SUMMARY REPORT	ABM University Health Board
Health Board	Date of Meeting: 25th May 2017 Agenda item : 2 (ii)

Report Title	**Integrated Performance Report**
Prepared by	Hannah Roan, Performance and Contracting Manager Darren Griffiths, Assistant Director of Strategy
Approved by	Siân Harrop-Griffiths, Director of Strategy
Presented by	Siân Harrop-Griffiths, Director of Strategy Executive Leads

Purpose

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 this case March 2017) in delivering key performance measures outlined in the National Outcomes and Performance Framework within the overall context of delivering the Health Board's strategic aims. This report is the first iteration of a revised reporting format for the Board, which builds on the report card system already in place and supplies a more detailed narrative to further inform the Board. This report is therefore transitional in nature and will be developed further for the July Board.	**Decision**	
	Approval	**X**
	Information	**X**
	Other	

Promoting and Enabling Healthier Communities	Delivering Excellent Population Outcomes	Demonstrating Value and Sustainability	Securing a Fully Engaged and Skilled Workforce	Providing Effective Governance and Partnerships
x	**x**	**x**	**x**	**x**

Executive Summary

This report provides a narrative overview of performance at the end of March 2017 (where available) against the Annual Plan for 2016/17 with a focus on delivery against key national targets.

The NHS Outcomes and Performance Framework was released at the end of March 2016 and details the indicators and measures that are used to provide an annual view of the impact that health services are having in improving health outcomes at a population level and the relative success in planning and delivering those services.

The Framework sets out 39 outcome indicators and 96 performance measures under 7 domains, against which the performance of the Health Board is measured. The Health Board does not receive a report card for each of these indicators, but receives report cards based on the key measures as agreed by the Board. This system has been in place for close to two years and the report cards have developed over this period to include new metrics, as the Board requires.

This report is compiled to include reporting on the key performance measures as they relate to the Health Board's strategic aims, as this was the structure in place for 2016/17. For the July report, the structure will be changed to match the Health Board's corporate objectives. It is also intended that for future reports a more forward-looking assessment will be actions underway and their planned impact on performance.

The five non-financial Approval Condition performance measures are drawn out in more detail in this report. These are: -

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

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

The sixth Approval Condition of finance is covered in a separate report.

Should this enhanced narrative and structure of report be found to be useful for Board members, the paper will be restructured for the next Heath Board meeting to reflected the new NHS Outcomes and Performance Framework aligned to the revised Health Board corporate objectives. (Also, a Finance and Performance Committee is to be established which will consider detailed performance in future).

Key Recommendations

The Board is asked to:

- **Note current Health Board performance against key measures and targets and the actions being taken to improve performance.**
- **Consider the value of the new format of narrative report supported by the detailed performance report cards.**

MAIN REPORT		ABM University Health Board
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1. INTRODUCTION

This report provides a high-level overview of performance at the end of March 2017 against the Annual Plan for 2016/17 with a focus on delivery against key national targets as set out in the NHS Outcomes and Performance Framework.

This report is compiled to report on the key performance measures as they relate to the Health Board's strategic aims as set out for 2016.17. Within this structure, the five non-financial Approval Condition performance measures are drawn out in more detail. These are: -

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

The report builds on the report card system, which has been used to inform the Board on performance delivery over the last two years or so. The full suite of report cards as routinely reported to the Health Board is attached as **Appendix A** to this report.

Should this enhanced narrative and structure of report be found to be useful for Board members the first report covering financial year 2017/18 will be restructured to reflect the new NHS Outcomes and Performance Framework aligned to the revised Health Board corporate objectives for 2017/18. It is also intended that for future reports a more forward-looking assessment including actions underway and their planned impact on performance will be included.

2. SUMMARY OF PERFORMANCE AGAINST WELSH GOVERNMENT PERFORMANCE MEASURES

At a summary level, the table below sets out the current performance assessment for the totality of the report card routinely reported to the Board.

	Change since last reporting period		
Strategic Aim	**Improving**	**Sustained**	**Decline**
Healthier Communities	3	0	3
Excellent Patient Outcomes and Experience	6	2	8
A Fully Engaged and Skilled Workforce	2	0	0
Accessible and Sustainable serviced	13	3	12
Total	**24**	**5**	**23**

The detail of each of the measures which constitute the table above and their performance is set out in each of the Strategic Aim sections which follow below, with the exception of the Approval Condition measures which have been extracted and placed at the front of the report to enable them to be discussed as a considered group of key metrics.

At a high level, improvements have been seen across all of the Approval Condition measures in 2016/17 (with the exception of cancer access), although the absolute target levels set by Welsh Government have not been achieved. In our performance, access to Mental Health services is strong and our increased focus on Child and Adolescent Mental Health (CAMHS) access times is resulting in improvement in this area. On metrics such as sickness absence and delayed follow-ups for outpatient attendances, the Health Board needs to improve performance to reverse the current trend and move towards target levels.

The performance measures selected for reporting in this narrative report are the performance measures set out in the agreed range of report cards routinely reported to the Health Board. This system has been in place for close to two years and the report cards have developed over this period to include new metrics, as the Board requires.

3. PLAN APPROVAL CONDITION MEASURES

WG Measures 64 - 67 Unscheduled Care

Unscheduled care improvement is a critical element of the Health Board's delivery requirements and is one of the Plan Approval Condition measures.

The Health Board achieved a largely stabilised and improving performance until October but an increase in emergency admissions in the older age group from late Autumn over and above predicted levels has impacted on flow, capacity and unscheduled care performance over the winter months. This has been a particular challenge in Swansea despite the fact that Singleton Hospital is playing an extended role in relation to urgent and emergency care in Swansea.

The simple table below sets out the high-level comparators of the key indicators for March 2016 and March 2017. Care must be taken when comparing monthly figures

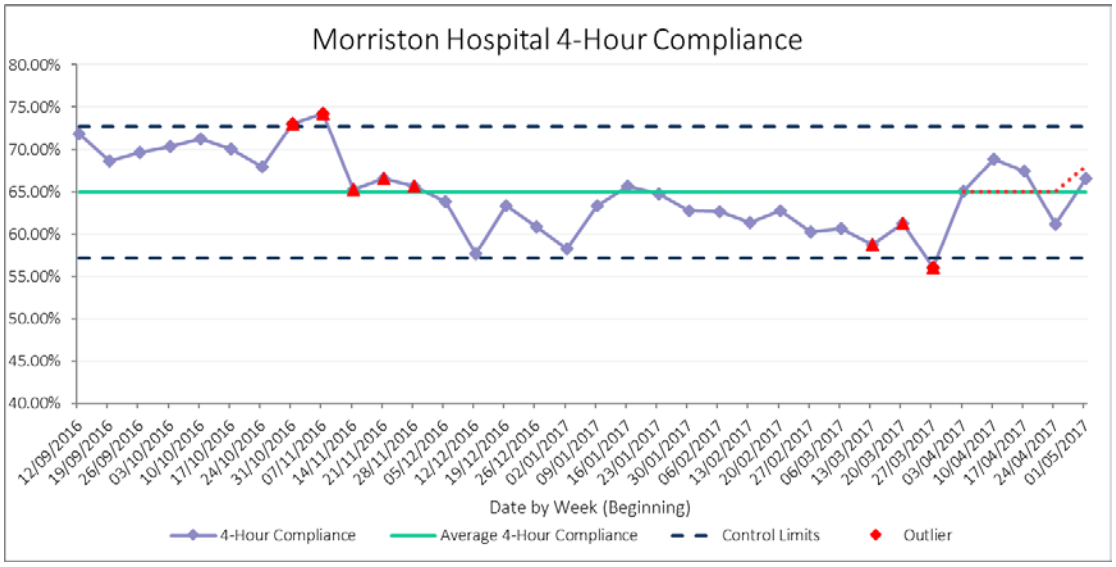
in unscheduled care as months can have very different patient presenting patterns. Given the key nature of this measure, the sections, which follow, explore recent unscheduled care issues by Morriston and POW Units to provide the Board with more detailed information on performance and actions.

	March 16	March 17
% of patients waiting < 4 hours in ED	74.37%	75.74%
No of patients waiting < 12 hours in ED	915	677
No of patients waiting >1hour for an ambulance transfer	1024	525
% response time with 8 minutes for red category	64.5%	77.1%

MORRISTON HOSPITAL

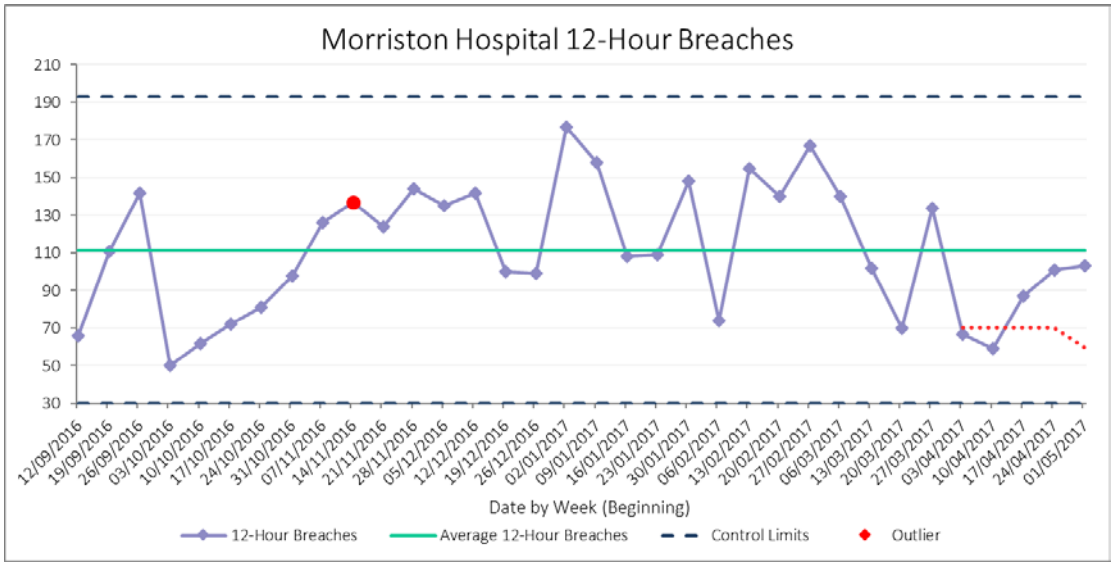
4 hour performance

Having seen performance exceed target for 3 consecutive weeks at the start of April, performance dipped in the last week of the month. However, Morriston Unit exceeded its 4 hour target for the month with performance likely to be c.69%, which is above the 68% target for the month. The performance in April was achieved despite the unit having the highest number of attendances over the last 8 months at 1,685; the average over the period was 1,600. The table below shows the weekly run chart of 4 hour performance for the Morriston Unit.



12 hour waits

Despite the agreed 4-hour target being achieved in April, 12-hour performance remains a particular challenge for the Morriston Unit with performance being below target for the last 3 weeks. During the week commencing 24th April there were 814 admissions in the week but this has since fallen to 730 in the first week of May. Despite this, the Unit has been able to continue to reduce the numbers of outlying medical patients into other specialty beds.

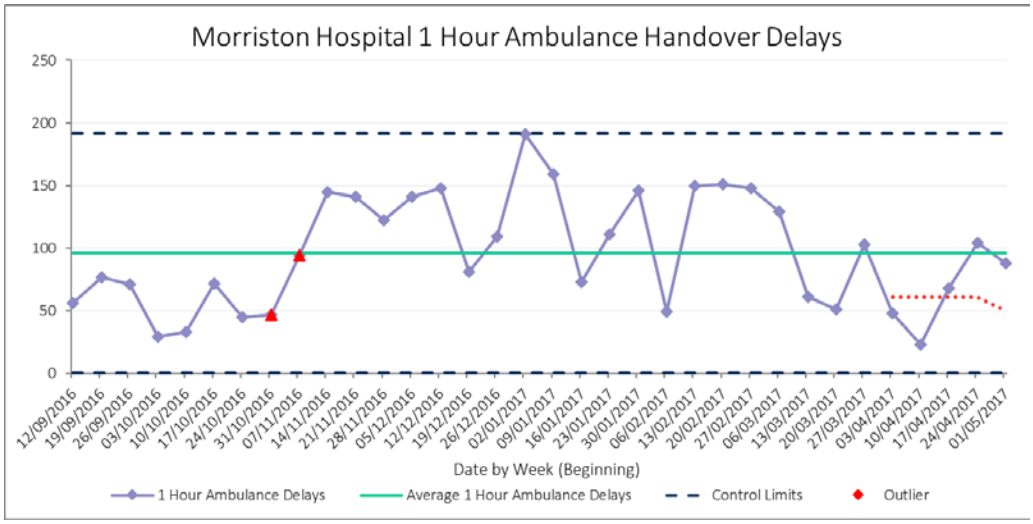


Note: Red line is 2017/18 trajectory

Ambulance handover delays

The month of April to date has seen an average of 73 ambulance arrivals per day at this hospital. There were a number of days in the week ended 5th May where ambulance activity fell below the average however the end of the week was exceptionally busy with over 80 ambulances arriving on 3 days with up to 8 arriving in a 60-minute period.

The average number of 60 min + ambulance handover delays in the month of April was 8 although there have been particular days where this has been as high as 26. Pressure points indicating delays to patients off-loading correlate with a high number of ambulance arrivals classified as Category Red calls on 23rd April. Red calls are off loaded immediately in line with the Code Red and Amber One protocols agreed with WAST. When multiple vehicles arrive within an hour Red Calls will be prioritised over lower acuity ambulance arrivals. Despite seeing a higher number of arrivals last week, the number of 1-hour offload delays fell improving performance from 80% to 83%.



Note: Red line is 2017/18 trajectory

The table below sets out the challenges to performance and focus for action for Morriston Hospital.

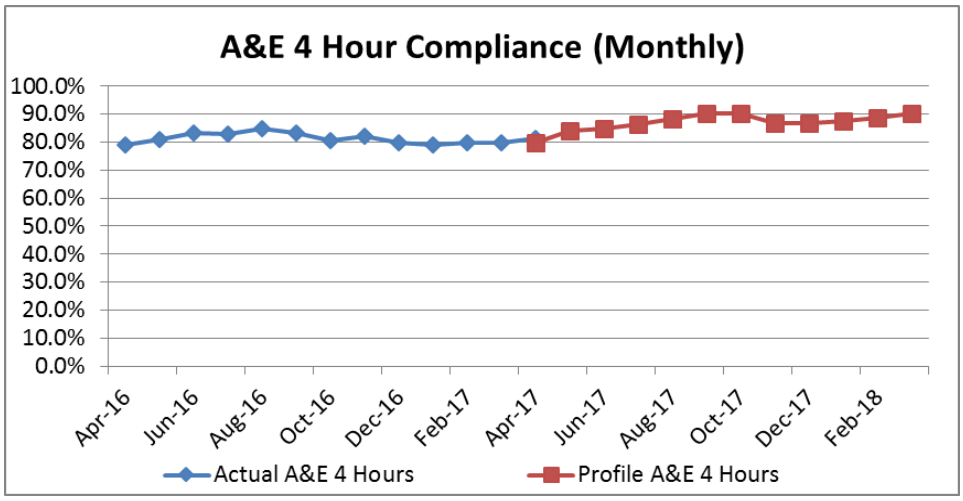
Challenges to Performance	Immediate Actions and Expected Impact	Timescales for improvement in performance
Delays in ED First Assessment – Clinical leadership particularly out of hours	Medical Director clinical case review of patients who breach 4, 12, 1hr standards with Clinical Lead for ED Continuation of night shift support from senior manager to ED Medicine Service Group Consultant presence in ED during periods of peak demand continues to enable direct referral from triage.	Trajectory for improvement in April to the end of June is set at 65%, 68%, 70%.
Breaches in minors pathway as a result of space and/or resource constraints during high volume demand for inpatient beds or majors cubicle	Minors' clinical area now fully protected in and out of hours with noted improvement in breach position for non-majors patients	Immediate reduction in breaches for patients who do not need a full medical or specialist referral
Breaches for patients requiring emergency admission who wait for medical beds (Release of beds to improve patient flow)	Director of Nursing leading discussions with Primary Care & Community with Local Authority to revert to discharge to assess models rather that assessing patient in hospital. Agreement with ITU Clinical Director to transfer to assess patients for critical care review in resus. Ambulatory Care Pathways developed in Medicine; including assessing patients for admission avoidance potential from ED.	In week reduction in admitted patients breaching 4hr and 12hrs
Breaches for patients requiring admission to medical beds (Release of beds to improve patient flow)	Expanding the Ward D 'Homes Best' pilot that successfully used 'home trials' to discharge patients. Introducing new protocol for management of alcohol dependency; improving clinical outcomes, experience and potential to release bed days.	In week reduction in admitted patients breaching 4hr and 12hrs
Breaches for patients attending as 'GP Expected'; accepted by	GP expected patients to be expedited to the relevant clinical areas wherever it is possible to await speciality review. This will improve the quality of patient care in both	In week reduction in patients on GP Expected pathway breaching in ED

Challenges to Performance	Immediate Actions and Expected Impact	Timescales for improvement in performance
specialties but remaining in ED	ED and specialities as well as support flow out of the department	
Breaches for patients who are delayed in ED but who need a specialist opinion, decision or admission	Fast track speciality review for specific conditions. Medical consultant present daily in ED to expedite specialist opinion.	In week reduction in 12hr delays for patients referred to clinicians and specialists
Breaches for patients requiring short stay admission to a medical bed or extended review (0-24 hours)	Introduce dedicated area to support specialist review and diagnostics – this area would allow extended review without impacting on performance. Plan on Monday 15th May to pilot Trauma Assessment Area, which will 'pull' patients across from ED to support trauma and orthopaedic assessment.	In week reduction in 4 hr and 12hr delays for patients with a short inpatient length of stay

PRINCESS OF WALES HOSPITAL

4 hour performance

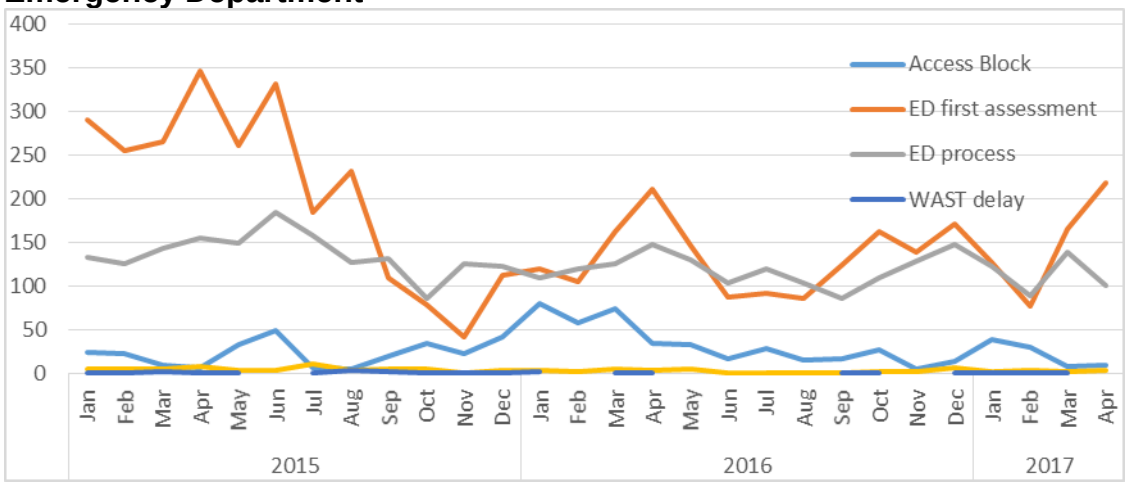
The 4 hour performance achieved for April 2017 for the Princess of Wales Hospital was 82.31%. This is an increase of 3.21% on the April 2016 position and exceeded the approval conditions profile for the delivery unit (81%) by 1.31%.



4hr Breach Reasons

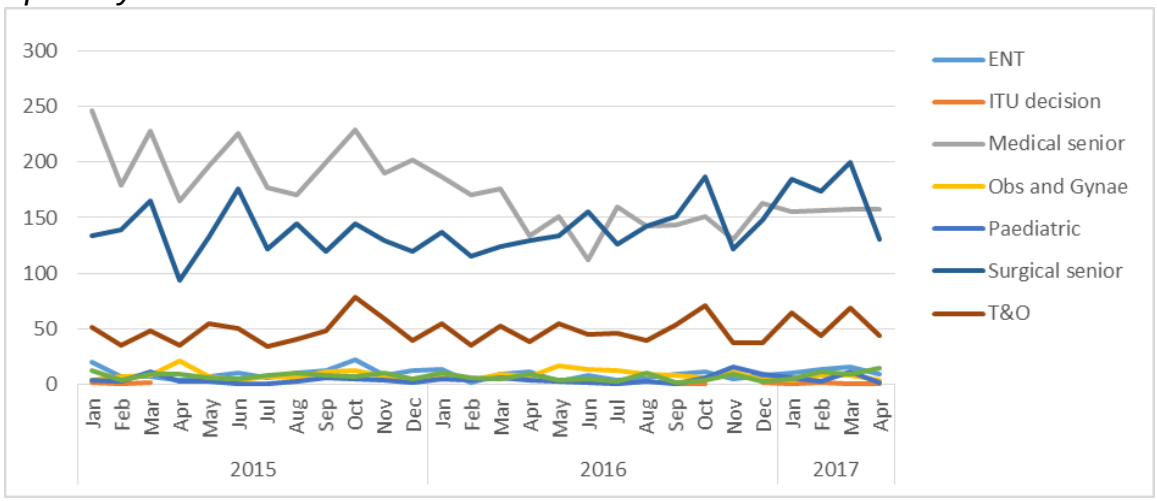
The process of allocating breach reasons within POWH ED provides robust intelligence of what is driving any deterioration in performance and also informs the identification of service improvements required. Set out below is some further detail on three main themes: Emergency Department, Specialty Review and Inpatient Admission.

Emergency Department



The reduction in the number of ED first assessment delays was continued throughout 2016/17 with the establishment of the Emergency Nurse Practitioner model within the 'minors' stream of the department. This increased in March and April for ED first assessment as a result of seasonal pressures.

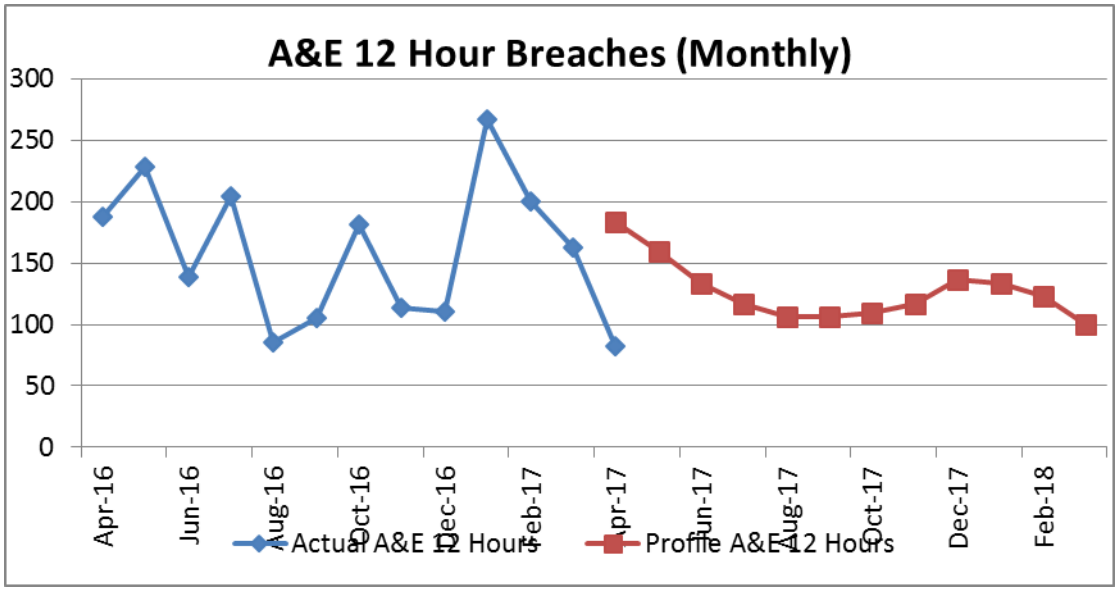
Specialty Review



There are a significant number of breaches caused due to patients awaiting speciality review prior to admission or discharge with a growing proportion of breaches due to senior surgical review. The Unit is currently working up options within the resources available to consider alternative pathway for surgical patients.

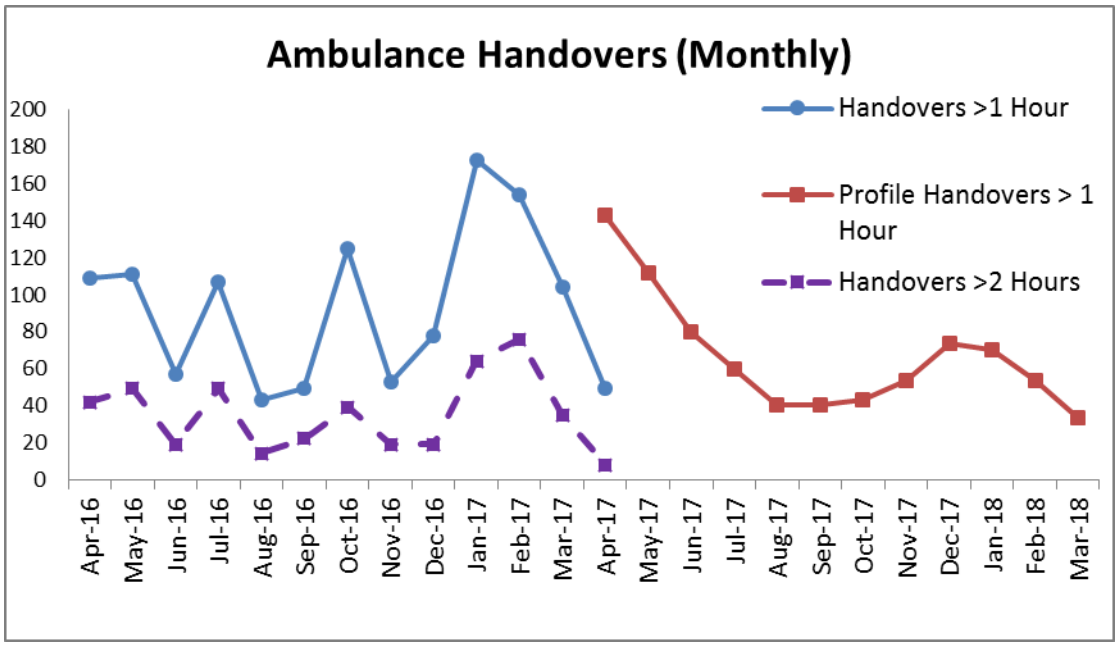
12 hour waits

There were a total of 82 12 hour breaches for April 2017, which is a decrease of 81 compared with the 163 reported in March 2017. This also positively exceeded the approval conditions profile for the delivery unit (150) by 68.



Ambulance handover delays

The end of month position for April 2017 was 50 ambulances delayed over 1 hour. This is a reduction on the March 2017 position of 104 vehicles delayed. This also positively exceeded the approval conditions profile for the delivery unit (130) by 80.



On the 1st February 2017, the speciality focus of Ward 20 was changed and the Unit was able to develop an acute frailty ward in the Princess of Wales Hospital to compliment the work of the two adjoining Care of the Elderly wards. The newly appointed Clinical Director had reviewed the current service model for Care of the Elderly services and identified 9 areas for service or pathway improvement. The Unit recognised that the length of stay of frail elderly patients should be for as few days as possible to reduce the risks and consequences of inevitable deconditioning that occurs when people spend extended time in bed.

In terms of the actions being undertaken to improve performance, a work programme to take forward delivering improvements is encompassed in the POWH Unscheduled Care Improvement Plan for 2017-18. The main actions included in the plan include, but are not limited to:

- Embed Emergency Department Patient Flow Co-ordinator Role 12 hours per day, 7 days a week
- Sustain 24/7 'middle grade' tier Friday – Sunday and develop proposal for 24/7 'middle grade' cover during weekdays.
- Minimise minors breaches by:
    - Scheduling overnight minors attendances
    - Further roll out x-ray requesting from triage
    - Explore ENP service provision to maximise impact
- Develop and agree internal professional standards for ED review by specialty teams
- Review function of Acute Medical Unit and Ambulatory Care Unit utilising process mapping and demand/capacity analysis to identify process and pathway efficiencies
- Formalise Acute Medicine cover for 'on-take' and 'on-call' models including securing additional Consultant in Acute Medicine sessions.
- Finalise Operational Policy for AMU including defined scope of Ambulatory Emergency Care area and extended weekend cover following established model being in place. (Driven by Delivery Unit audit)
- Formalise medical speciality in-reach into the AMU/ED
- Home First – co-ordinated work (campaign) within POWH to provide patients, relatives and carers with more information to change perceptions regarding extended inpatient admissions. Information regarding EDD, risks of remaining in hospital setting etc. The 'Home First' team at Princess of Wales Hospital spent the 2nd – 5th May joining the campaign to 'End PJ Paralysis' This campaign, that started on twitter, has spread across the UK and internationally.
- Develop improved literature to be provided to patients and families upon admission
- Develop Home First specific action plan to focus on the development of discharge to assess principles on site.

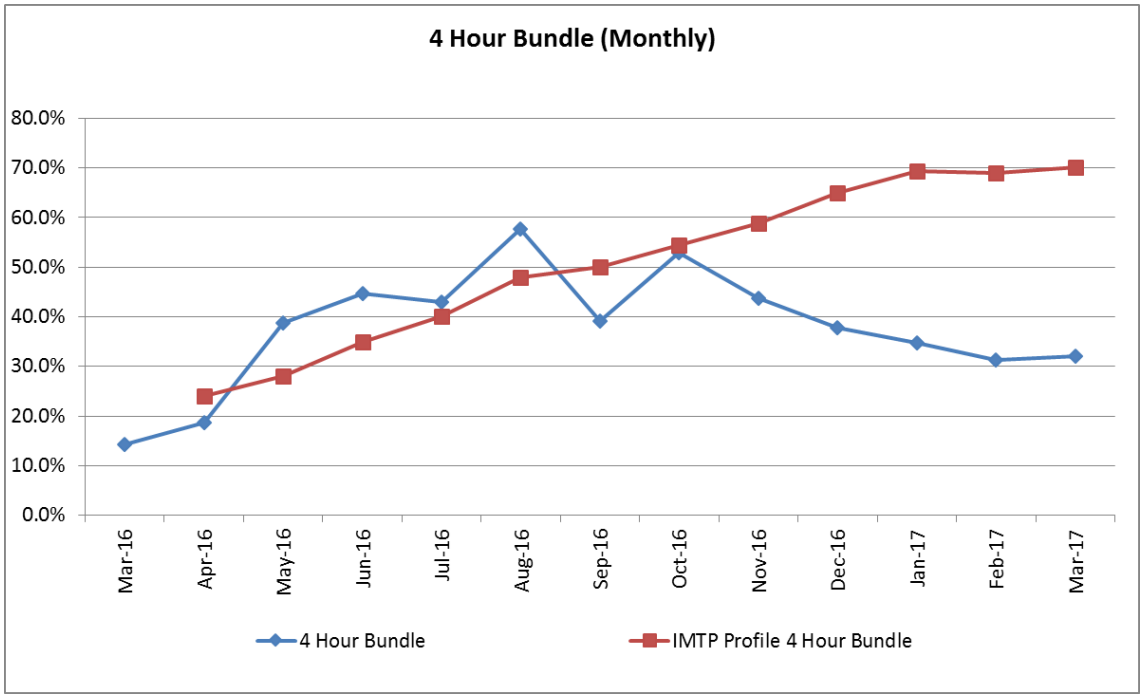
WG Measures 60 - 63 Acute Stroke Care

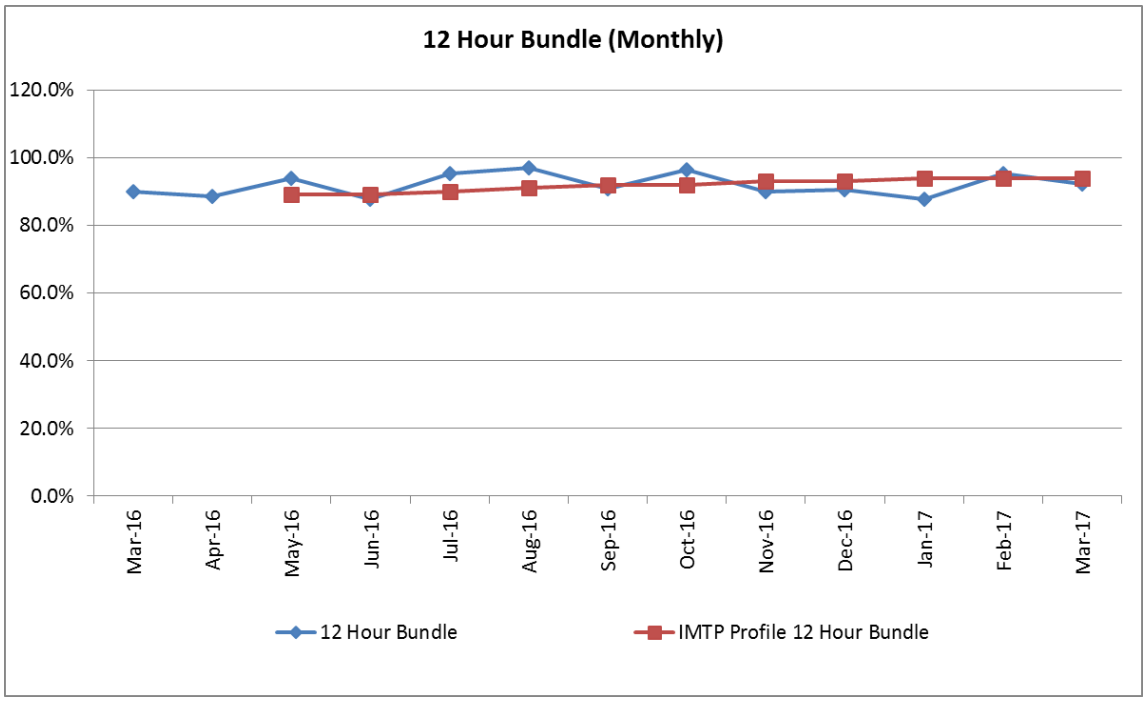
Improvements performance against each of the four stroke care bundles is an Approval Conditions measure.

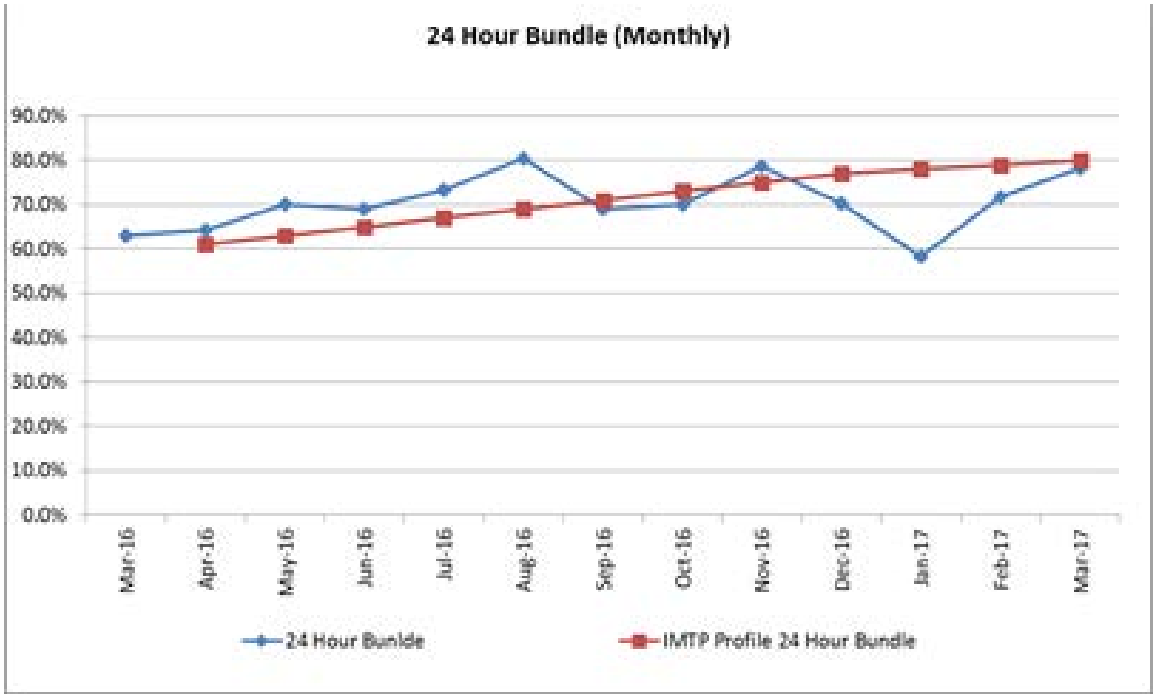
- First Bundle - Direct admissions to the Stroke Unit within 4 hours.
- Second Bundle - CT scan within 12 hours.
- Third Bundle - Assessed by a Stroke Consultant within 24 hours.
- Fourth Bundle - Formal swallow assessment within 72 hours.

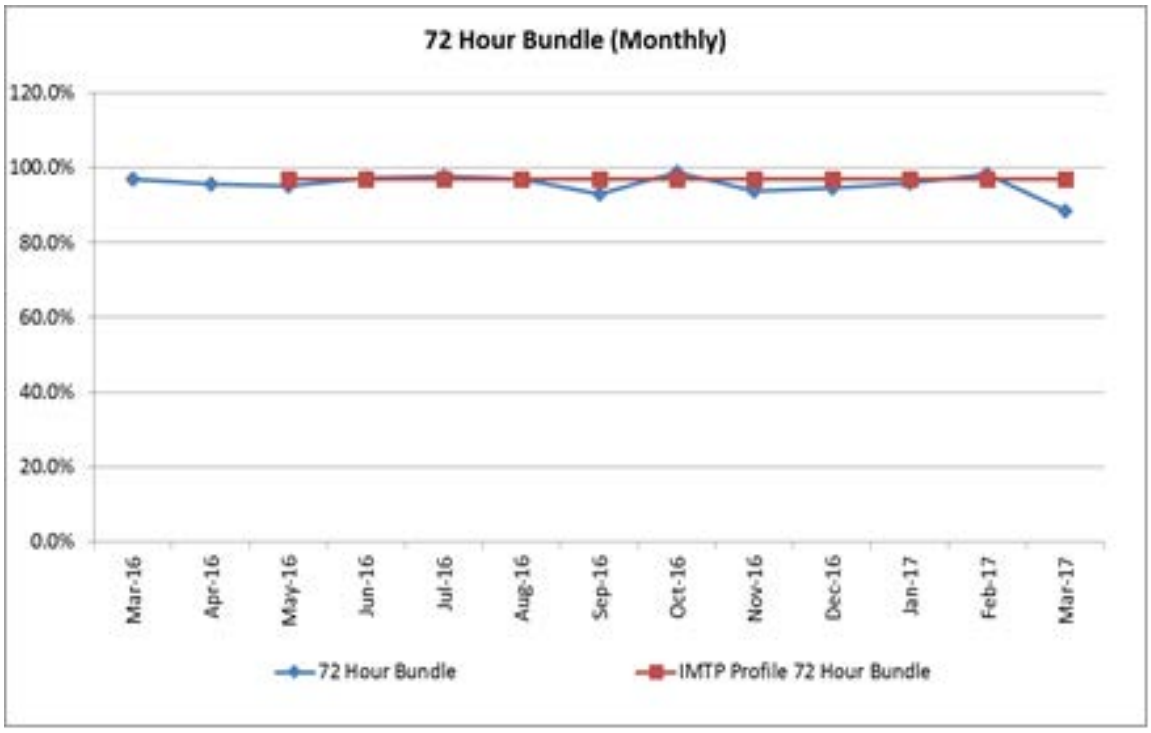
Performance here is intrinsically linked with unscheduled care performance and a large number of the actions set out later in this performance report to improve unscheduled care performance are relevant here.

The charts, which follow, set out the levels of performance against each of the four bundles of care.



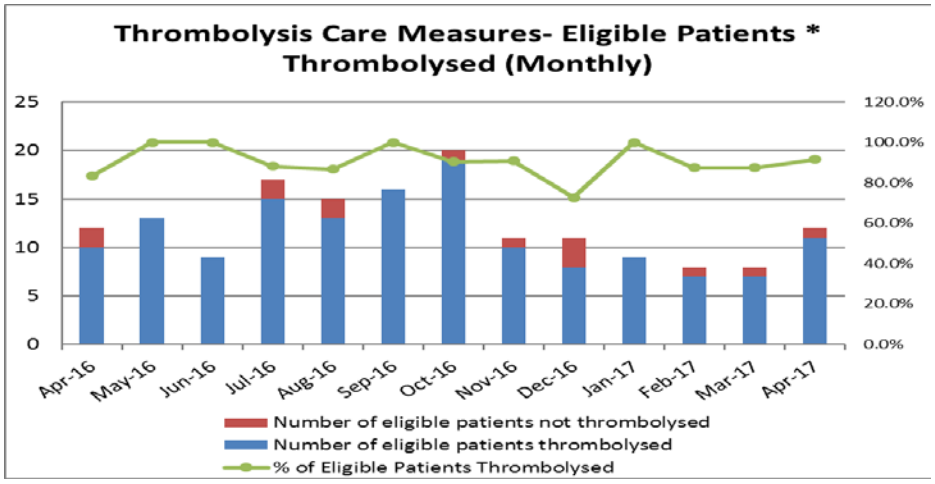






Throughout 2016/17 steady progress was made against the delivery of the quality improvement measures during 2016/17 against a profile of increasing demand on both sites equating to a 10% increase in confirmed stroke admissions at Morriston and 3.3 % increase at the Princess of Wales hospital.

Progress has been informed by a number of benchmarking visits to other Units in Wales to identify new ways of working and good practice and our thrombolysis rates for patients eligible for thrombolysis remain amongst the best in Wales.



Achieving sustained improvement against the 4 hour measure has been challenging during the winter months despite good progress in implementing strict ring fencing policies earlier in the year. Performance for April looks set to improve across all measures and further actions are in place to improve performance in the coming months. These include: -

- Continue to implement unit based multi-disciplinary plans to improve compliance against the stroke measures.
- Continue to benchmark and learn from other units particularly in relation to ESD and HASU developments
- Progress the agreed stroke services redesign model in conjunction with Hywel Dda Health Board under the umbrella of the ARCH programme.
- Implement enhanced service for INR testing, and early detection of Atrial Fibrillation in Primary Care

Beneath these Health Board level actions, each Unit has a detailed Stroke improvement action plan, which is managed via the Health Board's Stroke Steering Group.

WG Measures 56, 57 and 58 Planned Care

Planned care is an Approval condition measure and a critical measure of patient experience in terms of access to our non-emergency services. The end of March 2017 position compared to the March 2016 position is set out in the table below: -

Target Area	March 2016	March 2017
Patients waiting > 26 weeks for first Outpatient appointment	973	704
Patients receiving treatment within 26 weeks	87.70%	88.17%
Patients waiting > 36 weeks	3,843	3,485
Patients waiting > 52 weeks	1,295	1,275
Patients waiting > 8 weeks for a diagnostic test	0	320

Whilst the Health Board carried out 3,000 more operations during 2016/17, these were mainly emergency cases and the planned care system within the Health Board remained relatively stable in terms of numbers waiting in total and numbers waiting

against the key targets as set out in the table above. The challenge for the Health Board is to ensure improvement in the long wait patient cohorts whilst stabilising the OP and diagnostic waits with minimal cost in 2017/18. In 2016/17, the Health Board committed its planned funding of £9m to RTT capacity and incurred further cost above this to commission additional capacity to treat patients.

For Quarter 1, the Health Board received correspondence from Welsh Government that set out the Quarter 1 planned care expectations for all Health Boards in Wales. These expectations are: -

- 36 weeks – no deterioration as a minimum
- 52 weeks – reduction in numbers
- 26 weeks – attention to be paid
- 8 weeks – sustain or improve

The Health Board has developed a plan to meet these requirements and the plan was approved at the Executive Team meeting held on 8th May 2017. The plan will commit £1m of expenditure to provide capacity to sustain the March positon at the end of June, resource which is included within the current Health Board financial framework for 2017/18. At this stage, the plan contains some delivery risks and is being updated to provide actions to mitigate these risks.

However, the Quarter 1 plan consumes the totality of the £1m in Quarter 1 and there are currently no financial provisions within the Health Board's 2017/18 financial framework for future investment in RTT beyond Quarter 1. Based on the modelling work undertaken to date, this represents a risk to future sustainability of waiting lists as the Health Board's modelling suggests that a blend of efficiency, productivity and investment is required to sustain and then improve access times. Units have been challenged to utilise the performance benchmarking information provided in February 2017 and to utilise the outputs from the recent PWC report to look for opportunities to use core resources in different ways to increase productivity and efficiency and prevent the need for further resource requirements to stabilise RTT in future Quarters.

In terms of actions that the Health Board is taking to improve performance, the bullet points below set out the key areas although there are very detailed plans at Unit and specialty level behind these.

- Weekly meetings with service delivery units to agree actions to maintain profile.
- A significant focus on unscheduled care flow is in place across the Health Board.
- Theatre performance is being monitored and each service delivery unit is identifying one area to take forward as a service improvement project that challenges clinical practise and maximises theatre capacity.
- Plans are being developed to utilise available theatre space in Singleton hospital for non-complex short stay surgery cases.
- Clinical review of longest waiting patients.
- Supporting review of current working practices to be carried out by Aneurin Bevan Health Board through our partnership arrangements.

- Delivery Unit scrutiny of 2017/18 plans.
- Local Access Policy to be agreed by June 2017.

WG Measures 68 and 69 Cancer

The final Approval Condition measure in this report is cancer access. Cancer access performance has been disappointing throughout 2016/17 and despite a number of initiatives and increased levels of support has not achieved the anticipated levels of performance.

The section which follows sets out the challenges the Health Board has been facing and provides context to the current performance position.

The Health Board has seen an increase in the overall numbers of referrals received over the last 12 months and it has treated more patients than in previous years within this timeframe.

There were 19,743 referrals received in 2015 and 21,504 referrals received in 2016 – a 9% growth.

The Health Board treated 3,193 USC and NUSC patients in 2015 and 3,322 in 2016 – a 6% growth in USC patients and a 4% combined growth overall.

Health Board information and tracking processes have been reinforced and improved, and a focus on learning from our breaches has been developed further in the form of a monthly report. These highlight that we still have further work to do on the two consistent themes which are:

1. Access to first appointments within 10 days,
2. Access to diagnostics.

In addition, the Executive led Cancer Supporting Delivery Board (CSDB) has been providing a much more focused approach on specific tumour site issues including capacity problems, process, and resource issues. Following the Capacity and Demand work undertaken by CAPITA, each Delivery Unit has developed a Cancer Delivery Action Plan for 2017/18 to address the recommendations in the final report.

The Peer Reviews held in 2015-16 have been very helpful in discussing the challenges and for giving some further clarity on actions that can help both with the pathways in general and with improving the access to high quality treatment for our patients. Sarcoma and Lower GI Cancer Services are currently undergoing peer review with visits planned in May and June respectively.

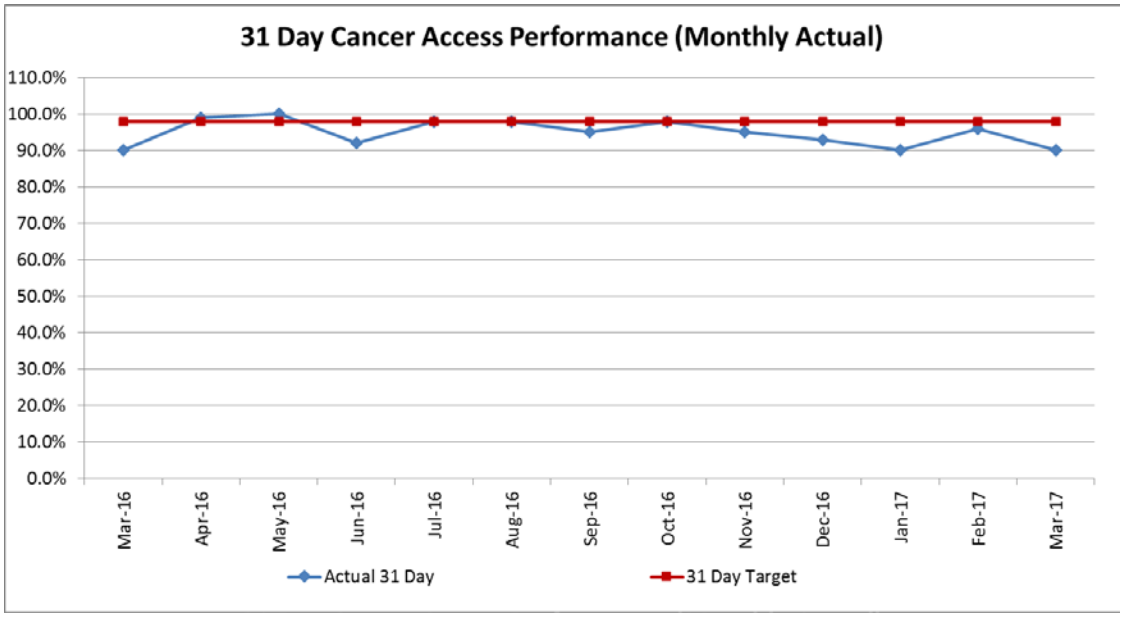
Whilst there have been some improvements in the waiting times for both 1st appointments and diagnostics, the issue of capacity still presents the Health Board with challenges in both recruiting to senior clinical posts and in providing timely diagnostics, oncology, and bed capacity. Without significant performance improvement in first OP access and diagnostic test access it, will prove difficult to reduce the backlog of patients waiting over 62 days and deliver the required level of performance improvement.

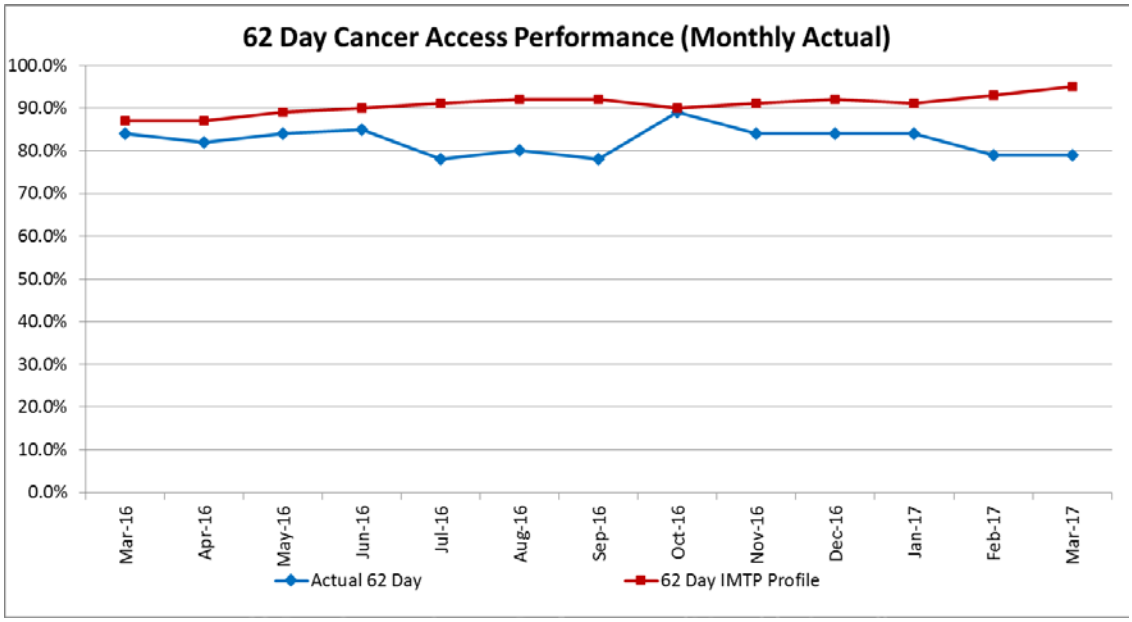
Performance

At the end of March 2017, the Health Board reported the following:

- USC pathway - 139 patients treated in total; 29 of which breached. 79% achievement against 95% target.
- Breaches occurred in the following tumour sites in descending order: Upper GI(7), Lower GI(5), Breast(5), Gynaecology(4), Haematology(3), Urology(2), Lung(2),Head & Neck(1)
- NUSC pathway – 153 patients treated in total; 12 of which breached. 92% achievement against 98% target.

The charts, which follow, provide a 13 month trend in access time performance for both USC and NUSC access targets.





The Health Board is taking specific and targeted action to improve performance to improve it to required levels. To help achieve this a comprehensive range of actions was included in the updated plan submitted to Welsh Government on 6th March, which now includes all tumours and all sites. Various actions are included ranging from demand/ capacity modelling, additional recruitment, pathway redesign etc.

At a very high level, the Health Board is:-

- Utilising the CAPITA Recommendations around ensuring there is sufficient capacity to meet the demand in key areas such as Outpatients and Diagnostics.
- Continuing the service improvement work to model solutions across all tumour sites.
- Continuing the service improvement work commenced in diagnostics and translate across the Health Board – utilising agreed definitions.
- In addition to work currently ongoing in endoscopy across Swansea and Neath, the NHS Delivery Unit have commenced work with the teams in Breast, Urology and Gynaecology.

WG measures - 15 and 16 Healthcare Acquired Infections
In terms of the Big Fight Campaign, the Health Board is meeting or exceeding the three Welsh Delivery Agreement Targets:

Target one	Overall reduction in the use of antibiotics, in primary care, across Abertawe Bro Morgannwg University (ABMU) Health Board by at least 1 percentage point better than the Welsh national average trend, December quarters.
Performance	3.54% reduction in items per 1,000 STAR PU for ABMU vs 1.14% reduction nationally (2015 vs 2016)
Target 2	A reduction in variation of overall antibacterial prescribing in primary care across ABMU between December quarters.
Performance	Difference between highest and lowest prescribers was 193.78 items per 1,000 PU (2016) compared to a difference of 219.01 items per 1,000 PU (2016).
Target 3	To achieve a reduction in overall *Clostridium difficile* infection (CDi) cases in non-inpatients by at least 1 percentage point better the Welsh National average trend. December quarters 2016 vs 2015
Performance	ABMU 38.10% reduction (13 cases vs 21 cases) National 24.77% reduction (82 cases vs 109 cases).

With regard to other work to improve infection control, 90% of Nursing Homes within the ABMU community had been visited by the Big Fight Infection Prevention & Control Nurse by first week March 2017 to deliver a presentation to raise awareness of *C. difficile* infection and antimicrobial stewardship. At the end of each session,

understanding is assessed and learning is apparent with staff having an increased knowledge of the need for prudent prescribing, Clostridium difficile and UTI.

A range of future actions are set out for 2017/18 and these will be reported to the Board through these performance update reports. There will be continued collaboration with primary care to improve a range of national prescribing indicators, in relation to the national targets to reduce prescribing of quinolones, ephalosporins and broad-spectrum agents. Further work will be undertaken to continuously improve appropriate antibiotic prescribing, attending clinical meetings at practice cluster and locality level. We plan to support the roll out of CRP Point of Care testing and prescribing strategies such as back up prescribing and educational materials to support co-production. Finally, we plan to extend campaign engagement with other health care professionals, including community pharmacy, to improve Antimicrobial Stewardship through a range of contractual activities, including multidisciplinary audit and public health campaigns relating to antimicrobial resistance.

Infection control

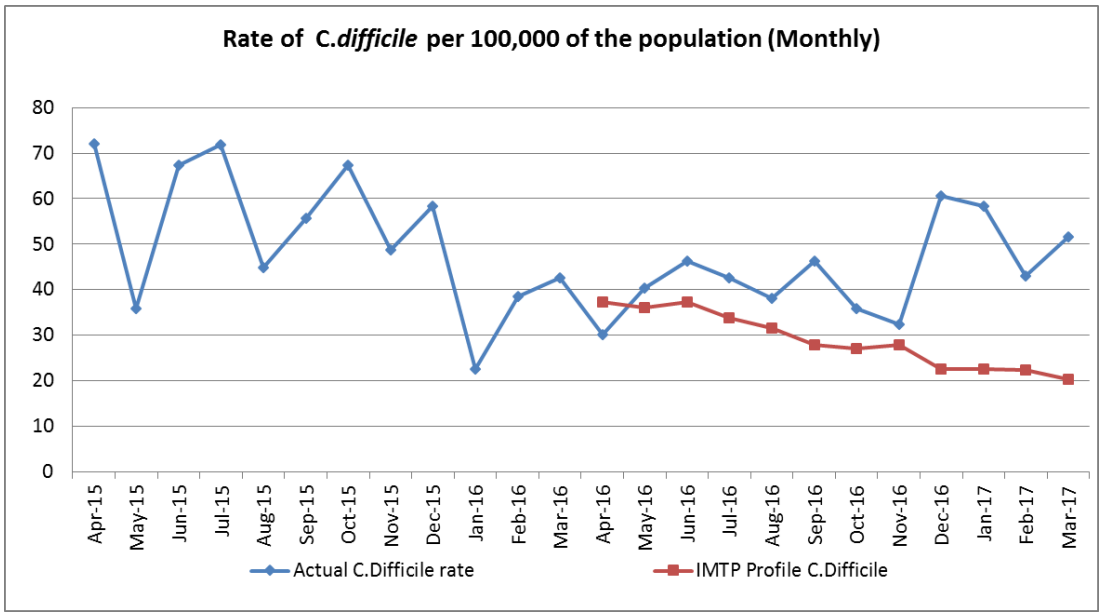
With regard to infection control, the charts, which follow this narrative section, set out how performance has varied over the last 24 months. In recent months pressures have been seen in both infection control measures and a range of further actions are being put in to place to improve the position.

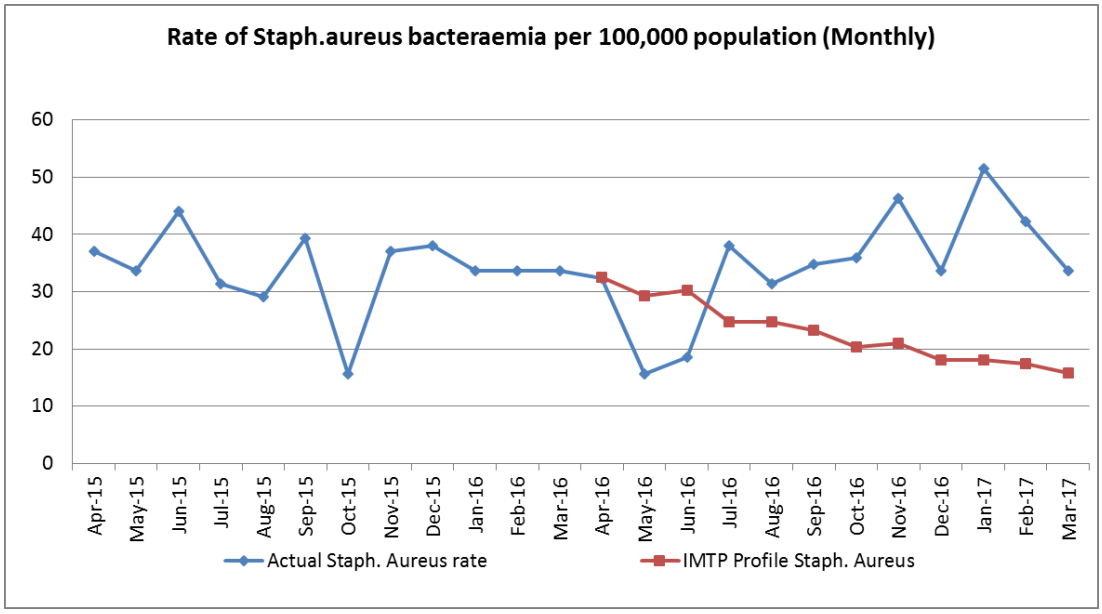
- The Health Board has agreed to establish a multidisciplinary Antimicrobial stewardship Group for secondary care to support Antimicrobial Resistance Delivery Plan. This will be chaired by a Unit Medical Director and will support the identification of clinical champions across secondary care.
- Ongoing implementation of the all-Wales electronic IPC surveillance system (ICNet).
- The recommendations within the strategic review of decontamination including upgrading of the endoscopy decontamination facilities within Princess of Wales Hospital and Singleton Hospital are being taken forward. Both initiatives will support movement towards JAG accreditation.
- Plans to provide negative pressure isolation facilities at Morriston Hospital have been drafted and are provided for within the draft discretionary capital plan for 2017/18.
- Further discussions have taken place between the Health Board and Public Health Wales (PHW) regarding the provision of Medical Microbiology and Infection Control Doctor support. In the interim, one of the Medical Microbiologists has retired and, following recruitment processes, this post has been appointed to but only in a part-time capacity. As such, the existing resource has been further reduced.
- Discussions have continued between ABMU and PHW to re potential options to increase clinical microbiology & the number of Infection Control Doctor hours. ABMU has supplied PHW with information on where it considers increased ‘bedside’ microbiology is essential.
- Development of a programme of Planned Preventative Maintenance continues.

2017/18 actions

- The next phase of ICNet implementation, establishing an interface with Patient Admin System, should occur in April 2017. Following training validated reports should be available in 3-6 months
- Mobile PCs will be in place to support ICNet and this will increase clinical presence of Infection Prevention & Control Nurses on wards/units.
- Work will be completed on upgrading and moving endoscopy decontamination facilities within each site and on HSDU improvements.
- Subject to Board sign off work on the first negative pressure isolation room should commence once contracts have been awarded.
- ABMU will work with PHW to draft an action plan for increased input
- Undertake a six-facet survey to support ongoing environment and preventative maintenance works.

The charts, which follow, set out the performance levels for the two main rates of infection control for the last 24 months. These measures are Approval Condition measures.





4. PERFORMANCE BY STRATEGIC AIMS

4.1 Healthier Communities

The table below sets out the assessed performance of the key metrics under this Strategic Aim. For the majority of cases this data relates to February 2017. The detailed performance report cards attached as **Appendix A** to this report provide further background analysis to this performance assessment and also set out the reporting period for the performance metric.

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend
Staying Healthy	1	Uptake of the influenza vaccination among: • 65 year olds and over • Under 65s in risk groups • Health care workers	✗ ✗ ✓	↓ ● ↓ ● ↑ ●
Staying Healthy	4	The percentage of adult smokers make a quit attempt via smoking cessation services	✗	↑ ●
Staying Healthy	5	The percentage of those smokers who are co-validated as quit at 4 weeks	✓	↑ ●
Staying Healthy	9	Percentage of children who received the following scheduled vaccinations at age 4	✗	↓ ●

- 124 Flu Champions were trained for the 2016/17 staff flu campaign to support Occupational Health staff resulting in 57% of frontline staff receiving the vaccination (as of March 2017).• Uptake of influenza vaccine for 2 and 3 year olds in ABMU has increased from 33.6% in 2015/16 to 44% in 2016/17 (IVOR 21/3/2017).

- Although there is only a marginal increase in uptake amongst those aged 65 years and older compared to 2015/16 the actual number of individuals eligible for and receiving influenza vaccine has increased from last season.
- Approaches and good practice identified this season will be shared with GP practices to inform their flu plans for 2017/18.
- Continue to build on the plans from 2016/17.

The performance assessment made in the table above is evidenced by the detail provided in the tables, which follow.

WG Measure 1- uptake on influenza vaccines

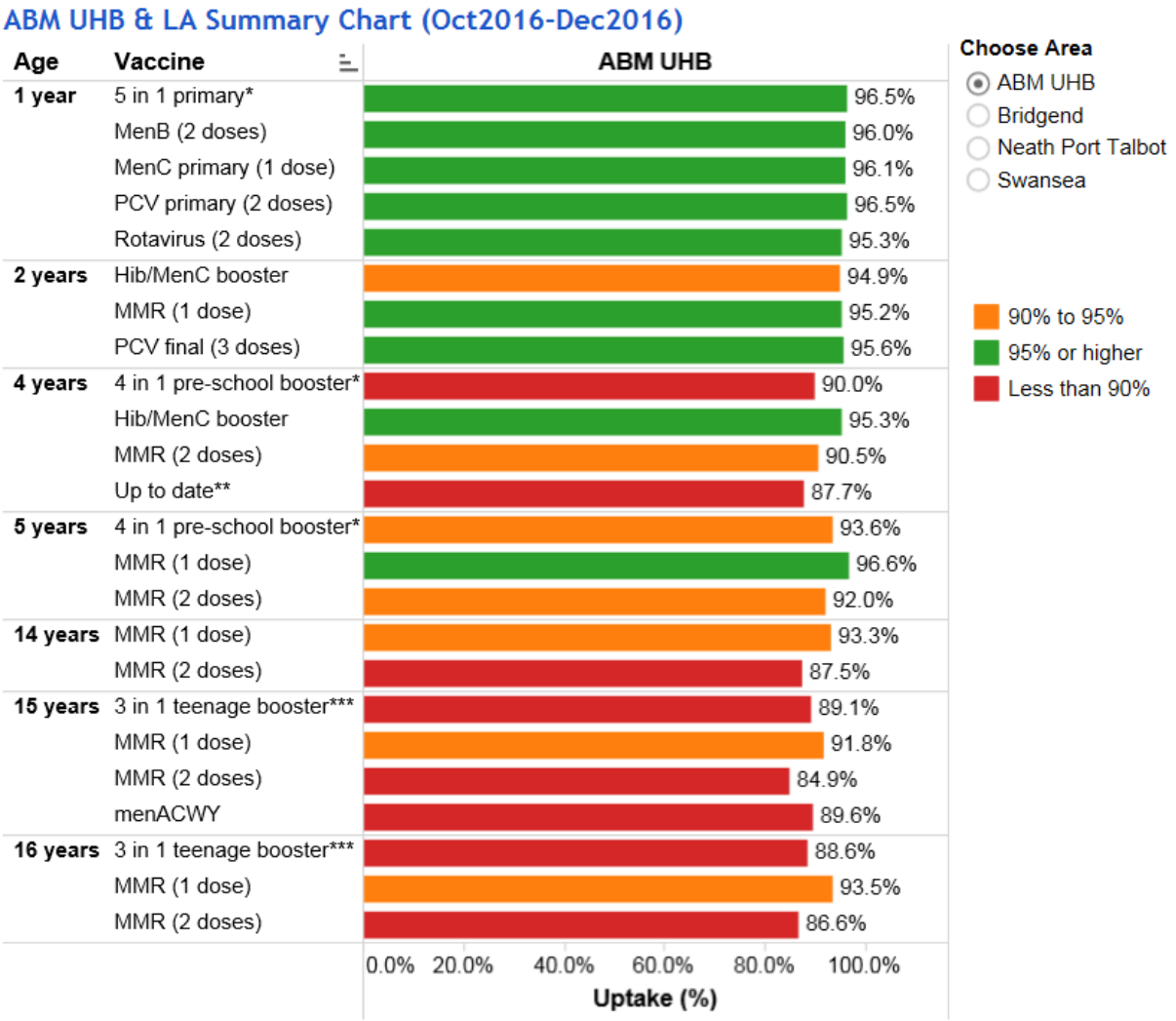
ABM Total risk group breakdown

Patient group	Denominator (n)	Immunised (n)	Uptake (%)
65y and older	109,461	71,210	65.1%
Asplenic patients (<65y)	1,636	580	35.5%
Chronic diabetes patients (<65y)	15,317	8,833	57.7%
Chronic heart patients (<65y)	11,953	5,295	44.3%
Chronic kidney patients (<65y)	3,029	1,436	47.4%
Chronic liver patients (<65y)	1,622	671	41.4%
Chronic respiratory patients (<65y)	33,822	14,705	43.5%
Immunosuppression (<65y)	3,451	1,635	47.4%
Morbidly obese patients (<65y)	13,600	3,921	28.8%
Neurological/ stroke patients (<65y)	6,644	2,822	42.5%
2 year olds	5,779	2,675	46.3%
3 year olds	6,003	2,500	41.6%

Summary by Health Board and Local Authority (11apr2017)

		65y and older			Clinical risk <65y			Children 2 to 3 years		
		Pop (n)	Imm'd (n)	Uptake (%)	Pop (n)	Imm'd (n)	Uptake (%)	Pop (n)	Imm'd (n)	Uptake (%)
ABM UHB	Bridgend	31,646	21,461	67.8%	19,790	8,733	44.1%	3,557	1,676	47.1%
	Neath Port Talbot	28,692	18,535	64.6%	17,448	7,845	45.0%	2,891	1,248	43.2%
	Swansea	49,123	31,214	63.5%	28,939	12,337	42.6%	5,334	2,251	42.2%
	ABM Total	109,461	71,210	65.1%	66,177	28,915	43.7%	11,782	5,175	43.9%
Wales	Wales	647,318	431,548	66.7%	372,933	174,802	46.9%	70,525	31,915	45.3%

WG Measure 9-Childhhod Immunisations



Actions undertaken to support performance improvement include: -

- The Healthy Child Wales Programme launched in October 2016 now ensures a pre-school contact, which priorities public health priorities and compliance to immunisation programme.
- A Children's Immunisation group sits regularly to look at specific issues surrounding immunisations around the 11 clusters.
- Immunisation rates are monitored in line with other Health Boards and remain stable.
- Immunisations continue to be encouraged by Health Visitors and other primary Care and Community services in the promotions of "Making every Contact Count".
- There have been opportunities in HB and Local authority events across the HB to promote immunisation uptake
- Monthly Updates given to HV service on late/ missed appointments so that Health Visitors actively chase up missed appointments and offer domiciliary visits where appropriate.

2017/18 Actions: -

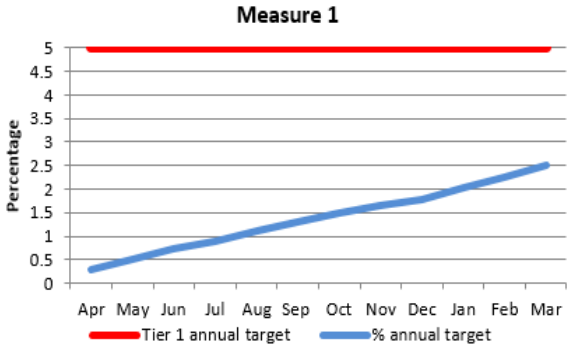
- The amalgamation of the children's immunisation group with the primary care immunisation group to prioritise strategic direction in relation to Immunisation trends.
- Close links to be maintained with child health colleagues and ongoing liaison with practice nurses and GP's ensure that every opportunity is given to clients to access immunisations
- To identify persistent defaulters and look to highlighting on GP system.
- Health Visitors/School Nurses to use every opportunity to promote immunisations in and around workplace, on the community and in clinics and schools across the HB and using Flying start venues and groups to promote timely vaccination to ensure that immunisation rates increase accordingly.

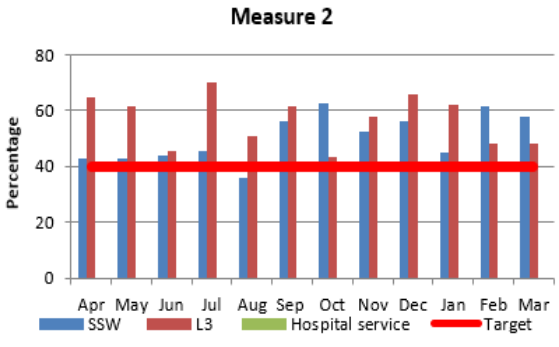
WG Measures 4 & 5 - Smoking Cesstaion

The most recent data from 2014/2015 estimates that 19.0% of ABMU's adult population, smoke. Smoking rates have decreased faster in ABMU than for Wales, from 23% in 2013/14 (Wales 22%) to 19% in 2015 (Wales 20%). Given this current progress, ABMU would be on track to achieve the WG population target of 16% smoking prevalence by 2020.

To achieve the 5% cessation target 4,119 smokers need to be treated in ABMU stop smoking services per year, with an average of 343 smokers treated per month. To date (January 2016) monthly activity data suggests that ABMU treated 1,674 smokers against the cumulative monthly target of 3,433, achieving to date 2.0% of the 5% target. This is an improved performance of 0.5% compared with the same time last year in 2015/16, where 1,385 smokers had been treated and 1.5% of the Tier 1 target was achieved.

ABMU has consistently achieved the target of 40% CO validated quits at 4 weeks. In light of performance, the Health Board has developed a Cessation Target Recovery and Delivery plan 2016-2020 outlining proposals as to how the Health Board could achieve the smoking cessation target over the next three years, and further reduce population smoking prevalence. This will be subject to funding opportunities.





Priorities suggested for further action are:

- The expansion of the level 3 pharmacy smoking cessation service to cover all community pharmacies
- The extension of the in house smoking cessation service to mental health inpatients
- The provision of a smoking cessation service for pregnant women.

These are subject to the availability of funding.

Further actions planned include: -

- Support national work via PHW/WG to drive a unified referral system
- Linking national and local promotion for the promotion of the universal cessation umbrella brand 'Help me Quit' (launch April 2017)
- Monthly scrutiny of performance from ABMU Cessation services

Cessation

- Align the work of the three ABMU Cessation services more closely (the Local Public Health team are facilitating a new working group comprising all services)
- Progress improvement action plan for cessation services and priority groups – maternity, mental health, primary care as per ABMU Recovery Plan
- actively engage with all Primary care clusters to actively increase knowledge of local services and referrals

Wider tobacco control

- Support and implement locally the emerging work/actions from the all Wales Tobacco Board and its cessation. Prevention and denormalisation sub groups
- Revise ABMU Smoke-Free Hospitals Policy.
- Progress work with Delivery Units to nominate senior level champion to drive improvement work in preparation for PH Bill
- Roll out smoke free school gates to Neath locality schools.
- Continue Tobacco related work across ABMU schools and preschools programmes.
- Provide support to partners such as local authorities in providing smoke free public places.

4.2 Excellent Patient Outcomes and Experience

The table below sets out the assessed performance of the key metrics under this Strategic Aim. For the majority of cases this data relates to February 2017. The detailed performance report cards attached as **Appendix A** to this report provide further background analysis to this performance assessment and also set out the reporting period for the performance metric.

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend
Safe Care	15	The rate of laboratory confirmed *S.aureus* bacteraemias (MRSA and MSSA) cases per 100,000 population		
Safe Care	16	The rate of laboratory confirmed		

		c.difficile cases per 100,000 population		
Safe Care	17	Fluoroquinolone items as a % of total antibacterial items prescribed	✓	↓ ●
Safe Care	18	Cephalosporin items as a % of total antibacterial items prescribed	✓	↓ ●
Safe Care	19	Co-amoxiclav items as a % of total antibacterial items prescribed	✓	↓ ●
Safe Care	25	Number of Never Events	✓	→ ●
Effective Care	34	% Crude Mortality	✓	↓ ●
Effective Care	37	% episodes clinically coded within one month post episode end date	✗	↑ ●
Effective Care	39	Number of Health and Care Research Wales clinical research portfolio studies	✗	↓ ●
Effective Care	40	Number of Health and Care Research Wales commercially sponsored studies	✓	↑ ●
Effective Care	41	Number of patients recruited into Health and Care Research Wales clinical research portfolio studies	✗	↓ ●
Effective Care	42	Number of patients recruited into Health and Care Research Wales commercially sponsored studies	✗	↓ ●
Timely Care	60	Percentage of patients who have a direct admission to an acute stroke unit within 4 hours	✗	↑ ●
Timely Care	61	Percentage of patients who receive a CT scan within 12 hours	✗	↑ ●
Timely Care	62	Percentage of patients who have been assessed by a stroke nurse within 24 hours	✗	↑ ●
Timely Care	63	Percentage of patients who have received a formal swallow assessment in 72 hours	✗	↓ ●

WG measures - 15 & 16 Healthcare Acquired Infections
Covered in Approval Conditions Section 3 above.

WG Measures 17 - 19 Prescribing
Long term prescribing in the three indicators for Fluoroquinolone, Cephalosporin and Co-amoxiclav continues to reduce. This is supported by the Big Fight campaigns described above and is also supported by improved antimicrobial stewardship in Cluster Plans amongst other things.

WG Measure 25 - Never Events
There were no new never events report in March 2017. Detail on performance is provided in the report card in **Appendix A.**

WG Measure 34 - Crude Mortality and Universal Mortality Review
The crude mortality rate for the Health Board in the 12 months to January for under 75's was 0.78%, which is lower than for the same 10 month period last year (0.81%). The Health Board has agreed a new approach to review mortality for each Delivery Unit and was reported to the April 2017 Quality and Safety Committee.

Changes were required to the current way of looking at mortality data as it was not providing the Clinical Outcomes Group (COG) with the context and feedback about the mortality data. Construction of the Health Board's Mortality Dashboard has enabled the format of the reports to evolve into a condensed, three-page summary view of key indicators available at Health Board and individual Service Delivery Unit. The reports focuses on data trends and the learning derived from mortality reviews.

It is recognised that the variation in crude mortality rates month-on-month is often subtle and that without clinical input to provide context any variation can be easily misinterpreted. This is a particular problem when considering Delivery Unit or hospital site mortality where the number of deaths each month is small.

In common with all Health Boards and Trusts in Wales, ABMU publishes mortality information on its website each quarter.

Under the new system, the COG will receive details of any clinical or operational issues that may have influenced the mortality rate in a clinical area or site, and what action has been taken to investigate and address those. In this way, every UMD will present twice a year.

Any potential areas of concern that have come to the attention of the Information team or the Executive Medical Director will also be highlighted so that the UMD can include those in their report to the COG. Initially the data will be presented for the four hospital sites with a view to refining this to report by Delivery Unit in future.

A summary of the discussion, learning and agreed actions will be included in the regular COG report to the Q&SC.

WG Measure 37- Clinical Coding

Clinical coding rates have been a significant challenge for the Health Board and plans have been put in to place over the last 6 months to improve rates by reducing the backlog of uncoded episodes. In March 2017, this has reduced to 18,582 cases from over 40,000 in October 2016.

Coding completeness within 30 days improved to 90.33% in February, which compares favourably with the national position where the Health Board was previously an outlier. It is anticipated that the coding backlog will be cleared by the end of July 2017 and ongoing plans in terms of staff recruitment and training will ensure that by the end of 2017/18, the clinical coding process will be sustainable.

WG Measures 39 - 42 - Research studies

The following provides an update on the position in respect of research studies up to the end of Quarter 3.

Non-Commercial – up to Quarter 3 2016/17

- 92 open and recruiting studies.
- 1,691 patients recruited

- We are on track to attain the number of studies open and recruiting target however overall recruitment may be short of reaching the targets this year based on Q3 figures to date.
    - Number of studies: 76% of target achieved
    - Patients recruited: 55% of target achieved

Commercial – up to Quarter 3 2016/17

- 29 open and recruiting studies.
- 208 patients recruited
- Both Number of studies open and recruiting and overall recruitment may be short of reaching our targets this year based on Q3 figures.
    - Number of studies: 69% of target achieved
    - Patients recruited: 50% of target achieved
- Improved capture of non-medical R&D across ABMU, especially with Swansea University and UWTSD
- Draft Memorandum of Understanding submitted to Cardiff University for consideration

The research delivery team will continue to work closely with clinicians across the Health Board to identify and support research studies. The Health Board has recently appointed a research nurse to work in Morriston Hospital to provide support for clinical trials in the services that have relocated to Morriston. Our training team will also continue to work closely with clinical teams to ensure that they are suitably trained in "Good Clinical Practice" and are working with them to provide peer support to encourage research naïve teams to become involved with research.

WG Measures 60 - 63 Acute Stroke Care

Covered in Approval Conditions Section 3 above.

4.3 A Fully Engaged and Skilled Workforce

The table below sets out the assessed performance of the key metrics under this Strategic Aim. For the majority of cases this data relates to February 2017. The detailed performance report cards attached as **Appendix A** to this report provide further background analysis to this performance assessment and also set out the reporting period for the performance metric.

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend
Our Staff and Resources	91	Percentage of staff undertaking performance appraisal	✗	↑ ●
Our Staff and Resources	95	Percentage of sickness absence rate of staff	✗	↑ ●

WG Measure 91- Percentage of staff undertaking performance appraisal

The overall Health Board percentage of PADR's recorded within ESR as of 20th April 2017 for a 12 month rolling period is **53.93%,** however the all-Wales and local target is 85% of PADRs recorded in ESR and so continued improvement remains essential.

There are a growing number of areas across ABMU that now have access to Manager Self-Service in ESR. At the time of transition to ESR for the recording and reporting of PADRs, it was projected that the Health Board would have achieved 50% compliance by January 2015 in order to be realistic to the scale of the task. Since this date, there have been a number of factors that have impacted on maintaining and progressing against this target:

- The Health Board restructure impacted on accuracy of compliance and reporting due to movement of cost-codes in ESR. Restructure has also meant a change in personnel and potentially a lack of awareness from Unit Directors of the process for entry of PADR data into ESR via central administrators and the movement of those administrators into different units.
- Administrators leaving / changing role and not informing ESR / Learning and Development / Unit Directors and so not being replaced to undertake data entry and so there is no longer an accurate list of those undertaking the data entry.
- The revised All Wales PADR / Pay Progression policy has caused staff to have incorrect / no data in ESR due to timing of PADRs needing to align with incremental dates.
- Reliance on managers reporting PADR data through to administrators and administrators having the capacity in addition to their existing role to input the data into ESR.

Aside from the need to improve PADR recording in ESR, there are also continued improvements required in the quality of the PADRs being completed as highlighted in February's report. 55% of respondents to the NHS Wales Staff Survey (2016) confirmed that their PADR helped them improve how they undertook their job and 62% confirmed that their PADR left them feeling like their work is valued by the organisation.

Actions

In order to address some of the impacting factors and progress compliance with the recording and reporting of PADRs in ESR, the following actions have been taken:

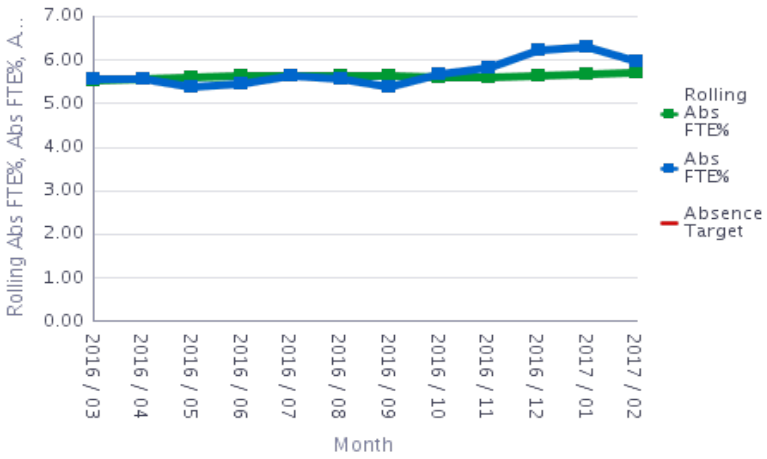
- Unit Directors have been written to in order to confirm the accuracy of those identified as having Learning Administrator access in ESR for the entry of PADR dates. Learning and Development have also offered to attend their senior management forums to verbally explain the process and what is required. To date Morriston, Neath Port Talbot, Princess of Wales and Mental Health and Learning Disability Delivery Units have taken up the opportunity to meet with Learning & Development.
- Learning & Development have provided intensive support and training for more administrators to be able to input data and produce compliance reports. Nominations are being put forward where there are gaps in training administrators or new administrators required e.g. Estates and Facilities, Morriston Delivery Unit.
- Continued proactive monitoring of the quarterly compliance figures achieved against the projected compliance targets by the ESR team, in order to hold units to account for delivery on compliance.

- Learning and Development have revised training to support up-skilling supervisor's and manager's PADR skills to reflect changes to the policy and documentation. Training includes recording of PADRs in ESR and how this is reported into a central administrator across each Unit (except where Supervisor Self Service has rolled out). Delivery of sessions has commenced and is advertised to staff under the Learning & Development Tab on the Intranet as part of Learning & Development's Training at a Glance. To date **274** managers have attended. PADR sessions for staff have also been offered as bespoke sessions delivered in the workplace, in order promote ownership of the process from staff and reduce any concerns with the revised process. Delivering in the workplace also reduces the difficulty in releasing staff from the workplace and maximises resources.
- Quality monitoring has commenced for PADRs. Learning and development have worked with Senior HR Managers at Singleton Unit and are now progressing to Princess of Wales Unit and Corporate Directorates. The remaining units will be covered in line with a progressive project plan over the next 8-9 months.
- Learning & Development plan to work with the Values Team to review the outcomes of the recent values survey to inform further actions relating to PADR and deliver on the plans set out in the Staff Experience Strategy launched this month.
- In order to improve up-take with PADRs and listening to what staff told us would work for them, group PADRs have been designed and piloted in a number of areas supported by the Learning & Development team.

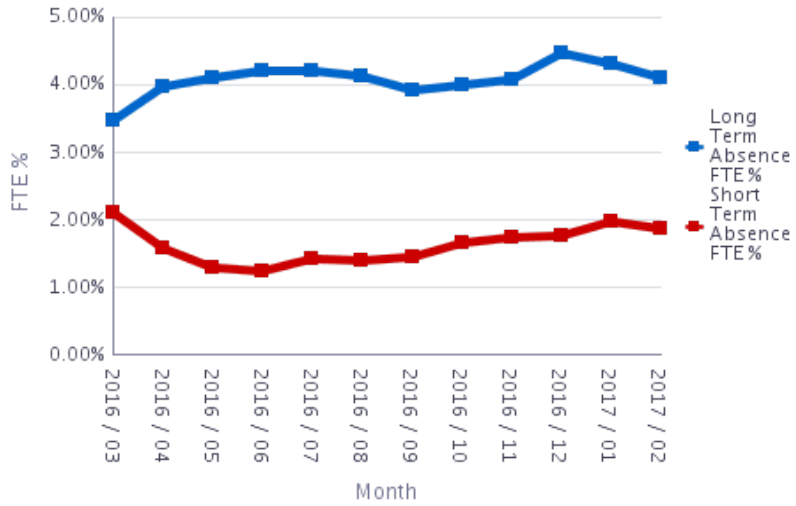
WG Measure 95 – Percentage of sickness absence rate of staff

The rolling 12 months absence rate has increased very gradually month on month since the beginning of 2016, the in-month rate (blue line) follows a seasonal pattern, which has not changed markedly for some years. High sickness rates remain a problem for the Health Board as it increases our reliance on agency and bank. A new focus on the management of long-term sick absence has started aimed at reducing the rate further.

Whilst the efforts made to improve sick absence management have clearly affected short terms absence rates long-term absence now presents a greater challenge to the Health Board. We need to work with the new Delivery Units to make sure we now focus more closely on long-term absence and case management of those staff who have been on sick for the longest.



Note: Absence target is 5.1% (no red target line on chart above)



Background and Actions taken

- A workshop was held with staff from different disciplines across the Workforce Directorate with the purpose of identifying different actions that could/have not been considered to date. The above approach will be repeated with operational managers.
- Actions arising from the workshops will be added to the improvement plan.
- In order to improve data accuracy in relation to the reporting of absence reasons payroll have been instructed to return any manual pay cards to managers that have unknown absence reasons entered into them. The ability to enter an unknown reason into any of our e rostering tools has already been removed.
- The review of all current long term sickness (LTS) cases as at the end of February has been undertaken by the operational HR teams to ensure that appropriate management actions have been taken in relation to each case.
- A work plan of sickness audits is in the process of being developed focussing on high sickness areas with a dedicated member of the HR team responsible for completion of these. Areas of non-compliance will be reported back to the managers responsible for the area in question and reported back to senior manager teams who will be responsible for managing the issues identified. Key

Performance Indicators (KPI's) will be produced to assist in tracking performance.

- The Staff Experience Strategy has been formally launched and will be key to preventing sickness absence and creating a 'well' workforce.

4.4 Accessible and Sustainable Services

The table below sets out the assessed performance of the key metrics under this Strategic Aim. For the majority of cases this data relates to February 2017. The detailed performance report cards attached as **Appendix A** to this report provide further background analysis to this performance assessment and also set out the reporting period for the performance metric.

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend
Effective Care	31	Delayed transfer of care delivery per 10,000 LHB population – mental health (all ages)	✗	↑ ●
Effective Care	32	Delayed transfer of care delivery per 10,000 LHB population – non mental health (aged 75+)	✗	↑ ●
Dignified Care	43	The percentage of patients who had their procedures postponed on more than one occasion for non clinical reasons with less than 8 days notice and are subsequently carried out within 14 calendar days or at the patient's earliest convenience	✗	↓ ●
Timely Care	50	Percentage of GP practices open during daily core hours or within 1 hour of daily core hours	✗	→ ●
Timely Care	51	Percentage of GP practices offering daily appointments between 17:00 and 18:30 hours	✓	↓ ●
Timely Care	55	Percentage of the health board population regularly accessing NHS primary dental care	✓	↑ ●
Timely Care	56	The percentage of patients waiting less than 26 weeks for treatment	✗	↓ ●
Timely Care	57	The number of patients waiting more than 36 weeks for treatment	✗	↓ ●
Timely Care	58	The number of patients waiting more than 8 weeks for a specified diagnostic	✗	↑ ●
Timely Care	59	The number of patients waiting for an outpatient follow-up who are delayed past their agreed target date	✗	↑ ●
Timely Care	64	The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	✗	↑ ●
Timely Care	65	The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	✓	↑ ●

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend
Timely Care	66	Number of ambulance handovers over one hour	✗	↑ ●
Timely Care	67	The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	✓	↑ ●
Timely Care	68	The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days of diagnosis (regardless of referral route)	✗	↓ ●
Timely Care	69	The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to & including) 62 days of receipt of referral	✗	↓ ●
Timely Care	70	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	✓	↓ ●
Timely Care	71	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	✓	↓ ●
Individual Care	79	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	✓	↑ ●
Individual Care	80	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	✓	↑ ●
Individual Care	81	The percentage of hospitals within a health board which have arrangements in place to ensure advocacy is available for all qualifying patients	✓	→ ●
Staff & Resources	83	The percentage of patients who did not attend a new outpatient appointment	✓	↓ ●
Staff & Resources	84	The percentage of patients who did not attend a follow-up outpatient appointment	✗	↓ ●

WG Measures- 31 and 32 Delayed transfer of care

Set out in the table below is the last four months' worth of data in respect of delayed transfers of care along with a supplementary table setting out the reasons for the delayed transfers.

Hospital/Service	January	February	March	April
Morriston	5	4	5	6
Singleton	4	6	6	5
Gorseinon	2	8	6	2
Mental Health	20	27	26	26
Learning Disabilities	6	8	7	6
Princess of Wales	10	5	6	9
Maesteg	2	2	5	6
NPT	20	10	10	11
Total	**69**	**70**	**71**	**71**

Reasons for delayed discharges

There are several codes which categorise the reason for a delayed transfer of care. The main issues contributing to the April delayed transfers of care are outlined below:

Reason	Total
Community Care Assessment/arrangements	20
Disagreements	2
Healthcare Assessment/arrangements	18
Selection of care home	15
Waiting for availability of care home place	16

Each of the service delivery units within the Health Board has discharge improvement actions plans to ensure that the recommendations from the Delivery Unit audits that were undertaken at the end of 2015, are reflected in these plans, with clear timescales for delivery. The main recommendations from the Delivery unit report were:

- The need for better and earlier differentiation of simple and complex discharges
- To increase nurse initiated discharge
- To optimise discharge to assess
- To improve access to community pathways and community services

- On a day-to-day basis, the Health Board continues to focus on internal processes that reduce the numbers of people who are "discharge fit" in order to reduce length of stay and reduce DToCs. SAFER flow bundles are a key part of this work, with a particular focus on Board Round process and practice at each site. This also includes senior management sponsorship of daily board rounds, multi-disciplinary/agency 'discharge fit' meetings and senior management escalation arrangements with the Local Authority for individual patients.
- It is intended to initiate a Patient Flow – 'Heart and Minds' programme through generic publicity within the Health board – to focus on the harm of deconditioning

in hospital with the aim of changing culture and thinking. This will be led by the Executive Team with a clear message around the evidence that a prolonged stay in hospital is harmful for older people in particular.

- The planned 'End PJ paralysis' awareness week at PoW in early May will inform this programme of work and also links with the wider UK social media campaign – but reinforcing it with the message of 'Home First'
- This links to the implementation of 'red' and 'green' days to further reinforce the SAFER flow bundle and reduce wasted bed days that do not add value to the patient's stay in hospital - as an integral part of our recovery and sustainability programme.
- The Health Board's discharge policy has been reviewed and strengthened to support operational teams with the discharge planning process and has the endorsement of the respective Local Authorities. It is intended to run additional training/awareness session for staff on the discharge process, service models and pathways out of hospital as these continue to change and develop.
- The Health Board's Choice policy has been reviewed and strengthened and each of the Delivery units is working towards ensuring that the policy is applied consistently. Nursing home capacity remains challenge in the Health Board in the Bridgend area in particular and EMI capacity is also limited.
- CAPITA has been commissioned to undertake capacity/demand modelling across the Western Bay to inform the capacity requirements in community services – to identify any gaps and inform models that deliver the biggest potential return on investment. The outcome of this work will be presented in May. Intermediate Care Funding will be used to maximum effect through investment/disinvestment to support this approach.
- The service delivery units have re-focussed discharge nurse expertise to concentrate on the more complex discharges. Alongside this, the Health Board has invested in patient flow roles for each hospital site to support ward staff with the simpler discharges and these individuals chase up any delays that may delay discharge.
- Common domiciliary care principles have been established across Western Bay served by the three Local Authorities. Progress is being made with the domiciliary care options appraisal to support sustainable domiciliary care capacity within ABMU. Engagement workshops have been scheduled with domiciliary care providers to inform this work.
- The Western Bay Regional Partnership Board has a pivotal role in ensuring that there is effective partnership working across health and social care through continuing to work towards the Western Bay optimal services model, and ensuring a consistent approach across the Health Board.

WG Measures 43 - Postponed Procedures

All currently available data and update are set out in the report card in **Appendix A**. This measure relates to the Welsh Government manifesto commitment that where patients have their procedure cancelled on more than one occasion, they should then have their procedure within 14 days or at the patient's earliest convenience.

During January (the most recent data available), of the 128 patients who had their procedure cancelled on more than one occasion, 57 had their procedure carried out

within 14 days day. In order to address this a range of actions are planned within the wider hospital systems to prevent cancellations for bed availability in particular.

WG Measures 50, 51 and 52- Primary Care Access

This suite of measures relates to the accessibility of primary care services. The Health Board has a partnership access and sustainability group established with LHB, CHC and LMC membership, which continues to meet regularly to decide on policy and process surrounding access and support for struggling practices. Further, a Practice Support Team has been established with a Primary Care Clinical Director, two salaried GPs, an ANP (who starts May 2017) and a practice development manager. The team provides diagnostic consultancy to practices that the Sustainability framework Panel decide warrant intervention

GP access in Wales 2016 survey shows that 85% of ABMU practices are open at least within one hour of daily core hours per day, which is also the Wales National average. Cluster networks have considered access as part of their annual plans and have introduced choose well/self-care campaigns, increased access to third sector and increased access to a wider range of community based professionals including paramedics, cluster pharmacists, chronic conditions nurses, physiotherapists.

For the most recent reporting period, the Health Board reported 86% of practices open during daily core hours and 81% of practices offering appointments between 17:00 and 18:30 on a minimum of 5 days per week.

WG Measures 56, 57 and 58 Planned Care

Covered in Approval Conditions Section 3 above.

WG Measure 59- Delayed Follow-up Outpatient (DNA rates included for information)

The ABMU Outpatient Improvement Group (OIG) provides support to the Health Board Delivery Units to review the current model of outpatient delivery and to explore new ways of working across the Health Board. Performance has been disappointing in recent months with the number of patients who are waiting beyond their scheduled waiting time increasing to 54,993 in March 2017.

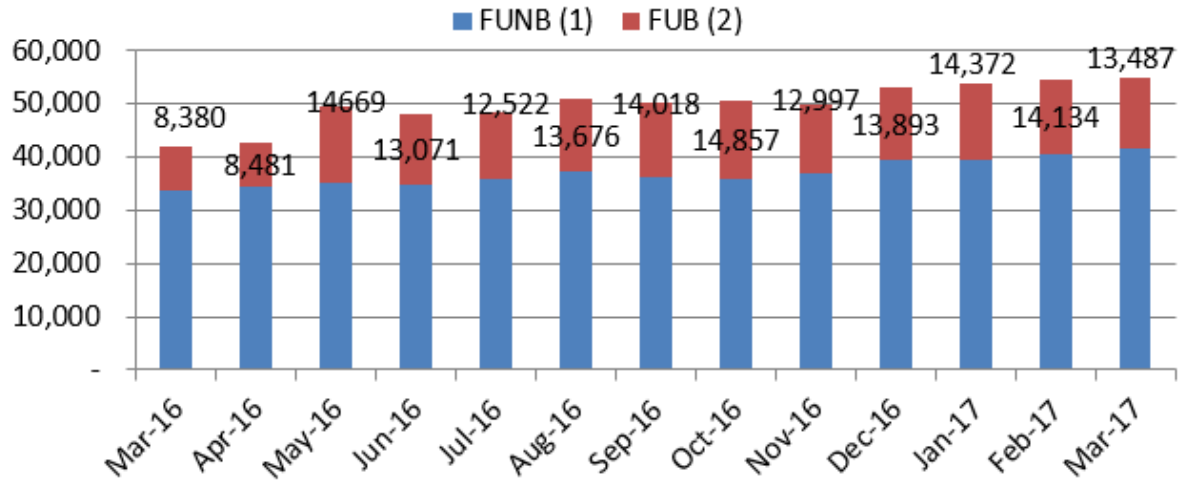
The Units, via the OIG process, have produced plans exploring alternative methods of service delivery including specialist telephone & email advice, virtual clinics, mobile phone applications and interactive patient portals. However, it is proving challenging to consistently achieve Health Board wide improvement, which builds on the pockets of excellence, developed through this process.

The report card attached as **Appendix A** sets out the next steps of action for the OIG and the engagement work to be undertaken with the Units to address performance issues. This includes cultural change, long waiting patient focus, service change, evaluation and benchmarking against best in class.

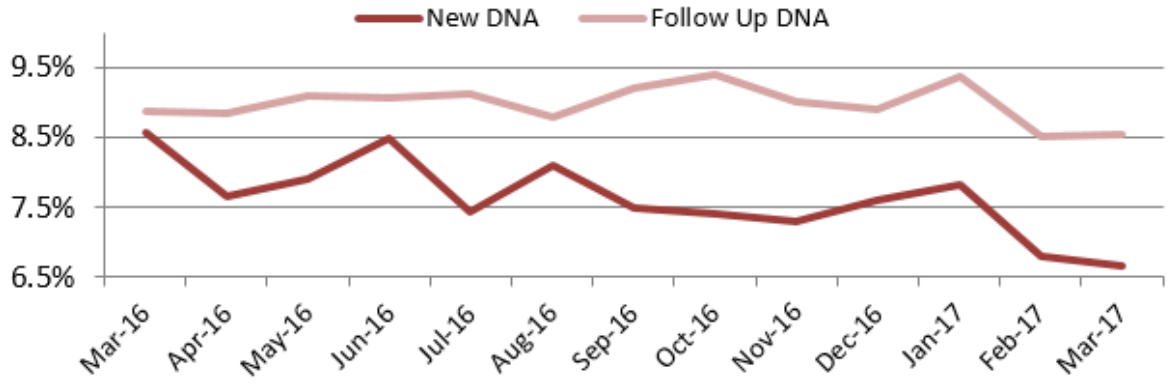
As with the main RTT elements, benchmarking has identified many opportunities for efficiency gain in improving new to follow up ratios so this will be a particular focus for the OIG going forward.

The benchmarking identifies a range of possible additional capacity to be released of between 37,836 and 42,411 by achieving benchmarked new to follow up ratios. The OIG work described above are intended to provide actions to release this capacity.

The table below shows how the delayed follow up volumes have changed over the last 13 months.



The table below sets out the Did Not Attend rates for new patients and follow up patients. The Health Board sees 0ver 600,000 outpatients during a financial year and improvements in DNA rates could provide much needed capacity to help reduce access times for new outpatients and reduced delays in the follow up system. The OIG is also working hard to drive the benefits from reduced DNA rates.



The actions that the OIG will oversee going forward are: -

- Integration of approach within Consultant job plans to accommodate See on Symptom (SOS)/virtual clinics
- Reduction in face to face consultations (new and follow up) where clinically appropriate
- Optimise efficient use of outpatient capacity
- Service Improvement projects ongoing to implement alternative models of outpatient delivery and to identify opportunities for improvement.

- Continue to play an active role in the national outpatient learning collaborative to learn of and share best practice across Wales

WG Measures 64 - 67 Unscheduled Care
Covered in Approval Conditions Section 3 above.

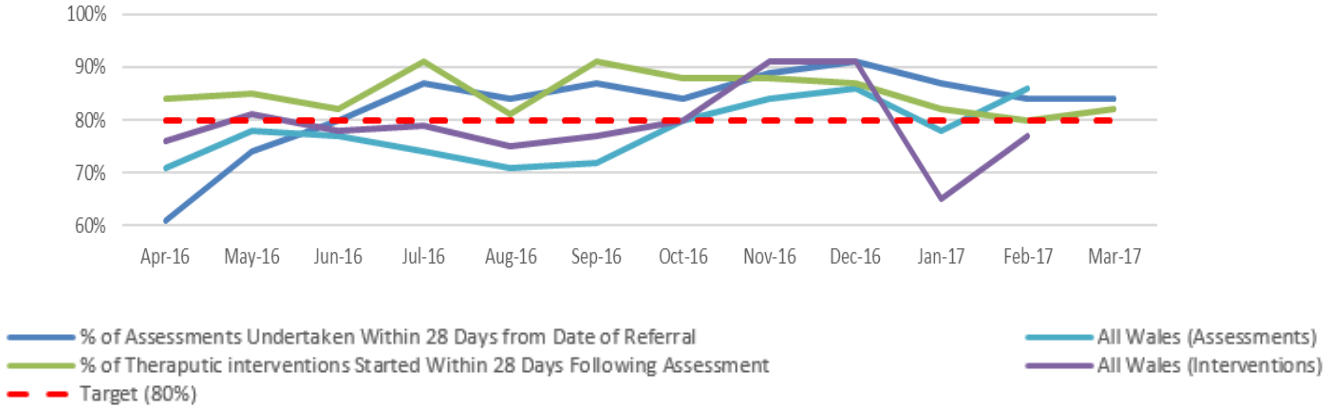
WG Measures 68 and 69 Cancer
Covered in Approval Conditions Section 3 above.

WG Measures 70 – 81 - Mental Health Specialist access performance
The table below sets out performance trend for mental health access areas. Board members are also referred to the report cards in **Appendix A**, which provide further detail on these measures and also include the recently developed Child and Adolescent Mental Health Services (CAMHS) scorecard, which tracks services access for this group of patients.

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend
Timely Care	70	The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral	✓	↓ ●
Timely Care	71	The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS	✓	↓ ●
Individual Care	79	The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	✓	↑ ●
Individual Care	80	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	✓	↑ ●
Individual Care	81	The percentage of hospitals within a health board which have arrangements in place to ensure advocacy is available for all qualifying patients	✓	→ ●

The section which follows provides further detail on performance against the metrics set out in the table above.

Part 1 Mental Health Measure



Waiting time for assessment

ABMU met the target in 10 out of the 12 months shown. It should be noted that actual time waiting is irrespective of weekends and bank holidays compliance up to the end of March. All Wales data for February ranged from 75.7% to 95%, with the ABMU performance at 84% achieved and sustained. All Wales data has not yet been published for March.

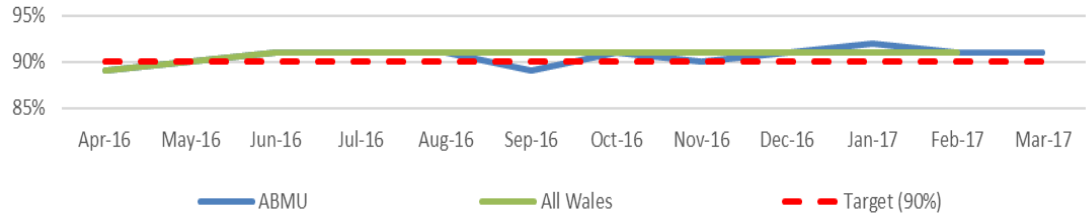
Waiting time for intervention

ABMU met the target for the 12 months shown. All Wales data for February ranged from 53% to 91%, as above ABMU 80%. Meeting the target does not tell you how many people are waiting or the length of longest waits, but are managed and monitored (the lists) locally.

Local Primary Mental Health Support Services (LPMHSS) in 2016:-

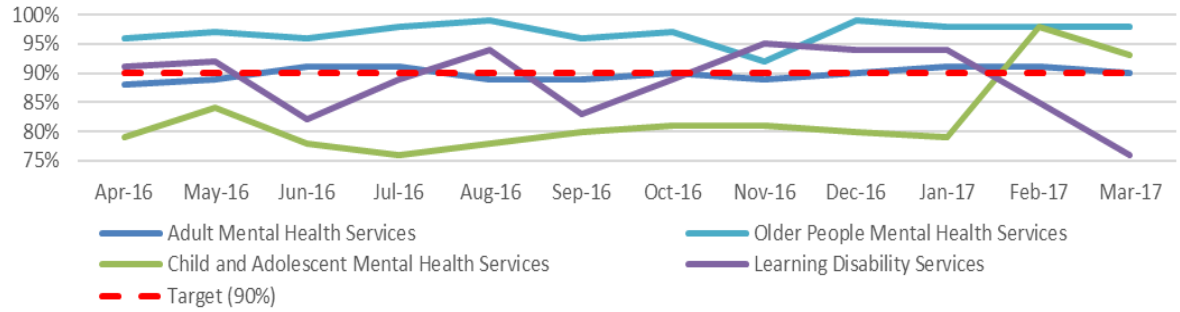
- **8,582** referrals
- **32** WTE practitioners
- **3,900** assessments undertaken
- The average rate of non-attendance at booked appointments is **[15%]**
- **2,905** people started an intervention during the year, an average of **242** people per month
- Only **323** people required referral on to secondary care services
- The priority for the LPMHSS is meeting the Welsh Government's access targets for assessment and commencing intervention with a variety of service improvements adopted during the year including 'cleansing letters', screening referrals when they are received & signposting if possible, reviewing people when they have been waiting for an extended period to check if their needs have changed.

Part 2 Mental Health Measure - Valid Care and Treatment Plan

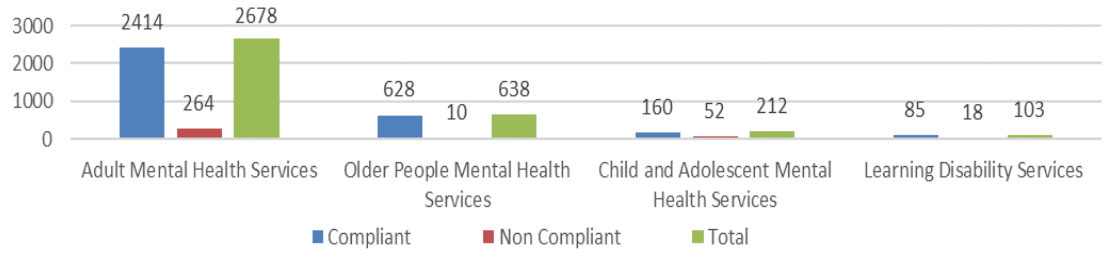


The data covers Adult, Older people, CAMHS and Learning Disability services. ABMU has met the target for 10 of the 12 months shown. There was a marginal dip in September but this increased and the target has been met every month since. ABMU compares favourably to the performance of other Health Boards. Alongside the Care and Treatment Plan (CTP) review audit the Delivery Unit continues to conduct annual CTP audits within each Community Mental Health Team, utilising the All Wales CTP Audit Tool.

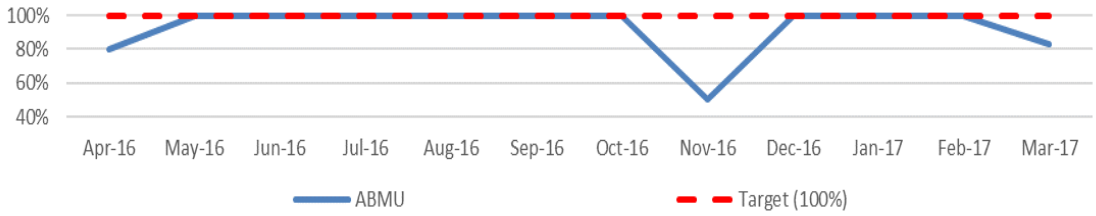
Valid Care and Treatment Plan for each service area



Number of patients with a valid Care and Treatment Plan



Part 3 Mental Health Measure - Percentage of outcome assessments sent within 10 working days



What does the data say?

ABMU met the target for 9 out of the 12 months shown. The percentage dipped in March to, 83%. ABMU compares favourably to the performance of other Health Boards in the All Wales MH measure report. All Wales Part 3 data in February ranged from 82% to 100%, as previously. All Wales data for March has not been published.

Part 4 Mental Health Measure - Percentage of ABMU Hospitals with advocate arrangements in place, including 1 independent hospital (Rushcliffe Hospital)

ABMU Hospitals (31st December 2016)	Number of Hospitals	Number who have arrangements in place to ensure advocacy is available to qualifying patients	%age Compliant
NHS Mental Health Hospitals	5	5	100%
Independent Mental Health Hospitals	1	1	100%
Other NHS Hospitals	9	9	100%

Performance across this range of access metrics with targets levels largely achieved in all areas.

5. RECOMMENDATION

The Board is asked to:

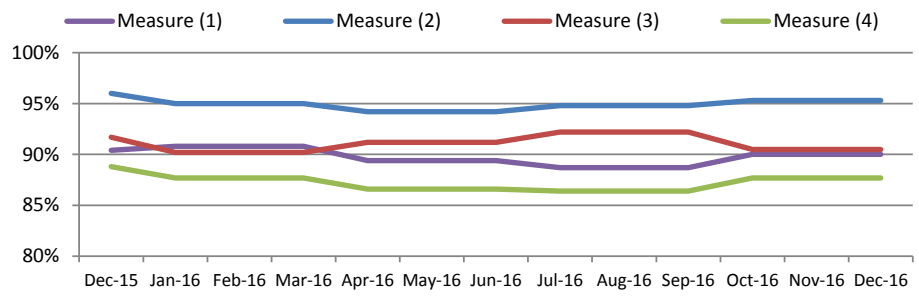
- **Note current Health Board performance against key measures and targets and the actions being taken to improve performance.**
- **Consider the value of the new format of narrative report supported by the detailed performance report cards.**

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

Measure 1: % uptake 4 in 1 pre school booster (at age 4), Measure 2: % uptake Hib/MenC booster (at age 4)
Measure 3: % uptake 2nd MMR dose (at age 4), Measure 4: % Up to date in schedule at 4th birthday.

Corporate Objective : Promoting & Enabling Healthier Communities			Executive Lead : Sandra Husbands (pending)	
Period : Dec 16	IMTP Profile Target :	WG Target : 95% or above	Current Status :	Movement : Worsening

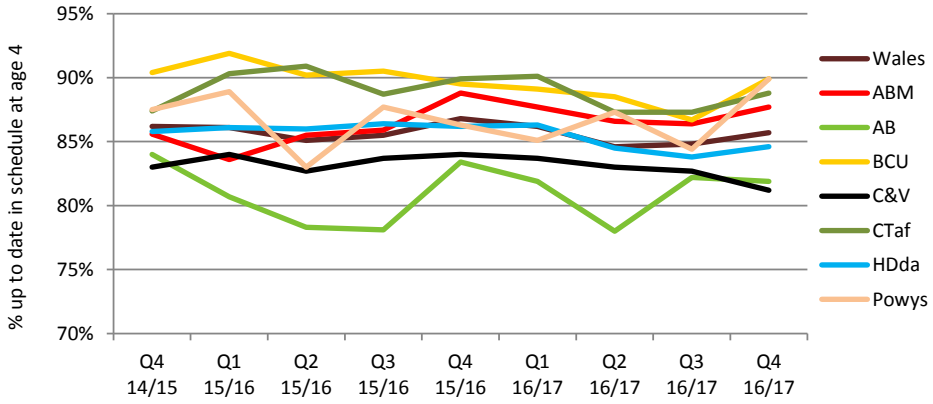
Current Trend: Dec 15 - Dec 16



How are we doing ?

- There is a slight increase in uptake rates of the 4 in 1 and the Hib Men C vaccination during the last quarter.
- During the last quarter we have seen a decrease in the number of children who have not had their 2nd MMR. This pattern is reflected Nationally across other HB's.
- There is an increase in the number of children who are currently up to date with their immunisations by the age of 4 yrs.

Benchmark



What actions are we taking?

- Waiting lists are monitored monthly. Any practices with persistently high waiting lists are highlighted to the relevant primary care support manager.
- Health visiting managers are receiving monthly reports of children who have outstanding MMR.
- Individual GP Practice immunisation profiles have been developed and have been met with a positive response. They contain uptake data on the 4 in 1, Hib Men C and MMR 2 at age 4 yrs. The number of remaining children to vaccinate to reach target is also included. This approach has proved helpful in increasing vaccination uptake in other HB areas.
- A National MMR Task and Finish Group will shortly be convening which will be chaired by VPDP (PHW) to address the decline in MMR uptake rates Nationally.
- Public Health Profiles produced for each GP Cluster include immunisation uptake data for the 4 in 1 pre school booster, up to date in schedule and MMR 2 at age 4 yrs (ABM Public Health Team, April 2017).

How do we compare with our peers?

- No Welsh Health Board is above 95% at 4 yrs.
- Currently ABMU are above the Welsh average for being up to date at 4 yrs

What are the main areas of risk?

- Currently MMR uptake rates are below 95% which is required for herd immunity.
- Health Visitors have received a separate report of all children currently on their caseloads who have not had 1 or 2 doses of MMR for action.

Source : Vaccine Uptake in Children in Wales October to December 2016 (COVER 121)

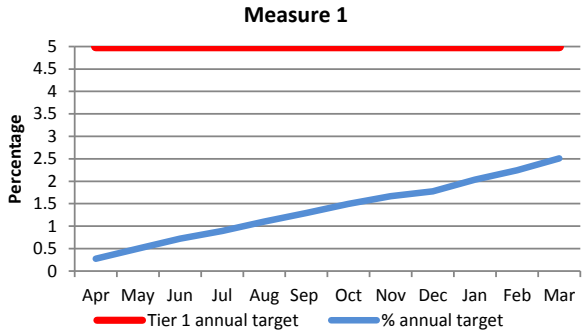
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

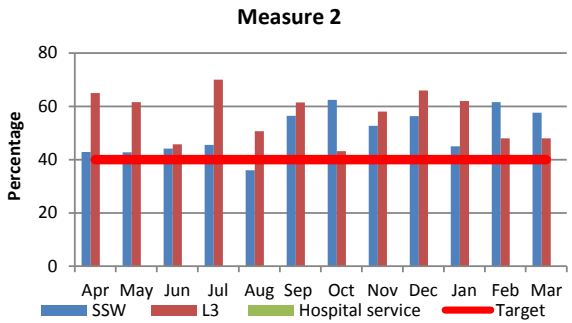
Measure 1: % Welsh resident smokers make a quit attempt via Smoking Cessation Services

Measure 2: % Welsh resident smokers who are Co validated as successfully quitting at 4 weeks

Corporate Objective : Promoting & Enabling Healthier Communities			Executive Lead : Sandra Husbands (pending)	
Period : Mar 2017	IMTP Profile Target : (1) 5% (2) 40%	WG Target : (1) 5% and above (2) 40% and above	Current Status : N/A	Movement : Improving

Current Trend: 2016-2017 (monthly)





How are we doing ?

- The most recent data from 2014/2015 estimates that 19.0% of ABMU's adult population, smoke. Smoking rates have decreased faster in ABMU than for Wales, from 23% in 2013/14 (Wales 22%) to 19% in 2015 (Wales 20%).
- To achieve the 5% Tier 1 target 4119 smokers need to be treated in stop smoking services per year, with an average of 343 smokers treated per month. ABMU has treated 2067 smokers (activity data) against the cumulative monthly target of 4119, achieving to date 2.5% of the overall target.

Benchmark

Treated Smokers

LHB	Current Q1-Q2 16/17	Previous Q1-Q2 15/16
Wales	1.5%	↑ 1.2%
ABM	1.3%	↑ 0.8%
AB	1.4%	↑ 0.5%
BCU	2.1%	↑ 1.8%
C&V	0.7%	↓ 0.7%
CTaf	2.1%	↑ 1.8%
HDda	1.2%	↑ 1.0%
Powys	1.1%	↓ 1.3%

Co Validated

LHB	Current Q1-Q2 16/17	Previous Q1-Q2 15/16
Wales	41.1%	↑ 37.3%
ABM	50.2%	↑ 42.9%
AB	41.4%	↑ 36.7%
BCU	30.5%	↓ 32.1%
C&V	54.1%	↑ 36.2%
CTaf	39.1%	↑ 37.3%
HDda	57.3%	↑ 48.9%
Powys	47.2%	↑ 39.3%

What actions are we taking?

1. Work is progressing nationally, supported by ABMU and Health Boards, to develop an integrated cessation system – with a single brand, common assessment, improved retention and 'hand-over' of clients between cessation service providers, and common data recording and reporting. 'Help me Quit' is the new national single brand for NHS stop smoking services in Wales. This work is being led by the Smoking Cessation Sub Group of the national Tobacco Control Strategic Board led by WG
2. Review of 2016/17 Tobacco control work undertaken. Planning for 2017/18 Tobacco control work programme with partners, work to include engagement activity; increasing numbers into cessation services and analysis of performance and effectiveness of cessation services
3. Health intelligence work undertaken on smoking prevalence and inequalities. Paper presented by DPH to Executive Team in March
4. Recommendations for improved compliance with Health Board's Smoke free site policy presented by DPH to Executive Team in March. Delivery Units to be performance managed on implementation of smoke free policy

How do we compare with our peers?

- As at the end of quarter two 2016/17, which is the latest published data available, ABMU was above the all-Wales position for the percentage of resident smokers who are co-validated as successfully quitting at 4 weeks but below the all-Wales position for the percentage of resident smokers making a quit attempt via smoking cessation services.

What are the main areas of risk?

The Recovery Plan outlines the financial implications and risk associated with improving performance of cessation services to meet the cessation target. The current budget of £253,000 allocated for level 2 and level 3 community pharmacy cessation services hosted in the Primary and Community Service Delivery Unit is inadequate to meet current performance and increase growth of service provision required to meet the target over the next three years.

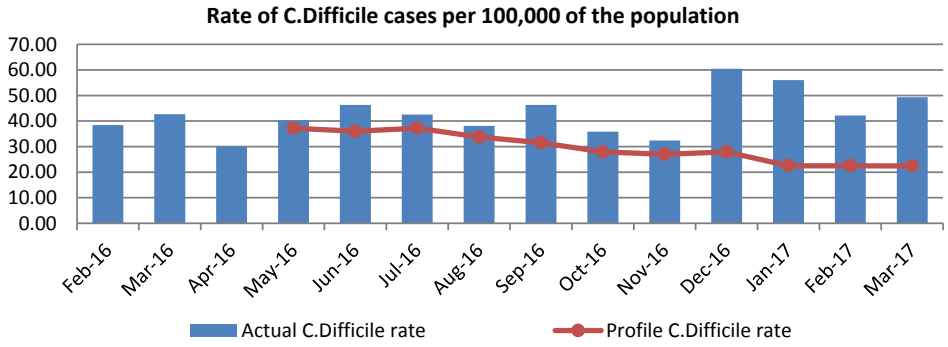
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Rory Farrelly	
Period : Mar 17	IMTP Profile Target : 22.5	WG Target : Improve	Current Status :	Movement : Worsening

Current Trend: Mar 16- Mar 17



How are we doing ?

- 22 reported cases of C. difficile infection identified in ABMU in March 2017; 18 from inpatient locations; 4 cases from non-inpatient locations.
- Cumulative number of cases between April 2016 and March 2017 was 229; 16% fewer cases than the same period in 2015/16 (All Wales reduction was 16% for the same comparison period).
- Monthly average for the 12 months April 2015 – March 2016 was 23 cases; monthly average for the same 12 month period in 2016/17 reduced by 4 cases per month. The Health Board has not achieved the expected reduction in C. difficile infection, having exceeded the target by 49 cases.
- No Service Delivery Unit (SDU) achieved the target in reducing C. difficile infection set by the Board.
- There has been a better rate of reduction in primary care antimicrobial prescribing in ABMU than the average rate of reduction for Wales as a whole.

Benchmark

LHB	Mar-17	Number Against Mar 17 Reduction Expectation
Wales	34.57	+61
ABM	49.30	+49
AB	40.48	0
BCU	35.60	+11
C&V	14.57	+2
Ctaf	11.90	-15
Hdda	49.16	+27

Not on trajectory to achieve expected reduction by Mar 17

On trajectory to achieve expected

What actions are we taking?

- Infection Prevention & Control training delivered to 93% Nursing Homes within ABMU.
- Decision aid for diagnosis and management of suspected urinary tract infection in older people in care homes distributed.
- Additional materials developed including posters on 'Minimising the Risk of Clostridium difficile infection & Good Practice Points' in each of the following: Primary Care, Care Homes, Secondary Care, and Community Pharmacies – Quarter 1 2017/18.
- The Health Board's Antimicrobial Stewardship Group is to be chaired by one of the Unit Medical Directors with the objective of improving medical engagement – Quarter 1 2017/18.
- Trial of novel sporicidal disinfectant (to kill/remove C. difficile spores) in Princess of Wales during Quarter 1 2017/18.

How do we compare with our peers?

- In the infection reduction expectation period, ABMU has highest incidence of C. difficile infection in Wales.
- At the end of the reduction expectation period, only 2 health boards provisionally met the reduction expectation. (Aneurin Bevan UHB at 27.92 and Cwm Taf UHB at 15.54). The 6-month rate in ABMU (October 2016 to March 2017) was 46.56.

What are the main areas of risk?

- Increase in morbidity and mortality directly or indirectly associated with C diff infection
- Contributory factors: secondary care antibiotic prescribing; impact of high numbers of outliers on good antimicrobial stewardship; use of pre-emptive beds; suspension of enhanced decontamination technologies; lack of decant facilities.

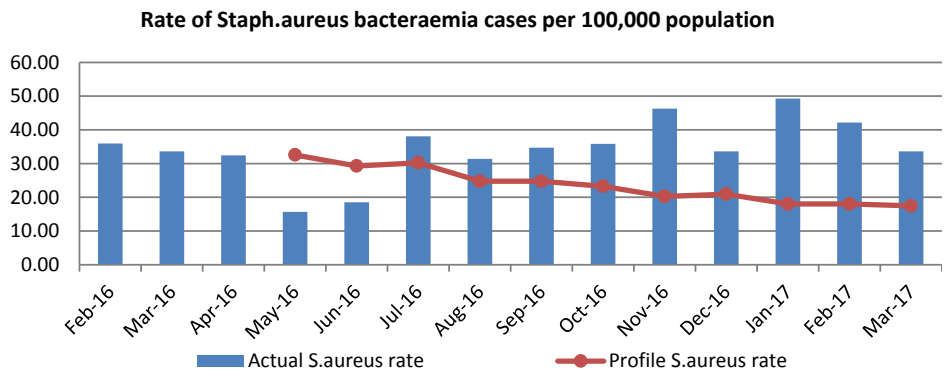
Source : Public Health Wales, C. difficile and S. aureus bacteraemia monthly dashboard (APRIL 2017)

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Rory Farrelly	
Period : Mar 17	IMTP Profile Target : 17	WG Target :	Current Status :	Movement : Stable

Current Trend: Mar 16- Mar 17



How are we doing ?

• 15 cases of Staph. aureus (SA) bacteraemia identified in March; 8 inpatients and 7 non-inpatients. One was MRSA bacteraemia in an inpatient case.
• Number of cases identified between April 2016 and March 2017 was 182; 2% more than cases than in the same twelve months in 2015/16. 52% cases occurred in non-inpatients; many inpatient cases will have been admitted to hospital with sepsis, later confirmed by obtaining a blood culture.
• Incidence in March 2017 decreased to 33.61/100,000 population (target is 20/100,000). The cumulative incidence, Apr-16 to Mar-17 was 34.64.
• By the end of March 2017, the Health Board failed to achieve the infection reduction expectation, exceeding the target by 55 cases.

Benchmark

LHB	Mar-17	Number Against Mar 17 Reduction Expectation
Wales	28.82	+157
ABM	41.23	+55
AB	21.42	+21
BCU	24.36	+13
C&V	34.89	+42
Ctaf	32.00	+20
Hdda	30.20	+23

Not on trajectory to achieve expected reduction by Mar 17

On trajectory to achieve expected reduction by Mar 17

What actions are we taking?

• Each Operational Delivery Unit (ODU) has specific monthly reduction projections, which are monitored weekly. With the exception of Neath Port Talbot, all ODUs exceeded their reduction profiles.
• Over 2,100 staff had completed the e- learning programme for Aseptic Non-touch Technique (ANTT) by 20 Feb-17.
• Health Board discussions with Welsh Government regarding methodology for Staph. aureus bacteraemia surveillance. Other Welsh Health Boards have also raised the issue of unavoidable community acquired cases; Welsh Government did not take this into consideration when setting the infection reduction expectation for 2017/18.

How do we compare with our peers?

• In the infection reduction expectation period, ABMU has the highest incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards.
• At the end of the infection reduction expectation period, none of the 6 major health boards provisionally met the reduction expectation.

What are the main areas of risk?

• Public perception higher risk of Staph. aureus bacteraemia in ABMU Health Board• Increased risk of morbidity and mortality
• A large proportion of MSSA bacteraemia is community acquired and, as such, may be more challenging to achieve reduction.
• Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.

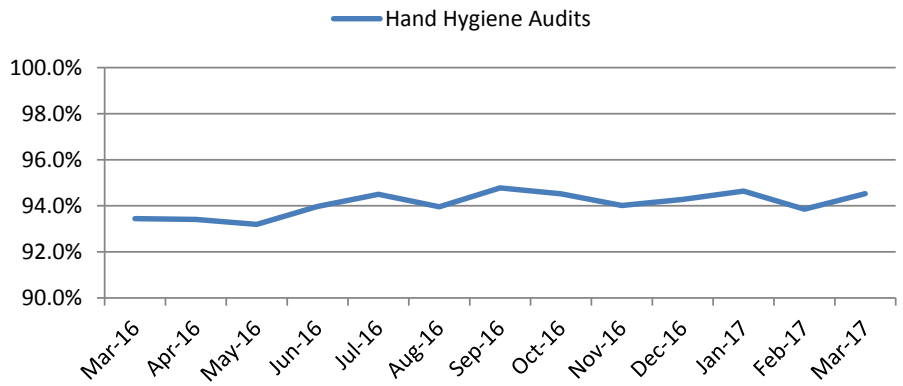
Source : Public Health Wales, C. difficile and S. aureus bacteraemia monthly dashboard (APRIL 2017)

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

Measure 1: % compliance with Hand Hygiene (HH)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 17	**IMTP Profile Target : 95%**	**Local Target : 100%**	**Current Status :** ✖	**Movement :** ⇧ ● **Improving**

Current Trend: Mar 16 - Mar 17



How are we doing ?

- Compliance with hand hygiene (HH) for March 2017 was 94.5%.
- For March, 88 wards/units (64%) reported compliance ≥95%. 87 wards/departments reported 100% compliance.
- 12 wards/departments (8.6%) reported compliance ≥90% <95%; 22 wards/units (16%) reported compliance ≤89%.
- 16 wards/departments had not uploaded the results of their audits undertaken in March.
- Two of the six Service Delivery Units (SDUs) reported compliance ≥95% in March 2017 (Neath Port Talbot and Princess of Wales); Mental Health, Morriston and Singleton reported compliance ≥90% <95%; Primary Care & Community Services reported compliance ≤89%.
- Results over time indicate there are challenges to achieving sustained improvements in compliance; however, there are recognised limitations with self-assessment.

Benchmark

No Benchmark Data Available

What actions are we taking?

- To date, no evidence of peer review audits (cross-ward audits) having been undertaken. Communication regarding the establishment of peer review – by 31 May 2017.
- The Infection Prevention and Control Team (IPCT) are participating in the All Wales HH product procurement exercise. The product specification has been agreed. Timescales for tendering process determined by Shared Services Procurement Sourcing.
- ABMU's Assistant Director of Nursing (ADN) has asked Public Health Wales to consider a new 'CleanYourHands'-style campaign to support local action, with centrally produced materials. Awaiting confirmation from Public Health Wales regarding timescales. The IPC team have also started a review process aimed at 'refreshing' their HH training programme / messages.

How do we compare with our peers?

- The HH score has been removed from the all Wales dashboard because of the inherent difficulty in using one score to represent a whole Health Board. The Infection Prevention & Control Team (IPCT) is discussing with colleagues in Hywel Dda Health Board the possibility of peer review of HH and the validation process to give the Board greater assurance of compliance with HH.

What are the main areas of risk?

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

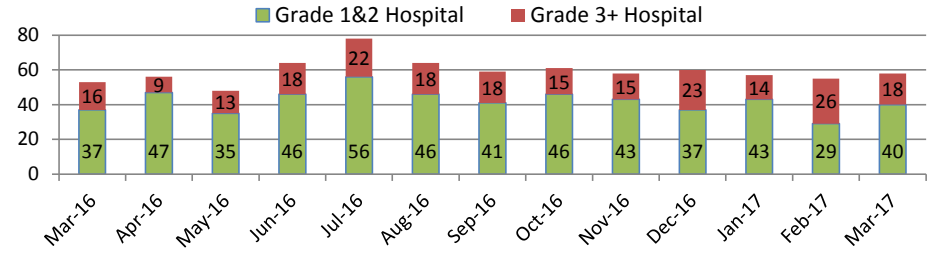
Source : ABMU Care Matrix

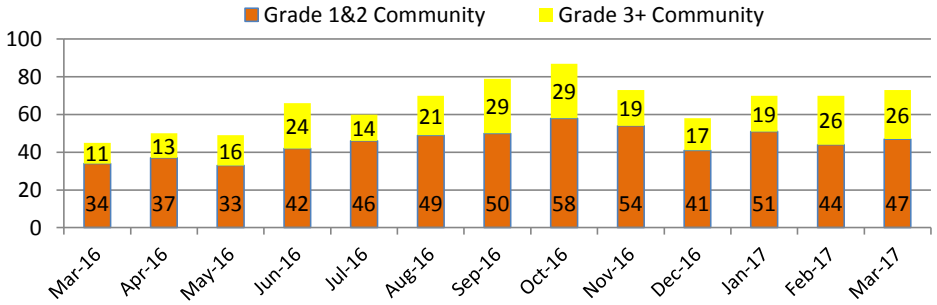
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of healthcare acquired pressure ulcers

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 2017	**IMTP Profile Target : Reduce**	**WG Target : Reduce**	**Current Status : N/A**	**Movement : Worsening**

Current Trend: Mar 16- Mar 17





Benchmark

Benchmark data no longer included in ALL WALES PERFORMANCE SUMMARY : Developing alternative source via CHKS

How are we doing ?

• The data for pressure ulcers developed in ABMU care during March shows a slight increase in overall numbers. However, the severity of the ulcers has decreased with less Grade 3+ ulcers being recorded.
• Hospital acquired PU's: The number of Grade 1&2 in February 2017 was 29, in March 2017 the results was worse at 40. The results for Grade 3+ in February 2017 were 26, in March there was a significant reduction to 18.
• Community acquired PU's: In both the grading of PU's, results were worse than the 2016/17 average. Grade 1&2 47 against average of 43, an increase from 44 in Feb, Grade 3&4 remain at 26 against an average of 19.

What actions are we taking?

•The meeting of the new Health Board Pressure Ulcer Prevention Strategy Group (PUPSG) was held on April 19th 2017. All SDU's were represented. The TOR for the group were finalised and agreed. The next meeting will be in quarter 2 and will share learning from the SDU Scrutiny Panels, identify priorities for action and inform the work plan for the group.
•Pressure Ulcer Peer Review Scrutiny Panels are in place for all SDU's
•Morriston Hospital is piloting a new risk assessment for the prevention of cast related pressure damage.
•The NHS wales Delivery Framework 2017-2018 has a new requirement for reporting of all hospital acquired pressure ulcers as per 100,000 admissions. Changes are underway to include these measurements in future score cards.

How do we compare with our peers?

What are the main areas of risk?

• It is recognised that this Datix web data may contain inaccuracies arising i.e. duplicate incident reports and unapproved incidents. A Group is to be set up to examine and cleanse the data each month to improve the reliability of the data measurements generated for performance reporting.

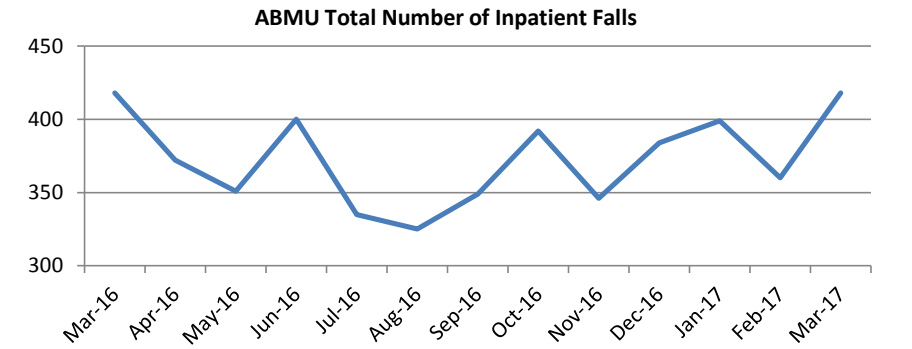
Source : DATIX

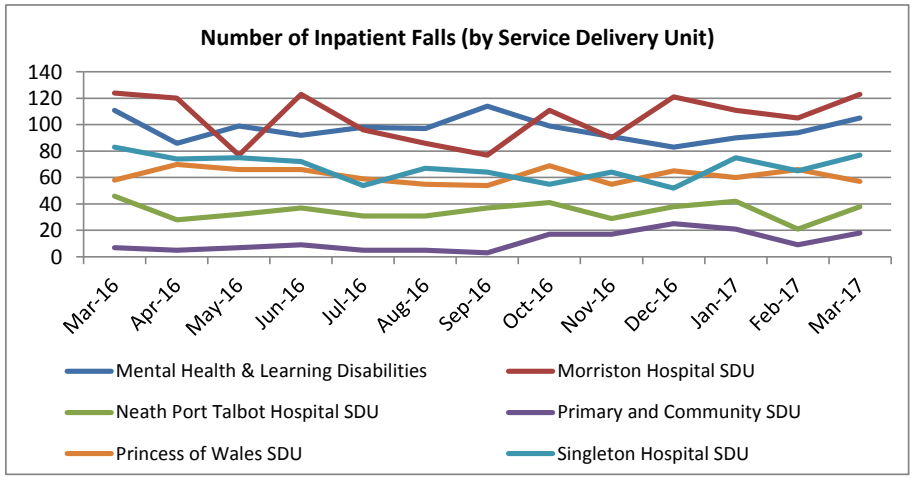
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure: Number of Inpatient Falls

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Amanda Hall	
Period : Mar 2017	IMTP Profile Target : Reduce	Local Target : Reduce	Current Status :	Movement : Stable

Current Trend: Mar 16- Mar 17





How are we doing ?

• The number of falls reported via Datix web increased from 360 in February to 418 in March. The 12 month movement on this reported figure is exactly the same as this time last year.

• All of the Service Delivery Units (SDU), except Princess of Wales SDU, have reported an increase in Falls in March from February. Morriston SDU reported the biggest increase, from 105 falls in February to 123 in March. Princess of Wales SDU had a decrease of 9 falls in March reported figures.

What actions are we taking?

• The Health Board has registered for the 2017 National Audit of Inpatient Falls which is taking place in May. Leads for the Audit have been identified in each Unit and the audit involves a documentation element as well as observation of practice.

• The revised Falls Group met with representation from each SDU. The Terms of Reference includes supporting the development of Falls Scrutiny Panels in each SDU, making recommendations on training for staff groups and supporting the development of shared learning from incidents.

• The Inpatient Falls Policy is due for revision in May, the Falls group will co-ordinate the revision of the Policy and develop an implementation plan.

How do we compare with our peers?

No Benchmark Data Available

What are the main areas of risk?

• It is planned to change the way that falls is reported on the scorecard, it will change to a graph illustrating rates for each SDU per 1,000 bed nights. However due to the difficulties in reporting the data without a benchmark for Community and Primary Care Services, there will be a delay in changing this report pending an all-Wales decision on reporting mechanisms.

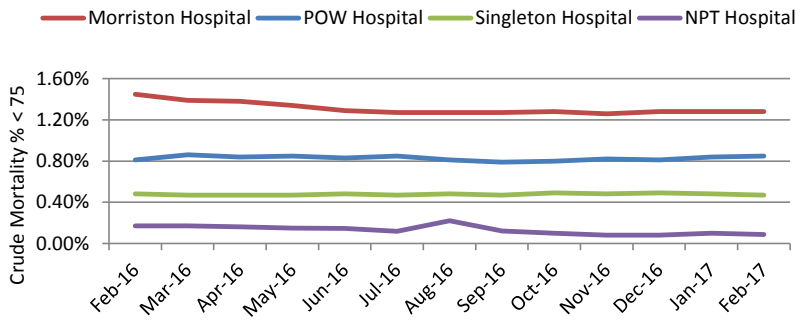
Source : DATIX

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Hamish Laing**	
Period : Feb 17	**IMTP Profile Target :**	**WG Target : 12 month reduction trend**	**Current Status :** ✓	**Movement :** ↓ ● **Improving**

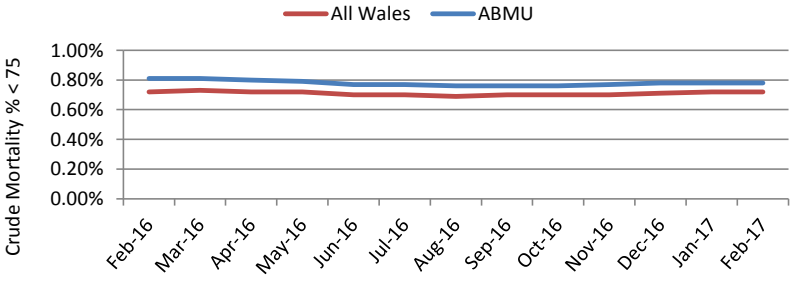
Current Trend: Feb 16 - Feb 17



How are we doing ?

- The ABMU Crude Mortality Rate for under 75s in the 12 months to January was 0.78%. This is lower than the same period last year which was 0.81%.
- At a site level performance is as follows: (prior year in brackets) Morriston 1.28% (1.44%), Princess of Wales 0.84% (0.82%), Neath Port Talbot 0.10% (0.17%), Singleton 0.48% (0.49%). Site comparison is not possible due to different service models being in place.
- There were 103 in-hospital Deaths in this age group in February 2017 compared to 112 in February 2016: Morr 53 (52), PWH 27 (42), NPTH 1 (2), SNG 22 (20).
- The number of deaths for Surgical and Elective cases remains consistently low for this age group.

Benchmark



What actions are we taking?

- The Clinical Outcomes Group (COG) agreed a new approach to review Mortality for each Service Delivery Unit (SDU) in March 2017. This approach was adopted in COG in April 2017 with the Singleton Delivery Unit Medical Director feeding back learning from the mortality review process and fluctuations in data.
- This approach was well received and several subtle changes to the report were suggested to support the feedback process going forward.
- A separate report was submitted to the Quality & Safety Committee outlining this approach in April 2017 and this report was supported by the Committee.
- Information and analysis for mortality and the two stage mortality review process continues to be available on a daily basis via the Mortality dashboard.

How do we compare with our peers?

- ABM are slightly above the all-Wales Mortality rate for the 12 months to March 17 – 0.78% compared with 0.72%.

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.

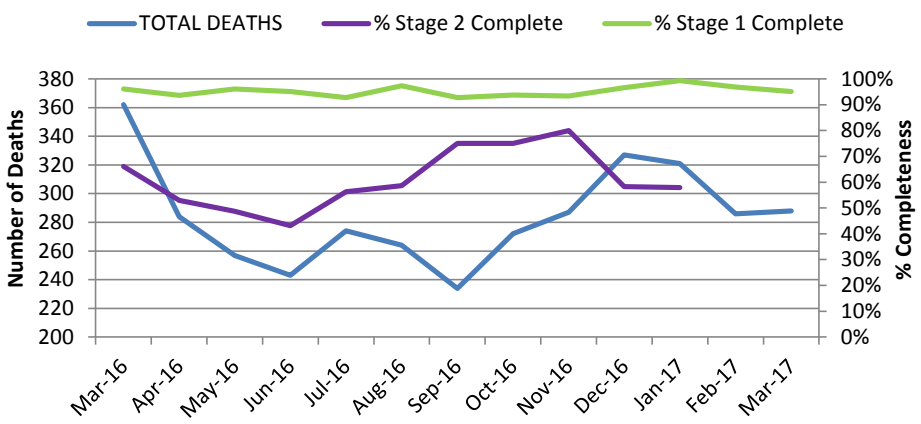
Source : NHS WALES OUTCOMES FRAMEWORK, Comparative Health Knowledge System (CHKS)

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

Measure 1: % Universal Mortality Review (UMR) forms completed
Measure 2: % Stage 2 Review forms completed
Measure 3: Number of Hospital Deaths of persons over the age of 16 (Excluding Emergency Department)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Mar 2017	IMTP Profile Target : (1) 96%	WG Target : Improve	Current Status : N/A	Movement : Worsening

Current Trend: Mar 16- Mar 17



How are we doing ?

• 288 deaths included in March. The HB UMR rate was 95%, a 2% reduction. Singleton and NPT achieved 100%. Morriston achieved 94% with 8 missing forms; 2 Cardiothoracic,2 Medicine,2 T&O & 2 ITU. There are 82 UMRs outstanding from April 2016 to date, 75 from Morriston
• Completion of Stage 2 reviews within 8 weeks has remained at 58%. For April 2016-January 2017 deaths there are 83 outstanding stage 2 reviews; 4 NPT, 24 POWH, 26 Singleton and 29 Morriston
• There were 6 deaths in Mental Health in March 2017, 5 had a UMR completed and none triggered a Stage 2 review. There were 4 deaths in community hospitals. 1/4 had a UMR completed, all 3 missing UMRs were in Gorseinon. The completed UMR did not trigger a Stage 2 review
• Thematic review of Stage 2 - 28% had no untoward events, there were delays in treatment in 8% and communication failures in 6%.

Benchmark

What actions are we taking?

• The Emergency Department in Morriston is piloting the standard mortality review process for a 3 month period with a view to adopting it in Spring 2017
• The AMD for patient safety has undertaken a case note review which has provided assurance that removing the "patient died from a condition other than that for which they were admitted" has not resulted in missed learning opportunities.

How do we compare with our peers?

No comparative data available

What are the main areas of risk?

•Timeliness of Stage 2 completion - although this is improving month on month and will continue to do so as new job plans are worked through

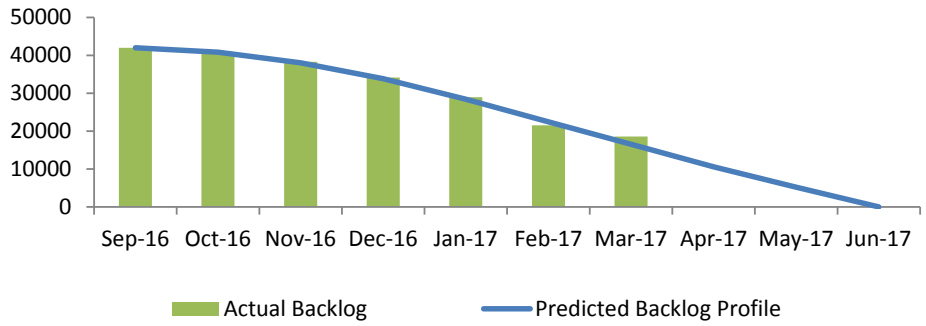
Source : ABM Mortality Review database, **note** data relates only to Princess of Wales, Morriston, Singleton and Neath Port Talbot Hospitals but excludes deaths in the Emergency Departments and neonatal deaths

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Hamish Laing**	
Period: Mar 2017	**IMTP Profile Target : N/A**	**WG Target : 12 month improvement trend**	**Current Status :** ✗	**Movement :** ↑ ● **Improving**

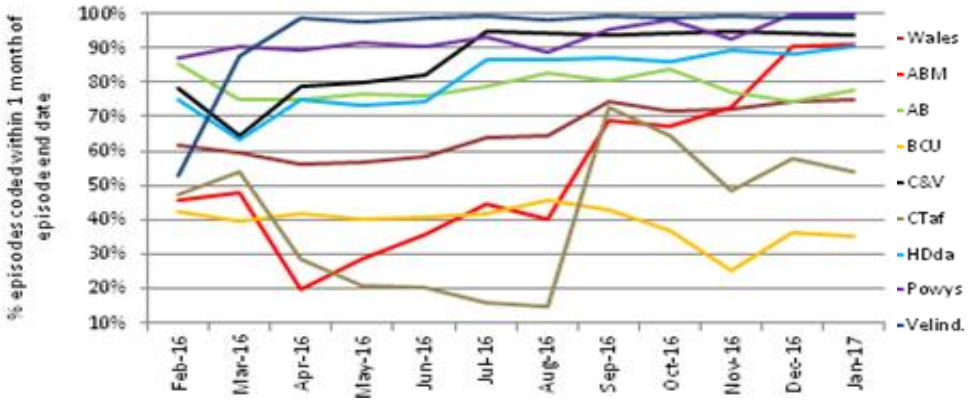
Current Trend: Sep 16- Mar 17



How are we doing ?

- As at 1st March 2017 the Coding completeness is – April 98.64%, May 97.63%, June 97.46%, July 96.99%, August 95.99%, September 96.62%, October 95.56%, November 94.92%, December 96.02%, January 94.56% and February 90.33%
- As at 1st March 2017 the outstanding backlog stands at 18,582 episodes for 2016/2017. This is slightly above target, however plans are in place to ensure achievement of the profile reduction to clear backlog by end of June 2017.
- Coding completeness within 1 month has improved with February at 90.33%. This continues the improvements in previous months of exceeding completeness of 90% in 30 days, but the target will not be achieved until the new recruits are fully trained and proficient - this will be end of 2017/18.

Benchmark



What actions are we taking?

- The all Wales benchmarking data has been updated to include up to January 2017 and demonstrates a significant improvement for ABM from the previous positon of 40% compliance in August 2016. The ABMU position will improve further in 2017.
- Achieving compliance against the 12-month plan to clear the coding backlog by July 2017.
- Additional one-off investment has allowed the recruitment of contract coders over a period of 9 months to help reduce the significant backlog. All of the contract coders have been secured and are working over a 7 day week period to clear the backlog. Productivity and quality of these staff is high
- Recruitment of 6.5 WTE permanent staff has been completed and are now in post. This will address the completeness in month once staff are trained and competent - end of 2017/18.
- Our experienced coders are undertaking overtime to support performance of the within 30 days target.

How do we compare with our peers?

- There is an ongoing discrepancy with the comparative data above which NWIS produce for Welsh Government, this is being investigated and has been suspended until resolved.

What are the main areas of risk?

- Failure to keep the contract coders as a result of more attractive contracts elsewhere in the UK.
- Maintaining the productivity levels in 2017/18 whilst the trainee Coders are still training and the contract coders are no longer employed

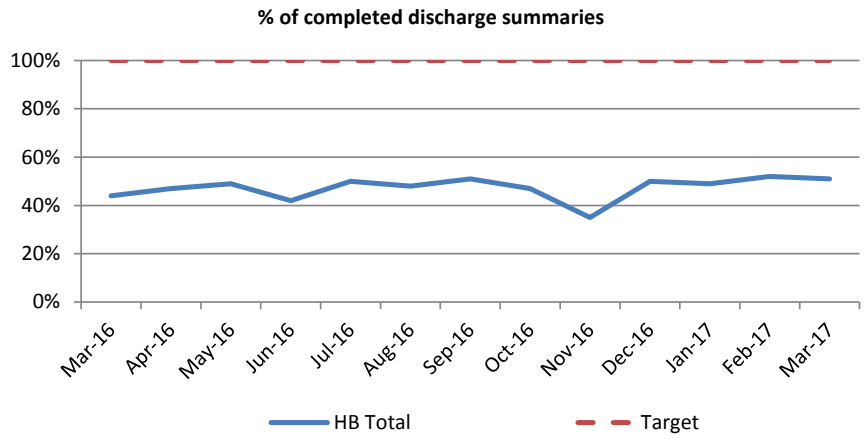
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

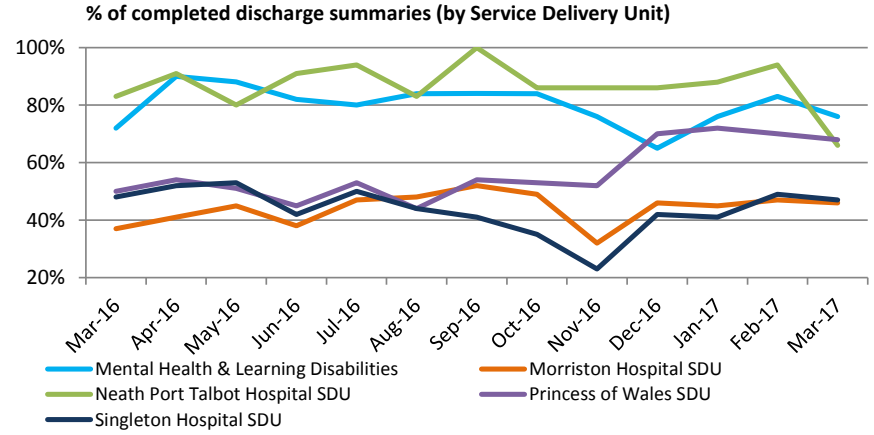
TIMELY CARE - I HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED & AM ACTIVELY INVOLVED IN DECISIONS ABOUT MY CARE

Measure 1: % of completed discharge summaries

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Hamish Laing**	
Period : Mar 2017	**IMTP Profile Target :**	**Local Target : 100%**	**Current Status :** ✗	**Movement :** ↑ ● **Improving**

Current Trend: Mar 16 - Mar 17





How are we doing ?

- In March 2017 51% of discharge summaries were completed and sent compared with 52% in February
- Performance varies between Service Delivery Units ranging from 46% - 68% in March
- This month the performance has worsened in 4 of the 5 delivery units
- The % compliance in March for medical wards directly managed by NPT DU was 97%

What actions are we taking?

- The Executive Medical Director wrote to each of the Unit Medical Directors on 10th February ask them to accelerate the "no discharge summary, no discharge" approach.
- Singleton – all CDs and Clinical Leads have been requested to adopt “no discharge summary, no discharge”. Performance summaries are being provided on a service unit level that include data on discharge summary completeness in order to stimulate improvement
- Morriston has drawn up a 6-month rollout plan for “No e-ToC, no Discharge” implementation, targeting the highest volume discharge areas first. Three wards are taking this forward in March, 4 in April and 5 in May.
- ABMU will be working with the Royal College of Physicians and NHS Wales Informatics Service (NWIS) to improve the e-discharge process so that it will provide information to secondary care users to support their patient care.
- Healthcare Inspectorate Wales (HIW) is undertaking an all Wales thematic review of discharge information. The first part of the review in March will concentrate on Primary Care. We have not received notification of when the review team will be visiting our hospital sites. HIW has commended ABMU for the positive steps it has taken to address poor performance.
- At POW the consultants have been asked to use the ward dashboard which will provide them with their local compliance data to help focus attention on discharge summaries over the next few months and maintain improvement

How do we compare with our peers?

At present ABMU is the only Health Board in Wales that collects and reports their data.

- Risk to patient care and the need for readmission.

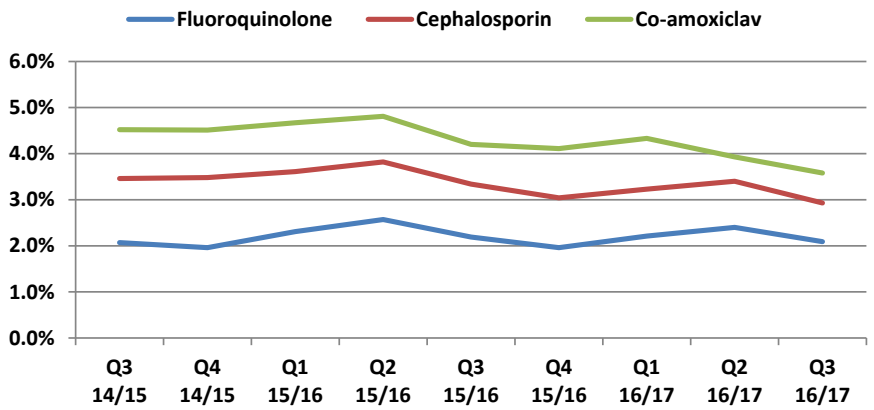
Source : ETOC Dashboard

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

Measure 1: Fluoroquinolone items as a % of total antibacterial items prescribed. - Measure 2: Cephalosporin items as a % of total antibacterial items prescribed.
Measure 3: Co-amoxiclav items as a % of total antibacterial items prescribed

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Rory Farrelly	
Period : Q3 16/17	IMTP Profile Target : N/A	WG Target : Lower Quartile or Show a Reduction (lowest quartiles = [1] < 1.3% [2] < 2.1% [3] < 2.3%)	Current Status : ✓	Movement : Improving

Current Trend: Q3 14/15 - Q3 16/17



How are we doing ?

•Long term prescribing trend in all three indicators is reducing and so demonstrating improvements NB: data will show seasonal variation.

Benchmark

	Fluoroquinolone			Cephalosporin			Co-amoxiclav		
	Current	Previous		Current	Previous		Current	Previous	
LHB	Q3 16/17	Q3 15/16	Q3 14/15	Q3 16/17	Q3 15/16	Q3 14/15	Q3 16/17	Q3 15/16	Q3 14/15
Wales	1.89%	1.93%	2.30%	3.13%	3.54%	4.60%	3.25%	3.60%	4.04%
ABM	2.09%	2.19%	2.54%	2.92%	3.33%	4.05%	3.58%	4.20%	4.52%
AB	1.35%	1.46%	1.78%	2.43%	2.72%	4.07%	3.29%	3.29%	3.44%
BCU	2.18%	2.15%	2.71%	4.05%	4.61%	6.23%	2.56%	2.67%	2.96%
C&V	1.82%	1.81%	2.30%	1.97%	2.43%	3.76%	2.73%	2.90%	3.68%
Ctaf	1.68%	1.63%	1.89%	4.59%	4.67%	5.26%	3.79%	4.66%	5.84%
Hdda	2.03%	2.16%	2.12%	3.15%	3.57%	3.92%	4.00%	4.66%	5.30%
Powys	2.09%	2.19%	2.67%	2.24%	2.91%	3.57%	3.58%	3.87%	3.48%

Improvement from same period in previous year Deterioration from same period in previous year

What actions are we taking?

• A key part of the Heath Board's priority initiative – The Big Fight – aimed at improving antimicrobial stewardship.
• Discussed in all practice annual prescribing visits.
• Included in the GP 2016-17 and 2017-18 Prescribing Management Schemes with incentives to improve quality of prescribing.
• Improved antimicrobial stewardship included in Cluster Plans.
• Significant education programme being delivered to GPs .
• Primary Care Prescribing Guidelines developed and updated, including availability of an app. version to improve accessibility.

How do we compare with our peers?

• Quinolnes – above Welsh average, but significantly reduced over the last few years from historic prescribing position.
• Cephalosporins – below Welsh average.
• Co-amoxiclav – above Welsh average, but currently being focussed on.

What are the main areas of risk?

• Lack of engagement with Big Fight work due to GP workforce pressures.
• Microbiologist capacity across HB.

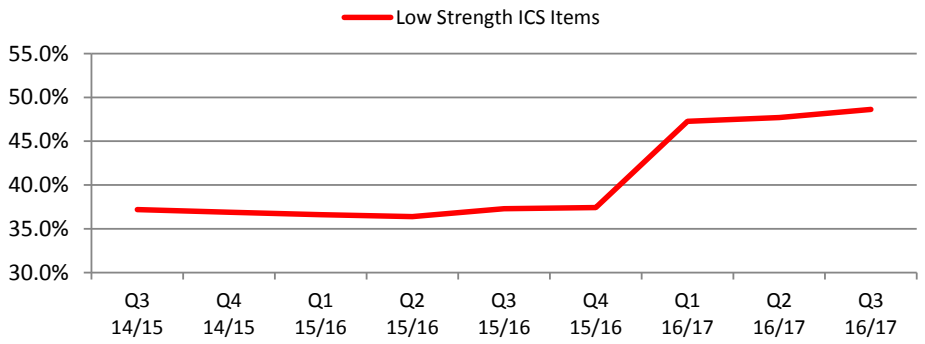
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

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

Measure 1: % of inhaled corticosteroids prescribed in primary care that are low strength

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Q3 16/17	**IMTP Profile Target : N/A**	**WG Target : Upper quartile or show an increase (Upper quartile = >61)**	**Current Status :** ✓	**Movement :** ↓ ● **Improving**

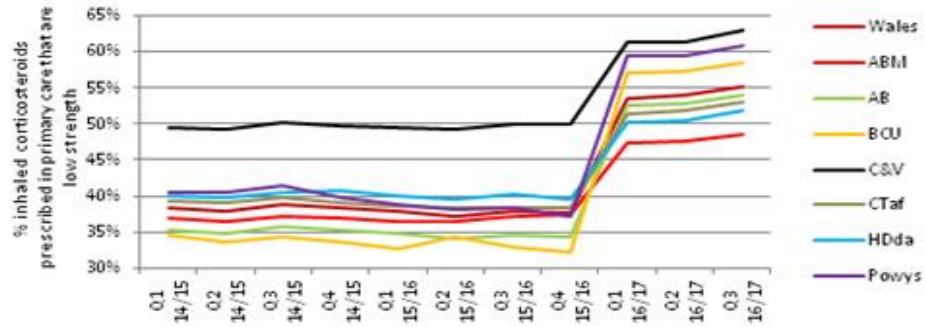
Current Trend: Q3 14/15 - Q3 16/17



How are we doing ?

- The spike in quarter 1 for low strength ICS was due to the fact that the low strength ICS drug basket (and subsequently the threshold) was amended at a national level by Primary Care Services, as certain preparations were originally omitted.
- Prior to this ABMU was also showing a gradual improvement from historically low levels.
- While there has been engagement on increasing levels of cost effective inhalers, achieving step down of doses has been more challenging, due to fears of exacerbation.
- Please note - further amendments to the drug basket may result in further spikes in quarter 4

Benchmark



What actions are we taking?

- The Respiratory Prescribing Management Scheme + is in its second year of operation and aims to support practices and clusters to rationalise respiratory prescribing, including reviewing use of high dose corticosteroids.
- This has also been discussed during the annual prescribing visit to each practice which took place from May 2016 and at educational sessions in Prescribing Leads and Cluster meetings.

How do we compare with our peers?

- While showing some improvement, ABM continues to prescribe the highest level of high dose ICS. This may in part be due to the relatively high prevalence of asthma and COPD.

What are the main areas of risk?

- Fears that reducing ICS doses will cause exacerbations.
- GP workforce pressure and time taken to step patients down.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

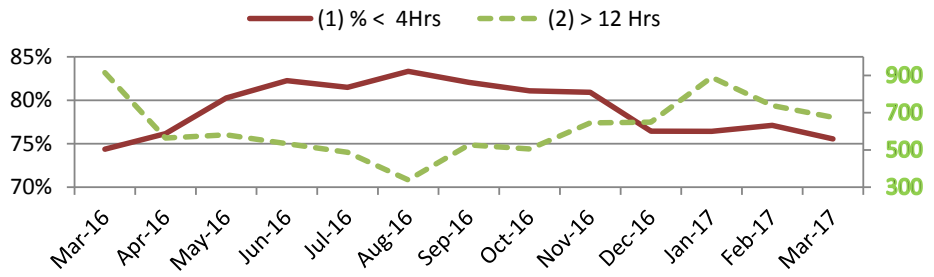
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % new patients spending no longer than 4 hours in an Emergency Department

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 2017	**IMTP Profile Target :** **(1) 95% (2) 140**	**WG Target :** **(1) 95% (2) 0**	**Current Status :** ✖	**Movement :** ↑ ● **Improving**

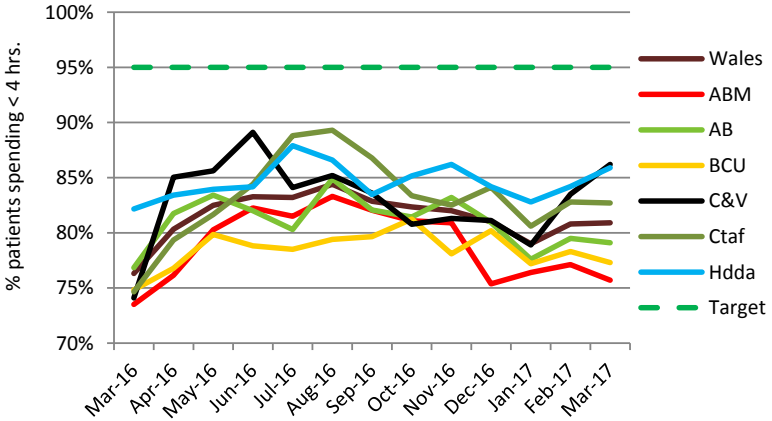
Current Trend: Mar 16- Mar 17



How are we doing ?

- Unscheduled care performance against the 4 hour target in March was 75.7%. This was an improved position when compared to March 2016 (73.5%) although a deterioration when compared to February 2017 (77.1%).
- 677 patients stayed over 12 hours in our Emergency Departments (ED's) during March which was a marked reduction when compared to January and February and also when compared to March 2016.
- Whilst overall the number of patients attending our Emergency departments and minor injuries units has been fairly stable, there was 3% increase in the number of patients requiring an unplanned hospital admission in March 2017 compared with March 2016.

Benchmark



No. > 12 Hrs.

LHB	Mar-17
Wales	3206
ABM	677
AB	573
BCU	1178
C&V	62
Ctaf	292
Hdda	423

What actions are we taking?

- The service delivery units are continued to use surge capacity in March on a targeted basis to support the increase in unscheduled care admissions. An evaluation of the integrated Winter Plan has taken place to inform the development of winter plans for 2017/18.
- There is an ongoing an increased focus on implementation of the SAFER flow bundle to support patient flow and release bed days, with evidence of reductions in the average length of stay for patients. There will be a particular focus on the development of frailty models of care during 2017/18 in light of the increase in the number of patients within this age profile.
- A Health Board wide ambulatory collaborative was held in March showcasing the new and emerging ambulatory care services being developed within the ABMU and to support the ongoing implementation of ambulatory care models during 2017/18.
- Confirming the detailed Unscheduled care improvement plans for 2017/18 to support delivery of the expected performance improvement in Unscheduled Care. Workshops facilitated by ECIP have been scheduled in Morriston Hospital to support the development of this unit's plan which is pivotal to achieving sustainable improvement in the new financial year.

How do we compare with our peers?

- The Health Board's 4 hour performance was 75.7% in March 2017 compared to the all Wales 4 hour performance of 80.9% for this period.
- Whilst 12 hour performance has improved it has continued to be a challenge for the Health Board when compared with performance across Wales.

What are the main areas of risk?

- Capacity gaps in Care Homes, Community Resource Teams. Capacity and fragility of private domiciliary care providers , leading to an increase in the number of patients in hospital who are 'discharge fit'.
- Workforce - with ongoing challenges in nursing, medicine and Social Work capacity.
- Peaks in demand/ patient acuity.
- The impact of infection on available capacity and patient flow.

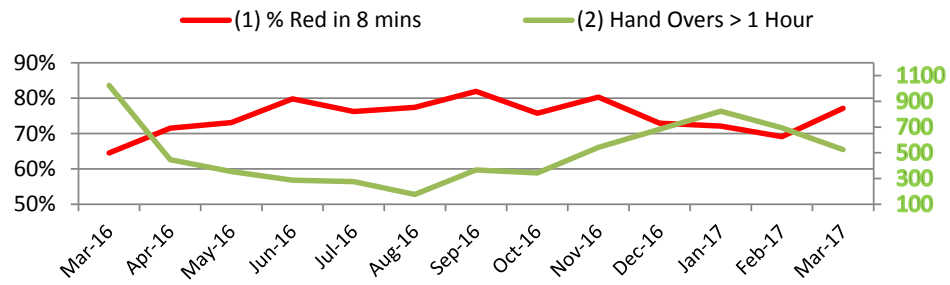
Source : NHS Wales Informatics Service, Emergency Department Dataset (EDDS) APRIL 2017

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

Measure 1:Red calls - % of emergency responses arriving at the scene within 8 minutes (Cat A up to 30/09/15)
Measure 2:Number of patients waiting more than 1 hour for an ambulance handover

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 2017	**IMTP Profile Target :** **(1) 65% (2) 104**	**WG Target :** **(1)65% or above(2) Zero**	**Current Status :** ✖	**Movement :** ↓ ● **Improving**

Current Trend: Mar 16- Mar 17

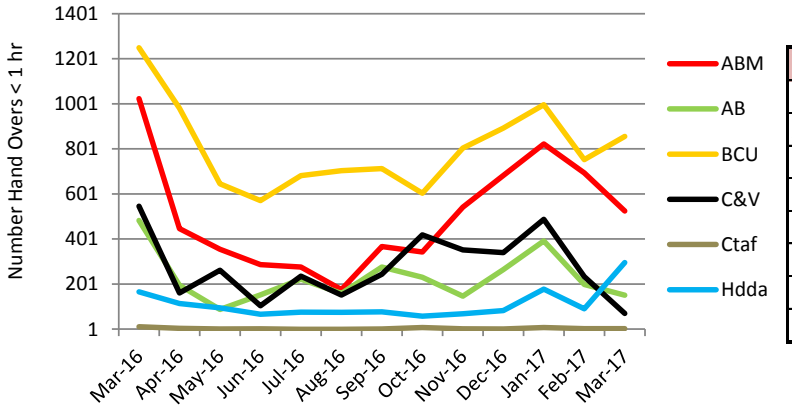


How are we doing ?

• The Health Board's Category A (Red response) was 77.1% in March 2017, against the target of 65%. This was an improving position particularly as the number of Category A patients arriving at our hospitals increased by 17% compared to March 2016.
• 525 patients waited >1 hour to receive ambulance handover from the Health Board in March 2017. This continued the steady reduction from the peak experienced in January 2017, and was a 49% overall reduction in patient handover delays when compared to March 2016. This correlates with a similar trend in terms of a reduction in the number of patients in the Emergency departments who were waiting > 12 hours for admission, discharge or transfer in the month of March

Benchmark

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



% Red ≤ 8 Min

LHB	Mar-17
Wales	77.9%
ABM	77.1%
AB	78.8%
BCU	74.9%
C&V	88.1%
Ctaf	73.8%
Hdda	75.0%
Powys	73.8%

What actions are we taking?

The key to ensuring an effective interface with ambulance services is to improve flow within Emergency Departments so that ambulances can be offloaded safely and quickly. However there are also a range of initiatives in progress including...
• Regular meetings with colleagues in WAST to review and identify opportunities for improvement within the patient handover/ early release/escalation process.
• Ensuring the most appropriate clinical management and signposting of patients as part of the launch of the new 111 service in October. There continues to be good uptake of direct paramedic contact being made with the clinical hub for advice since the formal launch of the 111 service which has correlated with a reduction in the lower acuity (green) conveyances to hospital.
• Continued working with WAST/111 to implement pathways that support admission avoidance, such as a new Health Board wide D&V pathway. The non injury falls service will be a key focus for 2017/18 to determine the optimum model for this service, as patient falls generate the highest request for an ambulance response within ABMU Health Board.

How do we compare with our peers?

• ABMU performance against the Category A - Red calls target of 77.1% in March compared well against the all-Wales average performance of 77.9%. Continued improvement in handover performance remains a key focus.

What are the main areas of risk?

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

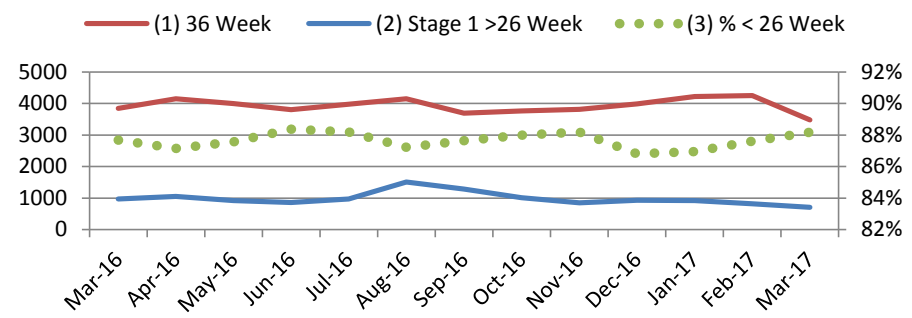
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Rory Farrelly	
Period : Mar 2017	IMTP Profile Target : (1)2857, (2) N/A, (3) 90.01%	WG Target : (1) 0 (2) 0 (3) 95%	Current Status : ✗	Movement : ↓ ● Improving

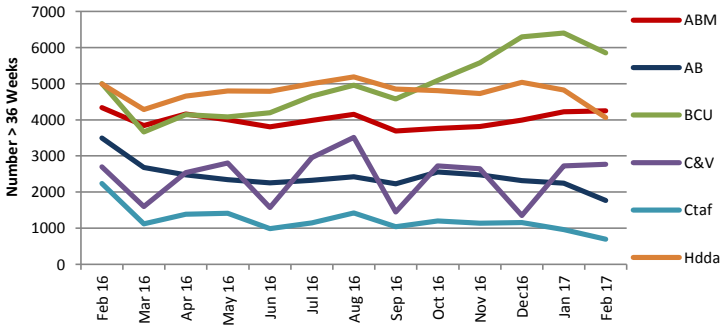
Current Trend: Mar 16- Mar 17



How are we doing ?

- In March 2017 the number of patients waiting over 36 weeks reduced by 768 in-month (from 4,253 to 3,485) and reduced by 358 compared with March 2016 (3,843 to 3,485).
- ENT, General Surgery, Oral/ Maxillo Facial (OMF) and Orthopaedics collectively account for 3,180 of the 3,485 over 36 weeks at March 2017 with 98% of the patients waiting over 36 weeks all in the treatment stage of their pathway.
- 1,275 patients are waiting over 52 weeks in March 2017 which is 2% fewer patients than in March 2016 and 5% less patients than February 2017.
- The number waiting over 26 weeks for a first outpatient appointment continues to see monthly improvement with a reduction of 269 in March 2017 compared to March 2016 (from 973 to 704) and is largely contained within Gastroenterology and Ophthalmology.
- The overall Health Board RTT target improved in March 2017 from 87.61% to 88.17%.

Benchmark



% > 26 weeks

LHB	Feb 17
Wales	87.0%
ABM	87.6%
AB	89.4%
BCU	85.5%
C&V	85.4%
Ctaf	90.8%
Hdda	83.8%

What actions are we taking?

- Weekly Executive led performance meetings with the each Service Delivery Unit (SDU) to closely monitor their forecast positions against their RTT delivery plan profiles for 2017/18, with a specific focus on the delivery of efficiency and productivity gains built into plans and not requiring investment.
- Funding of c£150k for April 2017 agreed and fed out to SDUs to maintain outpatient and diagnostic endoscopy waits with an element released for Orthopaedic backfill on the basis that the cost of recovering activity is significant for this specialty.
- Clinical review of longest waiting patients and review of chronological appointing to be undertaken during May.
- Each SDU to be set a Quarter 1 delivery target to maintain their March 2017 position across each of the measures. Funding to be allocated to the SDUs to support plans to deliver this on the basis of maximum benefit for minimal investment.

How do we compare with our peers?

- As at the end of February 2017, which is the latest published data available, ABMU was above the all-Wales position for the percentage of patients waiting less than 26 weeks for referral to treatment (RTT) (87.6% compared with 87.0%) however, was the second worst Health Board in Wales for the number of patients waiting over 36 weeks.

What are the main areas of risk?

- Impact of unscheduled care and trauma as a result of seasonal pressures.
- Priority of cancer and clinically urgent patients over routine long waiting patients.
- Anaesthetic and theatre workforce gaps.
- Containment of ring fenced beds and ability of private sector to deliver agreed outsourced activity.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

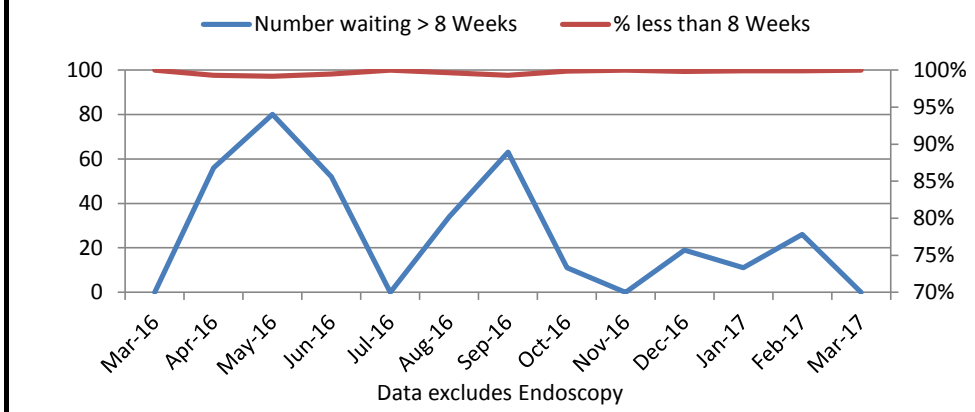
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 2017	**IMTP Profile Target : (1) 0 (2) 100%**	**WG Target : Zero**	**Current Status :** ✓	**Movement :** ↑ ● **Improving**

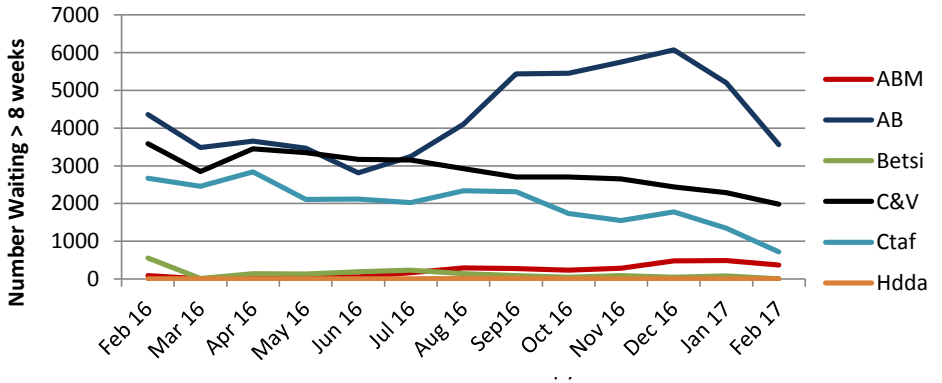
Current Trend: Mar 16- Mar 17



How are we doing ?

• There were no patients waiting over 8 weeks for reportable diagnostics as at the end of March 2017.

Benchmark



• Executive led weekly performance meetings are planned to continue to support the Service Delivery Units in scoping, agreeing and implementing solutions to sustain a nil position through Quarter 1 of 2017/18.

How do we compare with our peers?

• As at the end of February 2017, which is the latest published data available at the time of writing this report, ABMU was the third best performing Health Board excluding Powys.

What are the main areas of risk?

• Routine activity being displaced by urgent and cancer patients.
• Breakdown of equipment.
• Workforce constraints in key professional groups (nationally and locally).

Source : https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-weekswait-hospital

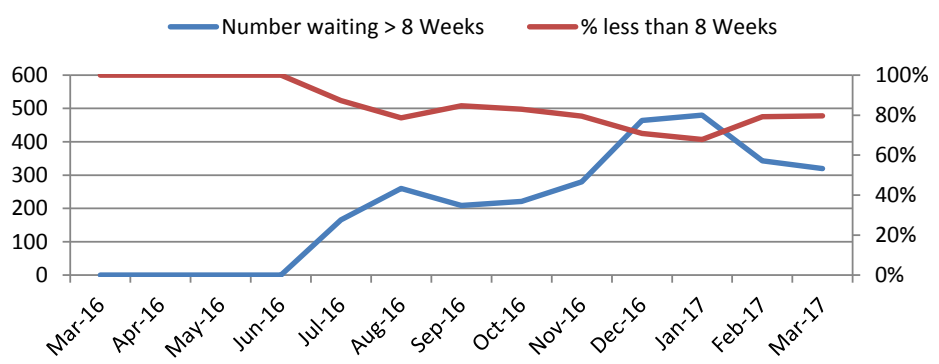
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Measure 2: % patients waiting less than 8 weeks for Endoscopy

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 2017	**IMTP Profile Target : (1) 0 (2) N/A**	**WG Target : Improve**	**Current Status :** ✖	**Movement :** ↓ ● **Worsening**

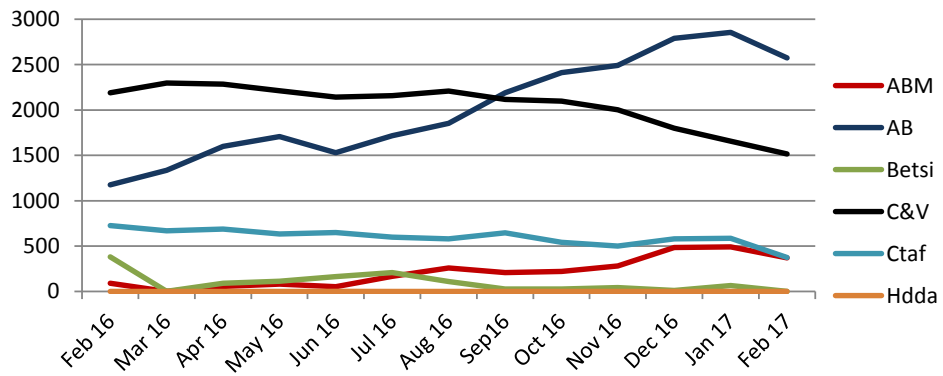
Current Trend: Mar 16- mar 17



How are we doing ?

- ABMU Health Board has 319 patients waiting over 8 weeks for endoscopy as at the end of March 2017. 80% of patients were booked within the 8 week target.
- Endoscopy has continued to see a significant increase in urgent suspected cancer referrals. The majority of the increase has been in the area of Lower Gastrointestinal referrals internally from surgical specialties.
- DNA rates continue to remain low at 3%.

Benchmark



What actions are we taking?

- Utilising all available capacity with an average of 30 backfill lists being undertaken per month - current agreement for funding until end of April 2017.
- Capacity Plans being reviewed to ensure that capacity is being maximised on all sites (this is a weekly ongoing process). Improved position on the January over 8 week position.
- Further Gastroenterologist commenced in September 2016 which is providing one endoscopy session in Neath Port Talbot Hospital to cover current vacant sessions.
- Development of alternative diagnostic pathways in partnership with Radiology (CT Colongraphy)
- Continued focus on effective triage of referrals.
- Configuring rotas to reduce variation in the service model across the Health Board.

How do we compare with our peers?

- ABMU endoscopy performance continues to be good in comparison with the rest of Wales

What are the main areas of risk?

- Routine activity being displaced by cancer, urgent and RTT patients with significant pressures in Gastroenterology and an increase in USC referrals in recent months which will exceed capacity.
- Ability to maintain the number of additional sessions undertaken with a very small pool of scopers; Funding currently agreed through IMTP to continue backfilling of lists until end of April 2017.

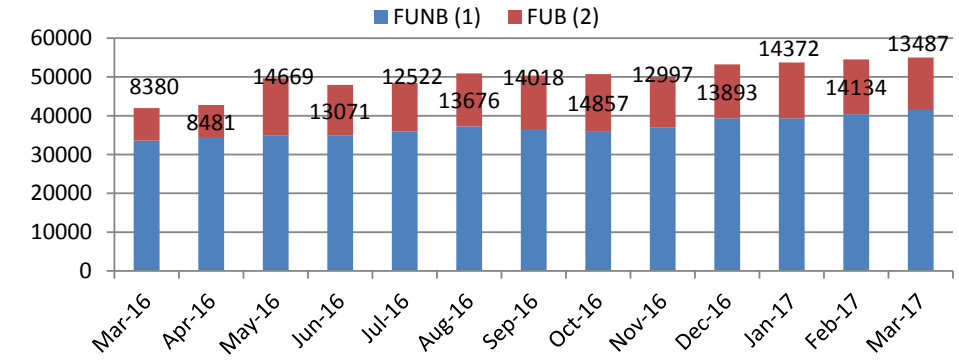
Source : https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-weekswait-hospital

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

Measure 1: Total number of not booked patients waiting for a follow up appointment delayed past their target date
Measure 2: Total number of booked patients waiting for a follow up appointment delayed past their target date

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Rory Farrelly	
Period : Mar 2017	IMTP Profile Target : 33,580	WG Target : Reduction	Current Status :	Movement : Worsening

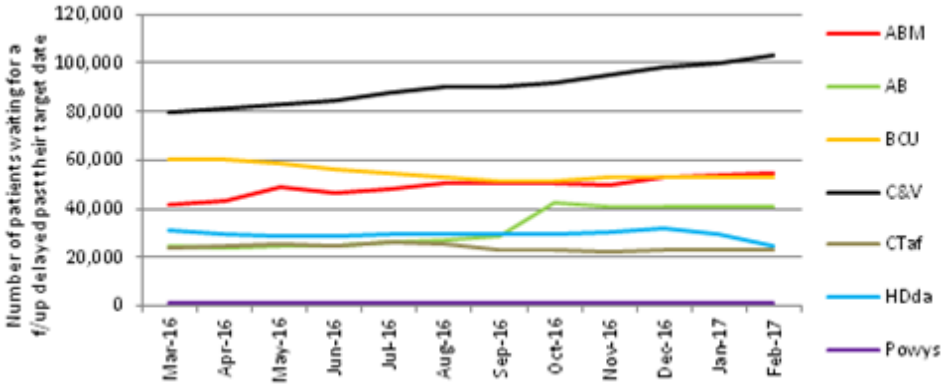
Current Trend: Mar 16- Mar 17



How are we doing ?

- The number of patients waiting for a follow up appointment delayed past their target date (booked and non booked) has increased from 41,980 (Mar 16) to 54,993 (Mar 17).
- Delayed Follow Up (Not Booked):In-month performance has slightly deteriorated with an increase in the number of not booked patients waiting for a follow up appointment delayed past their target date from 40,396 to 41,506.
- Delayed Follow Up (Booked): In-month performance has improved with a decrease in the number of booked patients waiting for a follow up appointment delayed past their target date from 14,134 to 13,487.

Benchmark



What actions are we taking?

- Weekly reporting of outpatient delays including booked and not booked delays to ensure complete understanding of the total size of the problem with delayed appointments.
- Outpatient Improvement Group to discuss at April 2017 meeting:

- work being undertaken by the delivery units to review culture and process for follow up to match the best in class performance, in line with financial recovery and sustainability baseline assessment;
- opportunities to appropriately reduce the number of follow up appointments offered to patients;
- service delivery focus on longest delayed patients and solutions to manage risk;
- evaluation of service changes adopted to address delayed follow ups.

- Wales Audit Office (WAO) has undertaken a follow-up audit to the 2015 review of follow-up outpatient appointments. Focus was given to assurance, scrutiny and reporting mechanisms; clinical risks on longest waiting patients; underlying issues for follow up backlog. A report is awaited from the WAO with further recommendations.

How do we compare with our peers?

From March 2016 to February 2017 BCU and HD have experienced a reduction in the number of patients waiting for a follow up appointment past their target date; AB, ABMU, C&V an increase with Ctaf and Powys stable.

What are the main areas of risk?

- Wales Audit Office review (2015) highlighted several risks including too many patients delayed with clinical risks not fully known; operational planning, scrutiny and assurance to be improved;
- Need to better prioritise validation activities. Service Delivery Units to provide regular assurance reports to Health Board Quality & Safety Committee, Outpatient Improvement Group and Planned Care Supporting Delivery Board.

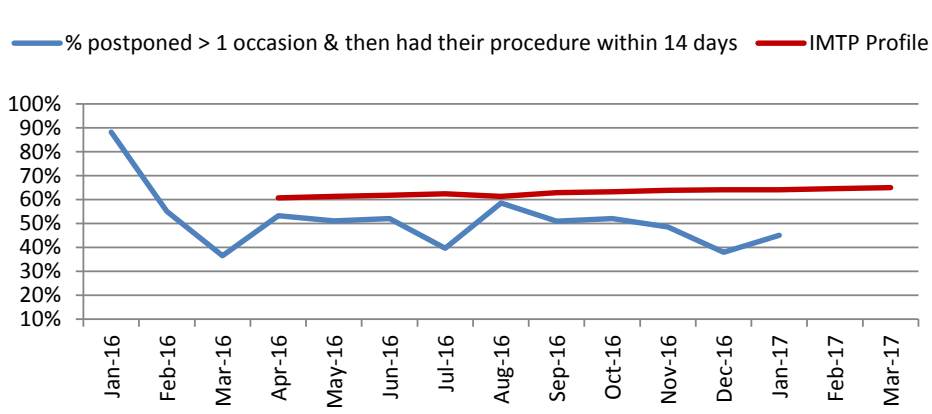
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Jan 2017	**IMTP Profile Target : 65.0%**	**WG Target : Improve**	**Current Status :** ✖	**Movement :** ↓ ● **Worsening**

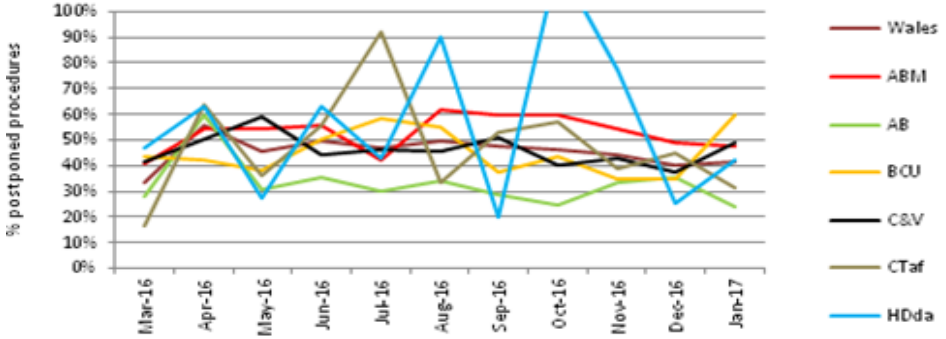
Current Trend: Jan 16 -Jan 17



How are we doing ?

- Percentages continue to fluctuate month on month due to the relatively small numbers involved.
- It is important to note that the data only represents those patients who have had their procedure within 14 days of their last postponed appointment and does not capture those patients who have chosen to have their procedure undertaken at their earliest convenience as Myrddin is currently unable to record this. 14 days does not constitute a reasonable offer under the Referral to Treatment (RTT) rules.
- Out of the 128 patients in January 2017 who had their procedure postponed on more than one occasion, 57 had their procedure carried out within the proceeding 14 days.

Benchmark



What actions are we taking?

- Escalate the development work required within the Myrddin Patient Administration System (PAS) to enable the health board to appropriately record and measure whether the appointment offered to undertake the procedure is at the patients earliest convenience, with the aim to have this functionality in place by September 2017.
- Review routine site management arrangements for cancellations and postponements to assure the health board that robust systems are in place to ensure patients are being re-booked at their earliest convenience. Review to be undertaken by June 2017.

How do we compare with our peers?

- As at the end of January 2017, which is the latest published data available at the time of writing this report, ABMU performance was 45% compared with the all-Wales performance of 41.4%. ABMU is above the all-Wales position for this measure and is the third best performing Health Board.

What are the main areas of risk?

- Continuing pressures on bed capacity as a result of unscheduled care demand.
- Priority of cancer and urgent patients ahead of routine activity.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

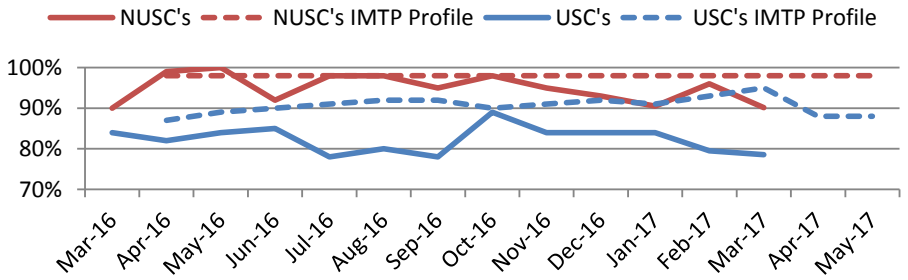
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 2017	**IMTP Profile Target :** **(1) 98% (2) 91%**	**WG Target :** **(1) 98% or above (2) 95% or above**	**Current Status :** ✖	**Movement :** ↓ ● **Worsening**

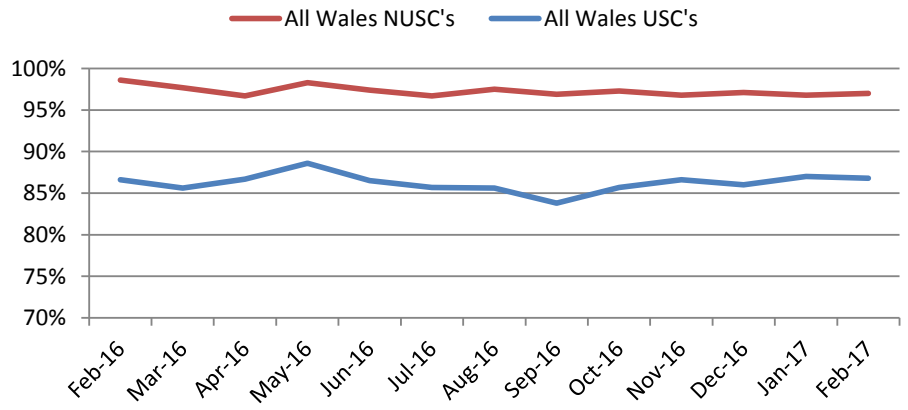
Current Trend: Jan 16- Mar 17



How are we doing ?

- NUSC performance in March 2017 is reporting 91% (13 breaches).
- USC performance in March 2017 is currently reporting 79% (29 breaches).
- USC Referrals received by the Health Board remain high. The monthly average during the 13 months Mar 16 to Mar 17, was 1780. March saw 1915 referrals received..
- The overall backlog position continues to fluctuate but did decrease through March to a peak of 88 at the 2nd April. The biggest improvement was seen in patients over 62 days with a reduction to 45 at the 9th April.

Benchmark



What actions are we taking?

•Action Plans to improve Cancer Performance / solutions to identified gaps have been prepared by Delivery units and are being discussed at the May Cancer Board, with revenue implications being agreed by the end of May - action plans have timescales and deliverables within them.

• Gastro/Endoscopy is currently being reviewed with improvements being implemented as they are identified.• Programmed timetable for clinicians to attend the Cancer Delivery Board over the next 12 months has been prepared and commences in June for improving MDT scrutiny of cancer performance. • Additional information analysis is targeting the development of a Cancer Dashboard, and access to cancer Information sharing. • Replacement Mammography equipment for Singleton in place and new Pathology Processers and Stainers are being commissioned over the next 4 months - impact in performance is being monitored once completed • Allocation of an SPA session to be agreed with each MDT Clinical Lead once agreed by the Medical Director – decision required within the next 4 weeks. Meeting scheduled for 18th May with MDT leads, managers and other stakeholders to discuss function and improvement.

How do we compare with our peers?

- USC performance continues to struggle in comparison with other Health Boards.
- Backlog in Wales remains high, with BCU and C&V and Cwm Taf reporting higher numbers than ABM, although this does not appear to translate into reported breaches.

What are the main areas of risk?

- Vacancies continue at Consultant level in key tumour sites - Gastroenterology; Oncology and Radiology.
- Long Term Sickness of key clinical staff – i.e. Gynaecology. • Service pressures within Urology continue at POWH, resulting in delays across most aspects of patient pathways. • Breast radiologist availability/vacancy for 1 stop clinic at Singleton resulting in long waits to first assessment. Consultant Breast surgeon leaving organisation at the end of May. • Large volume USC referrals. • Unscheduled Care pressures resulting in cancelled and/or delayed procedures

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

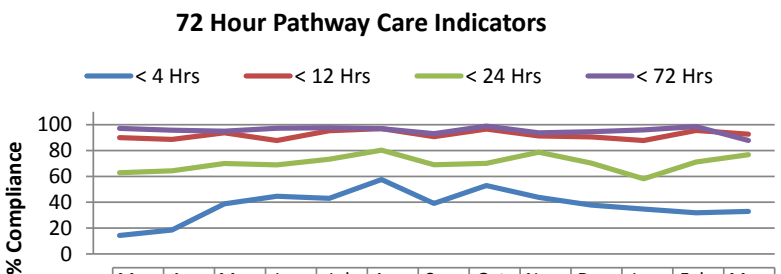
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Rory Farrelly	
Period : Mar-17	IMTP Profile Target : (1)70% (2)95% (3)80% (4)97%	WG Target : > 95%	Current Status :	Movement : Improving

Current Trend: Mar 16 - Mar 17

How are we doing ?



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
< 4 Hrs	14.3	18.6	38.8	44.6	43.0	57.6	39.1	52.9	43.8	37.8	34.7	31.8	32.9
< 12 Hrs	90.0	88.6	93.8	87.8	95.3	97.0	90.8	96.6	91.3	90.5	87.8	95.5	92.7
< 24 Hrs	62.9	64.3	70.0	68.9	73.3	80.3	69.0	70.1	78.8	70.3	58.2	71.2	76.8
< 72 Hrs	97.1	95.7	95.0	97.3	97.7	97.0	93.1	98.9	93.8	94.6	95.9	98.5	87.8

• The Stroke Quality Improvement Measures and thrombolysis measures are : less than 4 hours for patients to be admitted directly to an Acute stroke unit and the swallow screening assessment undertaken, less than 12 hours for access to a CT scan, less than 24 hours for assessment by a stroke doctor, stroke nurse and assessment by an occupational therapist, physiotherapist or speech and language therapist, and less than 72 hours for formal swallow assessment, occupational therapist assessment, physiotherapist assessment and speech therapist communications assessment. All measures have an assigned target of 95%. New thrombolysis targets for patients who meet the criteria for this intervention were also introduced in October 2015.
• Health Board performance in March saw improvement against the 4 and 24 hour bundles but a deterioration against the 12 and 72 hour bundles. The reasons for this included capacity in the small medical and nursing stroke teams which impacts upon their ability to provide a 7 day service, and increased demands on the medical teams as a result of unscheduled care pressures, particularly in the out of hours period.

Benchmark

72 Hour Care Indicators Mar-17	AB	ABM	BCU	C&V	CTaf	HDda
1. < 4 Hours Care Indicators	36.7%	32.9%	45.1%	46.3%	50.0%	71.4%
2. < 12 Hours Care Indicators	97.5%	92.7%	90.2%	100.0%	97.0%	97.4%
3. < 24 Hours Care Indicators	73.4%	76.8%	85.4%	73.2%	75.8%	67.5%
4. < 72 Hours Care Indicators	91.1%	87.8%	96.3%	82.9%	97.0%	94.8%

Thrombolysis Indicators Mar-17	AB	ABM	BCU	C&V	CTaf	HDda
1. Access						
1a - % All Strokes Thrombolsyed	17.7%	8.5%	9.8%	17.1%	10.6%	15.6%
2b - % Eligible Patients Thrombolsyed	100.0%	87.5%	88.9%	100.0%	100.0%	100.0%
2. Time						
1a - Door-to-Needle <= 30 mins	21.4%	0.0%	0.0%	0.0%	0.0%	16.7%
2b - Door-to-Needle <= 45 mins	28.6%	14.3%	50.0%	14.3%	14.3%	33.3%
3c - Onset to-Needle <= 90 mins	14.3%	0.0%	25.0%	0.0%	0.0%	25.0%
4d - % with Pre and Post NIHSS Score	100.0%	100.0%	100.0%	100.0%	85.7%	75.0%

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

What actions are we taking?

Improvements in this area continue to be overseen by monthly meetings of the ABMU Health Board stroke steering group and weekly multi disciplinary team meetings in Morriston and Princess of Wales hospitals to review individual patient pathways and to identify opportunities for improvement against the respective stroke quality measures. Key actions being progressed include:

Morriston

• Ongoing recruitment to medical and nursing staff to work on the acute stroke unit. This remains critical to the sustainable delivery of the 4 hr target for 2017/18. New Band 3 nursing roles are bringing benefit to the acute stroke ward • 7 day Clinical Nurse Specialist cover will be reinstated in April following a period of staff sickness and vacancy.

PoWH

• Introduction of a new ED checklist for swallow screen training which improved performance from the end of March and into April.
• Stroke specialist nurse capacity has returned to full complement in April following a period of sickness absence, providing extended cover from 8-8 from early May. • Auditing 7 day therapy working to assess impact on flow and stroke performance.

ABMU wide

• Shared learning with other Health Boards to highlight opportunities to improve patient flow and access to stroke care.
• Ongoing planning in terms of working towards the HASU model for ABMU Health Board.

How do we compare with our peers?

Performance against the quality improvement measures in March was broadly comparable with other Health Boards in Wales. However the 4 hour and 24 hour access measures remain challenging as a result of staffing constraints and overall unscheduled care pressures.

What are the main areas of risk?

• Insufficient capacity in medical workforce to support 7 day working which will ultimately require a strategic change to centralise acute stroke services.
•Nurse staffing levels at ward level and capacity within the clinical nurse specialist team owing to sickness.

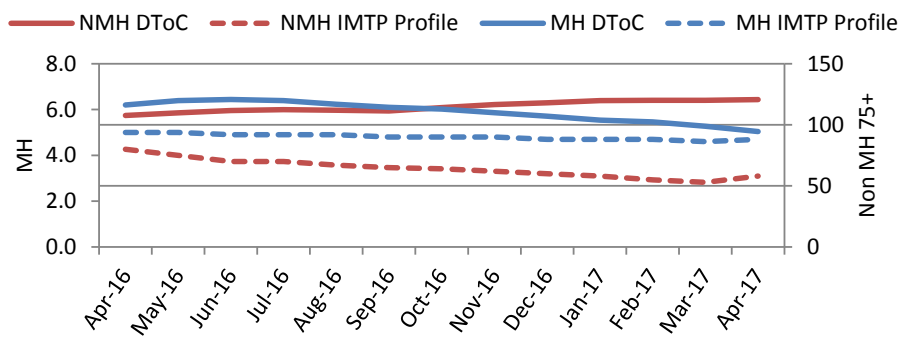
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017) + ACUTE STROKE QUALITY IMPROVEMENT MEASURES DU REPORT

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

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Rory Farrelly	
Period : Apr 2017	IMTP Profile Target : (1) 4.7 (2) 58	WG Target : Improve	Current Status : ✗	Movement : ▲ ● Worsening

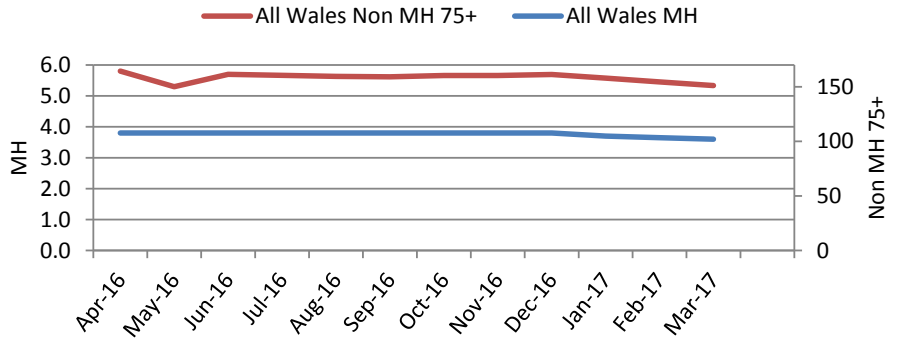
Current Trend: Apr 16- Apr 17



How are we doing ?

• The total number of patients classified as a delayed transfer in April was 71 - which has been fairly static over the winter months. Reducing discharge delays for our patients continues to be a key focus within the Health Board. The main reasons contributing towards a delayed discharge include Community Care assessment, Healthcare Assessment, and the selection and availability of a care home placement.

Benchmark



What actions are we taking?

• Continued implementation of recommendations regarding effective discharge planning, with a particular focus on earlier communication with patients and families on the quality and safety benefits of earlier discharge. This will be supported by a Health Board wide campaign during 2017/18.
• Joint work with Local Authorities (LA's) regarding options to support the provision of sustainable capacity in the care home and domiciliary care sectors. This will be supported by the findings of an external review by the Health Board to inform the optimum level of capacity required in community services to both support admission avoidance and to reduce delays in discharge.
• Health Board participation and learning from the National Unscheduled care event on 11th April on improving transfers of care for people in Wales.
• Good progress on adult mental health DTOCs with pathways into rehabilitation services working well. Increase in Bridgend Older People's DTOC linked to issues around patient choice.

How do we compare with our peers?

Delayed transfers of care continue to be a challenge for many Health Boards across Wales. ABMU Health Board compares comparatively well against the national benchmark for non mental health delays, but is slightly above the benchmark for mental health delays.

What are the main areas of risk?

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

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

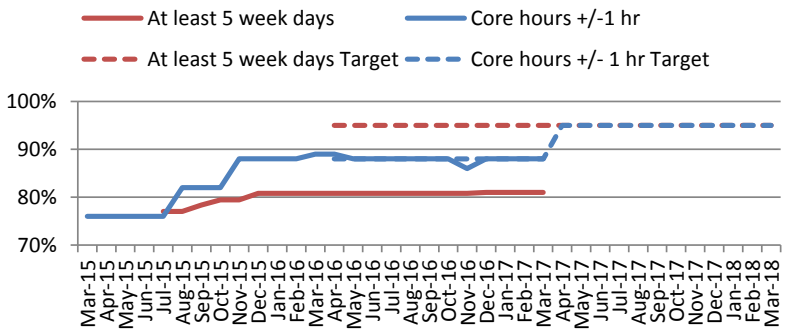
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Measure 2: % GP practices open during the daily core hours or within 1 hour of daily core hours

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Mar 2017	**IMTP Profile Target : (1) 95% (2) 88%**	**WG Target : Improve**	**Current Status :**	**Movement : Worsening**

Current Trend: Mar 15 - Mar 17



How are we doing ?

- As at 30 November 2016 59/73 practices (81%) offered appointments between 5 and 6:30pm a minimum of 5 days per week; 63/73 practices (86%) open during daily core hours.
- 4 practices have half day closures

Benchmark

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

What actions are we taking?

- The Unit's Access and Sustainability Forum continue to meet quarterly with an aim of driving forward improved and sustainable access within Primary Care General Medical Services.
- The Access and Sustainability Forum agreed the Telephone First Model which has identified standards and definitions of a telephone consultation system to be endorsed by service management board in May 2017
- The Unit has completed its engagement with key stakeholders on the development of a Primary & Community Services Strat
- Two additional GPs have been appointed to the Practice Support Team and an SLA is now in place to enable the team to offer direct support and improvement advice to practices with sustainability issues, this will improve resilience and help mitigate sustainability risks.
- All practices will receive by the end of April 2017 a prepopulated national sustainability risk matrix and will be required to consider as part of the development of their 3 year Practice Development Plan to strengthen the focus on access to services to be returned to the Unit by 31st May.

How do we compare with our peers?

At December 2015 the ABMU position was above the Welsh Average with:

- 81% of ABMU practices were open >5 nights per week.
- 86% of practices now opening 47.5 hours per week.

What are the main areas of risk?

- Reports of sustainability issues with difficulty in recruitment and retention of GPs plus a continuing issue in securing locum cover and associated costs.
- Practices will seek to manage their resources and workload by restricting or changing access arrangements that are not considered acceptable by patients, including reviewing their practice boundaries leading to complaints.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

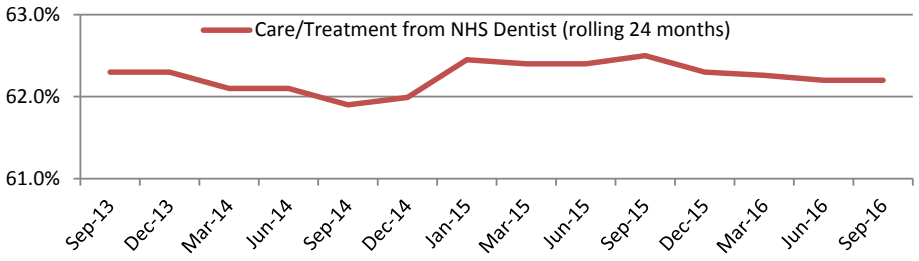
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access | **Executive Lead : Rory Farrelly**

Period: Sep 2016 | **IMTP Profile Target :** | **WG Target : Improve** | **Current Status :** ✓ | **Movement :** ↑ ● **Improving**

Current Trend: Sep 13 -Sep 16



Patient Group	No. of Patients receiving NHS Treatment in ABMU for 2 years to:			
	Sep 14	Sep 15	Sep 16	Change, 2014-16
Adults	245,743	249,408	248,810	+1.2%
Children	76,670	77,347	77,924	+1.64%
Total	322,413	326,755	326,734	+1.3%

Stats Wales

How are we doing ?

• The known position remains unchanged until the March 2017 data is made available. The latest Stats Wales release confirmed the number and percentage of adults and children who had received NHS treatment in the period up to September 2016, and indicated a relatively steady position, with a small but significant increase in children and adults seen over a 2 year period, but a slight drop in adults seen from 2015 - 2016

• Demand for an NHS dentist continues to outstrip supply of contracted activity in much of ABMU, central Swansea and Neath and Port Talbot areas in particular. However, targeted input into in-hours urgent access enables those patients without a regular dentist to access general dental care should they require it.

• Although there was a downturn to 0 in practices taking on NEW patients at the end of the financial/activity year, the year end contractual position indicates a significant increase in performance against contracts from previous years, with almost 95% reaching the 95% minimum required, 26% achieving 100% (the latter an increase of approximately 20%).

Benchmark

LHB	Current	Same Period Comparison		
	Sep-16	Sep-15	Sep-14	Sep-13
Wales	54.8%	54.8%	54.6%	54.7%
ABM	62.2%	62.5%	61.9%	62.3%
AB	56.7%	56.8%	56.3%	56.3%
BCU	49.7%	50.1%	50.4%	50.9%
C&V	56.1%	55.6%	55.2%	54.8%
Ctaf	57.4%	57.2%	57.6%	58.0%
Hdda	46.0%	45.2%	44.7%	44.8%

What actions are we taking?

• Incentivising contractors to achieve 100% of their target by allowing them in 2016/7 to over perform up to 5%, rolling into 2017/18 - hence improved performance reported above

•Reviewing all children only contracts to expand to full contracts accepting all categories of patients or termination to reinvest in areas of high need.

• Supporting 2 dental prototype contracts in Swansea (only Welsh LHB), Additional interest in the ABMU area in a model to advise on contract reform and support different skill-mix/ways of working

• Reestablished orthodontic Managed Clinical Network to oversee the provision of orthodontic services in the area to agreed clinical standards.

•Strategic Framework for dental services over next 3 yrs in development with Executive support to utilise dental underspend to increase provision in identified areas of high demand

• From mid-June 2017, single point of access to manage and evaluate paediatric referrals to ensure that patients receive care in most appropriate care setting

How do we compare with our peers?

• In the 24 months to September 2016, ABMU maintained its position as provider to the highest percentage of patients (adults and children) in Wales. This figure has remained static over the period.

What are the main areas of risk?

The inflexibility of the NHS Dental contract (e.g. constraints around the timing for contract reductions) may mean that the Health Board is unable to reduce contracts in order to commission additional access in areas of most need.

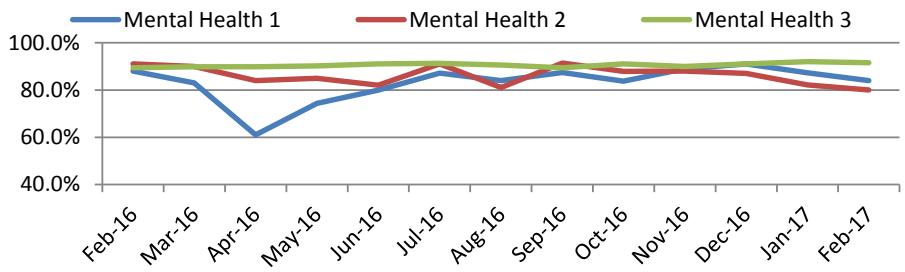
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017), STATS WALES

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

Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral
Measure 2: % of therapeutic interventions started within 28 days following an assessment by LPMHSS (up to 31/10/15 was 56 days)
Measure 3:% of Health Board residents in receipt of secondary Mental Health services (all ages) to have a valid Care and Treatment Plan (CTP)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Rory Farrelly**	
Period : Feb 2016	**IMTP Profile Target :** **(1)80% (2) 80% (3) 90% (4) 100%**	**WG Target :** **(1)80% (2) 90% (3) 90% (4) 100%**	**Current Status :** ✓	**Movement :** ↓ ● **Worsening**

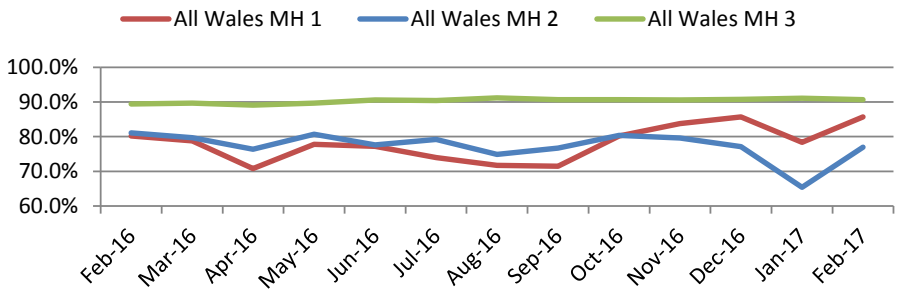
Current Trend: Feb 16- Feb 17



How are we doing ?

• Mental Health 1 - ABMU met the target from June to February 2017, and has been consistently higher than the All Wales figures since May. February's figure was 84%.
• Mental Health 2 - intervention levels have remained above target 80% from April to February 2017. February's figure was 80%.
• Mental Health 3 - This data covers Adult, Older People, CAMHS and Learning Disability Services. ABMU met the target from April to August, but there has been a marginal dip in September to 89.4%, but has remained above target from October to February 2017. February's figure was 92%.

Benchmark



What actions are we taking?

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

How do we compare with our peers?

February 2017
- All-Wales MH1 measure ranged from 75.7% to 95% ABM 90.9%
- All-Wales MH2 measure ranged from 53.3% to 90.8 % ABM 80%
- All-Wales MH3 measure ranged from 86.2% to 93.3 % ABM 91.5%

What are the main areas of risk?

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

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

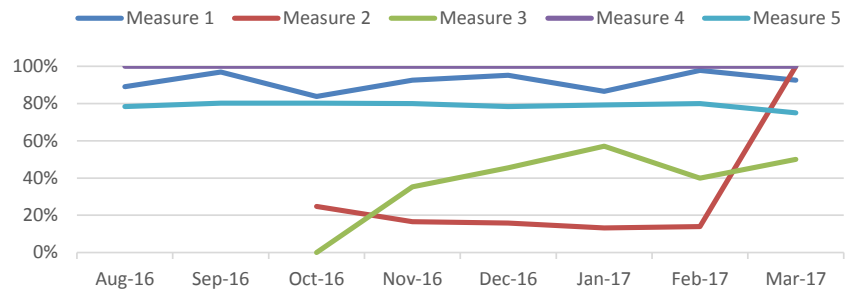
INDIVIDUAL CARE -PEOPLE IN WALES ARE TREATED AS INDIVIDUALS WITH THEIR OWN NEEDS AND RESPONSIBILITIES

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access | **Executive Lead : Siân Harrop-Griffiths**

Period : Mar-17	**IMTP Profile Target :**	**WG Target :** (1)100% (2) 100% (3) 100% (4) 100% (5) 90%	**Current Status :**	**Movement :**

Current Trend: Aug 16 - Mar 17



	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
% of urgent assessments undertaken within 48 hours from receipt of referral	83.8%	92.6%	95.2%	86.5%	97.8%	92.5%
% of routine assessments undertaken within 28 days from receipt of referral	24.7%	16.6%	15.8%	13.2%	14.0%	100.0%
% of patients with NDD receiving diagnostic assessment and intervention within 26 weeks	0.0%	35.3%	45.5%	57.1%	40.0%	50.0%
% of therapeutic interventions started within 28 days following assessment by LPMHSS	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
% of Health Board residents in receipt of CAMHS who have a Care and Treatment Plan	80.2%	80.0%	78.4%	79.2%	80.0%	75.0%

How are we doing ?

• Measure 1: 92.5% of urgent assessments by CAMHS undertaken within 48 hours of receipt of referral. The trend for this measure highlights that performance can fluctuate, and performance peaked to 100% in February.
• Measure 2: 100% of routine assessments by CAMHS for ABMU residents undertaken within 28 days from receipt of referral. Definition of this measure has been modified to align with what is reported to Welsh Government. Investigation underway to obtain retrospective performance using the revised definition.
• Measure 3: 50% of patients with a neuro-developmental disorder are receiving diagnostic assessment within 28 weeks. Performance is currently on an upward trend.
•Measure 4: 100% target achieved (relates to specialist CAMHS only).
• Measure 5: 75% of Health Board residents in receipt of CAMHS have a valid Care and Treatment Plan. Over the last 8 months 78%-80% compliance has been achieved.

What actions are we taking?

Q1 2017/18

• NDD provision for children will no longer sit within CAMHS Services, and work is being carried out by the Singleton Delivery Unit to scope and develop the Service.
• A dedicated consultant for NDD started on the 1st January 2017, and further recruitment activity in relation to the MDT is anticipated during Quarter 1.
• An outlined Service Specification has been developed for tiers 3 & 4, and regular monitoring arrangements have been agreed. Awaiting outcome of gap analysis exercise to be undertaken by Cwmt Taf (expected April 2017)
•Development of service model for tier 1/2 services with local authority colleagues from February 2017. Work to be scoped during quarter 1 of 2017/18.
• Waiting list initiative in place for Measure 2 to achieve by end March 2017.
• Waiting list initiative in place for Measure 3 to make significant progress by end March 2017 and achieve target by end July 2017.

How do we compare with our peers?

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

What are the main areas of risk?

• Whilst the data in this report highlights a lack of compliance - assurance has been received from CAMHS that the position is much improved as a result of the waiting list Initiatives . As a result of the Initiatives and the transfer of the ND Service to Child Health the Specialist CAMHS Service was compliant with measure 2 by 31st March 2017.

Source : Cwm Taf UHB

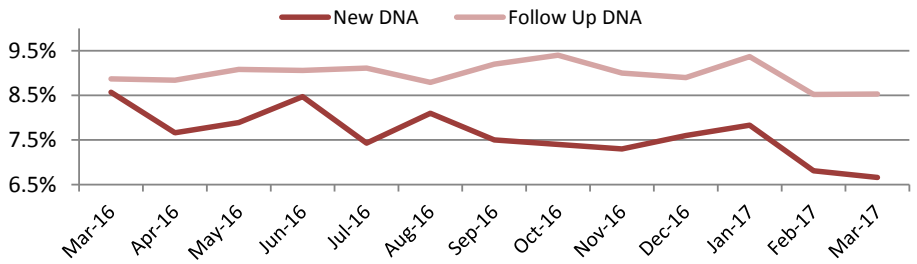
OUR STAFF & RESOURCES - PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

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

Corporate Objective : Demonstrating Value & Sustainability | **Executive Lead : Rory Farrelly**

Period : Mar 2017	IMTP Profile Target : 8.41%	WG Target : Reduction	Current Status :	Movement : Improving

Current Trend: Mar 16- Mar 17



Specific Specialties:
- The specialties include General Surgery, Urology, T&O, ENT, Ophthalmology, Oral Surgery, Neurosurgery, Combined Medicine, Dermatology, Rheumatology, Paediatrics and Gynaecology
- Figures are rounded to 1 decimal place

How are we doing ?

- New DNA: From Mar 2016 - Mar 2017 performance has improved from 8.6% to 6.7%.
- Follow-Up DNA: From Mar 2016 - Mar 2017 performance has improved slightly from 8.9% to 8.5%.

Benchmark

New DNA / Follow-Up DNA

LHB	New DNA Current Jan-17	New DNA Same Period Comparison Jan-16	Jan-15	Jan-14	Follow-Up DNA Current Jan-17	Follow-Up DNA Same Period Comparison Jan-16	Jan-15	Jan-14
Wales	7.9%	↓ 7.7%	↑ 8.9%	↑ 9.0%	9.7%	↓ 9.5%	↑ 10.5%	↑ 10.4%
ABM	7.2%	↑ 8.1%	↑ 8.0%	↑ 10.7%	8.7%	↓ 8.6%	↑ 9.1%	↑ 9.9%
AB	5.8%	↑ 6.5%	↑ 9.2%	↑ 8.8%	6.9%	↑ 7.4%	↑ 10.1%	↑ 10.0%
BCU	6.8%	↓ 5.6%	↓ 5.6%	↓ 4.9%	7.2%	↑ 7.4%	↑ 7.6%	↑ 7.6%
C&V	9.3%	↑ 9.4%	↑ 13.6%	↑ 14.7%	12.7%	↑ 12.9%	↑ 14.1%	↑ 14.5%
CTaf	9.5%	↑ 9.6%	↓ 9.3%	↓ 9.2%	13.2%	↓ 13.0%	↑ 14.3%	↓ 11.9%
HDda	10.3%	↓ 8.6%	↓ 8.9%	↓ 7.0%	9.8%	↓ 8.6%	↓ 8.5%	↓ 8.5%
Powys	4.2%	↓ 2.5%	↑ 6.0%	↑ 5.5%	5.7%	↑ 5.9%	↑ 6.0%	↑ 5.9%

What actions are we taking?

- The SDU's have been requested to produce action plans and profiles to address New and Follow Up DNA's with regular reports to be provided to the Health Board Outpatient Improvement Group and to the Planned Care Supporting Delivery Board.

The Health Board Outpatient Improvement Group (OIG) is currently:

- Taking forward the implementation of a patient appointment reminder system across the Health Board, phased implementation from June 2017.
- Reviewing the Health Board DNA policy to ensure consistent application across the Health Board.
- Identified a priority for the Health Board, to address both DNAs and UTAs and report on progress to June 2017 National Outpatient Learning Collaborative conference.

How do we compare with our peers?

- At January 2017, ABMU performance was better than the all-Wales average on New and Follow Up DNA performance. ABMU is 4th highest for New and Follow Up DNA rates.
- New DNA: ABM, AB, C&V and CT have experienced an improved performance from January 2016; BCU, Hywel Dda and Powys position deteriorated.
- Follow Up DNA: AB, BCU, C&V and Powys all experienced an improved position compared with January 2016; ABM, Cwm Taf and Hywel Dda position deteriorated.

What are the main areas of risk?

- The Wales Audit Office identified in a review of ABMU Outpatients in 2015 the need to ensure patients receive appointment letters in a timely manner in order to reduce DNAs. The efforts of the OIG to deploy an electronic appointment management system will help to address this issue.
- It is important for the Health Board to gain a better understanding of the specialties and clinical conditions which present the most risks of harm to patients who DNA their appointment.
- RTT risk to the Health Board as a result of under utilised capacity for new and follow up appointments with associated financial implications for idle capacity, rearranging appointments and potentially needing to arrange additional waiting list clinics.

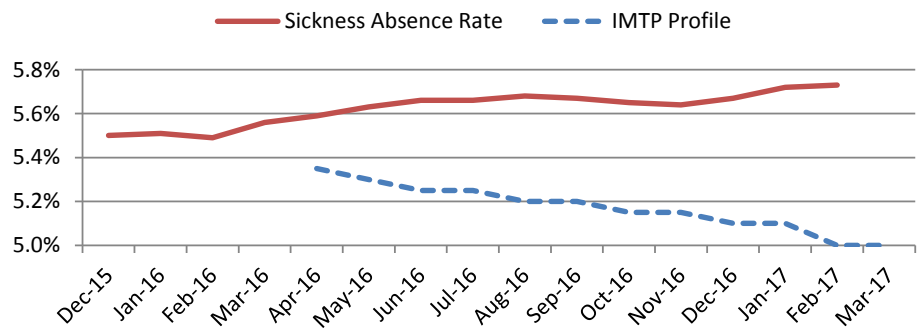
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

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

Measure 1: % workforce sickness absence

Corporate Objective : Securing A Fully Engaged & Skilled Workforce			**Executive Lead : Kate Lorenti**	
Period : Feb 17	**IMTP Profile Target : 5.1%**	**WG Target : Improve**	**Current Status :** ✕	**Movement :** ↑ ● **Worsening**

Current Trend: Dec 15- Dec 16



How are we doing ?

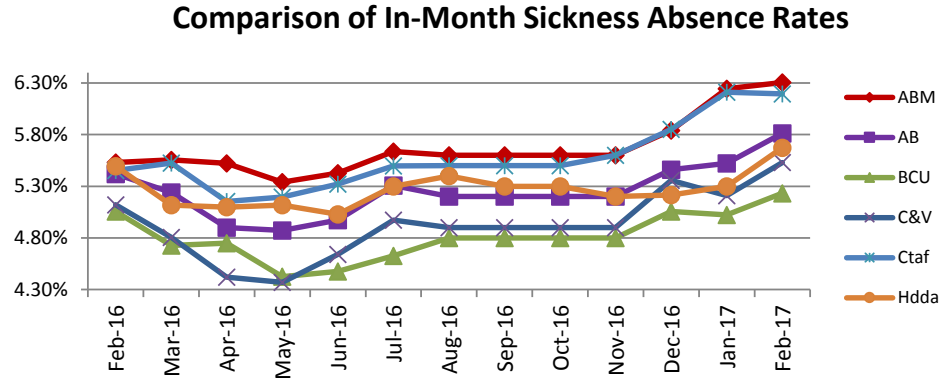
Rolling 12 month performance:
- Mar 15 - Feb 16 =5.50%
- Feb 16 - Jan 17 = 5.70%
- Mar 16 - Feb 17 = 5.71%

In Month performance:
- Jan 17 = 6.36%
- Feb 17 = 5.96% (was 5.67% in Feb 16)

Long-term sickness decreased in February compared to the previous month to 4.08% but is 0.25% higher than last February and remains our main challenge. Short term absence decreased slightly to 1.86%, a similar position in comparison to last year.

Our top reason for absence is for stress, anxiety, depression and other mental health illnesses and accounts for 25% of all absence as at Feb 17.

Benchmark



What actions are we taking?

- A review of all current LTS cases as at the end of February has been undertaken by the operational HR teams to ensure that appropriate management actions have been taken in relation to each case. Any issues identified will be fed back to the local unit management team in order to manage ongoing performance.
- In order to provide further assurance that sickness absence is being managed appropriately and in line with agreed policy a work plan of sickness audits is in the process of being developed focussing on high sickness areas with a dedicated member of the HR team responsible for completion of these.
- Unknown reasons for sickness have seen a decrease to under 10% due to actions taken to date. This should reduce further to below 5% due to shared services payroll agreeing to not accept any manual pay cards with unknown reasons recorded. This will further improve data accuracy.

How do we compare with our peers?

The latest 12 month cumulative differential between ABMU and the all-Wales performance is 0.50%.

- The latest differential between our monthly sickness absence rates and the all-Wales average is 0.60%.

What are the main areas of risk?

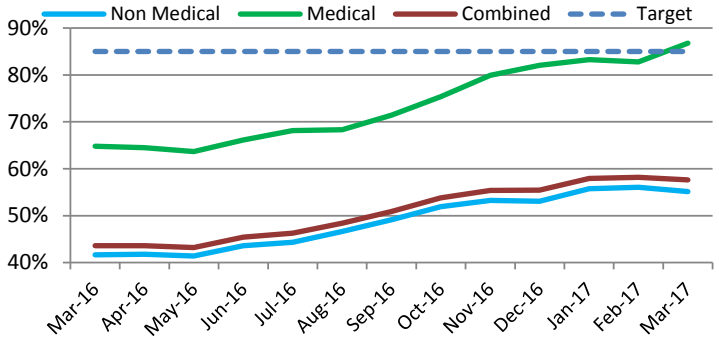
- Failure to maintain continued focus on sickness absence performance may lead to levels increasing.
- Singular focus on sickness management without measured attention on supporting staff attendance through health and wellbeing interventions congruent with our organisational values.
- Direct effect on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

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

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

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

Corporate Objective : Securing A Fully Engaged & Skilled Workforce			**Executive Lead : Hamish Laing/Kate Lorenti**	
Period : Mar 2017	**IMTP Profile Target : 85.0%**	**WG Target : Improve**	**Current Status :**	**Movement : Improving**

Current Trend: Mar 16- Mar 17	**How are we doing ?**
	**Medical:** • The upward trend in the 12 month rolling average continues, with the target level achieved for the first time - doctors and appraisers to be congratulated on this achievement • Figures do not yet account for 'exemptions' - only calculated annually (approximately 10% overall 2015/2016) • Outcome of the annual QA review of summaries coordinated by the Wales Deanery Revalidation Support Unit (RSU) through 3 Regional QA events shows quality of ABMU summaries in secondary care around average compared to results of other health boards. Improved on previous years but shows need to move from quantity to quality improvement **Non Medical:**• Reporting figures demonstrate a slight reduction in PADR compliance- Jan 55.73% to April 2017 53.93%. •Growing number of areas across ABMU that have access to Supervisor Self-Service(SSS). Finance Department are monitoring how PADRS are recorded onto ESR (SSS vs Central Administrator.) The workforce and OD committee are provided a report includes hotspot areas for PADR Compliance under 30%.• Feedback from the 1st stage of the Quality PADR Review shows that overall staff feel satisfied with PADR Experience and believe that the incorporation of Values has improved the PADR.
Benchmark	**What actions are we taking?**
	Medical: • Maintain current performance levels through continuing engagement with Unit Medical Directors, exception management, working with doctors to realign Appraisal Quarters to revalidation requirements • Now appraisal volumes being achieved, need Appraisal Lead appointments to improve appraisal quality and ensure delivery of appraisal benefits for doctors and Health Board services **Non Medical**:• Continued focus on training Managers to complete Values Based PADR/use ESR to improve reporting figures. •Completed review of Group PADR, shows increase in compliance in areas using this approach. Work to add to policy and embed by August 2017.•Focus on PADR Quality Review- 5% of staff from each service at Singleton Delivery unit (79)with completed PADRs were invited. 5% of Reviewers were also invited to discuss their experiences. Comments have been submitted to the unit for further action, follow up has been requested and the L+D team will support this during June 2017.
How do we compare with our peers?	**What are the main areas of risk?**
• Peer data is not currently available.	**Medical:**• Doctors fall behind on timescale to complete enough appraisals for next revalidation recommendation: stress for doctor; diversion of doctor's and management time / resource; potential delayed revalidation; significant consequences for licence to practise if ultimately fail to engage. • Poor quality appraisals - lack of personal / service development and progression; continuation of sub-optimal practices; resistance to change. **Non Medical:**• Misunderstanding around timings of PADR aligning with increment date.•Dependence on roll out of Supervisor self service for PADR Reporting data accuracy, double reporting, use of ESR, accuracy of ESR, IT skills of staff. • Time to complete PADR's in clinical areas- risk around the quality of PADR versus the target figures. • Local administrators and locally held data – change of culture and the time scales to do this.. • IT Equipment supporting the running of upgraded ESR Programme.

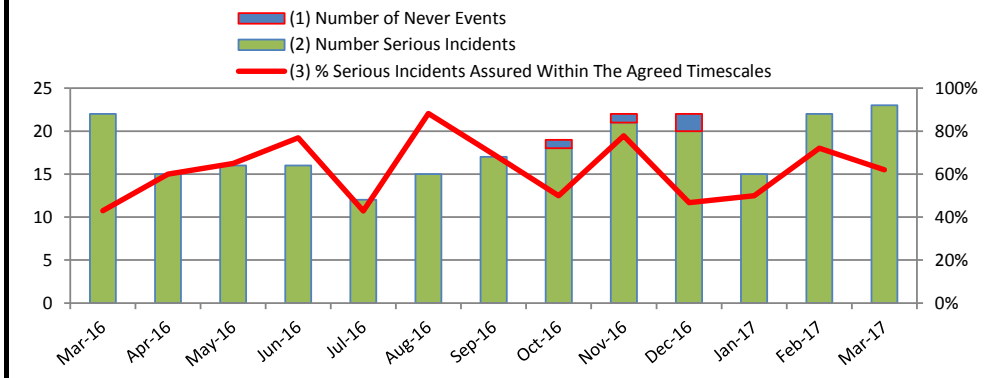
Source : Non Medical: Electronic Staff Record (ESR), Medical : Medical Appraisal and Revalidation System (MARS)

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

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

Corporate Objective : Embedding Effective Governance & Partnerships			**Executive Lead : Rory Farrelly**	
Period : Mar-17	**IMTP Profile Target : (1) Zero, (2) Improve, (3) 86%**	**WG Target : (1) Zero, (2) Improve, (3) 90%**	**Current Status :**	**Movement : Stable**

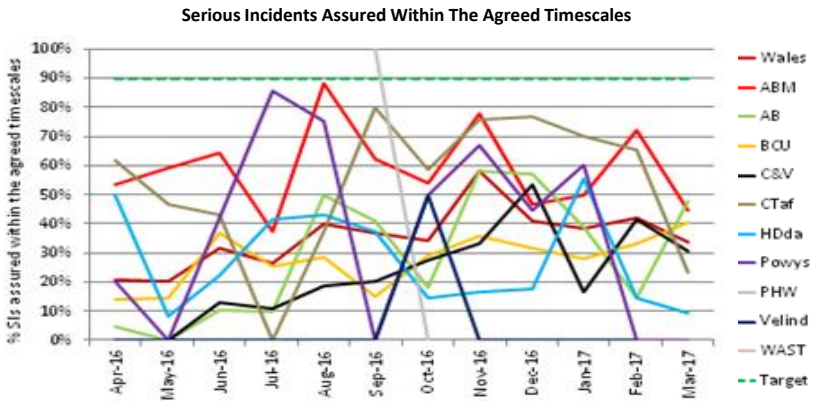
Current Trend: Mar 16 - Mar 17



How are we doing ?

- 2,059 incidents were reported in March 2017 (1,927 incidents were reported in February 2017 and 2,194 reported in March 2016).
- 23 (1.12%) Serious Incidents (SI's) were reported to Welsh Government in March 2017, 22 SI's were reported in February 2017 (1.14%) and 22 SI's were reported in March 2016 (1.00%).
- In terms of severity of incidents, the Health Board's target for severe harm (%red) incidents is less than 0.50% of the total number of incidents reported. For the month of March (0.05%), the measure for the percentage of Serious Incidents related to severe harm was achieved.
- No never events were reported in March 2017.
- Performance against closing SI's down within 60 working days in March was 62%.

Benchmark



Never Events

	Mar-17
Wales	3
ABM	0
AB	0
BCU	0
C&V	2
Ctaf	1
Hdda	0
Powys	0
PHW	0
Velind	0
WAST	0

What actions are we taking?

- Serious Incident Team continue to investigate the severe harm incidents and aim to produce investigation reports within 28 days of notification of the incident. The Team also monitor and actively support the closure of all SI's. The Units performance in relation to closure compliance will continue to be managed with Executive Directors at Health Board Performance meetings until compliance is 80%.
- 65% of the Serious Incidents (SI's) reported relate to pressure ulcer and the Pressure Ulcer Card provides details of the work ongoing in respect of actions being taken to reduce the occurrence and severity of harm of these incidents.

How do we compare with our peers?

- Three never event were reported in Wales (C&V and Cwm Taff Health Boards).
- The Health Boards compliance in closing serious incidents down by the Welsh Government target date has been consistently above the all Wales average during 2016/17.

What are the main areas of risk?

Main areas of risk relate to the pressure ulcer incidents and achieving the 80% compliance rate against the Welsh Government target to submit closure forms within 60 working days. Unvalidated data against this performance indicator for April 2017 is showing 100% performance rate.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 2017)

EFFECTIVE CARE - I RECEIVE THE RIGHT CARE & SUPPORT AS LOCALLY AS POSSIBLE & I CONTRIBUTE TO MAKING THAT CARE SUCCESSFUL

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

Corporate Objective : Embedding Effective Governance & Partnerships

Executive Lead : Rory Farrelly

Period : Mar 17

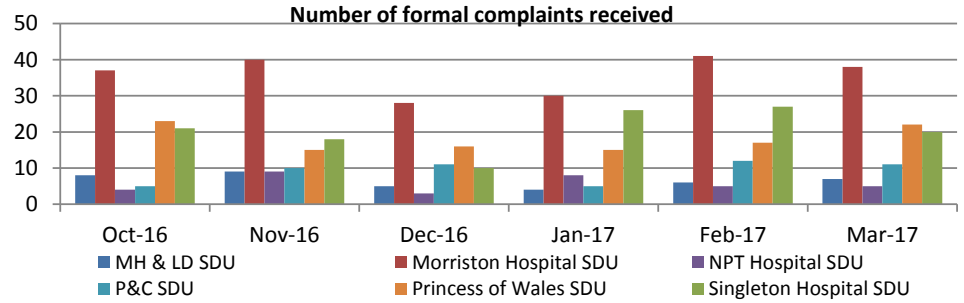
IMTP Profile Target :

Local Target :
(1) Monitor, (2) 80%

Current Status :

Movement : Improving

Current Trend: Oct 16- Mar 17



% of responses sent within 30 working days	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17 *
MH & LD SDU	55%	33%	63%	78%	60%	75%	50%	67%
Morriston Hospital SDU	38%	53%	49%	55%	55%	68%	74%	71%
NPT Hospital SDU	50%	50%	50%	100%	67%	88%	80%	67%
P&C SDU	40%	38%	40%	20%	60%	60%	42%	40%
Princess of Wales SDU	57%	68%	70%	87%	69%	86%	94%	60%
Singleton Hospital SDU	41%	33%	52%	28%	10%	54%	69%	73%
Health Board Total	**45%**	**45%**	**56%**	**56%**	**55%**	**69%**	**71%**	**64%**

* Note * *Mar-17 only contains data up to 14/03/17*

Percentage Acknowledgements Sent ≤ 2 Working Days	2016										2017		
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	96%	97%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

How do we compare with our peers?

No Benchmark Data Available

How are we doing ?

Morriston consistently remains the Service Delivery Unit receiving the highest number of formal complaints; with 30 complaints in January 2017 increasing to 38 in March 2017.

- Singleton saw a reduction in the number of formal complaints received in March to 21 compared to January 2017 (26 received) and February 2017 (27 received).
- The Health Board is on target to achieve the 80% 30 day response rate for March 2017. Performance in February 2017 was 71% against this target.
- The Health Board is consistently maintaining 2 day acknowledgement target in line with Putting Things Right Regulations.

What actions are we taking?

Primary Care Delivery Unit has been alerted to their performance against the unvalidated data for March 2017 and they are taking action to ensure performance achieves the 80% target.

- Performance in the 30 day response targets is addressed consistently at all performance reviews.
- The Unit Nurse Directors have provided assurance that the 30 day response rate target of 80% for the Health Board will be met for the month for March 2017.
- PALS activity for the period January - March 2017 identified 798 contacts of which 10 contacts turned into formal complaints.

What are the main areas of risk?

The main area of risk is the Health Board not achieving the 80% target for 30 day response rate.

Source :DATIX