, 11% with Neath Port Talbot, 3% with Gorseinon Hospital and 1% with Cefn Coed Hospital. • In March 2021, 58% of cases were considered hospital acquired; of these, 43% were associated with Morriston Hospital, 43% with Singleton Hospital and 14% with Neath Port Talbot Hospital.
What actions are we taking?
• Antimicrobial actions in Primary Care: *C. difficile pilot* - community cases are being reviewed by an antimicrobial pharmacist. *Focus on 4C (broad-spectrum antibiotics*), with a cluster-based approach. *Sore throat audit* agreed as the pre-qualifier for access to the Prescribing Management Scheme. *Presentation to Cluster leads* planned for May to discuss a proposal for a programme of practice-based antimicrobial quality improvement work. • Antimicrobial actions in Secondary Care: *Introduction of a programme of junior-doctor led antimicrobial quality improvement projects* planned for this Spring. *ARK 72-hour mandatory review incorporated into the e-prescribing system roll-out for all antimicrobials*. *Focus on surgical prophylaxis.* Audits undertaken in Theatre Recovery areas. *Review placement of gentamicin within the Antimicrobial Guidelines, with an aim of further reducing broad-spectrum antibiotic usage.* • Continued focus on the '4D' cleaning and decontamination programme, utilising Ultraviolet-C disinfection. • Continued review of Service Delivery Group *C. difficile* improvement plans by the *C. difficile* Scrutiny Group.
What are the main areas of risk?
• Contributory factors: antibiotic prescribing; impact of COVID-19 on antimicrobial prescribing; 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. • The current ratio of *C. difficile* carriers to *C. difficile* infection cases is approximately 2:1. In all cases where there are patients who are either carriers of, of infected with*, C. difficile*, it is critical that the care environment is thoroughly deep cleaned using the '4D' cleaning/decontamination process if the safety of the care environment is not to be compromised. To facilitate this, decant facilities and appropriately funded cleaning hours are priorities. • Reduction initiatives are compromised by increased activity and where activity levels are such that it is not possible to decant bays to clean effectively patient areas where there have been infections.
How do we compare with our peers?
• The Health Board cumulative incidence per 100,000 population for 2020/21 was 41.09, the highest incidence in NHS Wales. • The incidence in March 2021 was 36.29/100,000 population; this was the second highest monthly incidence in Wales, and was more than twice the incidence in the best-performing Health Board. • There has to be continued and significant improvement in relation to antimicrobial prescribing if Health Board performance is to be comparable with peers.

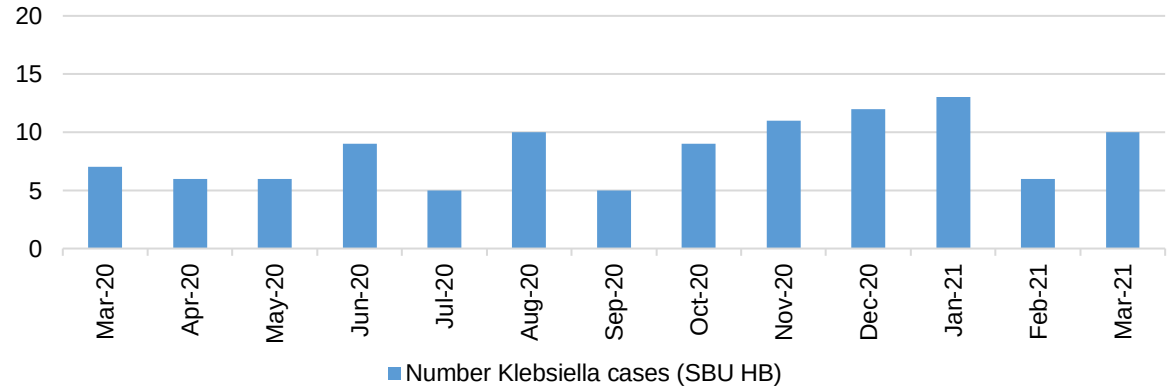
Klebsiella spp. *Bacteraemia*

Quadrant of Harm	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Cumulative rate of Klebsiella spp. bacteraemia cases per 100,000 of the population		N/A	N/A		↑
Measure 2: Number of Klebsiella spp. Bacteraemia cases		N/A	N/A		↑

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



(2) Number of Klebsiella spp. bacteraemia cases



Benchmarking

LHB	Cumulative Cases (Apr 20 - Mar-21)	Cumulative Rate (Apr 20 - Mar 21)	Rank (Cumulative Number)
Wales	620	19.75	-
SBU	102	26.2	4
AB	116	19.62	5
BCU	129	18.47	6
C&V	100	20.14	3
CTM	96	21.56	2
Hdda	73	18.93	1

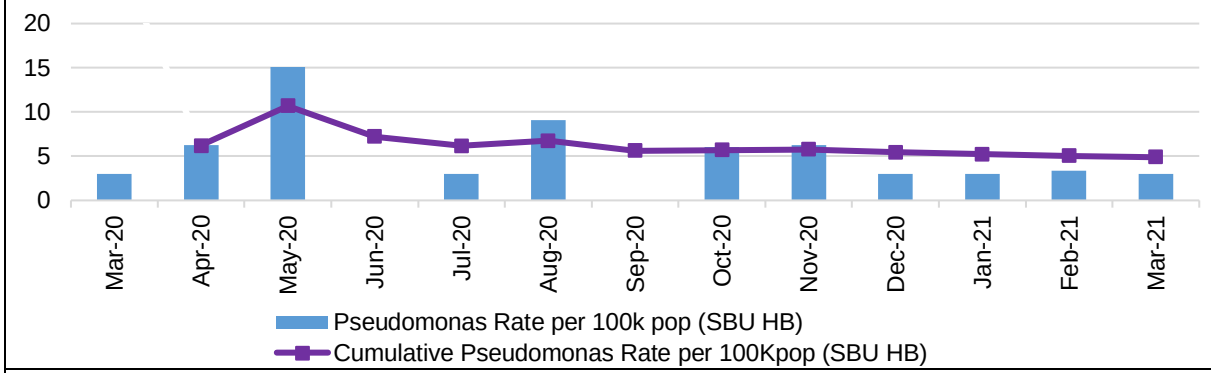
Source : Public Health Wales: Healthcare Acquired Infections Dashboard (April 2021)

Measure 1: Rate of Klebsiella spp. Bacteraemia cases per 100,00 of the population Measure 2: Number of Klebsiella spp. bacteraemia cases
How are we doing?
• In 2020/21, there had been 102 cases of *Klebsiella spp*. bacteraemia within the Health Board. This was 24% higher than the number of cases in the previous year. The cumulative cases for 2020/21 was 24 cases above the projected IMTP profile and 30 cases above the Welsh Government infection reduction expectation for the Health Board. • There were 10 cases of *Klebsiella spp*. bacteraemia in March 2021; this was 5 cases above the IMTP monthly profile and 4 cases above the Welsh Government monthly infection reduction expectation. • 45% of the cases in 2020/21 were considered community acquired; 55% were considered hospital acquired. Of the latter, 70% were associated with Morriston Hospital, 18% with Singleton Hospital, and 11% with Neath Port Talbot Hospital. • In March 2021, 1 of the 10 cases was considered hospital acquired; this was associated with Singleton Hospital. • Of the cumulative cases in 2020/21, 29% were thought to have a urinary source, 16% a hepato-biliary source, and 15% a respiratory source. For hospital acquired infections, 25% of cases were considered to have a respiratory source, 14% a urinary source, and 7% a hepato-biliary source.
What actions are we taking?
• Service Delivery Groups are monitoring staff training in relation to Standard Infection Control Precautions and ANTT training. • Morriston Service Delivery Group has established a Consultant-led bacteraemia review group. Neath Port Talbot & Singleton Hospital Service Delivery Group is establishing a Service Group IPC Group, plus a Divisional Ward Manager IPC group, which feeds into the main IPC Group, which will monitor Tier 1 hospital acquired infections.
What are the main areas of risk?
• A significant proportion of *Klebsiella spp*. 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. • Use of pre-emptive beds on acute sites increases risks of infection transmission. • Bed occupancy, which is frequently close to, or exceeds, 90% is associated with an increased risk of hospital acquired infections. • Reduction initiatives are compromised by high levels of service activity, staffing vacancies, and reliance on temporary staff.
How do we compare with our peers?
• The Health Board cumulative incidence of *Klebsiella spp*. bacteraemia per 100,000 population for 2020/21 was 26.20, the third highest incidence in NHS Wales. • The incidence in March 2021 was 30.24/100,000 population; this was the second highest monthly incidence for the major acute Health Boards in Wales.

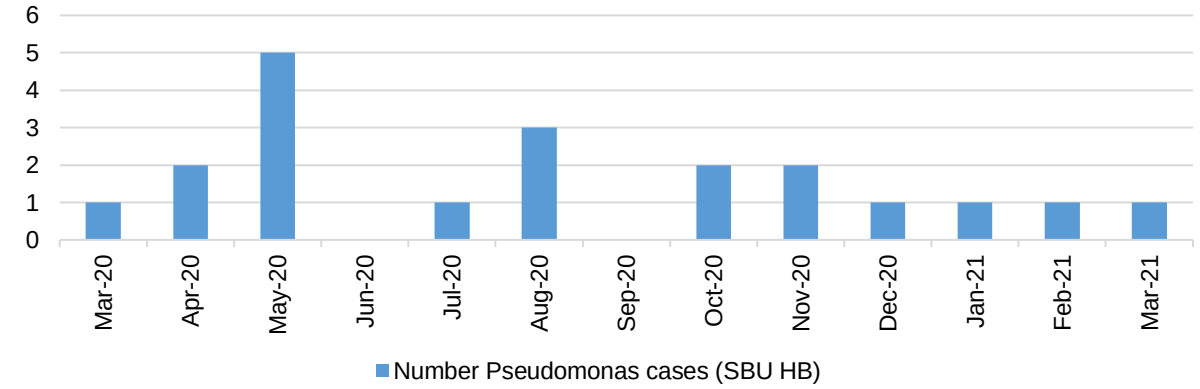
Pseudomonas Aeruginosa *Bacteraemia*

Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**IMTP Profile**	**WG Target**	**Period:** March 2021	
				Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Cumulative rate of P.aeruginosa bacteraemia cases per 100,000 of the population		N/A	N/A		↓
Measure 2: Number of P.aeruginosa bacteraemia cases		N/A	N/A		↓

(1) Rate of Pseudomonas aeruginosa bacteraemia per 10 0,000 of the population.



(2) Number of Psuedomonas aeruginosa bacteraemia cases



Benchmarking

LHB	Cumulative Cases (Apr 20 - Mar-21)	Cumulative Rate (Apr 20 - Mar 21)	Rank (Cumulative Number)
Wales	148	4.72	-
SBU	19	4.88	1
AB	24	4.06	4
BCU	33	4.73	6
C&V	29	5.84	5
CTM	20	4.49	2
Hdda	22	5.71	3

Source : Public Health Wales: Healthcare Acquired Infections Dashboard (April 2021)

Measure 1: Rate of Pseudomonas aeruginosa Bacteraemia cases per 100,00 of the population
Measure 2: Number of Pseudomonas aeruginosa bacteraemia cases

How are we doing?

- In 2020/21, there had been 19 cases of *Pseudomonas aeruginosa* bacteraemia within the Health Board. This was 32% fewer than the number of cases in the previous year. The cumulative cases for 2020/21 was 8 cases below the projected IMTP profile and 2 cases below the Welsh Government infection reduction expectation for the Health Board.
- There was one case of *Pseudomonas aeruginosa* bacteraemia in March 2021; this was community acquired. This was in line with the IMTP monthly profile and the Welsh Government monthly infection reduction expectation.
- 58% of the cases in 2020/21 were considered community acquired; 42% were considered hospital acquired. Of the latter, 75% were associated with Morriston Hospital, and 25% with Singleton Hospital.

What actions are we taking?

- Service Delivery Groups are monitoring staff training in relation to Standard Infection Control Precautions and ANTT training.
- Morriston Service Delivery Group has established a Consultant-led bacteraemia review group. Neath Port Talbot & Singleton Hospital Service Delivery Group is establishing a Service Group IPC Group, plus a Divisional Ward Manager IPC group, which feeds into the main IPC Group, which will monitor Tier 1 hospital acquired infections.

What are the main areas of risk?

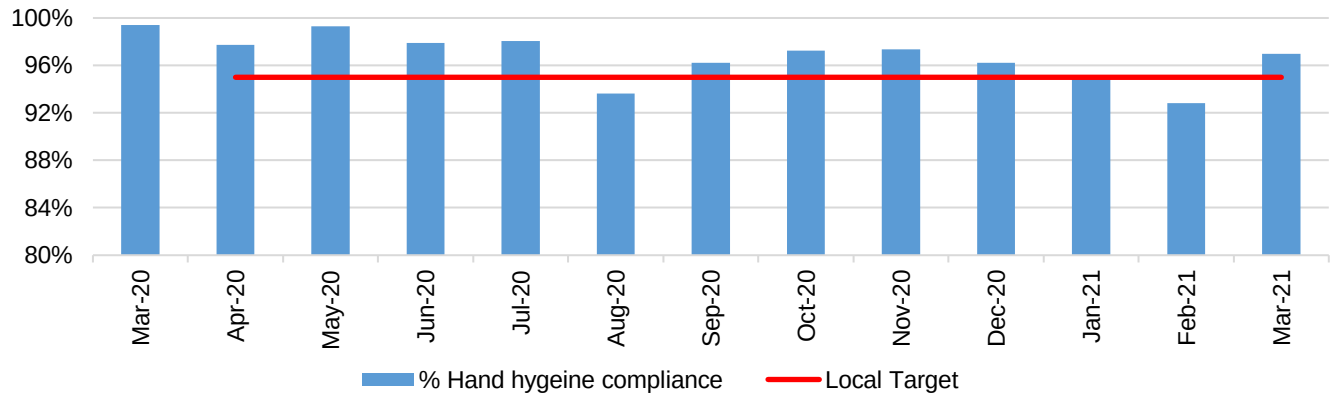
- A significant proportion of *Pseudomonas aeruginosa* bacteraemia is community acquired, with many patient related contributory factors. As such, it will be a challenge to prevent a significant proportion of these.
- Bed occupancy, which is frequently close to, or exceeds, 90% is associated with an increased risk of hospital acquired infections.
- Reduction initiatives are compromised by high levels of service activity, staffing vacancies, and reliance on temporary staff.

How do we compare with our peers?

- The Health Board cumulative incidence of *Pseudomonas aeruginosa* bacteraemia per 100,000 population for 2020/21 was 4.88, the third highest incidence in NHS Wales, although the lowest total number of cases.
- The incidence in March 2021 was 3.02/100,000 population; this was the third lowest monthly incidence for the major acute Health Boards in Wales.

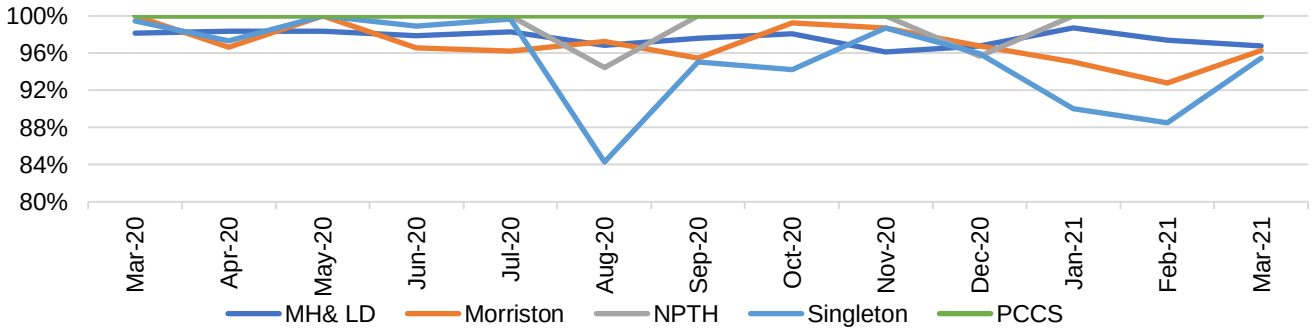
HAND HYGIENE					
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Local Target**	**WG Target**	**Period:** March 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % compliance with Hand Hygiene Audits		95%	N/A	✓	↓ ●

(1) % compliance with Hand Hygiene Audits.



Benchmarking

(1) % compliance with Hand Hygiene Audits.

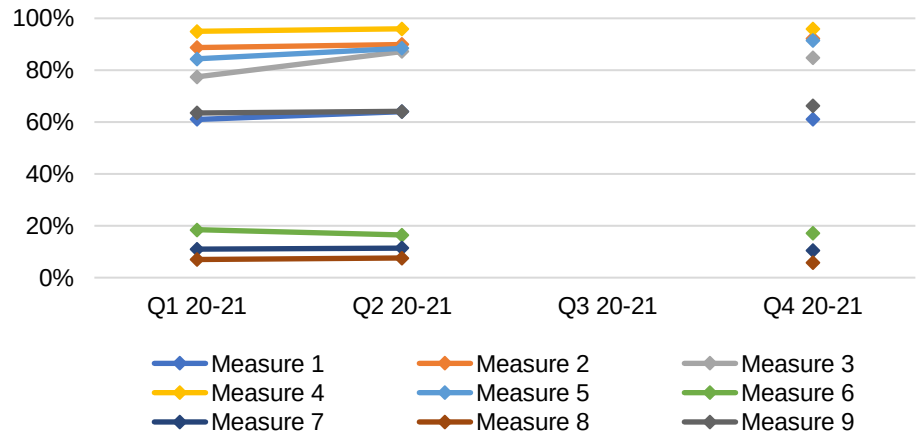


Source: Nursing Care Metrics (April 2021)

Measure 1: % compliance with Hand Hygiene Audits
How are we doing?
• Average compliance with Hand Hygiene for the Health Board for 2020/21 was 95.95%. Health Board compliance with hand hygiene (HH) for March 2021 was 95.53%. • Average compliance for all of the Service Delivery Groups for 2020/21 was ≥93%. • Due to COVID-19, many areas that would report on hand hygiene compliance were not operational during 2021/21. • For March 2021, 56 wards/units (57%) reported compliance ≥95%. • Five wards/departments (5%) reported compliance between 90% and 94%; nine wards/units (9%) reported compliance of 89% or below. • 28 wards/departments had not uploaded the results of their audits undertaken in March 2021 at the time of updating this report. • 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?
• Service Delivery Groups can agree internal peer review audit programmes, undertaking these between wards, specialties or Service Delivery Groups. • 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 Infection Prevention & Control undertakes spot-check Hand Hygiene compliance audits; results generally show good compliance but the impact of the Hawthorne effect is such that results should be viewed with caution. • The current system and format of scoring fails to highlight particular staff groups with lower compliance rates than others.
How do we compare with our peers?
• The Hand Hygiene score has been removed from the all-Wales dashboard because of the inherent difficulty in using one score to represent a whole Health Board.

Antimicrobial Audits				
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience	
Quadruple Aim:	Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes	**Local Target**	**Period:** March 2021	
			Current Status *(against target):*	**Movement:** *(Quarter on quarter)*
Measure 1: % Proportion narrow-spectrum antibiotics prescribed		>55%	✓	↓ 🔴
Measure 2: % Indication for antibiotic documented		100%	✗	↑ 🟢
Measure 3: % Stop or review date documented		100%	✗	↓ 🔴
Measure 4: % Appropriate antibiotic prescriptions choice		100%	✗	↑ 🟢
Measure 5: % Prescriptions reviewed within 72 hours		100%	✗	↑ 🟢
Measure 6: Outcome of 72hr review - % Stopped		Monitor		
Measure 7: Outcome of 72hr review - % Changed (escalated or de-escalated)		Monitor		
Measure 8: Outcome of 72hr review - Switched to Oral		Monitor		
Measure 9: Outcome of 72hr review - Continued unchanged		Monitor		

% compliance with Antimicrobial Audits



Q4 20-21	Morriston	Singleton	NPTH	MH & LD	HB Total
(1) Proportion narrow-spectrum antibiotics prescribed	63.0%	66.0%	62.0%	-	61.0%
(2) % indication for antibiotic documented	93.0%	93.0%	83.0%	100.0%	92.1%
(3) % stop or review date documented	81.0%	87.0%	97.0%	100.0%	84.8%
(4) % appropriate antibiotic prescriptions choice	96.0%	97.0%	95.0%	100.0%	96.0%
(5) % prescriptions reviewed within 72 hours	94.0%	86.0%	86.0%	67.0%	91.5%
(6) Outcome of 72hr review - % Stopped	16.0%	25.0%	14.0%	0.0%	17.2%
(7) Outcome of 72hr review - % Changed (escalated or de-escalated)	12.0%	4.0%	5.0%	0.0%	10.6%
(8) Outcome of 72hr review - Switched to Oral	4.0%	2.0%	5.0%	-	5.8%
(9) Outcome of 72hr review - Continued unchanged	68.0%	69.0%	77.0%	100.0%	66.4%

N.B Data collection for Q3 was suspended due to Covid-19

Source: SBU Pharmacy

Measure 1: % Proportion narrow-spectrum antibiotics prescribed
Measure 2: % Indication for antibiotic documented on chart
Measure 3: % Stop or review date documented
Measure 4: % Appropriate antibiotic prescriptions choice
Measure 5: % Prescriptions reviewed within 72 hours
Measure 6: Outcome of 72hr review - % Stopped
Measure 7: Outcome of 72hr review - % Changed (escalated or de-escalated)
Measure 8: Outcome of 72hr review - Switched to Oral
Measure 9: Outcome of 72hr review - Continued unchanged

How are we doing?

- Proportion of narrow-spectrum antibiotics used is above target across all sites
- Good compliance is achieved across most of the measures, however improvements in the consistency of review at 72 hours is needed within many of the acute sites
- The e-prescribing system in Neath, has led to a reduction in the number of indications recorded but an increase in stop/review dates when compared to the other sites.
- At the 72 hour review, a large proportion of prescriptions are continued unchanged with low rates of IV to oral switch.

What actions are we taking?

- An update to the e-prescribing system will introduce the ARK (Antibiotic Review Kit) 72 hour mandatory review into Neath and Singleton. for all electronic antibiotic prescriptions. This will mean that in line with the ARK paper charts, all antibiotic prescriptions will suspend at 72 hours and will require a review by a prescribers before further doses can be administered.
- Work is underway to introduce junior doctor-led Antibiotic Quality Improvement Projects focusing on the measures included above. These projects will be run a number of times a year and junior doctors will be asked to monitor and introduce interventions within their own speciality in order to improve antibiotic prescribing using quality improvement methodology.

What are the main areas of risk?

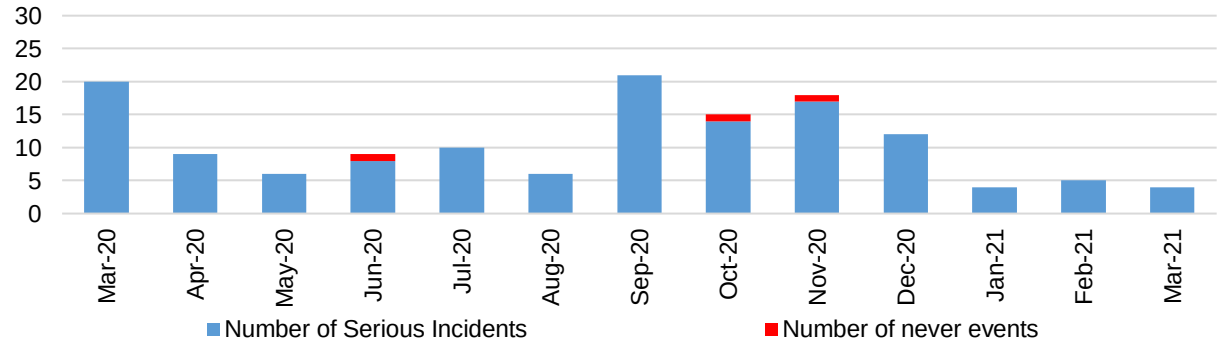
- Lack of consistent review of all antibiotic prescriptions by 72 hours
- Lack of review of IV antibiotics

How do we compare with our peers?

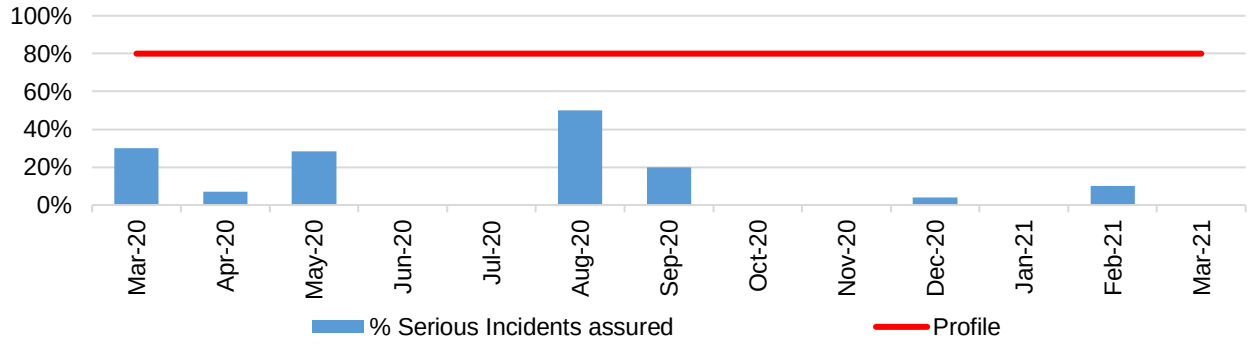
- Proportion of narrow-spectrum antibiotics is above the Welsh average for the acute sites in Wales
- All other measures are above the Welsh average with the exception of IV to oral switch.

SERIOUS INCIDENTS					
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Pam Wenger, Director of Corporate Governance		
Quadruple Aim:	Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Number of new Never Events		0	0	✗	↓ ●
Measure 2: Number of new Serious Incidents (SI's)		0	N/A	✗	↓ ●
Measure 3: % Serious Incidents Assured Within The Agreed Timescales		80%	N/A	✗	↓ ●

(1) and (2) Number of new Never Events and Serious Incidents (SI's)



(3) Serious Incidents Assured Within The Agreed Timescales



Source : NHS Wales Delivery Framework

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 27 April 2021.

Total number of incidents reported in March 2021 was 1,802. This compares to 1,552 reported in March 2020.
3 Serious Incidents (SI's) were reported to Welsh Government (WG) in March 2021. Of the 3 new serious incidents reported to WG in March, 1 was an unexpected death in Mental Health (MH) and 2 were patient falls.

In terms of severity of incidents, there were 6 incidents (0.3%) resulting in severe harm and 18 deaths recorded for the month of March. 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 for the month of March 2021.

What actions are we taking?

- SI consequence training being undertaken with representatives from each Service Group – commenced April 2021.
- Serious Incident training being delivered to Service Groups commencing September 2021.
- Weekly/Monthly meetings with each Service Group to review historical SI's and focus on getting these closed.

What are the main areas of risk?

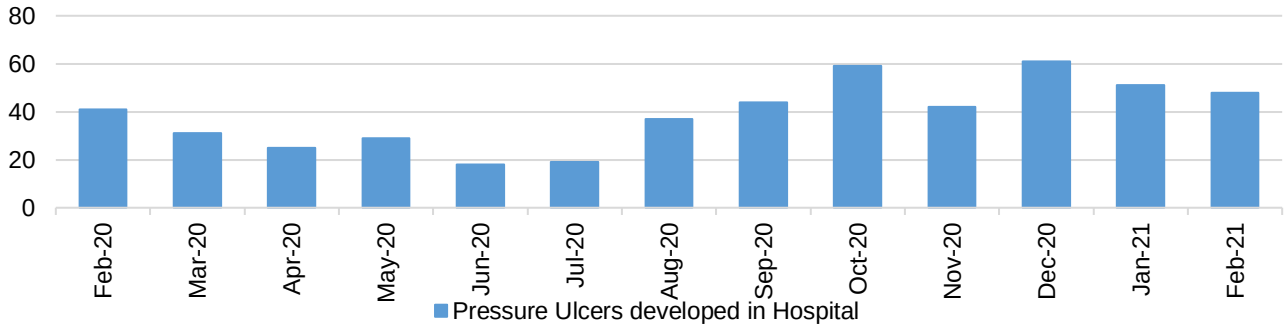
- Maintaining 80% target closure date whilst ensuring quality of investigation reports and robust learning from the incidents.
- Number of open MH incidents requiring closure.

How do we compare with our peers?

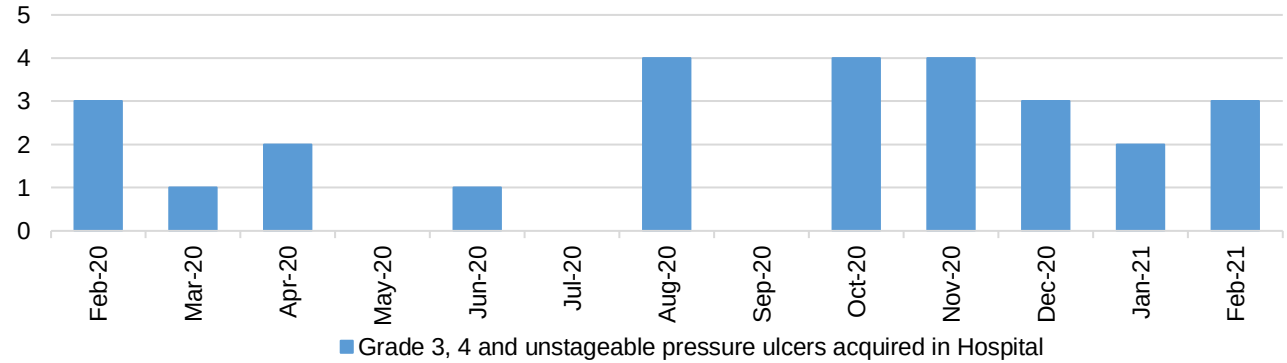
- Comparison data from peer organisations not available

PRESSURE ULCERS ACQUIRED IN HOSPITAL					
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience		
Quadruple Aim:	Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes	**Annual Plan Profile**	**WG Target**	**Period:** February 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Total Number of pressure ulcers acquired in hospital		Reduce	Reduce	✗	↑
Measure 2: Number of grade 3, 4 and un-stageable pressure ulcers acquired in hospital		Reduce	Reduce	✗	↑

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



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

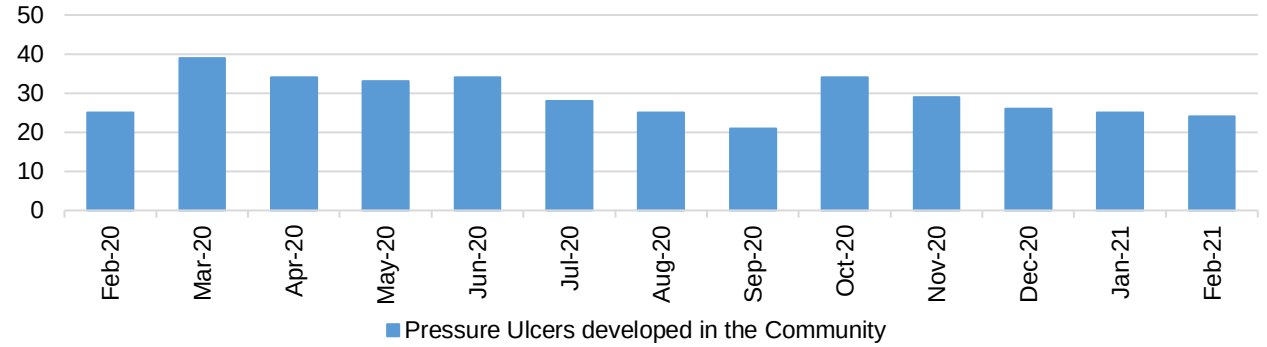


Source: Incident Data from Datix

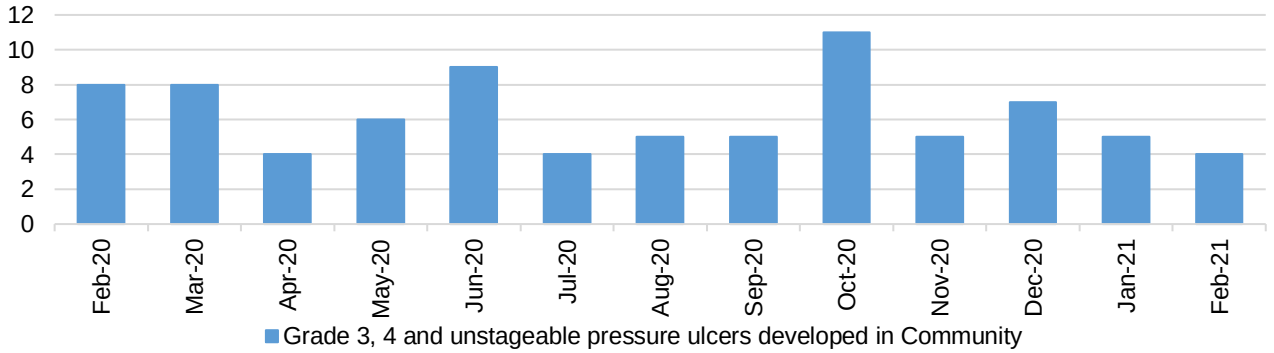
Measure 1: Total Number of pressure ulcers acquired in hospital Measure 2: Number of grade 3, 4 and unstageable pressure ulcers acquired in hospital
How are we doing?
• The measure for pressure ulcers is displayed as the number of pressure ulcers acquired in hospital. • There has been an increase in the rate of pressure ulcer development for in-patients since November 2020 to December with an increase from 42 to 61. The reports in January 2021 did then decrease to 51 and then further to 48 in Feb 2021 • The number of pressure ulcers in comparison to February 2020 has increased from 41 to 48 in Feb 2021. • The number of pressure ulcers reported between Feb 2020 and July 2020 were on average reducing and have increased between August 2020 and Dec 2020, and are since reducing. • The number of Deep pressure ulcers have reduced slightly since November 2020 from 4 to 3 in December 2020, 2 in January 2021 and slight increase to 3 in February 2021. • 8 Device related pressure ulcers were reported between December 2020 and February 20201 • The increase in pressure ulcers over the winter period corresponds with the surge in demand for unscheduled in-patient care.
What actions are we taking?
• Pressure ulcer risk assessment training and education for the All-Wales Risk Assessment PURPOSE T was rolled out by practice educators and Tissue Viability Nurses (TVN's) to registered nurses across all in-patient areas of the Health Board. Purpose T has now been rolled out across all acute sites and replaced Waterlow risk assessment in compliance with All Wales Documentation. • Ongoing training via the e-learning training package by NWIS in collaboration with All Wales TVN's is available for all NHS staff via ESR and for non-health board staff through e-learning@Wales. The TVNs are also providing training face to face. • The PURPOSE T risk assessment is included in the new Swansea Bay Risk Assessment booklet and single assessment sheets are available for re-assessments • The Pressure Ulcer Prevention Strategic Group (PUPSG) continue meet quarterly with a multi-disciplinary membership and representation from all Service Delivery Unit's (SDU's), the Executive team and Welsh Risk Pool. The next PUPSG meeting is to be held on 17th May 2021. • Each SDU submits a quarterly report to PUPSG containing an analysis of local pressure ulcer causal factors presented in a heat map. • Work streams for each SDU are aligned to their pressure ulcer causal factor heat map, ensuring that the work streams apply resources to mitigate the risk of repeat events causing avoidable pressure ulcers. • Each SDU continue to work on their Strategic Quality Improvement Plan (SQuIP) for pressure ulcer prevention. They continue to develop new work streams based on the heat mat for their area, and close those that have been implemented. The SQuIP creates a single source of information for each Service Delivery Unit in respect of Pressure Ulcer Prevention and will facilitate the escalation and monitoring of work in relation to prevention. • Peer review scrutiny panels are held in each hospital to identify causal factors for pressure ulcer development, develop work streams and to ensure the information regarding the type of injury and grade of pressure ulcer recorded in Datix is correct. These are now managed by individual directorates. • The Datix data for this report has been collated and reported one month in arrears as previously detailed, to ensure timely peer review scrutiny is completed and any relevant changes to the Datix incident actioned. The pressure ulcer data will continue to be presented one month in arrears
What are the main areas of risk?
• There remains a reliance on using bank and agency staff where there is a shortfall in the required staffing levels, due to the impact of COVID-19 and vacancies. • Staff that are not trained on PURPOSE T risk assessment which has replaced Waterlow as the risk assessment tool.
How do we compare with our peers?
• Benchmarking data not available.

PRESSURE ULCERS ACQUIRED IN THE COMMUNITY					
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience		
Quadruple Aim:	Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes	**Annual Plan Profile**	**WG Target**	**Period:** February 2021	
				Current Status *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: Total Number of pressure ulcers acquired in the community.		Reduce	N/A	✓	↓ ●
Measure 2: Number of grade 3, 4 and un-stageable pressure ulcers acquired in the community.		Reduce	N/A	✓	↓ ●

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



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



Source: Incident Data from Datix

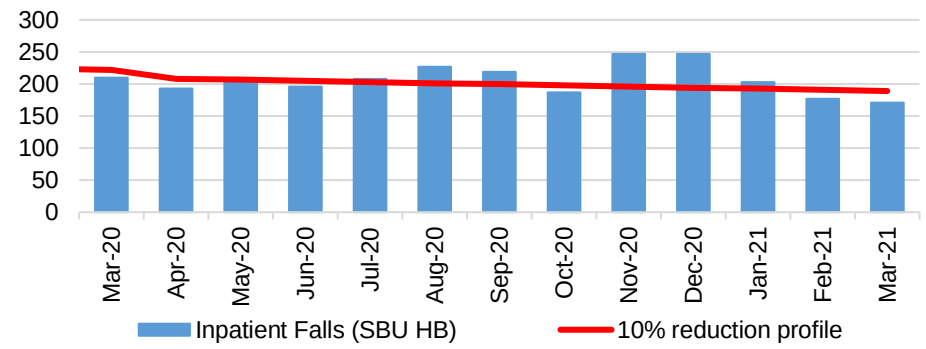
Measure 1: Total Number of pressure ulcers acquired in the community. Measure 2: Number of grade 3, 4 and un-stageable pressure ulcers acquired in the community
How are we doing?
• There has been a slight decrease in pressure ulcer development in the community during the months of December 2020, January and February 2021 • The number of pressure ulcers decreased from 29 in Nov to 26 in December 2020. With slight reduction to 25 in January 2021 and 24 in Feb 2021 • There has been a slight increase in the number of deep pressure ulcers, that is, Grade 3, 4 and Unstagable occurring in the community, between Nov 2020 and December 2021 by 2. There has since been a decrease between December 2020 and Jan 2021 and a further decrease between Jan 2021 and Feb 2021 when 4 Deep pressure ulcers have been reported. • Compared to February 2020 when 8 deep pressure ulcers were reported, the number of deep pressure ulcers is 50% less than Feb 2020. The average over the year was 6.2, with 4 being the least amount of Deep pressure ulcers developed in 1 month. 11 being the highest in the month of Oct 2020. • 4 Device related Pressure ulcers were reported between December 2020 and Febuary 2021.
What actions are we taking?
• The Pressure Ulcer Prevention Strategic Group (PUPSG) meet quarterly with a multi-disciplinary membership and representation from all Service Delivery Unit's (SDU's), the Executive team and Welsh Risk Pool. • A quarterly report is submitted to PUPSG from each SDU. The report contains analysis of local pressure ulcer causal factors presented in a heat map. The heat map presents a visual analysis, using colour, to convey causal factor data. • Work streams for each SDU are aligned to their pressure ulcer causal factor heat map, ensuring that the work streams apply resources to mitigate the risk of repeat events causing avoidable pressure ulcers. • Each SDU continues to update their Strategic Quality Improvement Plan (SQuIP) for pressure ulcer prevention. The SQuIP creates a single source of information for each Service Delivery Unit in respect of Pressure Ulcer Prevention and will facilitate the escalation and monitoring of work in relation to prevention. • Ongoing work with closing work streams on the SQUIP and the development of new work streams are ongoing to ensure their objectives are achieved & causal factor risks are managed effectively • Peer review scrutiny panels are held in each locality to identify causal factors for pressure ulcer development, develop work streams and to ensure the information regarding the type of injury and grade of pressure ulcer recorded in Datix is correct. • Education continues to be provided to staff by Tissue Viability Nurses (TVN's) and PUPIS. • The implementation of Purpose T All Wales Risk Assessment has been rolled out in the Acute hospitals in Swansea Bay university Health Board (SBUHB) and is now being rolled out in the community. Community staff have access to the e-learning package developed by NWIS in collaboration with the All Wales TVNs and Education sessions are being delivered face to face by the Lead TVN and the community TVNs. • The Datix data for has been collated and reported one month in arrears as previously detailed, to ensure timely peer review scrutiny is completed and any relevant changes to the Datix incident actioned. The pressure ulcer data will continue to be presented one month in arrears
What are the main areas of risk?
• The Primary Care & Community Services Delivery Unit are supporting large numbers of frail older people at home who are at increased risk of developing pressure damage.
How do we compare with our peers?
• No benchmark data available.

INPATIENT FALLS

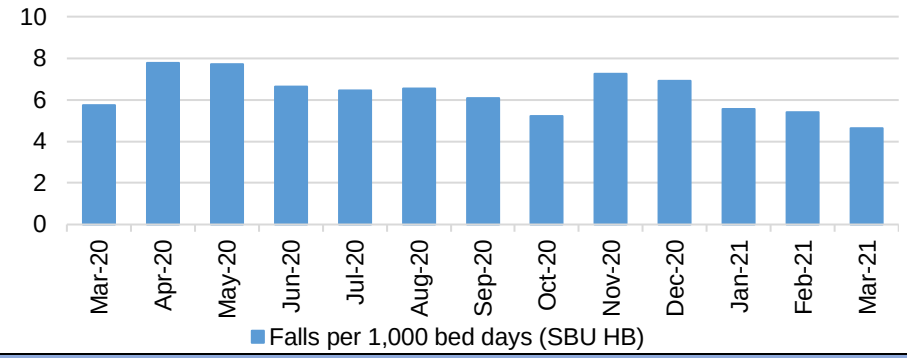
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Christine Williams, Interim Director of Nursing & Patient Experience
Quadruple Aim:	Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes	**Local Target**	**Period:** March 2021

		Current Status *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Total Number of Inpatient Falls	189 (10% reduction)	✓	↓
Measure 2: Falls per 1,000 bed days	12-month reduction trend	✓	↓

Measure 1: Total number of Inpatient Falls

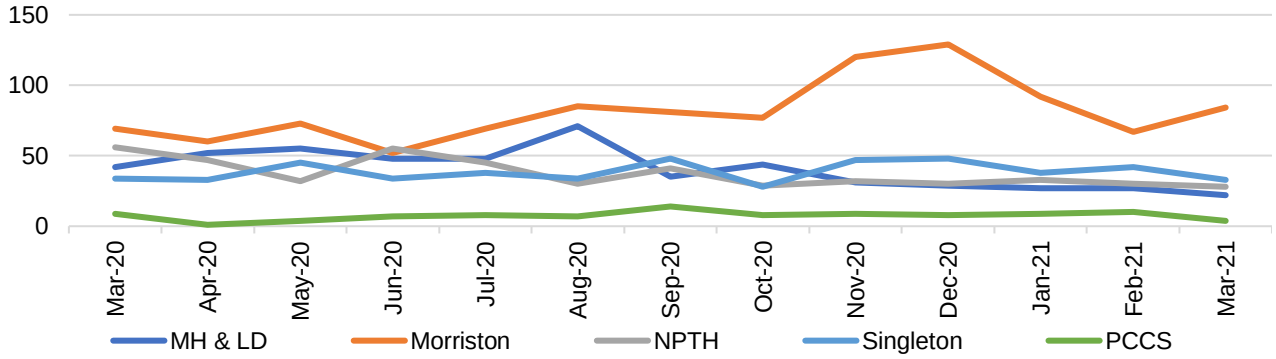


Measure 2: Falls per 1,000 bed days



Benchmarking

Total number of Inpatient Falls (by Service Delivery Unit)



Source: Incident data from DATIX

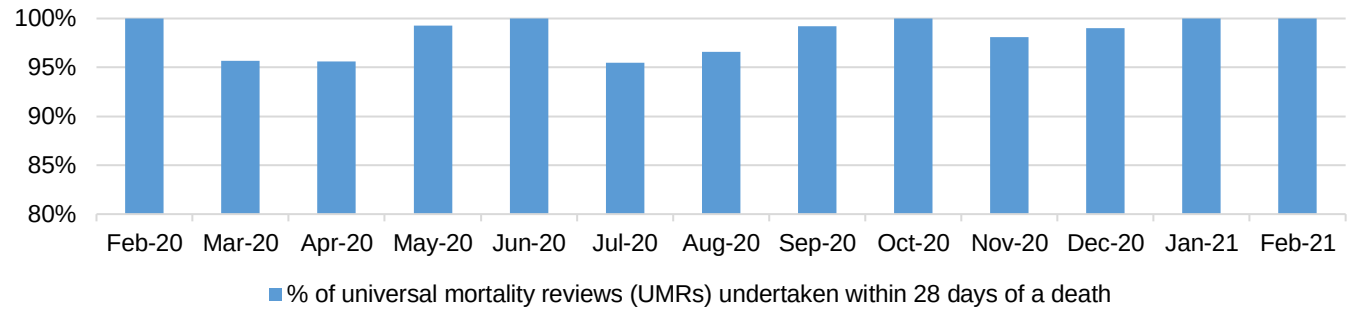
Measure 1: Total Number of Inpatient Falls Measure 2: Falls per 1,000 bed days
How are we doing?

• December 2018 shows 226 falls, December 2019 has 297 falls overall. March 2020 shows a total of 220 falls with an increase in November & December to 247. This reduced to 171 falls in March 2021. November & December was at the height of the 2nd COVID-19 wave.
 	
• Looking at the number of falls between March 2020 & March 2021:
  • Morriston recorded its lowest number in June where there were 52 falls and 129 at its highest in December 2020.
  • Singleton recorded its lowest number in October at 28 falls and its highest at 48 in September & December
  • NPT recorded its lowest number at 28 in March 21 and its highest in March 20 as 56
  • MH /LD recorded its lowest number at 22 in March 21 and its highest at 71 in August 20

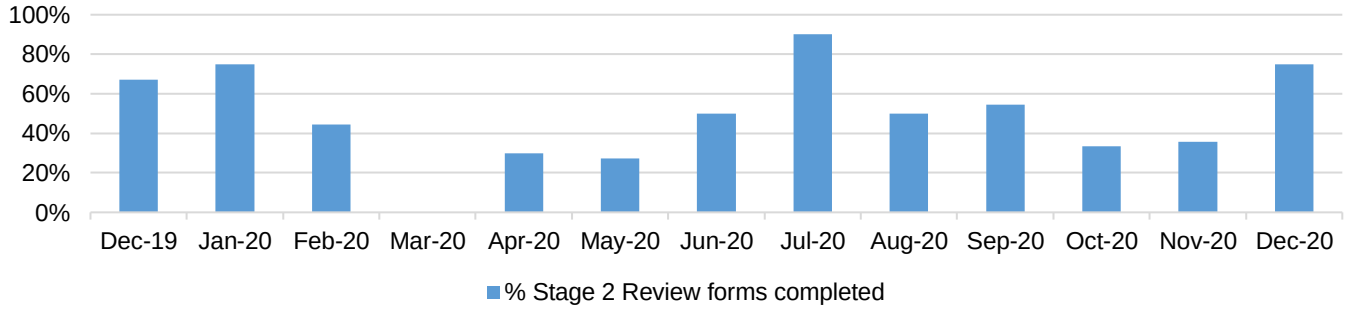
What actions are we taking?
• The strategic falls group (HFIPSG) reconvened in March 2021 and continued work on development of a causal factor matrix and working with Welsh Risk Pool . The aim being to provide standardised investigative tools which will be available within DATIX as part of the strategic improvement plan. • The group have requested that a sub-group develop an investigation tool to support a Hot debrief following a fall. • Delivery Group Scrutiny panels are in place and updates provided to the strategic group to support sharing & learning. • Learning and reflections from falls management during COVID-19 was discussed as part of the March agenda.
What are the main areas of risk?
• The Health Board (HB) continues to develop the Hospital Falls Inpatient Strategic Group • Further Develop the standardisation of investigation Tools. .
How do we compare with our peers?
• The Health Board (HB) policy includes the recommended guidance from NICE and the recommendations from the 2017 National inpatient Falls Audit, which is in line with the all-Wales approach. • The Health board will roll out the All Wales Datix system.

UNIVERSAL MORTALITY REVIEWS (UMR)					
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Richard Evans, Executive Medical Director		
Quadruple Aim:	Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes	**Annual Plan Profile**	**WG Target**	**Period:** February 2021	
				Current Status *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % Universal Mortality Reviews (UMR) undertaken within 28 days of death.		N/A	95%	✓	↑ ●
Measure 2: % Stage 2 Review forms completed.		N/A	N/A		

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



2) % Stage 2 Review forms completed



Source: NHS Wales Delivery Framework, all-Wales performance summary (January 2020)

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

How are we doing?

- Welsh Government Mortality Review Performance – Swansea Bay University Health Board (SBU HB) achieved 100% completion of Universal Mortality Reviews (UMRs) within 28 days of death in February 2021
- The Health Board UMR rate reported in February 2021 was 100%.
- Completion of Stage 2 reviews for December 2020 deaths was at 75%.
- Mental Health and Community data remains unavailable via the eMRA application at present. This is being addressed by Informatics.

What actions are we taking?

- Escalation process for missing stage 2 reviews confirmed with Morriston Unit Medical Director to improve completion rates.
- In Medicine, all the Stage 2 reviews to be discussed bi-monthly at their 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.

What are the main areas of risk?

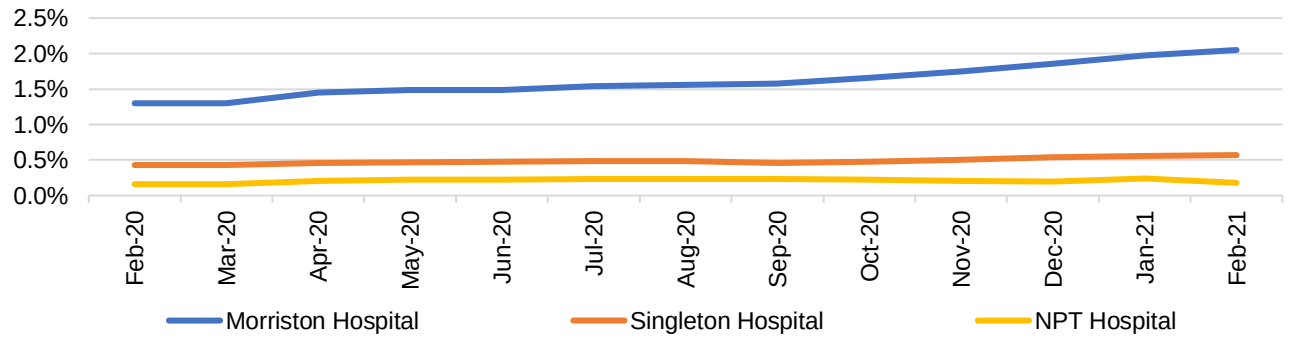
- Timeliness of Stage 2 completion.
- Implementation of the Medical Examiner role is accompanied by risk of increased numbers of 'Stage 2' reviews required: the Medical Examiner role will effectively deliver Stage 1 reviews. It is recognised that phased implementation and as yet uncertain recruitment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

How do we compare with our peers?

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

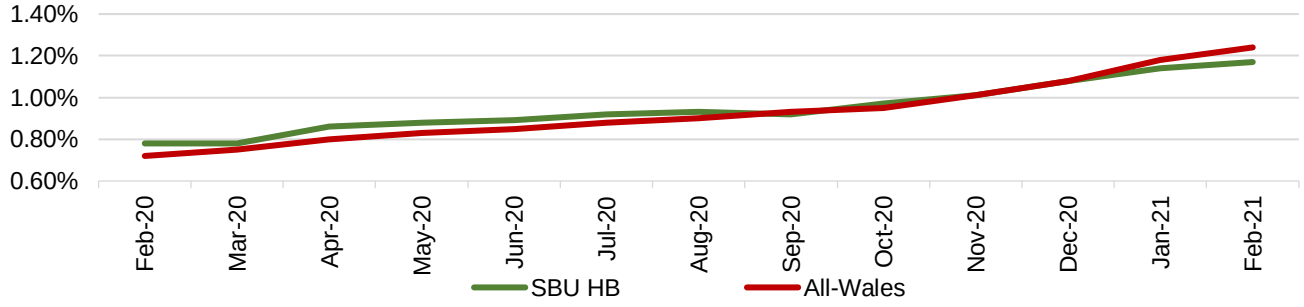
CRUDE HOSPITAL MORTALITY RATE					
Quadrant of Harm:	Harm from overwhelmed NHS and social care system.	**Executive Lead:**	Richard Evans, Executive Medical Director		
Quadruple Aim:	Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation and enabled by data and focused on outcomes	**Annual Plan Profile**	**WG Target**	**Period:** February 2021	
				Current Status *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Crude hospital mortality rate (less than 75 years of age)		N/A	12 month reduction trend	✗	↑ ●

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



Benchmarking

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



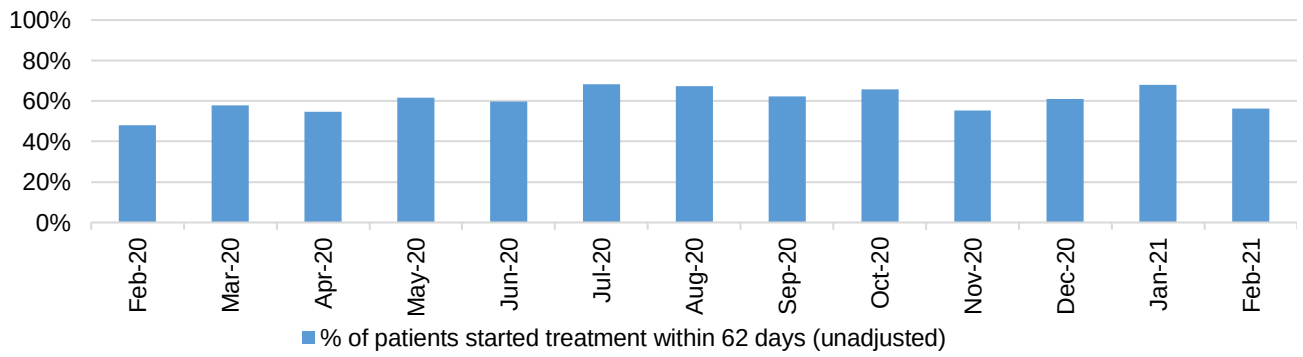
Source: CHKS and NHS Wales Delivery Framework, all- Wales performance summary (April 2021)

Measure 1: Crude hospital mortality rate (less than 75 years of age)
How are we doing?
• The Swansea Bay University Health Board (SBU HB) Crude Mortality Rate for under 75s in the 12 months to February 2021 was 1.17%, compared with 0.78% for the same period last year. • The graphs demonstrate a rolling 12 month position. Whilst there has been an increase in the overall mortality rate, there were less deaths in this age group between March 2020 and February 2021 compared with March 2019 and February 2020. The primary driver for the increase in the rate is less admissions in the most recent time period. • Site level performance is as follows: (previous year in brackets) Morriston 2.05% (1.30%), Neath Port Talbot 0.18% (0.16%), Singleton 0.57% (0.43%). Site comparison is not possible due to different service models being in place. • There were 60 in-hospital Deaths in this age group in February 2021 and 67 in February 2020: Morriston 41 (39), Neath Port Talbot Hospital 0 (4), and Singleton 18 (23). • 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 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?
• SB UHB are below the all-Wales Mortality rate for the 12 months to February 2021 – 1.17% compared with 1.24%.

3.2 HARM FROM THE REDUCTION IN NON-COVID ACTIVITY

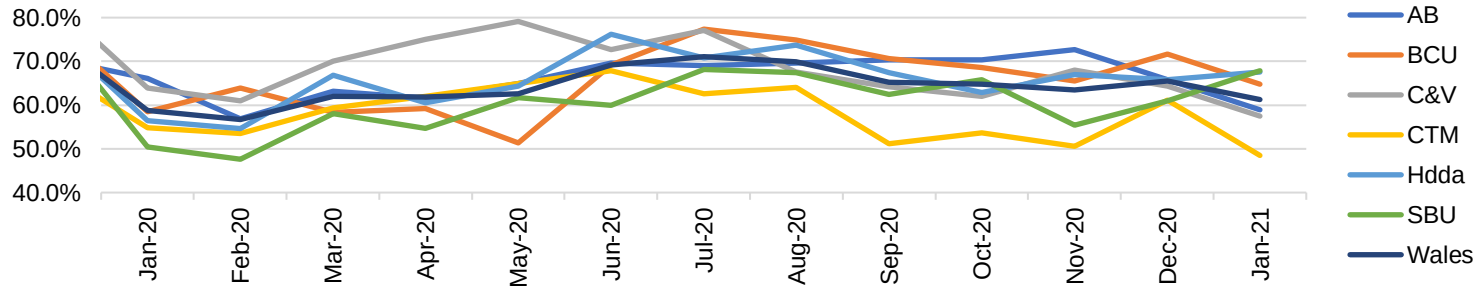
CANCER WAITING TIMES					
Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** February 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % patients starting first definitive cancer treatment within 62 days from point of suspicion		N/A	75%	✗	↑ ●

(1) % patients starting first definitive cancer treatment within 62 days from point of suspicion



Benchmarking

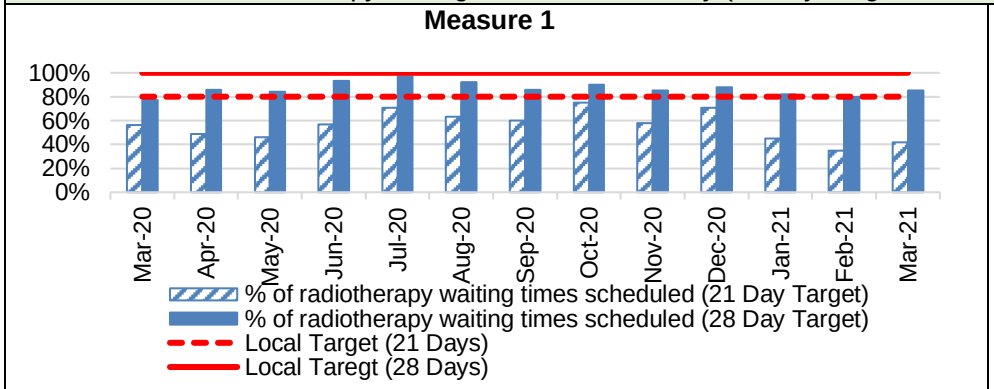
(1) % patients starting first definitive cancer treatment within 62 days from point of suspicion

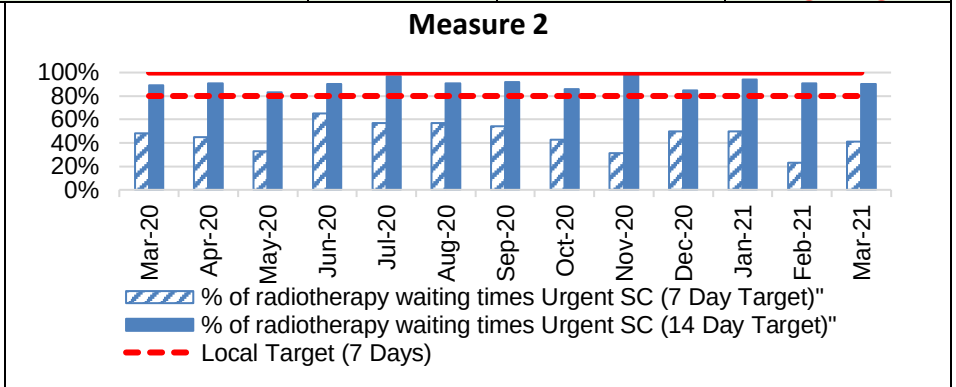


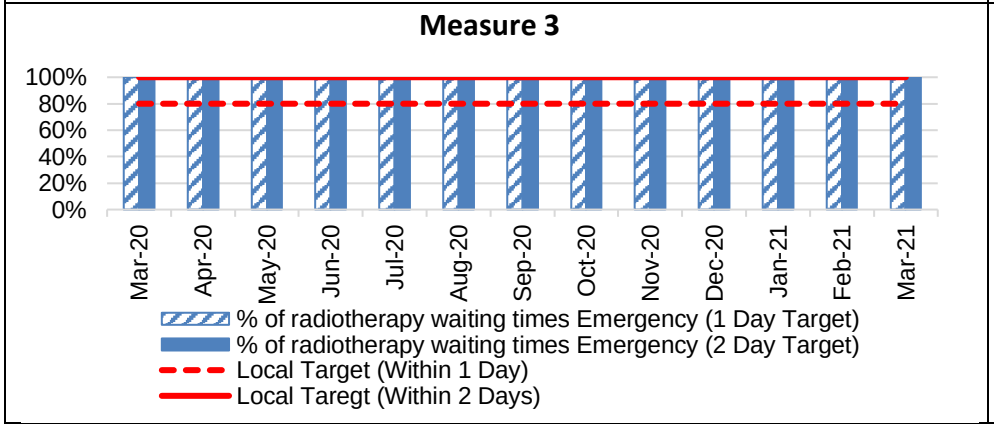
Source : NHS Wales Delivery Framework, all-Wales performance summary (April 2021)

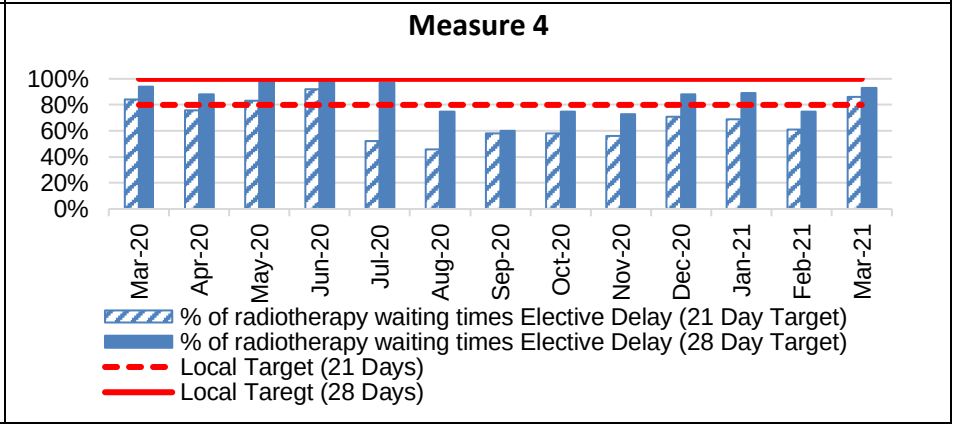
Measure 1: % patients starting first definitive cancer treatment within 62 days from point of suspicion
How are we doing?
• The root cause of delays is capacity issues across tumour site pathways, with both a reduction in theatre and OPD capacity due to Covid restrictions that are in place. Diagnostics is also challenged with similar concerns, although we have seen some improvements in Radiological investigations and Endoscopy in recent weeks. • There has been an increase in GP referrals and incidental findings, which could be indicative of the re-introduction of some services within the Health Board. • Incidental findings via diagnostic imaging increased by 103% in February compared to January.
What actions are we taking?
• More focus is being placed on outpatient capacity, reviewing the allocation of capacity as per the theatre prioritisation process. • Focused weekly meetings – particularly on backlog, endoscopy and capacity. • Cancer Performance Recovery Plan in development; detailed improvement plans centred on Urology, Gynaecological, Upper & Lower GI. • Re-zoning of theatre areas under consideration. • Reconfiguration of the utilisation of theatre capacity on all sites. • Five additional cancer trackers to commence in post in April 2021 • The additional Endoscopy capacity introduced to reduce backlog has resulted in improved performance for both Upper and Lower Gastrointestinal pathways. Additional capacity agreed to at least end of April 2021, with ongoing discussion as to how we can continue this additional capacity. Locum Consultant commenced in post 21st February. • STT protocols agreed with primary care clusters on the 11th February. • GA hysteroscopies are challenging due to the requirement for an inpatient bed and theatre capacity. Which is impacting on Gynae pathways, solutions to address this are being worked through. • From 25th February, theatre capacity was made available at Neath Port Talbot for Lower Gastrointestinal patients, this has resulted in additional Upper Gastrointestinal theatre capacity (1 list) being made available at Morriston. • Additional theatre capacity for Urology under review. • RALP (Robotic Assisted Laparoscopic Prostatectomy) lists reinstated at University Hospital of Wales.
What are the main areas of risk?
• Urology; Gynaecology; Upper & Lower GI pathways have been identified in particular as pathways with high volumes in terms of throughput, backlog and breaches. Actions above have been identified as a minimum, with further detailed review of these pathways in relation to the National Optimal Pathways is underway.
How do we compare with our peers?
• All Wales performance was 60% for February 2021. The performance for SBUHB was 56%. • BCU HB – 67%; HDda UHB – 66%; AB UHB – 57%; C&V UHB – 54%; CTM UHB – 52%.

RADIOTHERAPY WAITING TIMES				
Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer	
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**National Target**	**Period:** March 2021	
			Current Status *(against target):*	**Movement:** *(12 month trend)*
Measure 1 - % of radiotherapy waiting times Scheduled (21 Day Target / 28 Day Target)		80% / 100%	✗/✗	↓🔴 /↓🔴
Measure 2 - % of radiotherapy waiting times Urgent SC (7 Day Target / 14 Day Target)		80% / 100%	✗/✗	↓🔴 /↑🟢
Measure 3 - % of radiotherapy waiting times Emergency (Within 1 Day / 2 Days)		80% / 100%	✓/ ✓	⇔🟡/⇔🟡
Measure 4 - % of radiotherapy waiting times Elective Delay (21 Day Target / 28 Day Target)		80% / 100%	✓/✗	↓🔴 /↓🔴









1 - % of radiotherapy waiting times Scheduled (21 Day Target / 28 Day Target)
2 - % of radiotherapy waiting times Urgent SC (7 Day Target / 14 Day Target)
3 - % of radiotherapy waiting times Emergency (Within 1 Day / 2 Days)
4 -% of radiotherapy waiting times Elective Delay (21 Day Target / 28 Day Target)

How are we doing?

1. The number of patients who started treatment in March was 209. This is the highest number we have seen since January 2018. Urgent SC patients we had 4 patients that breached 14 days, 3 due to planning issues
2. For Emergency patients we continue to deliver 100% with all patients being treated in 1 day
3. Elective delay patients remain a challenge, we had 42 patients categorised as elective delay, with 3 patients not treated within the maximum target time of 28 days.

What actions are we taking?

- Monthly stakeholder meetings, which include the major staff groups involved in radiotherapy have been implemented to review the data on breach reasons to enable learning to inform changes to processes if necessary.
- We have undertaken hypo fractionation of breast radiotherapy (RT) and have just submitted business case as part of annual plan to offer hypo fractionation for Prostate RT.
- We will start commencing outsourcing of 70 prostate RT cases within the next 4-6weks at Rutherford to continue to support, improving our performance.

What are the main areas of risk?

- Age and capability of our Linac machines we currently have 3 new Machines and 1 old machine. This will give us 1 old machine, which is out of support from the supplier due to age and breakdown risks exist. This case for replacement for Lin C is in with Welsh Government and we hope to be operational by March 2021. New CT replacement scanner is due to go operational at end of May 21.
- Capacity on machines remains main concern. Currently losing treatment capacity monthly due to breakdown of Lin C.

How do we compare with our peers?

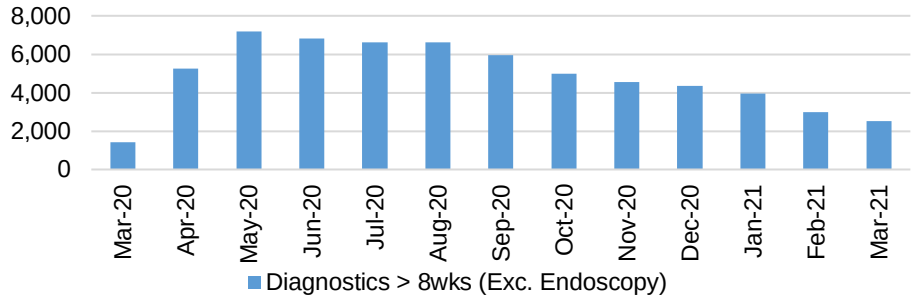
Comparison to high-income countries around the world, Linac's per million population. Demark has 3.37, Japan 6.75, Canada 7.5. UK wide – 5.2.
In Wales Cancer centres compare as table below

	LINACS	EXPANSION PLANS	POP'N (MILLION)	LINACS/MILLION POPN
VCC	8-	10	1.5	5.1/6.6
NWCTC	3.5	4	0.9	5.0/5.5
SWWCC	4-	5	0.7	4.4/5.5

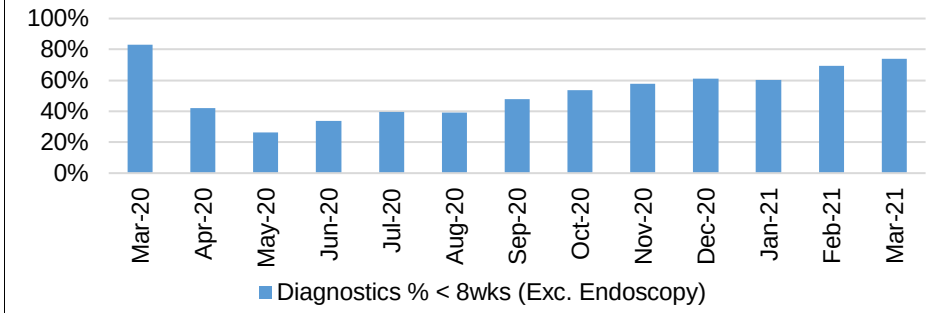
Data Source- IAEA DIRAC
We currently re-reviewing our work on workforce comparison across centres. Performance of these new targets across 3 centres in Wales is challenging and as we understand it all 3 centres are struggling to deliver.

DIAGNOSTIC WAITING TIMES (*EXCLUDING ENDOSCOPY*)					
Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** (against profile):	**Movement:** (12 month trend):
Measure 1: Number of patients waiting more than 8 weeks for specific diagnostics (excluding Endoscopy)		N/A	0	✗	↓ ●
Measure 2: % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)		N/A	100%	✗	↑ ●

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

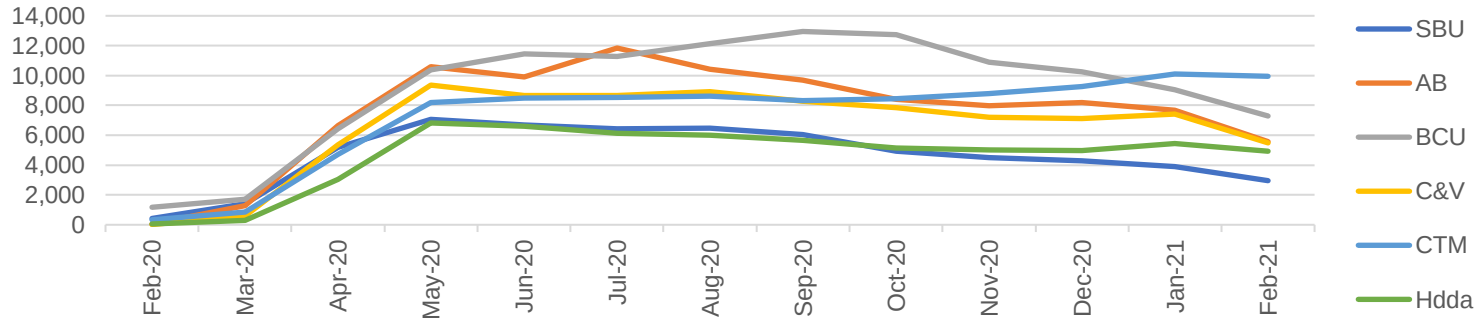


(2) % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy)



Benchmarking

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



Source : StatsWales (23.04.2021)

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 4,554 patients waiting over 8 weeks for reportable diagnostics as at the end of March 2021.

The breakdown for December 2019 is as follows:

- Cardiac: Echo Cardiogram = 630
    - Cardiac Magnetic Resonance Imaging (Cardiac MRI)= 177
    - Cardiac Computed Tomography (Cardiac CT)= 294
    - 24 Hour Tape / Holter = 158
    - 24 Hour Blood Pressure Monitoring = 1
    - Diagnostic Angiography = 2
    - Doppler Stress Echocardiogram = 8
    - Sleep Studies = 33
    - Myocardial Perfusion Scan = 25
    - Trans Oesophageal Echocardiogram (TOE)= 14
- Cystoscopy = 32, Vascular Tech = 17, Fluoroscopy = 25, Electromyography = 708, NCS = 177, Non-Cardiac MRI = 121, Non Obs Ultrasound = 89, Nuclear Medicine = 18, Endoscopies = 2,037

What actions are we taking?

- ECG – additional weekend work and additional activity provided by Swansea (including potential pilot scheme with primary care)
- Endoscopy • ID Medical Insourcing 40 sessions per month from NPTH agreed Q1/Q2 2021/22. • WLI sessions agreed funding for 40 sessions per month agreed Q1/Q2 2021/22. • Endoscopy capacity and Demand plan completed and awaiting approval
- Radiology • At risk recruitment for MR has commenced. **No applications from experienced candidates received.** Review of MRI recruitment advert being undertaken currently with a view to updating and going out to advert again by end of w/c 10th May 2021. • Scoping meeting with HR w/c 3rd May to **map out OCP timeline for extended working days** in MRI/CT. • MRI **extended day shift pattern trial** commenced. 2nd week 10th May 2021. • Work progressing to develop the Radiology Cancer dashboard to support performance management and pathway improvement for cancer and RTT. • Meeting with IT held 6th May 2021 to map out steps for securing **Health Board solution for home workstations f**or 5 consultants – capital requirements circa £50k. • Service develop weekly monitoring report for inpatient diagnostic access times. • Workforce resource requirements for extended working days 7 days a week across all Health Board scanners completed. • Other option for possible cost-effective staffed MRI scanner capacity currently being explored. • Radiology Plan being finalised by 14th May 2021.

What are the main areas of risk?

- Approval of an investment plan for all diagnostic specialties
- Endoscopy • Nursing workforce capacity limitations due to vacancy, shielding and sickness. Ability to recruit and retain sufficient workforce to meet service demand is the most significant risk to service sustainability. Work force constraints have resulted in the service becoming reliant in recent years on outsourcing / insourcing services •Capacity for new referrals being met at the expense of patients requiring surveillance or 'recall' procedures. •Extra time and space for procedures, because of increased infection control and cleaning procedures
- Radiology •Ability to recruit qualified staff to update MRI/CT/ and NOUS •Timely access to reporting for some inpatient and cancer patients for sub specialty areas •Sub specialty capacity issues in NOUS (Paediatrics/Head and Neck) due to hard to recruit to areas)

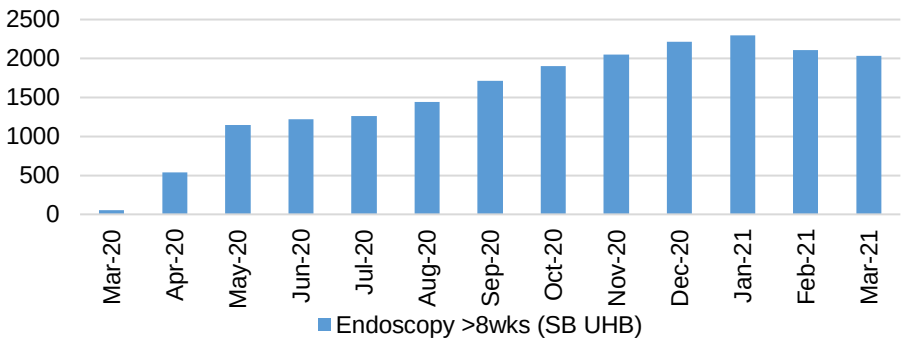
How do we compare with our peers?

- Best in Wales in the number of >8 week breaches (excluding Endoscopy)

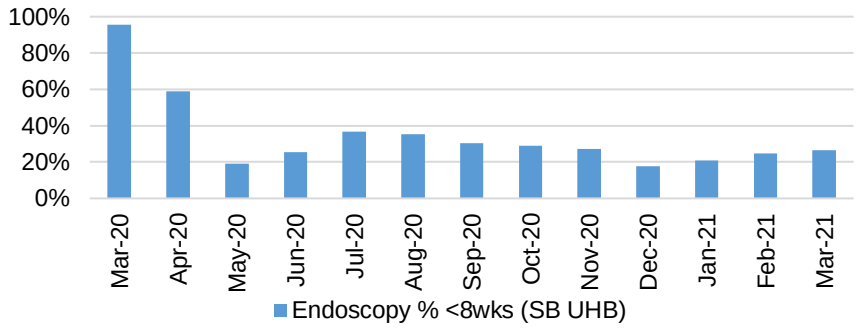
ENDOSCOPY

Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Number of patients waiting more than 8 weeks for Endoscopy		N/A	0	✗	↑
Measure 2: % patients waiting less than 8 weeks for Endoscopy		N/A	100%	✗	↓

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

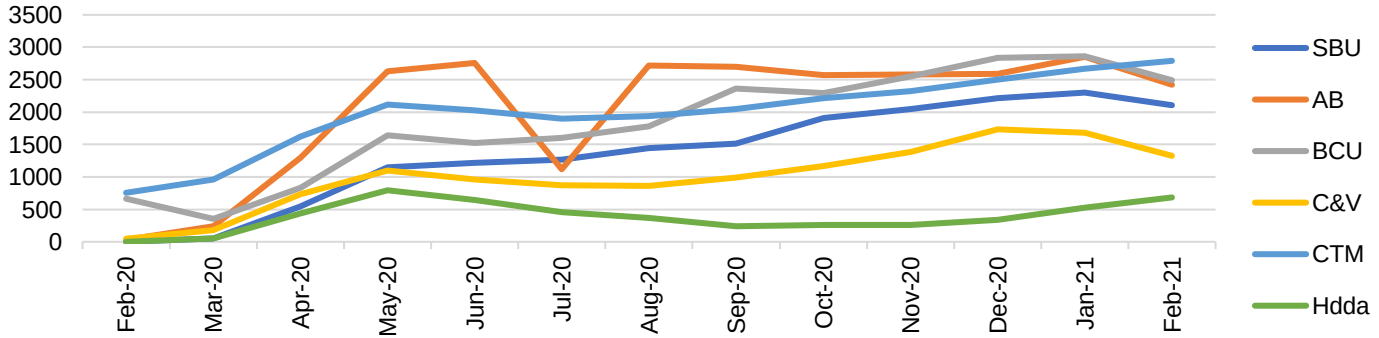


(2) % patients waiting less than 8 weeks for Endoscopy



Benchmarking

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



Source: StatsWales (23.04.2021)

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

How are we doing?

- The Health Board had achieved and maintained a zero position for patients waiting over 8 weeks for endoscopy up to the end of March 2020. Due to the COVID pandemic overnight the scheduling of all routine and urgent Endoscopy procedures ceased with a focus on Inpatient emergency activity and Urgent suspected cancer cases. The number of patients waiting over 8-weeks has increased significantly month on month due to the restrictions that have impacted upon the ability to schedule and these include AGP policy, social distancing and air exchange turnaround times.
- 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. The demand for Inpatient endoscopy has also increased as well as the complexity of the cases due to the late presentation of patients.
- DNA rates continue to remain low at 3%.
- Surveillance waits for upper GI Endoscopy have also increased

What actions are we taking?

- Utilising all available funded capacity as well as short term initiatives such as WLI backfill. Current agreement for funding until the end of August 2021.
- Insourcing 40 sessions a month in NPTH Unit.
- Ongoing additional funding for WLI and Insourcing support confirmed for Q2 2021/22.
- Continued focus on effective triage of referrals with the pending implementation of Straight to Test. The optimum Lower GI pathway has been agreed with Primary Care. The planned live date for full implementation of STT is the 01/06/2021.
- An Endoscopy Capacity and Demand Plan has been submitted for 2021/2022 for Swansea Bay University Health Board (SBUHB) and provides a plan to address current capacity issues and provides detailed plans in order for SBU Health Board to deliver a maximum waiting time for Endoscopy of 8 weeks. The plan is a combination of a more sustainable approach to achievement of the waiting time targets as well as a continued but decreased short- term capacity solution. The plan combines efficiency gains, increased productivity with increasing workforce to allow the service to move towards a closure of the known gap in capacity and also supports the move towards management of demand in a more robust and effective way. A national focus on developing an agreed all Wales capacity and demand tool is underway and SBUHB are active members of the National Endoscopy Demand and Capacity sub-group.
- The HB team are active participants of the National Workforce Subgroup and have attended all scheduled meetings. A workforce survey has been undertaken recently upon the request of the National Endoscopy Programme Lead.
- Surveillance Endoscopic waits in the HB are a risk and immediate action planned and implemented to review how high risk patients are managed. This includes a clinical review of the longest waiting surveillance patients by the three clinical leads. Risk stratification process being adopted.

What are the main areas of risk?

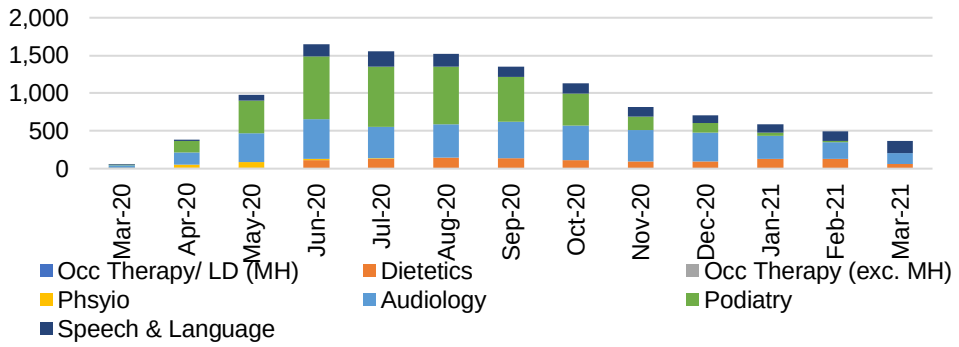
- Urgent activity being displaced by cancer and inpatient patients with significant pressures in Gastroenterology.
- Ability to maintain the number of additional sessions undertaken with a very small group of Endoscopists.
- Workforce constraints
- Covid restrictions with reduced capacity due to air exchange, social distancing and infection control procedures.

How do we compare with our peers?

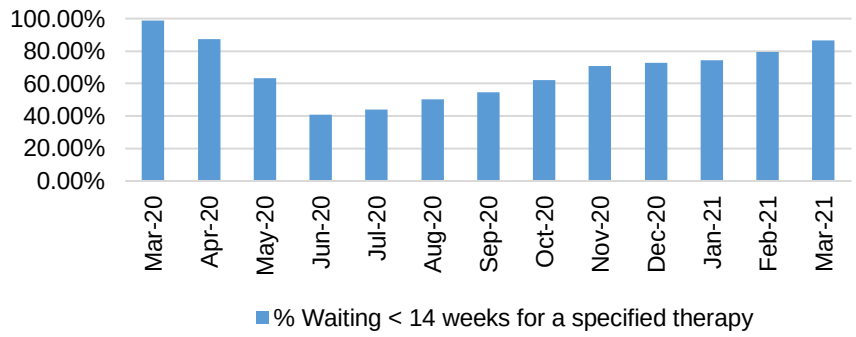
- SBUHB compare well to peers in Wales in relation to waiting times performance.

THERAPY WAITING TIMES					
Quadrant of Harm:	Harm from reduction in Non-Covid activity.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy		0	0	✗	↓ ●
Measure 2: % of patients waiting less than 14 weeks for a specified Therapy		N/A	N/A		↑ ●

(1) No. of patients waiting more than 14 weeks for a specified Therapy

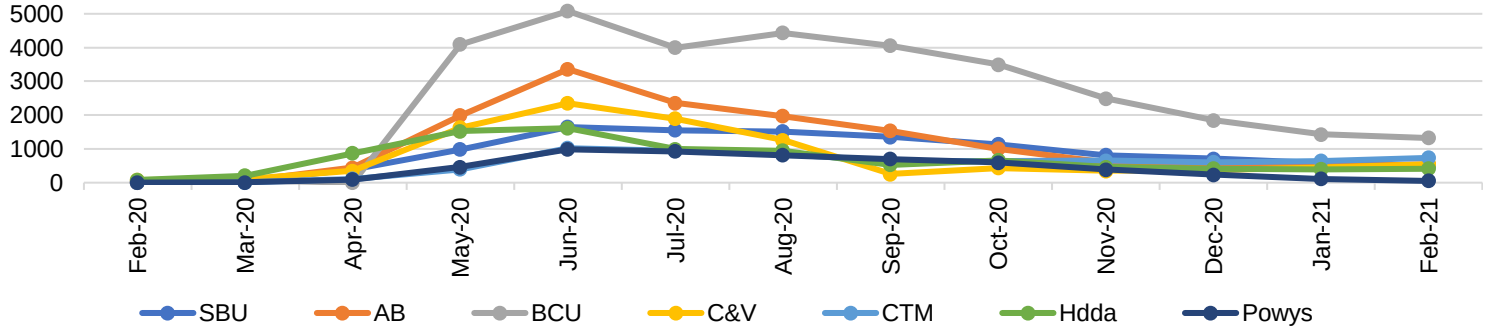


(2) % of patients waiting less than 14 weeks for a specified Therapy



Benchmarking

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



Feb-21	
SBU	491
AB	547
BCU	1329
C&V	546
CTM	740
Hdda	417
Powys	59

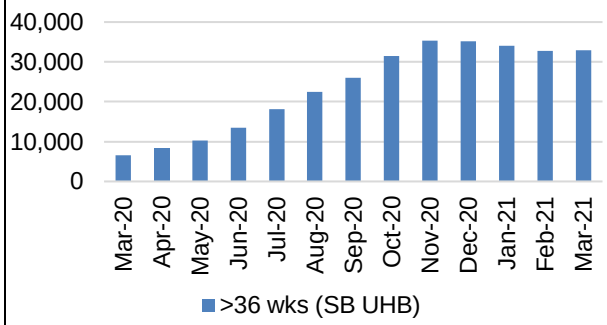
Source : StatsWales (21.04.2021)

Measure 1: Number of patients waiting more than 14 weeks for a specified Therapy
How are we doing?
Three areas are currently breaching (Speech & Language, Audiology and Nutrition & Dietetics) with Podiatry showing a recovered position from February 2021. Below are the main identified risks for a breaching position for each service: **Audiology** ●Current performance is a reflection of the backlog generated during four months of cessation of the service and eight months of staff redeployment in 2020. Steady gains have been made in the numbers of people waiting over 14 weeks since the New Year. ●Capacity continues to be around 75% of normal capacity due to social distancing and infection control requirements and so a significant increase in referrals to normal levels will mean that progress against the target will slow. ●Remote elements for patients who are digitally enabled (approximately 1/3) continues to provide some mitigation to this reduction in efficiency **Nutrition & Dietetics** ●COVID 19 – non essential services stopped ●Discontinuation of face to face group education programmes ●Reduced capacity within initial virtual education sessions ●Paediatric Staffing Capacity – vacancies during period ●Referral levels returning to pre COVID levels ●Majority of patient waiting >14 weeks are in adult weight management service **Speech and Language Therapy** ●Breaches within the paediatric services only - and can be accounted for by the following factors; 1. Ongoing Covid-19 Restrictions - This is largely due to restrictions in schools/nursery settings, access to, and maintenance of, clinical clean spaces, & staff sickness/self-isolation. 2. Demand on our services has increased with highly complex and time consuming patients. 3. 25% of SALT clinical time is allocated to managing the 14 week wait. 4. High vacancy factor.
What actions are we taking?
As part of internal monitoring and scrutiny of underperforming areas, each service has developed an action plan: **Audiology** • Action plan in place to recover against target by end of **June 2021** • Reset of face to face appointments •Staff continue to ensure that longest waiters are targeted. • Trial on the benefits of remotely programmable hearing aids continues in order to assess whether these can provide a benefit in reduction of F2F appointments required for follow-up and review. **Nutrition & Dietetics** • Action plan in place to recover against target by end of **July 2021** •Adult weight management service Virtual Weight Management Group education programmes re-established February 2021 •Increased capacity within core group sessions from April 2021. Capacity 50 patient per 6 weeks. Groups to be fully utilised to reflect drop off and DNA rates • Additional Foodwise sessions offered with delivery from March, temporary increase in capacity within service utilised. • Development of alternative resources for people unable to access virtual education offer •Rolling programme of evening education programmes has been re-established from end April 2021. **Speech and Language Therapy** •Action plan in place to recover against target by end of **December 2021** •Each therapist has been allocated a specific number of patients which must be seen in the next 10 weeks. They are accountable to this through regular planning meetings. •Review of patients on the initial referral waiting list to ensure they continue to require assessment. •Additional sessions are being made available to manage this waiting list from other areas of the services. •Where possible, assessments are being carried out on 'Attend Anywhere'. It should be acknowledged that this method of assessment is only suitable for a small percentage of the caseload. •Individual school risk assessments are being reviewed to establish whether schools are able to allow children in different bubbles to be seen on the same day, and whether it is possible to visit more than one school in a day. •There is hope to increase access to clinical spaces within the HB through collaboration with Estates in PCTGs •Recruitment of additional staff through service re-design to support demands on waiting list. The action plan & recovery schedules are being monitored within the PCT Group and reported on a fortnightly basis against their recovery trajectories via Reset & Recovery Silver Operational Group meeting.
What are the main areas of risk?
Audiology - Increased referral rates during recovery programme would impact on timescales. **Nutrition & Dietetics** - Recruitment to vacancies particularly in paediatrics **Speech and Language Therapy**• Difficulties recruiting into vacancies• Anticipated increase in referrals as schools return to assessment in the summer term.• Interruptions in access to CYP at school sites due to Covid 19 restrictions. • Reduced capacity due to demands of ALN upskilling/training events
How do we compare with our peers?
The Health Board is performing as well as or above our peers

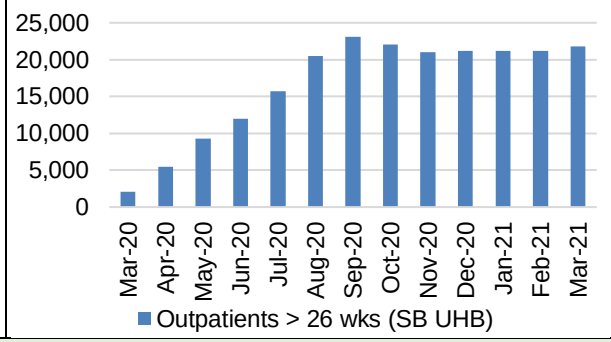
REFERRAL TO TREATMENT TIMES (RTT)

Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status**	**Movement:** *(12 month trend)*
Measure 1: Number of patients waiting more than 36 weeks for referral to treatment (RTT)		N/A	0	✗	↑
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment		N/A	0	✗	↑
Measure 3: % patients waiting less than 26 weeks for referral to treatment (RTT)		N/A	95%	✗	↓

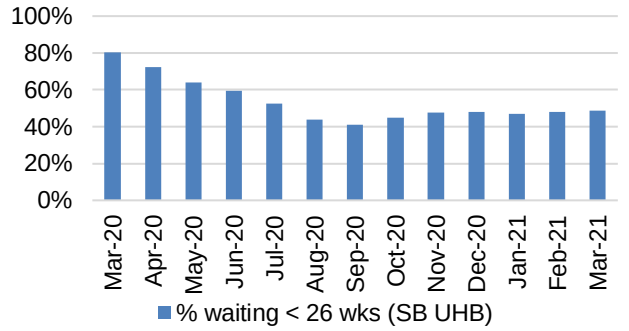
Measure 1



Measure 2

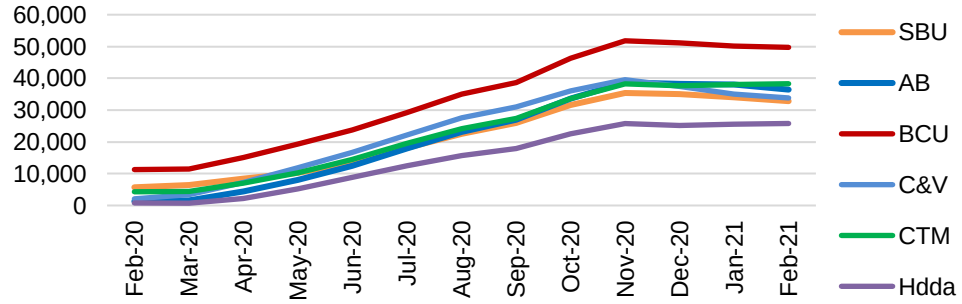


Measure 3

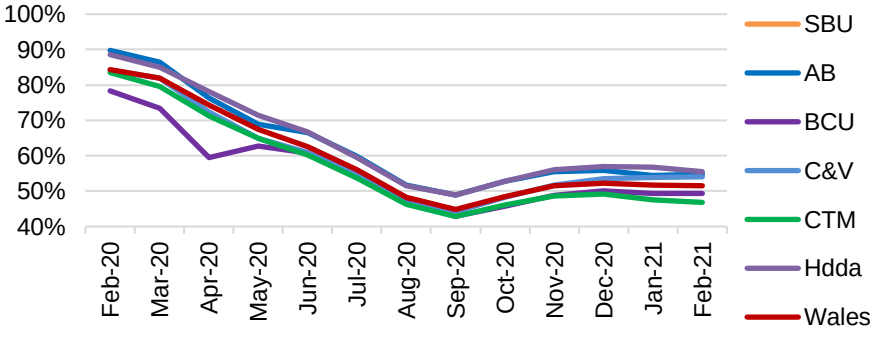


Benchmarking

(1) No. of patients waiting more than 36 weeks for referral to treatment



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



Source : StatsWales (21.04.2021)

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?

- 21,750 Stage 1 >26 weeks
- 32,411 >36 weeks
- 27,226 >52 weeks
- T&O , ENT, Ophthalmology are the big ticket items in all three performance measures

What actions are we taking?

- A Planned Care Recovery Programme Board has been established to oversee the recovery programme for RTT. The initial plans include
    - Advice and guidance (via Consultant Connect) to be introduced in the top 10 specialties with highest number of patients waiting by June 2021 and in all specialties by Sept 2021 to assist in managing demand from Primary Care
    - Investment in primary care to reduce demand for secondary care referrals
    - Improved access to diagnostics for primary care
    - Independent sector capacity to be utilised to support the reduction of waiting times in longest waiting specialties including orthopaedics, ophthalmology and ENT
    - Demand and capacity plans developed for all specialties outlining actions to reduce waiting times including outsourcing and additional internal capacity
    - Plans for additional orthopaedic capacity at NPT Hospital
    - Maximising the surgical activity that can be undertaken in Singleton Hospital

What are the main areas of risk?

- Approval of capital funding to develop orthopaedics solutions
- Securing independent sector capacity
- Development of HDU/PACU to support additional surgical activity at Singleton

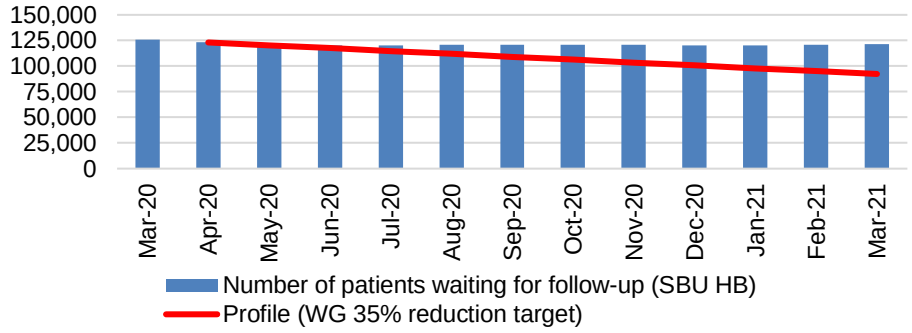
How do we compare with our peers?

- Better than Wales %age of patients waiting >36 weeks
- In line with other Health Boards %age Stage 1 patients >26 weeks

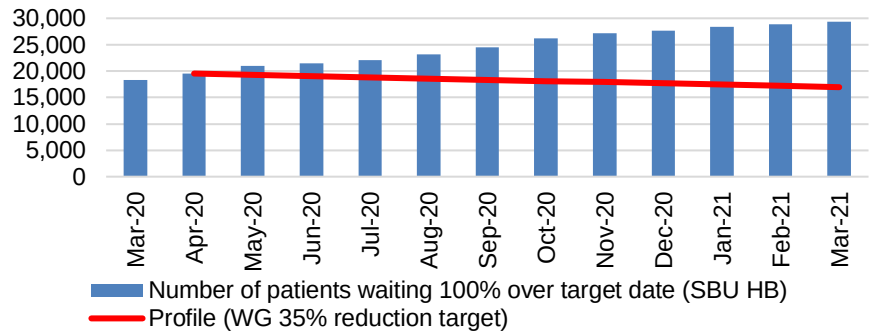
DELAYED FOLLOW-UP APPOINTMENTS

Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** March 2021 **Current Status** *(against profile):*	**Movement:** *(12 month trend)*
Measure 1: The number of patients waiting for a follow-up outpatient appointment		N/A	92,307	✗	↓ ●
Measure 2: The number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%		N/A	16,952	✗	↑ ●

Measure 1

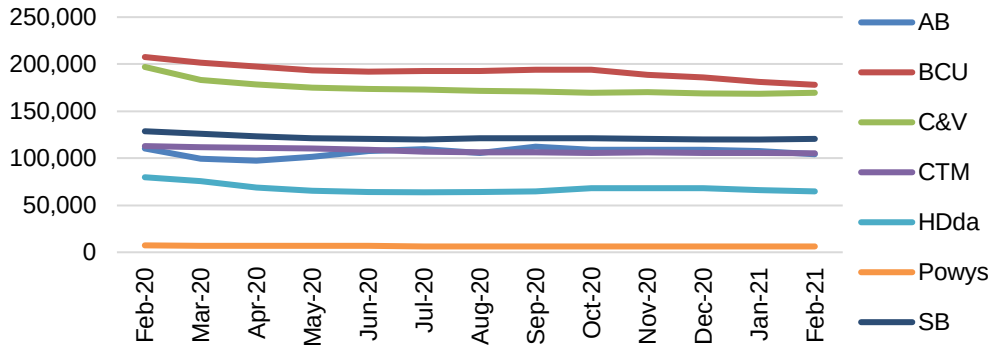


Measure 2

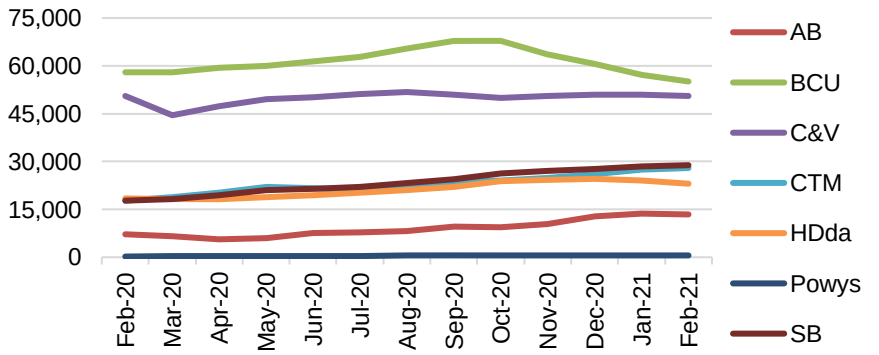


Benchmarking

(1) The number of patients waiting for a follow- up outpatient appointment



(2) Number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%

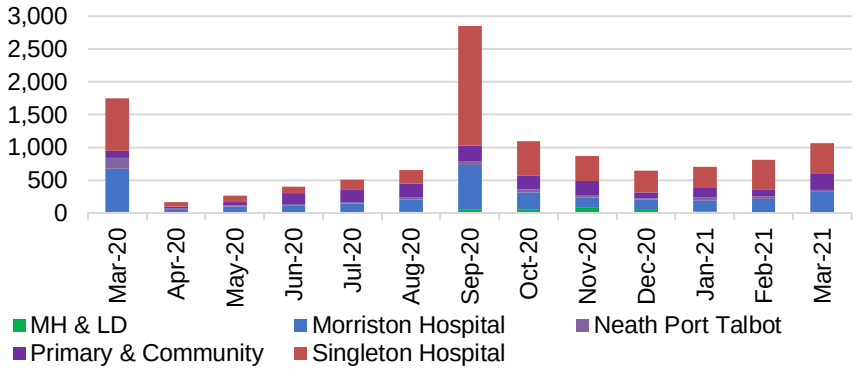


Source: NHS Wales Delivery Framework, all-Wales performance summary (April 2021)

Measure 1: The number of patients waiting for a follow-up outpatient appointment Measure 2: The number of patients waiting for a follow-up outpatient appointment who are delayed by over 100%
How are we doing?
• The impact of the Covid -19 pandemic has resulted in a decrease in appointments available to patients, even though virtual appointments have been utilised. This has still lead to delays with patients having appointments which is reflected in the increase in the number of patients waiting over 100%. This has resulted in us not being able to reach March 2020/21 targets. • The number of patients on a follow up waiting list (booked & un-booked) with & without a clinical review date has increased from 120,962 (September 2020) to 121,403 (March 2021) (0.4%). • Number of patients waiting for a follow up delayed past their target date – over 100%; Has increased from 24,472 (Sept 2020) to 29,316 (March 2021).
What actions are we taking?
• Additional funding has been released by the Health Board to support medium term validation reviews of the Follow up lists – being led by Morriston Delivery Unit. • New deliverables have been put in place as of March 2021. The outpatient transformation team are implementing consultant connect and Dr Doctor quick question validation into the top 10 services • Working with the national Outpatient Modernisation Working Group has been refreshed and this is actively taking forward new measures to address these pressures which are being seen across Wales. Actions include improved digital access for patients, virtual consultations, consultant connect available for clinicians in key departments and validation of waiting list over 100% to allow transfer of patients onto the correct pathways SOS/PIFU). • The Health Board has refreshed the Outpatient Modernisation Group and it has put an advertisement out for a new clinical lead, after Dr Phil Coles departure, to facilitate clinical engagement and build a bridge between the outpatient transformation teams targets and benefits with clinical targets. • Monthly Outpatient transformation meetings are being conducted with biweekly outpatient recovery meetings The membership of these will be reviewed to transform these groups to a more performance driven group to allow working towards achieving deliverables pretend by the Chief Executive Officer. • An outpatient dashboard has been created by the digital team to allow for concise and accessible facilities for service user to monitor and propose action on waiting lists. The aim is to push workshops and to allow for smooth running utilisation of this across the Health Board. • The health board have brought in Productive Partners for a 6 week interval to allow for promotion and communication across the Health Board in Primary and Secondary Care of Consultant Connect. This team will be looking at the communication of this project and dealing with the barriers and concerns the transformation team are experiencing in regards to the role out and the take up of consultant connect.
What are the main areas of risk?
• The lack of clinical engagement from service managers regarding implanting Dr Doctor Quick question validation and the execution of this within the top 10 services. • Promotion of Consultant connect within Primary and Secondary care to ensure there is awareness of the services and availabilities to ensure paramount engagement with the services. This will ensure that only essential referrals are made and will prevent unnecessary waiting list times. • The lack of resources available regarding staff and space for validation process.
How do we compare with our peers?
• SBUHB has had highest impact when implementing Dr Doctor validation process and is predicted to be more advanced with this in comparison to neighbouring Health Boards. Most Health Boards have experienced a deteriorating position in the number of patients waiting for an outpatient follow up (booked and not booked) who are delayed past their target date for planned care specialties and are, as is SBUHB, implementing new plans with traction and pace.

PATIENT EXPERIENCE					
Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Pam Wenger, Director of Corporate Governance		
Quadruple Aim:	Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable.	**Local Target**	**WG Target**	**Period:** March 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Number of friends and family surveys completed		Increase	N/A	✓	↑
Measure 2: % of who would recommend and highly recommend		90%	N/A	✗	↓
Measure 3: % of all-Wales surveys scoring 9 or 10 on overall satisfaction		90%	N/A	✓	↓

(1) Number of friends and family survey s completed



(2) % of who would recommend and highly recommend

	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
MH&LD	44%	36%	57%	57%	33%	41%	39%	19%	41%	21%	36%	88%	73%
Morriston	96%	98%	94%	94%	94%	83%	91%	82%	86%	70%	76%	82%	86%
NPT	97%	60%	67%	47%	68%	92%	94%	90%	75%	67%	58%	32%	75%
PCCS	88%	84%	77%	88%	91%	79%	74%	65%	80%	62%	76%	77%	90%
Singleton	95%	93%	96%	83%	92%	87%	96%	88%	87%	85%	85%	92%	87%
HB Total	**95%**	**90%**	**92%**	**87%**	**91%**	**83%**	**93%**	**82%**	**84%**	**77%**	**79%**	**85%**	**87%**

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

	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
MH&LD	-	-	-	-	0%	100%	100%	100%	-	-	-	-	50%
Morriston	100%	100%	100%	67%	90%	80%	79%	58%	100%	33%	80%	71%	90%
NPT	67%	-	-	-	100%	100%	90%	100%	-	67%	67%	100%	100%
PCCS	100%	-	100%	100%	94%	83%	100%	100%	80%	67%	90%	100%	100%
Singleton	90%	95%	100%	67%	90%	82%	79%	90%	86%	80%	77%	95%	92%
HB Total	**90%**	**95%**	**100%**	**79%**	**91%**	**83%**	**84%**	**79%**	**85%**	**65%**	**81%**	**94%**	**93%**

Source : NHS Wales Delivery Framework, all-Wales performance summary (April 2021)

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?

Health Board Friends & Family patient satisfaction level in March 2021 was 87% and 1,050 surveys were completed:

- Neath Port Talbot Hospital (NPTH) completed 16 surveys for March, with a recommended score of 75%.
- Singleton Hospital completed 453 surveys for March, with a recommended score of 87%.
- Morriston Hospital completed 326 surveys for March, with a recommended score of 86%.
- Mental Health & Learning Disabilities completed 11 surveys for March, with a recommended score of 73%.
- Primary & Community Care completed 255 surveys for March, with a recommended score of 90%.

What actions are we taking?

Friends and Family Survey. Due to the current pandemic we have stopped collecting paper feedback and it is only available online, this explains why figures are so low at this current time. With cases dropping we are in talks of collecting paper feedback again from all of the hospitals.

March data: Due to the close of the SNAP system there were 162 cases from the Mass Vaccination Centre (MVC) that were unable to link to the month end data for March. This was discussed with the MVC managers and all agreed to populate the new Civica system with the missing 162 cases for April's data. This has been actioned.

New patient feedback system - Civica. Civica is built and live enabling us to capture feedback. All surveys are now up and running online, including the All Wales surveys and the online link for Friends and Family has been pushed out to over 2,000 iPads across the Health Board.

Bay Blood Testing Service/Mass Vaccination Centres. The Anti Body Testing Service has been set up on Friends and Family and for the month of March they received a 96% satisfaction score. The 3 MVC's have also been set up on the new system to capture Friends and Family data, they will be doing paper and online.

What are the main areas of risk?

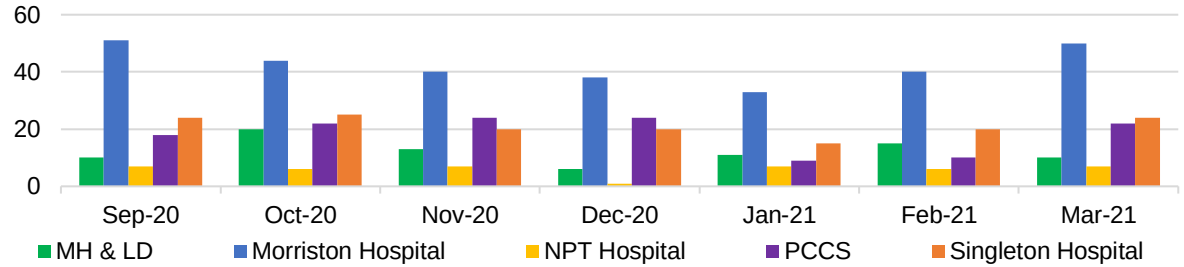
- The Main risk is not having the system set up and collecting feedback.

How do we compare with our peers?

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

COMPLAINTS					
Quadrant of Harm:	Harm from reduction in non-Covid activity.	**Executive Lead:**	Pamela Wenger, Director of Corporate Governance		
Quadruple Aim:	Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable.			**Period:** March 2021	
		Local Target	**WG Target**	**Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: Number of new formal complaints received		12 Month ↓	N/A	✗	↑ 🔴
Measure 2: % of responses sent within 30 working days		80%	75%	✓	↑ 🟢
Measure 3: % of acknowledgements sent within 2 working days		100%	N/A	✓	→ 🟡

(1) Number of new formal complaints received



(2) % of responses sent within 30 working days

	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
MH & LD	67%	67%	100%	78%	63%	69%	50%	80%	70%	92%	75%	73%	64%
Morriston Hospital	75%	40%	88%	94%	89%	88%	84%	90%	86%	89%	91%	81%	95%
NPT Hospital	88%	100%	75%	80%	71%	100%	50%	100%	67%	86%	0%	57%	67%
P&C	64%	29%	83%	73%	50%	80%	60%	92%	67%	76%	77%	63%	67%
Singleton Hospital	80%	58%	75%	75%	83%	50%	65%	63%	64%	70%	70%	57%	68%
Health Board Total	76%	48%	81%	81%	75%	79%	72%	82%	75%	82%	80%	71%	80%

(3) % of acknowledgements sent within 2 working days

Percentage Acknowledgements Sent ≤ 2 Working Days	2020										2021		
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

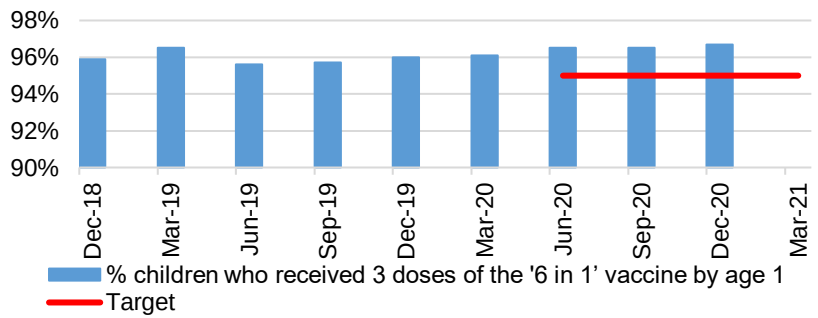
Source: Datix and NHS Wales Delivery Framework, all-Wales performance summary (April 2021)

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 118 formal complaints in March 2021 compared with 87 for March 2020. • The overall Health Board response rate for responding to concerns within 30 working days was 80% for February 2021, which is above the Welsh Government target of 75%. • The Health Board continues to consistently maintain the 2 day acknowledgement target at 100%.
What actions are we taking?
• Performance of the 30 day response target is addressed consistently at all Service Delivery Unit (SDU) performance reviews. February's performance for the Health Board was 80%. • Currently there are 30 open Ombudsman investigation cases; Morriston 11, Singleton 7, Mental Health & Learning Disabilities 5, NPT 3 and ; Primary Care and Community Service 4. • On a monthly basis, the Health Board conducts a Concerns Redress Assurance Group (CRAG) where the Corporate Complaints Team review recently closed complaints. A 'deep dive' review is undertaken on each Service Delivery Unit in turn, as well as the review of a selection of closed complaints from the other Service Delivery Units. During this review, any agreed actions by the Service Delivery Units are monitored by the Corporate Complaints Team to confirm actions are completed to ensure compliance. CRAG is continually developing and evolving to ensure that the best possible learning and assurance is attained by the Health Board. The Health Board has also introduced CRAG workshops where learning is shared with senior members of the Service Delivery Units.
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.

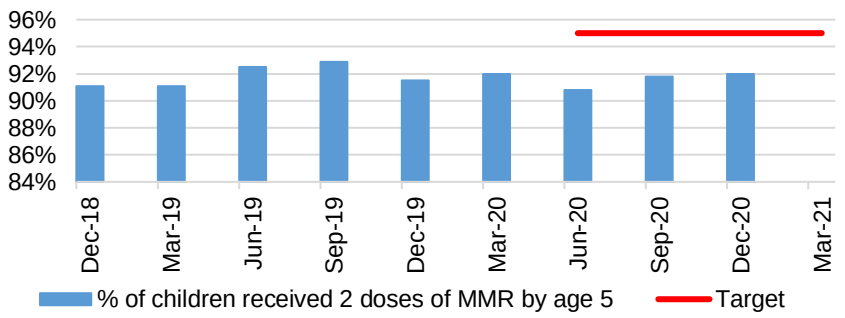
3.3 HARM FROM WIDER SOCIETAL ACTIONS/LOCKDOWN

CHILDHOOD IMMUNISATIONS					
Quadrant of Harm:	Harm from wider societal actions/lockdown	**Executive Lead:**	Keith Reid, Director of Public Health		
Quadruple Aim:	Quadruple aim 1: People in Wales have improved health and well-being and better prevention and self-management.	**Annual Plan Profile**	**WG Target**	**Period:** December 2020 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
Measure 1: % of children who received 3 doses of the '6 in 1' vaccine by age 1		N/A	95%	✓	↑
Measure 2: % of children who received 2 doses of the MMR vaccine by age 5		N/A	95%	✗	↑

(1) % of children who received 3 doses of the '6 in 1' vaccine by age 1

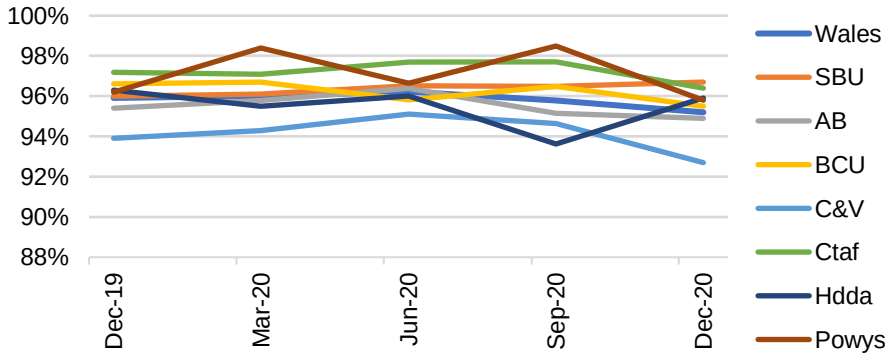


(2) % of children who received 2 doses of the MMR vaccine by age 5

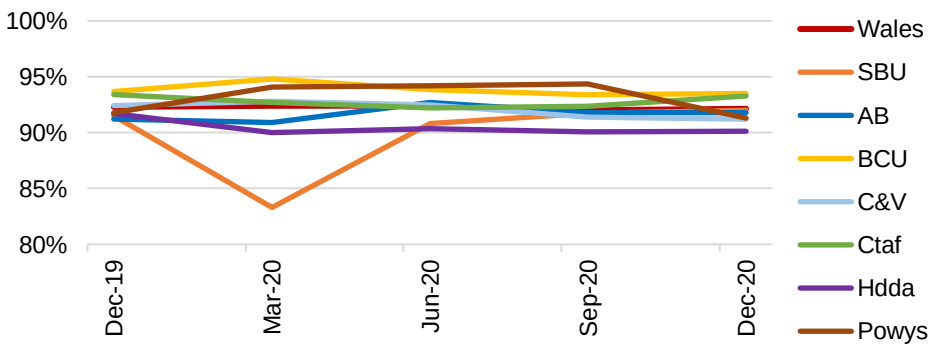


Benchmarking

(1) Benchmark – '6 in 1' Vaccine by Age 1



(2) Benchmark – MMR Vaccine by Age



Source: Public Health Wales COVER Report December 2020

Measure 1: % of children who received 3 doses of the '6 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: October – December 2020 96.7% of children in the Swansea Bay catchment area received the 6 in 1 vaccine by age 1 year. This is above the 95% target and above the all-Wales average of 95.2%.

Measure 2: October – December 2020 92% of children received 2 doses of the MMR vaccine by age 5. This was below the 95% target and similar to the all-Wales average of 92.1%.

What actions are we taking?

- Waiting lists and cancelled clinics are monitored closely by the primary care team. There is a robust reporting mechanism that includes plans for follow up clinics if required.
- Health professionals (GP's/HV/SN/PN) are advised to check and promote immunisation status at every contact.
- A pilot is underway in collaboration with Abertawe Medical Group, Health Visiting and the Child Health Department to cleanse data for children aged 0-5th birthday held by all three systems/services. This commences May 21 and will last up to 8 weeks. Purpose of the pilot is to ensure core demographics are correct, ensure immunisation status held by all is correct, check that all three lists of children align and add or remove children as required.

What are the main areas of risk?

- The number of resident children who have received 2 doses of the MMR by 5 years remains below the required 95% for herd immunity and leaves the population vulnerable to an outbreak. Swansea is currently 92%, below the 95% target. Those who have had 2 doses of MMR by age 4 are 88%.
- Resident children up to date for all immunisations by age 4 years for Swansea Bay University Health Board (SBUHB) is 87.2% and lower than the same time last year (87.4%)
- Child Health Information System SBAR remains on the Internal Audit Risk Register as red and as an overdue action to be undertaken. Action to reduce health inequalities in immunisation uptake remains hampered by the Child Health Information System not being able to cleanse data regularly. This risk of children being missed or immunisation further delayed is increased due to potential incorrect demographic information or incomplete immunisation history. This related to the pilot above, further work will be progressed if this pilot is successful, but will have a long timescale to complete with every practice.
- Public Health Wales "Inequalities in uptake of routine child hood immunisations in Wales 2018-19" annual report - the gap in up to date immunisations at age 4 years between highest and lowest quintile has increased to 8.6% from 7 % in 2017/18. At age 5 years, the gap has increased by 1% to 4.2% from 3.1% in 17/18. This is the most current report.

How do we compare with our peers?

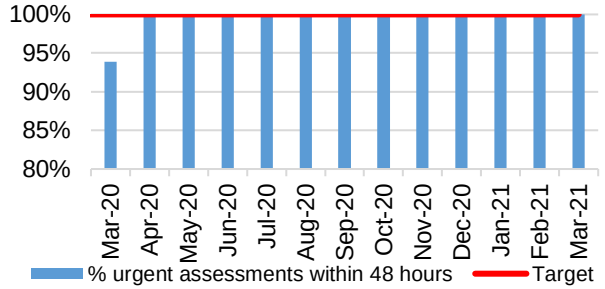
- Measure 1 – SBUHB is ranked 4th in comparison to the other Welsh Health Boards for 6:1 and above the Welsh average of 95.2% during this reporting quarter
- Measure 2 – SBUHB is ranked 3rd in comparison to the other Welsh Health Boards for MMR x2 slightly above the Welsh average of 92.1% during this reporting quarter

CHILD & ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

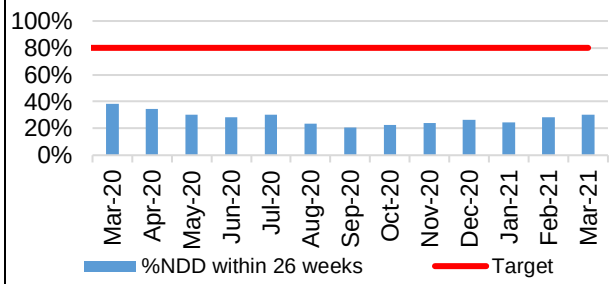
Quadrant of Harm:	Harm from wider societal actions/lockdown	**Executive Lead:**	Siân Harrop-Griffiths, Director of Strategy
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Local Target**	**Period:** March 2021

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

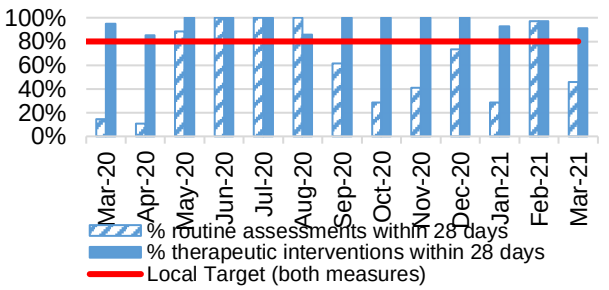
Crisis



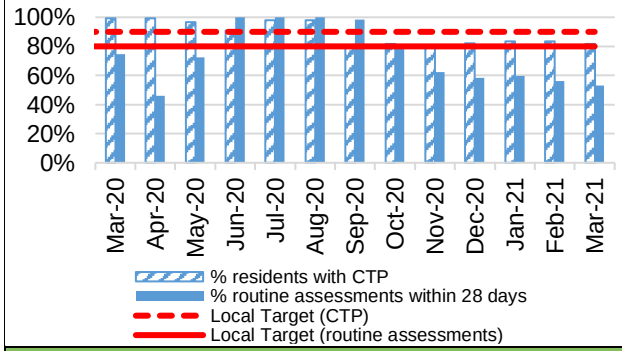
NDD



P-CAMHS



SCAMHS



Benchmarking (SCAMHS)

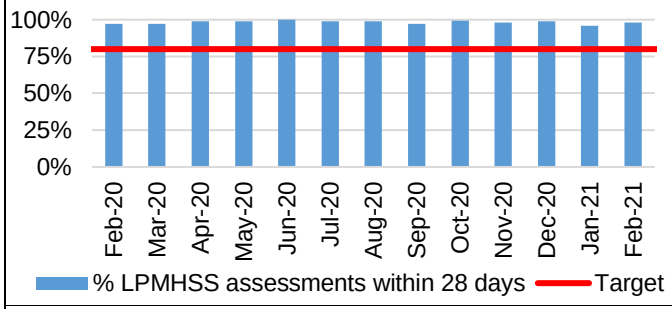
Benchmarking currently unavailable.

Source: Cwm Taf LHB

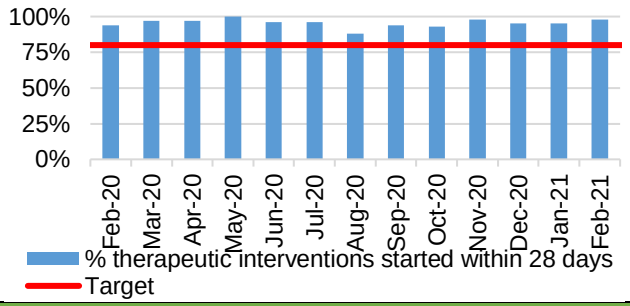
How are we doing?
Measure 1: Crisis - Service now operates 7 days a week, and the performance trend shows that compliance against the target is good, and when performance does deteriorate this is down to staff vacancies. Compliance for March is at 100%. Measure 2: NDD – The referral rate has stabilised at an average of 67 per month over the past 12 months but unsure of the Covid impact of this level so this will be monitored closely now schools have re-opened. Compliance against the target has seen a slight improvement to 30% in March. Measure 3: P-CAMHS – Compliance against the assessment within 28 days can vary considerably, and the main driver for this is staff vacancies. During the first wave of the pandemic P-CAMHS staff were deployed to other areas of the service to cover staff sickness and this continued until Nov 20. An increase in referrals has been seen with the re-opening of schools, and an increase in demand is expected as a result of the pandemic. Compliance against this target is always challenging and will remain low until all CYP are being seen within 28 days. The service are currently progressing with waiting list initiatives to increase activity. Measure 4: P-CAMHS – Compliance against the 80% target for therapeutic interventions has consistently been achieved during 2020/21. The service prioritises this target since it is seen as a key quality indicator that once young people start their interaction with CAMHS they are seen quickly. Measure 5: S-CAMHS – Compliance against the Care and Treatment Plan target has also been affected and has seen a slight decline in compliance. Measure 6: S-CAMHS - Compliance against this target has improved significantly over the last 18 months and the trend has been upwards, however vacancies have contributed to variable levels.
What actions are we taking?
NDD –A paper was presented at the April 2021 Performance and Finance committee. The referral rate has stabilised at an average of 67 per month over the past 12 months but unsure of the Covid impact of this level so this will be monitored closely now schools have re-opened. The paper outlined the long waiting times for initial assessments and also an update on the increased capacity which will be delivered from April 2021 by the appointment of the new staff now in post which will start to reduce the number of patients waiting for an appointment. This also highlighted the remaining demand and capacity gap and backlog of patients who need to be seen to improve performance and reduce waiting times together with further funding required to close this gap. The patient pathway and processes continue to be reviewed by the clinical team. A similar position regarding performance and waiting times is seen across Wales and is being monitored by the All Wales Steering Group. A demand, capacity and pathway redesign review has been commissioned by Welsh Government which has been welcomed by the NDD clinical team. **CAMHS** – The SCAMHS compliance has deteriorated recently due to vacancies, sickness and internal movement of staff to new posts. The service has also seen an expected increase in demand. The service has maintained a >70% compliance in spite of the increased demand due to COVID 19 until recently. Remedial action is being taken to recover the current position. The PCAMHS position deteriorated due to sickness and redeployment within the team during September to November. The position deteriorated further following the holiday period. However, all staff have since returned and a plan has been put into place to ensure compliance increases. CAMHS have been through a period of significant change over the last year, with the three small CAMHS teams combining to form a single integrated service, which will ultimately see performance and access for young people improve and stabilise. During the pandemic, the service fully implemented a single point of access, and have recruited Emotional Health & Wellbeing officers to provide direct support to schools. The Swansea Service will soon occupy new refurbished premises on the Kingsway. Swansea Bay continue to work with CTM, and support them with implementing the agreed multi-agency strategic vision for the Swansea Bay population, including the roll out of a digital platform for online counselling - Kooth which is scheduled to go live at the end of May.
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 SBU is addressing with Cwm Taf via formal commissioning meetings and the introduction of the new service model.
How do we compare with our peers?
There is limited comparative data for CAMHS. An external peer review of the Swansea Bay University Health Board was carried out in February 2021, which found no issues in need of immediate resolution, and the feedback was positive. The report on the outcome of the peer review is expected in May 2021.

MENTAL HEALTH MEASURES					
Quadrant of Harm:	Harm from wider societal actions/lockdown	**Executive Lead:**	Rab McEwan, Interim Chief Operating Officer		
Quadruple Aim:	Quadruple Aim 2 - People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement.	**Annual Plan Profile**	**WG Target**	**Period:** February 2021 **Current Status** *(against target):*	**Movement:** *(12 month trend)*
(1): % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral		80%	80%	✓	↓
(2): % of therapeutic interventions started within 28 days following assessment by LPMHSS		80%	80%	✓	↓
(3): % of Health Board residents in receipt of secondary Mental Health services (all ages) to have a valid Care and Treatment Plan (CTP)		90%	90%	✓	↑
(4): % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health		N/A	80%	✓	↑

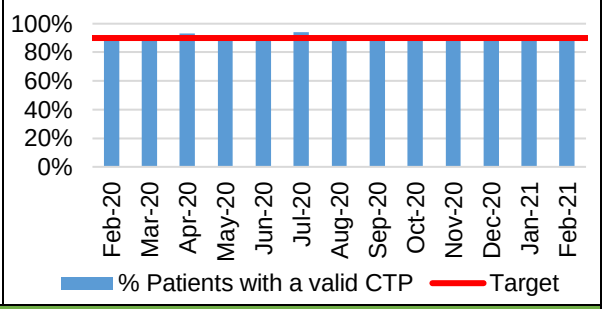
Measure 1



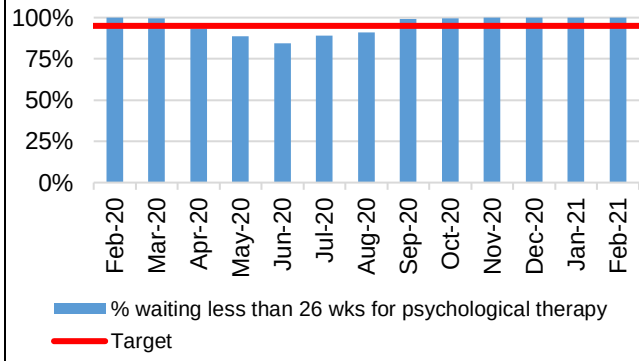
Measure 2



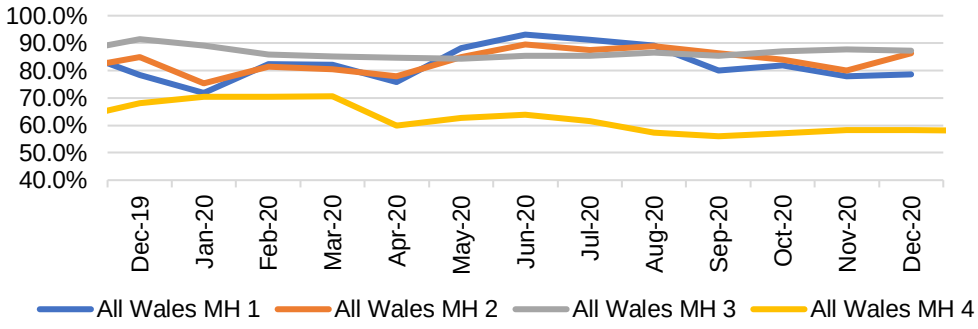
Measure 3



Measure 4



Benchmarking



Source: NHS Wales Delivery Framework, Stats Wales (22.04.21)

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 patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health.

How are we doing?

- **Measure 1** – Swansea Bay University Health Board (SBUHB) met the target (80**%**) for the twelve months excluding CAMHS data. Including CAMHS we met the target five of the twelve months. It should be noted that actual waiting time is irrespective of weekends and bank holidays.
- **Measure 2** - SBUHB met the target (80%) for the twelve months including and excluding CAMHS data 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.
- **Measure 3** - This data covers Adult, Older People, CAMHS and Learning Disability Services. SBUHB met the target (90%) for eleven of the 12 months, most recent data for February 91%
- **Measure 4** - The % of patients waiting to start a psychological therapy at end of February 2021 was 100%, as defined as high intensity or specialist psychological therapies (as defined in Matrics Cymru). Referrals for low intensity interventions are excluded.

What actions are we taking?

- The Local Primary Mental Health Support Service (LPMHSS) has benefited from recent additional Welsh Government resources to develop teams and this is allowing them to recruit additional assessors and therapists.
- The LPMHSS is in the process of developing a further range of group interventions, in order to offset the demand for 1:1 therapy.
- The LPMHSS is supporting the GP cluster networks as they seek to develop bespoke mental health interventions.

What are the main areas of risk?

- Part 1 demand remains under scrutiny due to the potential of an increase in relation to the social, economic and psychological impact of the pandemic. Currently, demand is not exceeding pre-Covid levels and the assessment & intervention targets continue to be met.

How do we compare with our peers?

February 2021

- All-Wales MH1 measure ranged from under 18 (11.1% to 97.5%, SBU 97.5%) target 80%, over 18 (11.4% to 99.1%, SBU 97.6%).
- All-Wales MH2 measure ranged from under 18 (23.3% to 96.9%, SBU 96.9%), over 18 (60.3% to 98.1%, SBU 98.1%).
- All-Wales MH3 measure ranged from under 18 (54.7% to 100%, SBU 83.5%), over 18 (68.6% to 92.1%, SBU 90.9%)
- All-Wales MH4 measure ranged from 28.2% to 100%, SBU 100%

APPENDIX 1: INTEGRATED PERFORMANCE DASHBOARD

Harm from Covid itself

Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average/ Total	SBU's all-Wales rank	Performance Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
COVID19 related measures	Number of new COVID19 cases	Local	Apr-21	406		Reduce					1,381	303	57	53	66	787	4,664	5,525	11,976	3,759	1,208	907	406
	Number of staff referred for Antigen Testing	Local	Apr-21	11,892		Reduce					2,281	2,785	3,102	3,329	3,564	4,765	6,460	8,201	10,065	10,749	11,115	11,683	11,892
	Number of staff awaiting results of COVID19 test	Local	Apr-21	0		Reduce					0	19	16	1	0	38 (as at 10/10/20)	21 (as at 06/11/20)	41 (as at 06/12/20)	99 (as at 05/01/21)	78 (as at 07/02/21)	69 (as at 06/03/21)	2 (as at 11/04/21)	0
	Number of COVID19 related incidents	Local	Apr-21	74		Reduce					119	67	40	26	39	30	87	141	127	84	63	53	74
	Number of COVID19 related serious incidents	Local	Apr-21	0		Reduce					1	0	2	0	11	1	1	1	0	0	0	0	0
	Number of COVID19 related complaints	Local	Apr-21	38		Reduce					77	61	39	58	27	30	37	50	83	106	131	98	38
	Number of COVID19 related risks	Local	Apr-21	2		Reduce					19	20	19	5	8	2	6	7	10	3	3	3	2
	Number of staff self isolated (asymptomatic)	Local	Mar-21	145		Reduce					851	516	474	422	420	353	329	291	475	218	160	145	
	Number of staff self isolated (symptomatic)	Local	Mar-21	108		Reduce					860	292	141	70	36	72	132	294	394	316	156	108	
	% sickness	Local	Mar-21	1.9%		Reduce					13.2%	6.0%	4.5%	3.6%	3.5%	3.2%	3.5%	4.4%	6.5%	4.0%	2.4%	1.9%	

Harm from overwhelmed NHS and social care system

Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average/ Total	SBU's all-Wales rank	Performance Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Unscheduled Care	% of emergency responses to red calls arriving within (up to and including) 8 minutes	National	Apr-21	72%	65%	65%	✓	62.5% (Mar-21)	1st (Mar-21)		70%	75%	76%	74%	72%	69%	66%	67%	54%	67%	70%	73%	72%
	Number of ambulance handovers over one hour	National	Apr-21	337	0			2,778 (Mar-21)	3rd (Mar-21)		61	20	47	120	163	410	355	500	510	195	219	231	337
	Handover hours lost over 15 minutes	Local	Apr-21	877							209	125	178	315	418	1,100	916	1,474	1,804	455	550	583	877
	% of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	National	Apr-21	75%	95%			74.2% (Feb-21)	6th (Feb-21)		78.4%	83.5%	87.7%	80.1%	80.6%	76.4%	77.2%	75.4%	72.6%	77%	71%	77%	75%
	Number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	National	Apr-21	631	0			4,768 (Feb-21)	3rd (Feb-21)		131	97	81	223	286	537	494	626	776	570	534	457	631
NOF	% of survival within 30 days of emergency admission for a hip fracture	National	Jan-21	65.3%	12 month ↑			74.7% (Jan-21)	4th (Jan-21)		78.9%	77.1%	95.5%	93.5%	93.9%	89.4%	90.0%	67.9%	68.0%	65.3%			
	% of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	National	Jan-21	87.0%	12 month ↑			60% (Jan-21)	2nd (Jan-21)		79.0%	80.0%	82.0%	83.0%	83.0%	84.0%	84.0%	85.0%	86.0%	87.0%			
Stroke	Direct admission to Acute Stroke Unit (<4 hrs)	National	Apr-21	20%	54.0%			21.4% (Feb-21	3rd out of 6 organisations (Feb-21)		Data not available		52.7%	57.4%	51.4%	50.0%	29.8%	23.7%	7.1%	6.8%	18.2%	20.4%	20.3%
	CT Scan (<1 hrs) (local	Local	Apr-21	30%									49.1%	48.2%	52.8%	62.5%	42.1%	31.7%	22.7%	42.2%	30.6%	40.8%	29.7%
	Assessed by a Stroke Specialist Consultant Physician (< 24 hrs)	National	Apr-21	97%	85.3%			85.4% (Feb-21)	1st (Feb-21)				100.0%	94.6%	97.2%	97.5%	98.2%	96.7%	95.5%	95.6%	97.2%	100.0%	96.9%
	Thrombolysis door to needle <= 45 mins	Local	Apr-21	25%	12 month ↑								30.0%	25.0%	0.0%	12.5%	11.1%	28.6%	0.0%	12.5%	0.0%	55.6%	25.0%
	% compliance against the therapy target of an average of 16.1 minutes if speech and language therapist input per stroke patient	National	Apr-21	47%	12 month ↑			43.0% (Feb-21)	1st (Feb-21)				30.7%	44.3%	61.7%	80.1%	86.5%	65.1%	63.4%	65.7%	61.2%	55.9%	47.1%
	% of stroke patients who receive a 6 month follow-up assessment	National	Q3 19/20	49.6%	Qtr on qtr ↑			62.2% (Q3 19./20)	5th out of 6 organisations (Q3 19/20)														
DTOCs	Number of mental health HB DToCs	National	Mar-20	13	12 month ↓	27	✓				DTOC reporting temporarily suspended												
	Number of non-mental health HB DToCs	National	Mar-20	60	12 month ↓	50	✗				DTOC reporting temporarily suspended												
	% critical care bed days lost to delayed transfer of care	National	Q1 20/21	26.2%	Quarter on quarter ↓			5.3% (Q1 20/21)	2nd (Q1 20/21)				2.5%										

Harm from overwhelmed NHS and social care system

Sub Domain	Measure	National or Local Target	Report Period	Current Performance	National Target	Annual Plan/ Local Profile	Profile Status	Welsh Average/ Total	SBU's all-Wales rank	Performance Trend	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
infection control	Cumulative cases of E.coli bacteraemias per 100k pop	National	Apr-21	99.8	<67		✗	59.90 (Mar-21)	3rd (Mar-21)		43.8	43.0	46.4	53.8	62.5	64.0	65.7	63.8	60.7	60.0	59.8	61.9	99.8
	Number of E.Coli bacteraemia cases (Hospital)		Apr-21	*12*							*6*	*6*	*3*	*8*	*8*	*7*	*14*	*5*	*5*	*6*	*6*	*9*	*12*
	Number of E.Coli bacteraemia cases (Community)			*20*							*8*	*8*	*14*	*17*	*24*	*16*	*11*	*11*	*7*	*12*	*11*	*19*	*20*
	Total number of E.Coli bacteraemia cases			32							14	14	17	25	32	23	25	16	12	18	17	28	32
	Cumulative cases of S.aureus bacteraemias per 100k pop		Apr-21	40.5	<20		✗	24.85 (Mar-21)	6th (Mar-21)		31.5	24.7	28.8	26.1	28.2	30.7	31.5	32.7	31.7	31.6	31.4	31.6	40.5
	Number of S.aureus bacteraemias cases (Hospital)		Apr-21	*4*							*4*	*2*	*4*	*3*	*5*	*7*	*6*	*7*	*6*	*5*	*7*	*4*	*4*
	Number of S.aureus bacteraemias cases (Community)			*8*							*6*	*4*	*8*	*3*	*7*	*7*	*6*	*6*	*3*	*4*	*2*	*7*	*8*
	Total number of S.aureus bacteraemias cases			12							10	6	12	6	12	14	12	13	9	9	9	11	12
	Cumulative cases of C.difficile per 100k pop		Apr-21	62.3	<26		✗	28.04 (Mar-21)	6th (Mar-21)		34.4	42.9	49.5	45.3	50.2	51.2	50.4	48.4	45.7	42.0	41.5	41.1	62.3
	Number of C.difficile cases (Hospital)		Apr-21	*15*							*9*	*6*	*14*	*7*	*9*	*12*	*12*	*8*	*6*	*3*	*9*	*7*	*15*
	Number of C.difficile cases (Community)			*5*							*2*	*10*	*6*	*4*	*14*	*6*	*3*	*2*	*3*	*0*	*2*	*5*	*5*
	Total number of C.difficile cases			20							11	16	20	11	23	18	15	10	9	3	11	12	20
	Cumulative cases of Klebsiella per 100k pop		Apr-21	28.1							18.8	18.4	21.6	20.0	22.1	21.0	21.9	23.4	24.9	26.4	25.8	26.2	28.1
	Number of Klebsiella cases (Hospital)		Apr-21	*4*							*1*	*4*	*4*	*3*	*6*	*3*	*7*	*7*	*8*	*8*	*4*	*1*	*4*
	Number of Klebsiella cases (Community)			*5*							*5*	*2*	*5*	*2*	*4*	*2*	*2*	*4*	*4*	*5*	*2*	*9*	*5*
	Total number of Klebsiella cases			9				69 (Mar-21)	Joint 1st (Mar-21)		6	6	9	5	10	5	9	11	12	13	6	10	9
	Cumulative cases of Aeruginosa per 100k pop		Apr-21	9.4							6.3	10.7	7.2	6.2	6.7	5.6	5.7	5.8	5.5	5.2	5.1	4.9	9.4
	Number of Aeruginosa cases (Hospital)		Apr-21	*2*							*2*	*3*	*0*	*0*	*0*	*0*	*1*	*1*	*1*	*0*	*0*	*0*	*2*
	Number of Aeruginosa cases (Community)			*1*							*0*	*2*	*0*	*1*	*3*	*0*	*1*	*1*	*0*	*1*	*1*	*1*	*1*
	Total number of Aeruginosa cases			3				7 (Mar-21)	Joint 2nd (Mar-21)		2	5	0	1	3	0	2	2	1	1	1	1	3
	Hand Hygiene Audits- compliance with WHO 5 moments	Local	Apr-21	96%		95%	✓				98%	99%	98%	98%	94%	96%	97%	97%	96%	95%	93%	97%	96%
Serious Incidents and risks	Of the serious incidents due for assurance, the % which were assured within the agreed timescales	National	Apr-21	0%	90%	80%	✗				7%	29%	0%	0%	50%	20%	0%	0%	4%	0%	10%	0%	0%
	Number of new Never Events	National	Apr-21	0	0	0	✓				0	0	1	0	0	0	1	1	0	0	0	0	0
	Number of risks with a score greater than 20	Local	Apr-21	132		12 month ↓	✗				109	101	110	115	121	117	130	138	146	148	140	142	132
	Number of risks with a score greater than 16	Local	Apr-21	217		12 month ↓	✗				202	193	204	204	210	206	224	224	238	242	233	230	217
Pressure Ulcers	*Number of pressure ulcers acquired in hospital*	Local	Mar-21	36		*12 month ↓*	✗				*25*	*29*	*18*	*19*	*37*	*44*	*59*	*42*	*61*	*51*	*48*	*36*	
	Number of pressure ulcers developed in the community		Mar-21	26		*12 month ↓*	✓				*34*	*33*	*34*	*28*	*25*	*21*	*34*	*29*	*26*	*25*	*24*	*26*	
	Total number of pressure ulcers		Mar-21	62		12 month ↓	✗				59	62	52	47	62	65	93	71	87	76	72	62	
	Number of grade 3+ pressure ulcers acquired in hospital		Mar-21	1		*12 month ↓*	✗				*2*	*0*	*1*	*0*	*4*	*0*	*4*	*4*	*3*	*2*	*3*	*1*	
	Number of grade 3+ pressure ulcers acquired in community		Mar-21	2		*12 month ↓*	✓				*4*	*6*	*9*	*4*	*5*	*5*	*11*	*5*	*7*	*5*	*4*	*2*	
	Total number of grade 3+ pressure ulcers		Mar-21	3		12 month ↓	✓				6	6	10	4	9	5	15	9	10	7	7	3	
Inpatient Falls	Number of Inpatient Falls	Local	Apr-21	176		12 month ↓	✓				193	209	196	208	227	219	187	247	247	203	177	171	176
Mortality	% of universal mortality reviews (UMRs) undertaken within 28 days of a death	Local	Mar-21	98%	95%	95%	✓				95.6%	99.3%	100.0%	95.5%	96.6%	99.2%	100.0%	98.1%	99.0%	100.0%	100.0%	97.6%	
	Stage 2 mortality reviews required	Local	Mar-21	11							10	11	10	10	10	11	9	17	12	19	6	11	
	% stage 2 mortality reviews completed	Local	Jan-21	36.80%		100%	✗				30.0%	27.3%	50.0%	90.0%	50.0%	54.5%	33.3%	35.7%	75.0%	36.8%			
	Crude hospital mortality rate (74 years of age or less)	National	Mar-21	1.17%	12 month ↓			1.56% (Mar-21)	4th (Mar-21)		0.80%	0.88%	0.89%	0.92%	0.90%	0.93%	0.97%	1.01%	1.08%	1.14%	1.17%	1.17%	
	% of deaths scrutinised by a medical examiner	National			Qtr on qtr ↑						New measure for 2020/21- awaiting data												
NEWS	% patients with completed NEWS scores & appropriate responses actioned	Local	Apr-21	97%		98%	✗				92.0%	93.9%	91.6%	96.6%	92.4%	93.6%	93.9%	94.6%	98.5%	95.0%	96.3%	93.5%	97.4%
HAT	Number of potentially preventable hospital acquired thromboses (HAT)	National	Q2 20/21	3	4 quarter ↓			6					3			3							
Coding	% of episodes clinically coded within 1 month of discharge	Local	Mar-21	96%	95%	95%	✓				94%	97%	97%	96%	96%	96%	95%	93%	93%	95%	96%	96%	
	% of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	National	2019/20	91%	Annual ↑			93.9% (2019/20	7th (2019/20)														
E-TOC	% of completed discharge summaries (total signed and sent)	Local	Apr-21	63%		100%	✗				61%	63%	67%	63%	66%	70%	68%	66%	59%	67%	63%	64%	63%
Workforce	Agency spend as a % of the total pay bill	National	Aug-20	3.62%	12 month ↓			4.2% (Aug-20)	5th out of 10 organisations (Aug-20)		4.04%	3.21%	4.32%	2.81%	3.62%								
	Overall staff engagement score – scale score method	National	2018	3.81	Improvement			3.82 (2018)	7th out of 10 organisations (2018)														
	% of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months (excluding doctors and dentists in training)	National	Apr-21	57%	85%	85%	✗	61.9% (Aug-20)	7th out of 10 organisations (Aug-20)		68%	63%	60%	59%	58%	58%	58%	56%	54%	52%	51%	53%	57%
	% staff who undertook a performance appraisal who agreed it helped them improve how they do their job	National	2018	55%	Improvement			54% (2018)	2nd (2018)														
	% compliance for all completed Level 1 competency with the Core Skills and Training Framework	National	Apr-21	80%	85%	85%	✗	80.2% (Aug-20)	7th out of 10 organisations (Aug-20)		82%	79%	79%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	% workforce sickness absence (12 month rolling)	National	Mar-21	7.44%	12 month ↓			5.92% (Aug-20)	10th out of 10 organisations (Aug-20)		6.65%	6.88%	6.98%	7.03%	7.03%	7.03%	7.07%	7.23%	7.48%	7.57%	7.56%	7.44%	
	% staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	National	2018	72%	Improvement			73% (2018)	7th out of 10 organisations (2018)														

Harm from reduction in non-Covid activity																								
Sub Domain	**Measure**	**National or Local Target**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average/ Total**	**SBU's all-Wales rank**	**Performance Trend**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
Primary Care	% of GP practices that have achieved all standards set out in the National Access Standards for in-hours GMS	National	2019/20	38.80%	100%			59.7% (2019/20)	7th (2019.20)														
	% of children regularly accessing NHS primary dental care within 24 months	National	Q2 20/21	72.6%	4 quarter ↑			63.8% (Q2 20/21)	1st (Q2 20/21)				75.9%			72.6%							
	% adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	National	Mar-21	6.6%	4 quarter ↓			21.8% (Q3 20/21)	1st (Q3 20/21)		19.2%	16.8%	14.7%	18.6%	24.7%	23.8%	27.2%	17.2%	12.0%	5.9%	5.3%	6.6%	
Cancer	% of patients starting definitive treatment within 62 days from point of suspicion (without adjustments)	National	Apr-21 (draft)	47.6%	12 month ↑			61.2% (Jan-21)	1st out of 6 organisations (Jan-21)		54.7%	61.8%	59.9%	68.2%	67.4%	62.4%	65.9%	55.4%	61.0%	67.9%	56.4%	71.6%	47.6%
Radiotherapy waiting times	Scheduled (21 Day Target)	Local	Apr-21	37%	80%		✖				49%	46%	57%	71%	63%	60%	75%	58%	71%	45%	35%	42%	37%
	Scheduled (28 Day Target)	Local	Apr-21	77%	100%		✖				86%	84%	93%	97%	92%	86%	90%	85%	88%	82%	80%	85%	77%
	Urgent SC (7 Day Target)	Local	Apr-21	38%	80%		✖				45%	33%	65%	57%	57%	54%	43%	31%	50%	50%	23%	41%	38%
	Urgent SC (14 Day Target)	Local	Apr-21	83%	100%		✖				91%	83%	90%	97%	91%	92%	86%	100%	85%	94%	91%	90%	83%
	Emergency (within 1 day)	Local	Apr-21	91%	80%		✔				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%
	Emergency (within 2 days)	Local	Apr-21	100%	100%		✔				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Elective Delay (21 Day Target)	Local	Apr-21	82%	80%		✔				76%	83%	92%	52%	46%	58%	58%	56%	71%	69%	61%	86%	82%
	Elective Delay (28 Day Target)	Local	Apr-21	92%	100%		✖				88%	100%	100%	97%	75%	60%	75%	73%	88%	89%	75%	93%	92%
Planned Care	Number of patients waiting > 8 weeks for a specified diagnostics	National	Apr-21	4,804	0			48,136 (Feb-21)	2nd (Feb-21)		5,788	8,346	8,033	7,510	8,070	7,666	6,645	6,610	6,579	6,239	5,087	4,554	4,804
	Number of patients waiting > 14 weeks for a specified therapy	National	Apr-21	201	0			4,129 (Feb-21)	3rd (Feb-21)		387	982	1,646	1,554	1,518	1,350	1,135	817	708	584	491	369	201
	% of patients waiting < 26 weeks for treatment	National	Apr-21	49.1%	95%			51.6% (Feb-21)	6th (Feb-21)		72.3%	64.0%	59.4%	52.5%	43.7%	41.0%	44.8%	47.6%	48.0%	47.0%	47.9%	48.8%	49.1%
	Number of patients waiting > 26 weeks for outpatient appointment	Local	Apr-21	22,752	0						5,499	9,300	11,964	15,721	20,497	23,069	22,050	21,005	21,179	21,208	21,225	21,750	22,752
	Number of patients waiting > 36 weeks for treatment	National	Apr-21	33,395	0			217,655 (Feb-21)	3rd (Feb-21)		8,355	10,247	13,419	18,078	22,494	26,046	31,508	35,387	35,126	33,991	32,719	32,874	33,395
	The number of patients waiting for a follow-up outpatient appointment	National	Apr-21	122,303	HB target TBC			748,769 (Feb-21)	5th (Feb-21)		123,082	121,434	120,468	120,062	120,969	120,962	120,968	120,874	119,963	119,999	120,882	121,403	122,303
	The number of patients waiting for a follow-up outpatients appointment who are delayed over 100%	National	Apr-21	29,334				199,704 (Feb-21)	5th (Feb-21)		19,538	21,026	21,448	22,101	23,209	24,472	26,217	27,156	27,641	28,419	28,862	29,316	29,334
	% of R1 ophthalmology patient pathways waiting within target date or within 25% beyond target date for an outpatient appointment	National	Mar-21	47.7%	95%			43.5% (Feb-21)	3rd (Feb-21)		69.9%	64.1%	63.4%	55.5%	50.9%	47.7%	45.2%	48.4%	47.3%	46.7%	47.4%	47.7%	
Hepatitis C	Number of patients with Hepatitis C who have successfully completed their course of treatment in the reporting year	National			HB target TBC						New measure for 2020/21- awaiting data												
DNAs	% of patients who did not attend a new outpatient appointment	Local	Apr-21	5.5%	12 month ↓						4.7%	3.1%	4.4%	3.9%	4.7%	6.4%	6.0%	6.6%	7.7%	7.1%	6.2%	5.6%	5.5%
	% of patients who did not attend a follow-up outpatient appointment	Local	Apr-21	6.2%	12 month ↓						5.7%	3.5%	4.7%	5.2%	6.0%	6.9%	6.5%	7.2%	8.2%	7.1%	6.2%	6.7%	6.2%
Theatre Efficiencies	Theatre Utilisation rates	Local	Apr-21	80.0%		90%	✖				6%	11%	16%	42%	90%	75%	75%	74%	59%	65%	73%	75%	80%
	% of theatre sessions starting late	Local	Apr-21	38.0%		<25%	✖				45%	43%	46%	51%	46%	49%	44%	39%	45%	40%	42%	40%	38%
	% of theatre sessions finishing early	Local	Apr-21	41.0%		<20%	✖				43%	45%	36%	37%	28%	39%	38%	50%	47%	44%	44%	48%	41%
Postponed operations	Number of procedures postponed either on the day or the day before for specified non-clinical reasons	National	Jan-21	1,200	> 5% annual ↓			5,398 (Jan-21)	6th (Jan-21)		3,091	2,869	2,659	2,391	2,281	2,090	1,888	1,677	1,509	1,200			
Treatment Fund	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	National	Q2 20/21	98.8%	100%	100%	✖	98.3% (Q2 20/21)	3rd out of 6 organisations (Q2 20/21)				98.7%			98.8%							

Harm from reduction in non-Covid activity																								
Sub Domain	**Measure**	**National or Local Target**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average/ Total**	**SBU's all-Wales rank**	**Performance Trend**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
Prescribing	Total antibacterial items per 1,000 STAR-PUs	National	Q3 20/21	258.8	4 quarter ↓			241.96 (Q3 20/21)	6th (Q3 20/21)				243.8			249.9			258.8				
	Patients aged 65 years or over prescribed an antipsychotic	National	Q2 20/21	1,511	Quarter on quarter ↓			10,205 (Q2 20/21)	5th (Q2 20/21)				1,464			1,511							
	Number of women of child bearing age prescribed valproate as a % of all women of child bearing age	National	Q2 20/21	0.23%	Quarter on quarter ↓			0.16% (Q2 20/21)	7th (Q2 20/21)				0.23%			0.23%							
	Opioid average daily quantities per 1,000 patients	National	Q2 20/21	4,369	4 quarter ↓			4,390.4 (Q2 20/21)	3rd (Q2 20/21)				4,308			4,369							
	Biosimilar medicines prescribed as % of total 'reference' product plus biosimilar	National	Q2 20/21	78.6%	Quarter on quarter ↑			82.6% (Q2 20/21)	4th (Q2 20/21)				80.2%			78.6%							
Patient experience	Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	National	2018/19	6.4	Annual ↑			6.31 (2018/19)	2nd (2018/19)														
	% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at their GP/family doctor	National	2019/20	88.7%	Annual ↑			88.6% (2019/20)	3rd (2019/20)														
	% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital (Local)	Local	2018/19	92.9%	Annual ↑																		
	Number of friends and family surveys completed	Local	Mar-21	1,050		12 month ↑	✓				150	247	393	502	625	2,804	1,047	787	584	678	798	1,050	
	% of who would recommend and highly recommend	Local	Mar-21	87%		90%	✗				90%	92%	87%	91%	83%	93%	82%	84%	77%	79%	85%	87%	
	% of all-Wales surveys scoring 9 out 10 on overall satisfaction	Local	Mar-21	93%		90%	✓				95%	100%	79%	91%	83%	84%	79%	85%	65%	81%	94%	93%	
Complaints	Number of new formal complaints received	Local	Apr-21	100		12 month ↓ trend	✗				37	52	73	77	74	107	121	103	83	78	94	117	100
	% concerns that had final reply (Reg 24)/interim reply (Reg 26) within 30 working days of concern received	National	Feb-21	80%	75%	80%	✓	71.9% (Q3 20/21)	2nd (Q3 20/21)		81%	81%	75%	79%	72%	82%	75%	82%	80%	71%	80%		
	% of acknowledgements sent within 2 working days	Local	Apr-21	100%		100%	✓				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Research	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	National	Q1-Q3 20/21	1,328	10% annual ↑	1,651	✓	6,378 (Q1-2 20/21)	5th out of 10 organisations (Q1-2 20/21)				210			376			1328				
	Number of patients recruited in Health and Care Research Wales commercially sponsored studies		Q1-Q3 20/21	36	5% annual ↑	215	✗	73 (Q1-2 20/21)	2nd out of 10 organisations (Q1-2 20/21)				2			21			36				

Harm from wider societal actions/lockdown																								
Sub Domain	**Measure**	**National or Local Target**	**Report Period**	**Current Performance**	**National Target**	**Annual Plan/ Local Profile**	**Profile Status**	**Welsh Average/ Total**	**SBU's all-Wales rank**	**Performance Trend**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**
Early years measures	% of babies who are exclusively breastfed at 10 days old	National	2019/20	34.2%	Annual ↑			35.3% (2019/20)	5th (2019/20)															
	% children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	National	Q3 20/21	96.7%	95%			95.3% (Q3 20/21)	1st (Q3 20/21)				96.5%			96.5%			96.7%				
	% of children who received 2 doses of the MMR vaccine by age 5	National	Q3 20/21	92.0%	95%			92.1% (Q3 20/21)	3rdh (Q3 20/21)				90.8%			91.7%			92.0%				
Smoking cessation	% of adult smokers who make a quit attempt via smoking cessation services	National	Q1-Q2 20/21	1.66%	5% annual target			1.65% (Q1-2 20/21)	4th (Q1-2 20/21)							1.66%							
Alcohol	European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales	National	Q3 20/21	308.8	4 quarter ↓			349.6 (Q3 20/21)	2nd (Q3 20/21)				279.6			331.7			308.8				
	% of people who have been referred to health board services who have completed treatment for alcohol abuse	National	Q3 20/21	39.5%	4 quarter ↑			64% (Q3 20/21)	6th (Q2 20/21)				32.8%			23.2%			39.5%				
Influenza	% uptake of influenza among 65 year olds and over	National	Mar-21	75.5%	75%			76.5% (Mar-21)	4th (Mar-21)		Data collection restarts October 2020						65.6%	72.4%	74.8%	75.2%	75.4%	75.5%	Data collection restarts October 2021
	% uptake of influenza among under 65s in risk groups	National	Mar-21	49.4%	55%			51.07% (Mar-21)	5th (Mar-21)								34.4%	42.8%	47.2%	48.7%	49.4%	49.4%	
	% uptake of influenza among pregnant women	National	2019/20	78.2%	75%			78.5% (2019/20)	5th out of 10 organisations (2019/20)								Data not available						
	% uptake of influenza among children 2 to 3 years old	Local	Mar-21	53.4%	50%			56.3% (Mar-21)	5th (Mar-21)								35.7%	48.8%	52.5%	53.2%	53.4%	53.4%	
	% uptake of influenza among healthcare workers	National	Mar-21	63.4%	60%			58.7% (2019/20)	7th out of 10 organisations (2019/20)								56.2%	62.9%	63.0%	63.4%	63.4%	63.4%	
Screening services	Uptake of screening for bowel cancer	National	2018/19	57.0%	60%			57.3% (2018/19)	4th (2018/19)														
	Uptake of screening for breast cancer	National	2018/19	73.6%	70%			72.8% (2018/19)	2nd (2018/19)														
	Uptake of screening for cervical cancer	National	2018/19	72.1%	80%			73.2% (2018/19)	5th (2018/19)														
CAMHS	% of urgent assessments undertaken within 48 hours from receipt of referral (Crisis)	Local	Mar-21	100%		100%	✓				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	% Patients with Neurodevelopmental Disorders (NDD) receiving a Diagnostic Assessment within 26 weeks	National	Mar-21	30%	80%	80%	✗	29.7% (Feb-21)	5th (Feb-21)		35%	30%	28%	30%	24%	21%	22%	24%	26%	24%	28%	30%	
	% Patients waiting less than 28 days for a first outpatient appointment for CAMHS	National	Mar-21	63%	80%	80%	✗	58.8% (Feb-21)	4th (Feb-21)		44%	78%	100%	100%	100%	98%	90%	88%	61%	53%	66%	63%	
	P-CAMHS - % of Routine Assessment by CAMHS undertaken within 28 days from receipt of referral	National	Mar-21	46%		80%	✗	58.0% (Feb-21)	1st (Feb-21)		11%	89%	100%	100%	100%	62%	29%	41%	73%	29%	97%	46%	
	P-CAMHS - % of therapeutic interventions started within 28 days following assessment by LPMHSS	National	Mar-21	91%		80%	✓	75.3% (Feb-21)	1st (Feb-21)		85%	100%	100%	100%	86%	100%	100%	100%	100%	93%	97%	91%	
	S-CAMHS - % of Routine Assessment by SCAMHS undertaken within 28 days from receipt of referral	Local	Mar-21	53%		80%	✗				46%	72%	100%	100%	100%	98%	79%	62%	58%	60%	56%	53%	
	% residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)	National	Mar-21	82%		90%	✗	82.3% (Feb-21)	5th (Feb-21)		99%	97%	91%	98%	98%	81%	82%	81%	82%	83%	84%	82%	
Mental Health	% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (over 18 years of age)	National	Mar-21	97%	80%	80%	✓	81.3% (Feb-21)	2nd (Feb-21)		99%	99%	100%	99%	99%	97%	99.5%	98%	99%	96%	98%	97%	
	% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (over 18 years of age)	National	Mar-21	97%	80%	80%	✓	83.0% (Feb-21)	2nd (Feb-21)		97%	100%	96%	96%	88%	94%	93%	98%	95%	95%	98%	97%	
	% patients waiting < 26 weeks to start a psychological therapy in Specialist Adult Mental Health	National	Mar-21	100%	95%	95%	✓	60.0% (Feb-21)	1st (Feb-21)		93%	89%	84%	89%	91%	99%	99.7%	100%	100%	100%	100%	100%	
	% residents in receipt of secondary MH services (all ages) who have a valid care and treatment plan (CTP)	National	Mar-21	91%	90%	90%	✓	85.5% (Feb-21)	3rd (Feb-21)		93%	92%	92%	94%	92%	90%	91%	91%	89%	91%	91%	91%	
Self harm	Rate of hospital admissions with any mention of intentional self-harm of children and young people (aged 10-24 years)	National	2019/20	3.29	Annual ↓			3.97 (2019/20)	4th (2019/20)														
Dementia	% of people with dementia in Wales age 65 years or over who are diagnosed (registered on a GP QOF register)	National	2018/19	59.4%	Annual ↑			53.1% (2019/20)	2nd (2019/20)														