Meeting Date	**31st May 2018**	**Agenda Item**	**3ii.**
Report Title	**Integrated Performance Report**		
Report Author	Hannah Roan, Performance and Contracting Manager Darren Griffiths, Assistant Director of Strategy		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Siân Harrop-Griffiths, Director of Strategy Executive Leads		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report is to provide an update on the current performance of the Health Board at the end of the most recent reporting window in delivering key performance measures outlined in the 2017/18 NHS Wales Delivery Framework within the overall context of the delivering the Health Board's Corporate Objectives.		
Key Issues	The latest data available at the time of writing this report for the majority of national and local measures is March 2018. The report highlights that 40% of the measures were achieved however this is likely to increase as additional March 2018 becomes available.		
Specific Action Required ***(please ✓one only)***	**Information**	**Discussion**	**Assurance** / **Approval**
			✓ /
Recommendations	Members are asked to: • **Note** current Health Board performance against key measures and targets and the actions being taken to improve performance.		

INTEGRATED PERFORMANCE REPORT

1. INTRODUCTION

The purpose of this report is to provide an update on the current performance of the Health Board at the end of the most recent reporting window in delivering key performance measures outlined in the 2017/18 National Delivery Framework within the overall context of the delivering the Health Board's Corporate Objectives.

2. BACKGROUND

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

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

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

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

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

3. GOVERNANCE AND RISK ISSUES

Appendix 1 of this report provides an overview of how the Health Board is performing against the National Delivery measures and key local quality and safety measures. Actions are listed where performance is not compliant with national or local targets as well as highlighting both short term and long terms risks to delivery.

4. FINANCIAL IMPLICATIONS

The financial overview for the Health Board is covered in a separate report and the financial resources required to achieve national measures are outlined in the report cards in Appendix 1 of this report.

5. RECOMMENDATION

Members are asked to:

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

Governance and Assurance

Link to corporate objectives *(please ✓)*	Promoting and enabling healthier communities	Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships
	✓	✓	✓	✓	✓

Link to Health and Care Standards *(please ✓)*	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
	✓	✓	✓	✓	✓	✓	✓

Quality, Safety and Patient Experience

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

Appendix 1 is aligned to the Health Board's Corporate Objectives and the measures directly aligned with Quality, Safety and Patient Experience can be found in Appendix 1 of this report under the sections titled Delivering Excellent Patient Outcomes, Experience & Access and Embedding Effective Governance and Partnerships.

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

Financial Implications

Financial implications of aiming to achieve the measures or non-compliance with the national measures are outlined in the report cards in Appendix 1 of this report.

The achievement of the efficiency and productivity targets will deliver savings to support the financial position

Legal Implications (including equality and diversity assessment)

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

Staffing Implications

A number of indicators monitor progress in relation to Workforce, such as Sickness and Personal Development Review rates. Specific issues relating to staffing are also addressed individually within each report card in Appendix 1.

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

Report History	The last iteration of the Integrated Performance Report was presented to the Health Board in March 2018. Quality and Safety elements of the report are also presented to the Quality & Safety Committee and the full report is received by the Performance & Finance Committee.
Appendices	Appendix 1- Summary of performance against national and local measures.

Appendix 1- Summary of performance against national and local measures

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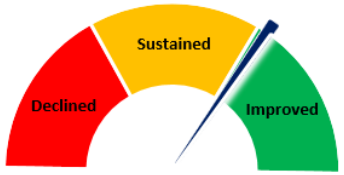
1. Assessment

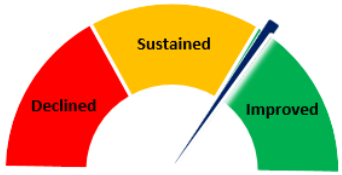
Appendix 1 of this report provides detailed performance against all national and local measures. At a summary level, the tables below sets out the current performance assessment for the totality of the 2017/18 NHS Delivery Framework and local measures included in this report by the Health Board's Corporate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

Corporate Objective	Number of measures in the reporting period that have been:	
	Achieved ✓	Not Achieved X
Promoting and Enabling Healthier Communities	7	11
Delivering Excellent Patient Outcomes, Experience and Access	21	37
Demonstrating Value and Sustainability	2	1
Securing a Fully Engaged and Skilled Workforce	4	3
Embedding Effective Governance and Partnerships	4	5
Total	**38**	**56**

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

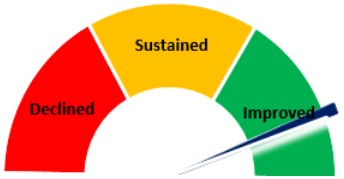


Promoting and enabling healthier communities

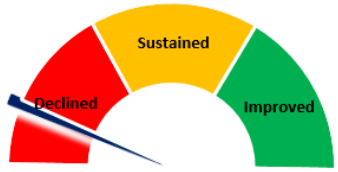


Delivering Excellent Patient Outcomes, Experience and Access

Demonstrating Value and Sustainability



Securing a Fully Engaged and Skilled Workforce



Embedding Effective Governance and Partnerships

2. Targeted Intervention Priority Measures Summary- Health Board Level

			Quarter 1			Quarter 2			Quarter 3			Quarter 4			Welsh Government Target
			Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	
Unscheduled Care	4 hour A&E waits	Actual	82.0%	83.1%	83.2%	82.3%	82.3%	84.1%	79.1%	75.7%	73.4%	76.1%	73.8%	71.4%	95%
		Profile	*81.3%*	*84.5%*	*84.7%*	*85.1%*	*85.7%*	*86.2%*	*88.3%*	*87.4%*	*87.4%*	*85.5%*	*88.0%*	*90.0%*	
	12 hour A&E waits	Actual	428	379	370	296	294	350	706	880	871	924	957	1,051	0
		Profile	*550*	*480*	*400*	*350*	*320*	*320*	*330*	*350*	*410*	*400*	*370*	*300*	
	1 hour ambulance handover	Actual	332	244	295	206	295	289	617	752	904	1,030	815	1,006	0
		Profile	*430*	*335*	*240*	*180*	*120*	*120*	*130*	*160*	*220*	*210*	*160*	*100*	
	Red calls responses within 8 minutes	Actual	83.2%	79.9%	81.3%	76.0%	78.9%	82.4%	72.7%	73.4%	69.0%	65.7%	68.9%	66.6%	65%
		Profile	*72.0%*	*73.0%*	*74.0%*	*75.0%*	*76.0%*	*76.0%*	*76.0%*	*74.0%*	*74.0%*	*75.0%*	*76.0%*	*76.0%*	
Stroke	4 hour bundle	Actual	40.0%	58.2%	50.5%	56.5%	48.8%	49.5%	41.8%	35.2%	25.3%	32.4%	25.0%	34.1%	The most recent SSNAP UK National quarterly average
		Profile	*47.0%*	*55.0%*	*60.0%*	*69.0%*	*72.0%*	*72.0%*	*72.0%*	*66.0%*	*63.0%*	*66.0%*	*69.0%*	*72.0%*	
	12 hour bundle	Actual	90.0%	89.8%	90.8%	88.4%	91.9%	91.9%	96.7%	94.5%	95.4%	93.2%	96.4%	96.7%	
		Profile	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	*95.0%*	
	24 hour bundle	Actual	61.1%	79.6%	79.8%	81.2%	84.9%	83.8%	89.0%	73.6%	89.7%	93.2%	73.8%	72.5%	
		Profile	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	*75.0%*	
	72 hour bundle	Actual	93.3%	98.0%	95.4%	97.1%	95.3%	98.0%	96.7%	96.7%	95.4%	94.6%	95.2%	91.2%	
		Profile	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	*97.0%*	
Planned care	Outpatients waiting more than 26 weeks	Actual	1,061	1,395	1,029	1,134	1,599	1,567	1,438	1,524	1,679	1,111	732	292	0
		Profile							*2,074*	*1,678*	*2,493*	*1,969*	*896*	*551*	
	Treatment waits over 36 weeks	Actual	3,997	4,155	3,966	4,388	4,642	4,284	4,463	4,561	4,714	4,609	4,111	3,363	0
		Profile			*3,989*	*4,132*	*4,026*	*3,919*	*3,706*	*3,493*	*3,280*	*3,066*	*2,853*	*2,640*	
	Diagnostic waits over 8 weeks	Actual	411	519	481	533	601	455	349	361	460	444	226	29	0
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
	Therapy waits over 14 weeks	Actual	206	210	235	224	258	117	111	111	95	32	3	0	0
		Profile	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	
Cancer	NUSC patients starting treatment in 31 days	Actual	94.0%	94.0%	93.0%	97.0%	96.0%	98.0%	95.0%	99.0%	94.0%	91.0%	94.0%	93.0%	98%
		Profile	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	*98.0%*	
	USC patients starting treatment in 62 days	Actual	87.0%	74.0%	73.0%	77.0%	80.0%	79.0%	85.0%	89.0%	82.0%	79.0%	83.0%	88.0%	95%
		Profile	*88.0%*	*88.0%*	*88.5%*	*89.5%*	*90.0%*	*90.0%*	*90.0%*	*89.0%*	*88.5%*	*88.0%*	*89.0%*	*90.0%*	
Healthcare Acquired Infections	Rate of S.aureus Bacteraemias per 100,000	Actual	51.2	41.9	44.5	31.1	66.7	53.4	50.6	57.8	53.4	75.9	46.7	51.2	≤ 20 cases per 100,000
		Profile	*41.0*	*40.0*	*39.0*	*38.3*	*37.7*	*37.0*	*35.8*	*34.7*	*33.5*	*32.3*	*31.2*	*30.0*	
	Rate of C.difficile per 100,000 population	Actual	31.1	51.7	31.1	57.8	39.1	28.9	34.5	24.5	42.3	32.2	42.3	31.4	≤ 26 cases per 100,000
		Profile	*40.0*	*39.0*	*38.0*	*37.0*	*36.0*	*35.0*	*34.0*	*33.0*	*32.0*	*31.3*	*30.7*	*30.0*	

**RAG status derived from performance against trajectory*

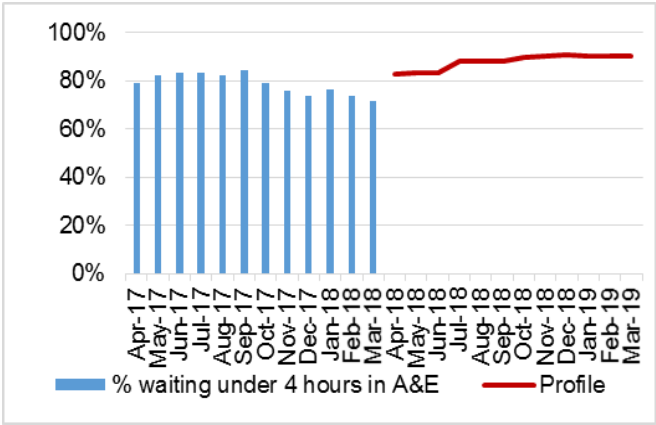
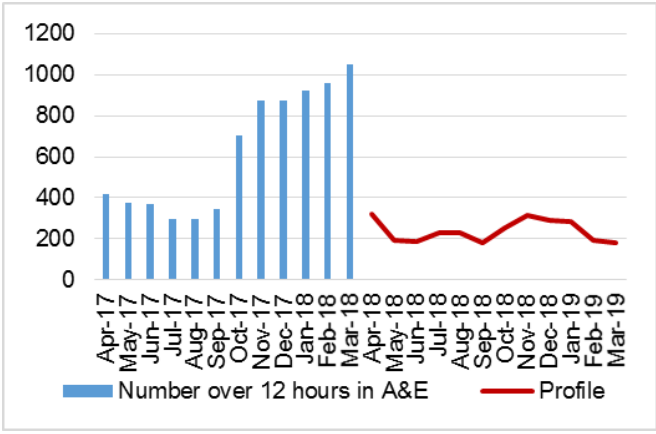
3. Overview

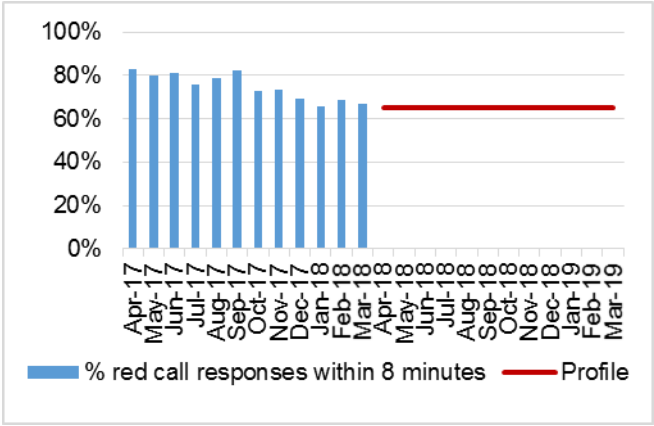
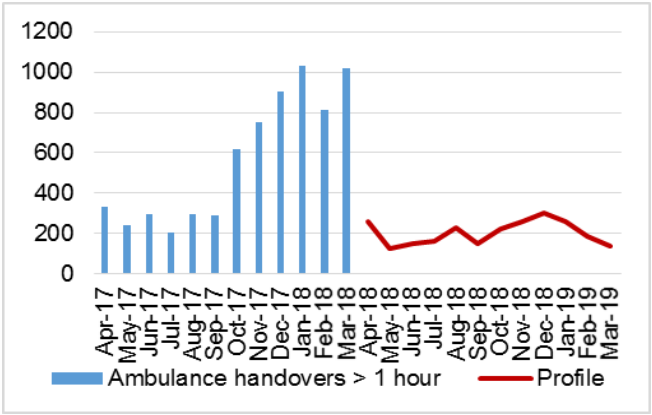
The following summarises the key success in March 2018, along with the priorities, risks and threats to achievement of the quality, access and workforce standards

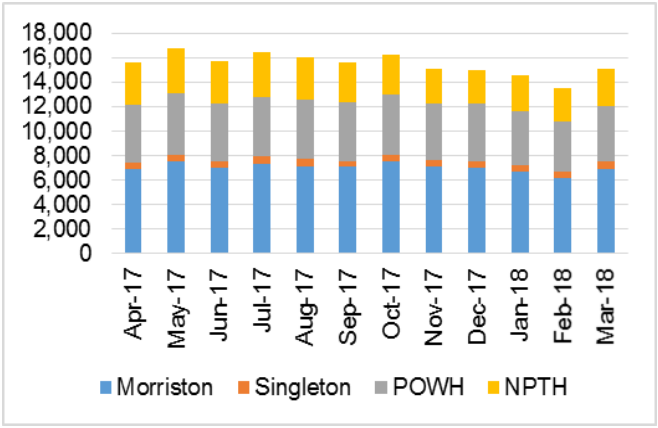
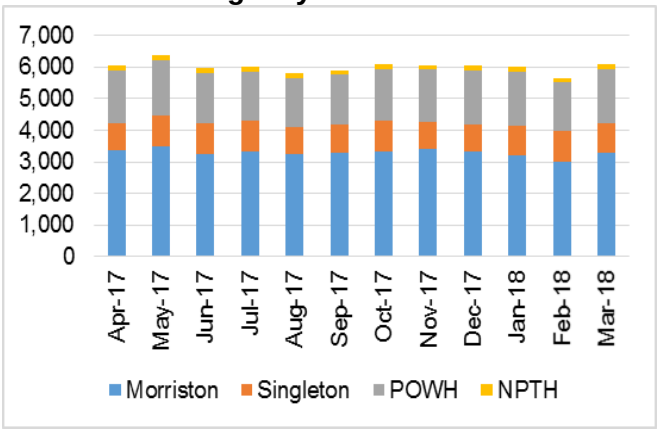
Successes	Priorities
• There were 292 patients waiting over 26 weeks for an outpatient appointment. This is the best position since April 2013. • There were 3,363 patients waiting over 36 weeks from referral to treatment. This is the best position since June 2014. However the Health Board has been subject to financial clawback on this measure. • There were no patients waiting over 8 weeks for Endoscopy. This is the best position since June 2016. • DNA rates continue to reduce for both new and follow-up appointments. DNA rates are the lowest for 4 years. • Access rates for assessment by and intervention commencement for Local Primary Mental Health Support Services within 28 days are improving steadily from December 2017.	• Implement the actions set out for Q1 to build improved performance and increased resilience in our Emergency Departments (ED) • Supporting and promoting the UK wide #endpjparalysis campaign. • Resolve pressures in breast, urology and gynaecology tumour sites • Engagement with Unit Medical Directors (UMDs) regarding alternative processes for completion of discharge summaries in order to improve performance by involving wider members of the clinical teams. • Maximising opportunities for planned care improvements in Q1 and Q2 • Ongoing planning of the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from national funding to fund a dedicated project manager to support this work. • Work continues with the Datix user group to configure the system to collate and report accurately falls with harm versus falls without harm.
Opportunities	**Risks & Threats**
• Continued focus of reducing sickness rates by focusing on improving staff wellbeing and looking at opportunities to provide training on ‘Mental Health in the workplace for managers’ and HSE work related stress risk assessment. • Continue to reduce elective waiting times by maximising routine capacity through insourcing and outsourcing. • Aid the delivery of unscheduled care measures through learning from Breaking the Cycle and implementation of the SAFER bundle. • Full implementation of outpatient appointment text reminder service implementation by October 2018 with the aim of continuing to improve DNA rates and maximise outpatient capacity.	• Demand for cancer and urgent surgical cases utilising planned routine elective capacity and protecting elective bed capacity. • Health Board is currently an outlier in relation to the number of Never Events. • Continued pressures on the ambulance service and occupancy of in-patient areas increase the challenge for staff in preventing pressure ulcers. • The acuity and complexity of patients arriving at ED by ambulance is increasing. • Capacity gaps in Care Homes, Community Resource Teams. Capacity and fragility of private domiciliary care providers, leading to an increase in the number of patients in hospital who are 'discharge fit' and increasing length of stay.

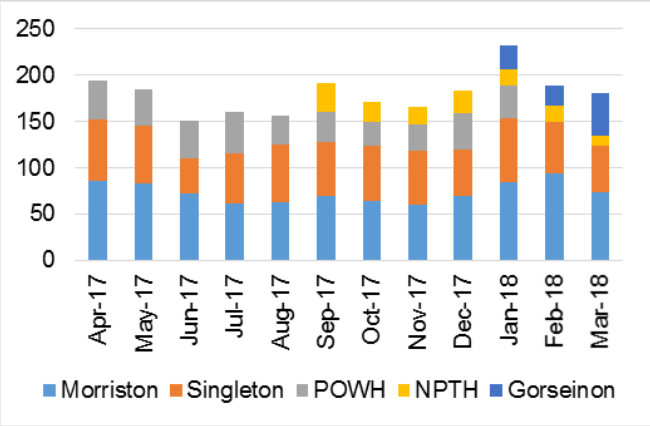
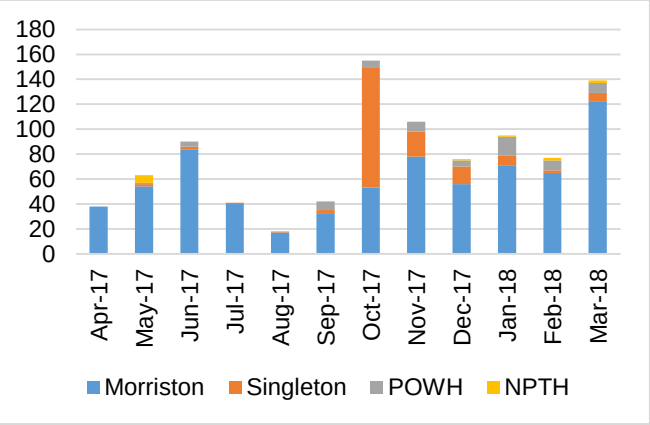
4. TARGETED INTERVENTION PRIORITIES

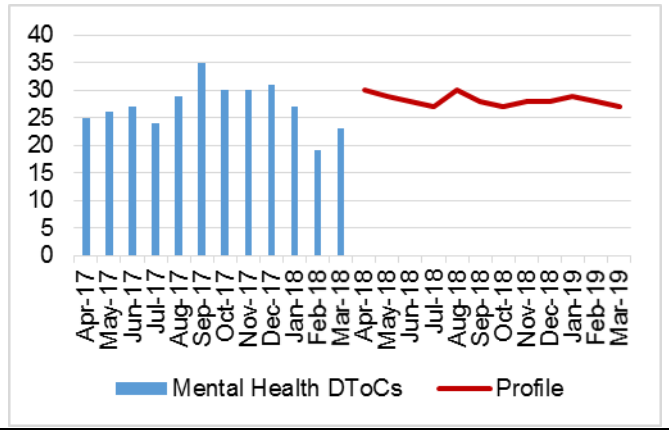
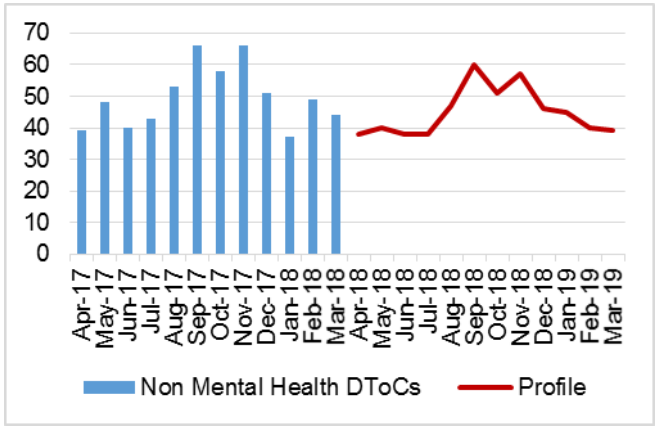
4.1 Unscheduled Care (WG Measures 73-76)

Description	Current Performance	Trend	Actions planned for next period
A&E waiting times The percentage of patients who spend less than 4 hours in all major and minor emergency care facilities from arrival until admission, transfer or discharge	The achievement of the 4 hour performance measure continues to be a challenge and in March 2018, the Health Board was below the internal profile of 90%. Singleton and Neath Port Talbot Hospitals continue to exceed the national target of 95% but Morriston and Princess of Wales are below profile achieving 60% and 70% in March 2018.	**% patients waiting under 4 hours in A&E** 	• Additional locum consultants starting in Morriston will provide consistent medically led 1st assessment in ED. • Conclude evaluation of winter plan with learning event in May • Implementation of the new patient tracking system is underway and the system developed which will improve patient flow. • Additional ANP/ENP in POWH to further support minors flow (and 4 hour performance) • Implement “Breaking the Cycle” action plan
A&E waiting times The number of patients who spend 12 hours or more in all hospital major and minor care facilities from arrival until admission, transfer or discharge	Performance against the 12 hour A&E measure also continues to be a challenge especially through the Winter period. In March 2018, the Health Board had 1,051 12 hour breaches of which 745 were attributed to Morriston Hospital; 305 to Princess of Wales and 1 in both Singleton and Neath Port Talbot Hospitals.	**Number of patients waiting over 12 hours in A&E** 	As above.

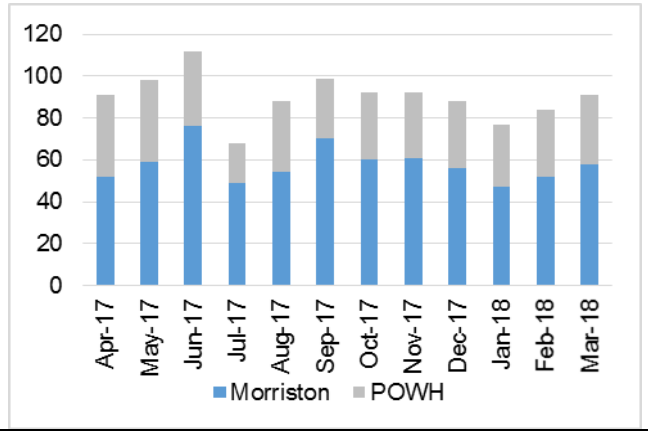
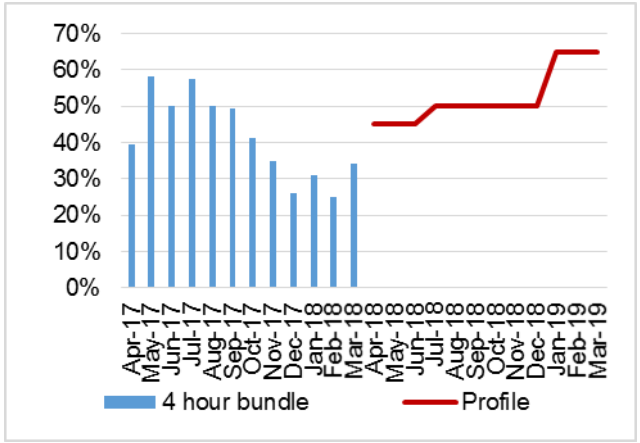
Description	Current Performance	Trend	Actions planned for next period
Ambulance responses The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	Ambulance response times are consistently above the national target of 65% but fell short of the 76% internal profile in March 2018 with an achievement of 66.7%. The number and proportion of red call conveyances continues to increase, with Welsh Ambulance Services Trust (WAST) data suggesting that ABMU HB has the highest number and proportion of red calls in Wales for the population served.	**Percentage of red call responses within 8 minutes** 	• Work with WAST/111 to increase publicity with non-NHS partners (to increase 111 use and divert from ED) • Monitor and progress Bevan Exemplar WAST Stack review project by the Acute Clinical Care Team (to reduce emergency admissions and WAST ambulance use)
Ambulance handovers The number of ambulance handovers over one hour	The number of ambulance handovers to local hospitals taking over 1 hour continue to be significantly over profile which is a reflection of the pressures being felt in A&E departments and the subsequent challenge of the 4 and 12 hour A&E targets. In March 2018, Morriston Hospital saw an increase of 295 compared with March 2017 (392 to 687). Princess of Wales Hospital (POWH) saw an increase of 159 (104 to 263) and Singleton Hospital saw an increase of 40 (29 to 69).	**Number of ambulance handovers over one hour** 	• Additional Nursing within POWH ED to support additional escalation overnight (reduce handover delays) • Continue use of WAST Hospital Ambulance Liaison Officers (HALO) in order to reduce 1 hour ambulance delays. Initial feedback is that this worked well in terms of earlier release of ambulance crews. WAST has requested formal feedback on the impact of this by mid-April.

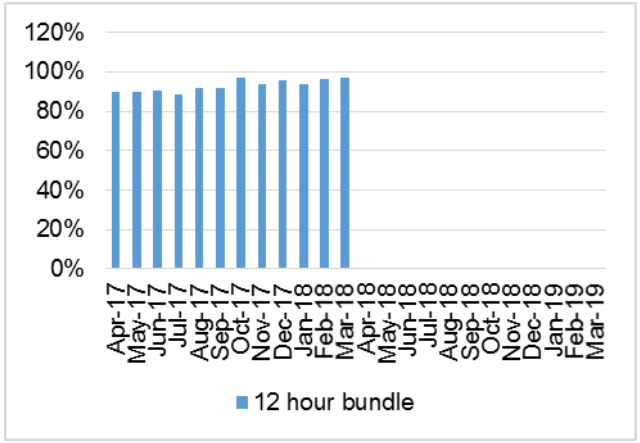
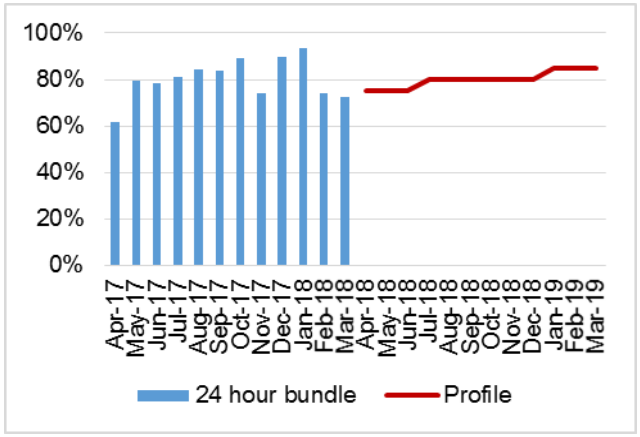
Description	Current Performance	Trend	Actions planned for next period
A&E Attendances The number of attendances at emergency departments in the Health Board	In March 2018, there were at total of 15,098 A&E attendances across the Health Board which is 718 less than March 2017: • Morriston Hospital: 2.5% reduction in attendances • Singleton Hospital Minor Injury Unit (MIU): 20% reduction in attendances • Princess of Wales Hospital: 2% reduction in attendances • Neath Port Talbot Hospital MIU: 9% reduction on attendances	**Number of A&E attendances** 	• Evaluate impact of extended opening hours at the community pharmacy at Port Talbot Resource Centre (to support 111) • Commission equivalent of < 4 WTE dentists in high need areas (to reduce Primary Care/ED demand) • Pilot agreement with WAST to see Mental Health patients in the community and not ED. Planning and confirmation of governance arrangements undertaken in March with aim of commencing in April 2018, dependant on staffing availability/rotas
Emergency Admissions The number of emergency admissions across the Health Board by site	In March 2018, there were a total of 6,146 emergency admissions across the Health Board which is 343 less than March 2017: • Morriston Hospital: 6% reduction in admissions • Singleton Hospital: 4.5% increase in admissions • Princess of Wales Hospital: 11% reduction in admissions • Neath Port Talbot Hospital: 28% increase in admissions (from 132 to 169)	**Number of emergency admissions** 	• Increased therapies in Morriston ED and Green to Go ward to reduce length of stay and support appropriate alternatives to admission. • Introduce on-call Out of Hours community pharmacy for palliative care (to reduce emergency admissions) • Psychiatric Liaison - Quicker turnaround times in ED / Ward assessments. One hour target for ED, Emergency ward referrals on same day, routine referrals with 24 hours.

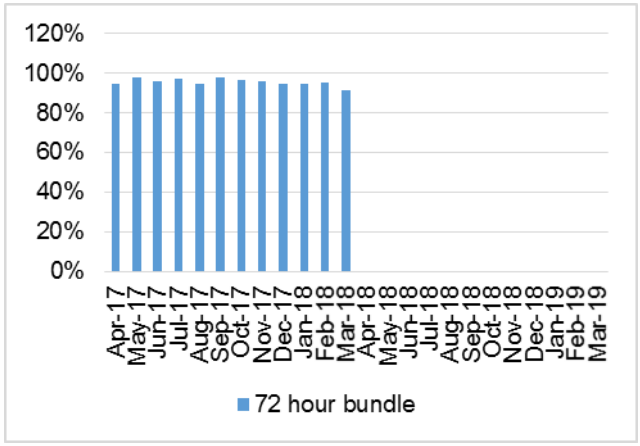
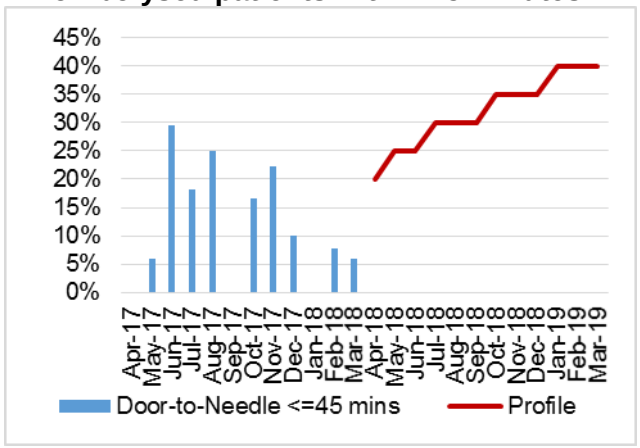
Description	Current Performance	Trend	Actions planned for next period
Medically Fit The number of patients waiting at each site in the Health Board that are deemed discharge/ medically fit	In March 2018, there were 204 patients who were deemed medically/ discharge fit but were still occupying a bed in one of the Health Board's Hospitals. This is a 67% increase when compared with March 2017.	**The number of discharge/ medically fit patients by site**  ***Standardised collection of data from Gorseinon Hospital only commenced in January 2018*	• Weekend opening of Morriston Discharge Lounge and Discharge Lounge Liaison role to ensure optimised use of lounge before 10:30am and 12 midday. • Extend Patient Flow Co-ordinators to weekends to maintain momentum in discharge planning and reduced delays. • Redesigned process implemented for Medically and Discharge Fit information and patients to reduce delays in POWH.
Elective procedures cancelled due to lack of beds The number of elective procedure cancelled across the hospital where the main cancellation reasons was	In March 2018, the number of elective procedures cancelled due to lack of beds was moderately in line with the position in March 2017. Across the Health Board 139 procedures were cancelled in March 2018 compared with 133 in March 2017 (5% increase). Morriston saw the largest proportion of procedures cancelled procedures but had 33% less cancellations than last winter.	**Total number of elective procedures cancelled due to lack of beds** 	• Introduce revised escalation process in Morriston Hospital to reduce ward delays and early release of bed space for admissions. • Continue to implement additional arrangements to mitigate impact of unscheduled care pressures on elective capacity.

Description	Current Performance	Trend	Actions planned for next period
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board- Mental Health (all ages)	The number of mental health related delayed transfers of care in March 2018 were slightly higher than the internal profile of 25 but were the lowest number since August 2017. In March 2018, Swansea had 21 delays compared with 12 in Bridgend and 11 in Neath Port Talbot.	**Number of Mental Health DToCs** 	• Discussions are taking place with LA partners at all levels to discuss collaborative opportunities to improve the discharge pathway and patient experience, and to consider how this may be supported through the Transformation fund in 2018/19.
Delayed Transfers of Care (DTOC) The number of DTOCs per Health Board - Non Mental Health (age 75+)	In March 2018, the number of non mental health delayed transfers of care was 23 which is significantly lower than the internal profile of 50. Swansea Locality continues to account for the largest proportion of delays (57%), followed by NPT with 35% and Bridgend with 9%.	**Number of Non Mental Health DToCs** 	• Define and maximise use of Discharge to Assess at Home (to increase patient flow) • Piloting Accelerated Placement team in NPT to ensure that individuals who no longer require medical interventions but who are waiting for a package of care or a residential home placement to be transferred to into the supportive environment of the Assessment Unit in Plas Bryn Rhosyn.

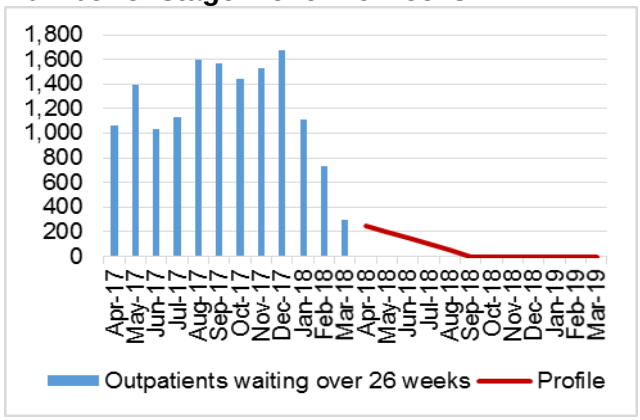
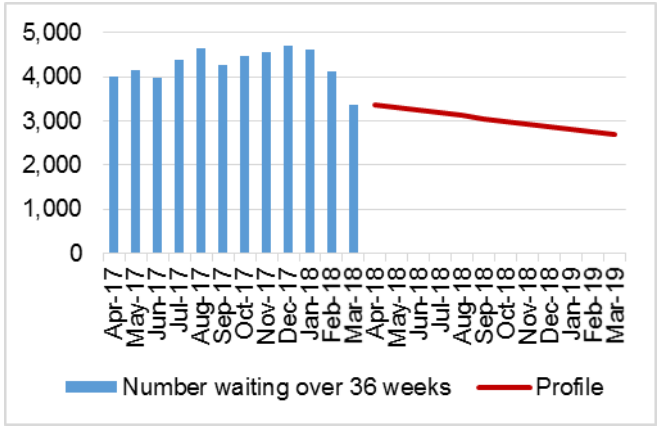
4.2 Acute Stroke Care (WG Measures 69-72)

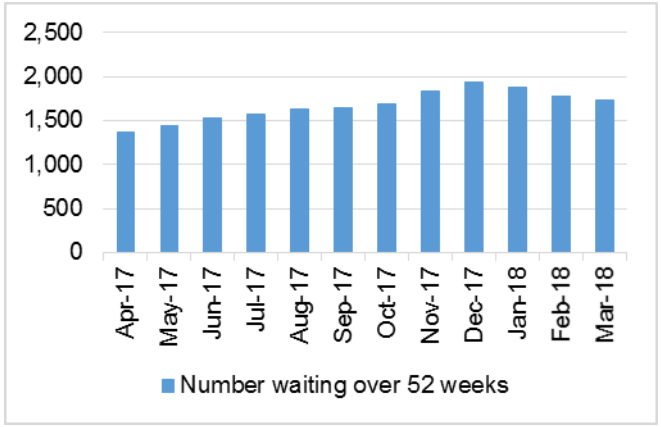
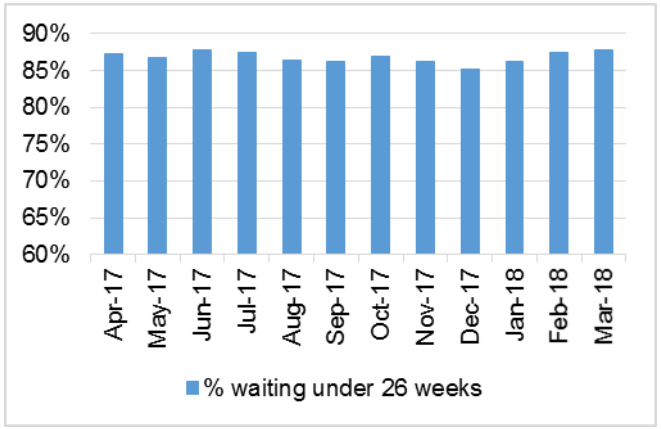
Description	Current Performance	Trend	Actions planned for next period
Stroke Admissions The total number of stroke admissions into the Health Board	In March 2018, there were 91 confirmed stroke admissions across the Health Board; 58 in Morriston and 33 in Princess of Wales. This is higher than the 80 admissions in March 2017.	**Total number of stroke admissions** 	• Training sessions for out of hours nurse practitioners undertaken in February to improve the identification and assessment of stroke patients who arrive overnight
Stroke 4 hour bundle	In March 2018 only 31 out of the 91 patients had a direct admission to an acute stroke Unit within 4 hours. This appears to be a challenge across Wales as in March 2018 performance ranged from 24.4% to 69.6%. ABMU achieved 34.1%.	**Percentage compliance with stroke 4 hour care bundle** 	• Delivery Unit support reviewing stroke pathways in POWH Unit. • Training new cohort of medical doctors on stroke pathway, SAFER flow, board rounds to improve flow. • Ongoing planning in terms of working towards the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from national funding to fund a dedicated project manager to support this work.

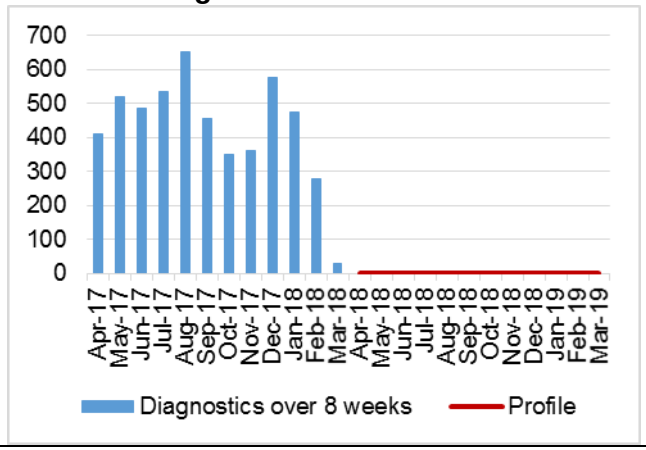
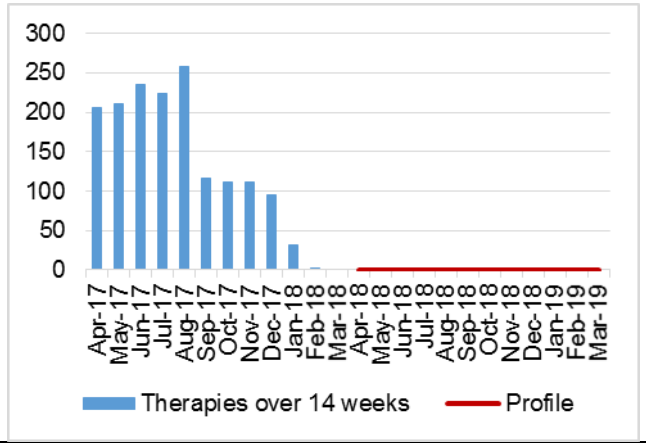
Description	Current Performance	Trend	Actions planned for next period
Stroke 12 hour bundle	In March 2018, ABMU achieved 96.70% which exceeded the internal profile of 95% and the SSNAP national average of 94.3%.	**Percentage compliance with stroke 12 hour care bundle** 	• Process mapping undertaken on the stroke pathway with the support of 1000 Lives - further work required to review and improve the 12 hour access pathway and supported need for additional medical registrar cover to improve timeliness of assessment. Recruitment to additional post continues. • No 18/19 trajectory as measure being superseded.
Stroke 24 hour bundle	In March 2018, ABMU achieved 72.53% which was short of the internal profile of 75% and the SSNAP national average of 82.9%.	**Percentage compliance with stroke 24 hour care bundle** 	• As above.

Description	Current Performance	Trend	Actions planned for next period
Stroke 72 hour bundle	In March 2018, ABMU achieved 91.21% which is below the internal profile of 97%. ABMU has consistently achieved above 90% for this bundle in 2017/18.	**Percentage compliance with stroke 72 hour care bundle** 	• Review of stroke pathway with the support of the Delivery Unit - to identify potential for targeted improvement. • No 18/19 trajectory as measure being superseded.
Thrombolysed Patients with Door-to-Needle <= 45 mins	In March 2018, 93.5% of eligible patients were thrombolysed but only one out of the seventeen patients (5.9%) were thrombolysed within the 45 minutes (door to needle) standard.	**Thrombolysed patients within 45 minutes** 	• As above.

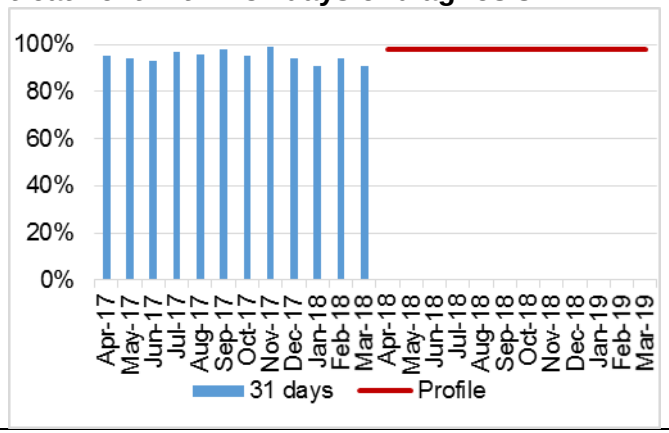
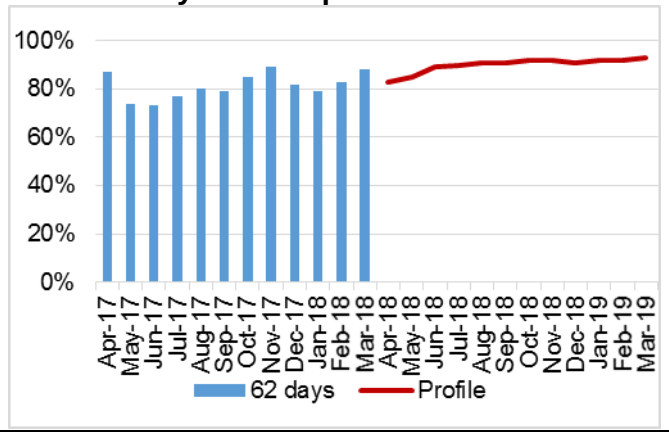
4.3 Planned Care (WG Measures 65-67)

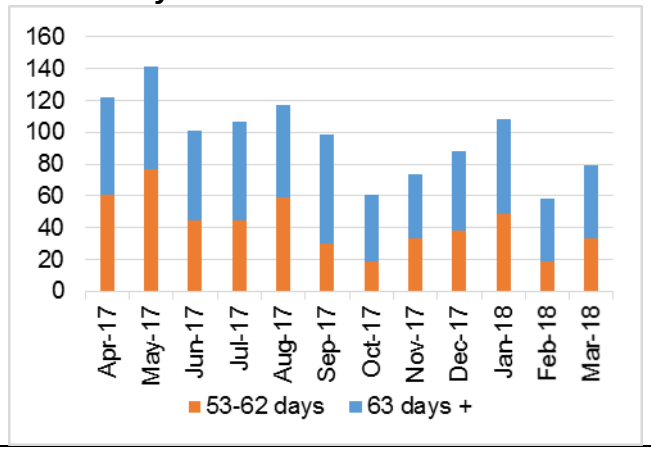
Description	Current Performance	Trend	Actions planned for next period
Outpatient waiting times The number of patients waiting more than 26 weeks for an outpatient appointment (stage 1)	The number of patients waiting over 26 weeks for a first outpatient appointment continues to reduce in line with the internal trajectory. In March 2018 there were 292 patients waiting over 26 weeks compared with 704 in March 2017. OMFS account for 96% of the breaches, followed by Ophthalmology with 3% and Restorative Dentistry (1%).	**Number of stage 1 over 26 weeks** 	• Core capacity being maximised and additional clinics being secured across a range of specialties to improve on the March 2018 position. • OMFS is forecasting a further improvement of 151 in April (128 forecast). • There is a risk in Gynaecology due to mid-long term sickness of 3 consultants. A 12 month locum is being secured to provide some sustainability.
Total waiting times The number of patients waiting more than 36 weeks for treatment	The number of patients waiting longer than 36 weeks from referral to treatment continues to be a challenge for the Health Board. In March 2018 there were 122 less patients waiting over 36 weeks compared with March 2017. 97% of patients are waiting in the treatment stage of the pathway and Orthopaedics accounts for 57% of the breaches, followed by General Surgery with 17%. However, the 3,363 end of year position was above the 2,640 target level and has been subject to financial clawback from Welsh Government.	**Number of patients waiting longer than 36 weeks** 	• Delivery plans being refreshed by 9th May to demonstrate additional capacity gained through theatre productivity, Treat in Turn and a focus on reducing DNA and cancellation rates. Profile will be revised at this point via performance and finance committee • Assessment of additional gain the Vanguard Unit will bring at Morriston. • Outsourcing continuing to be maximised.

Description	Current Performance	Trend	Actions planned for next period
Total waiting times The number of patients waiting more than 52 weeks for treatment	The number of patients waiting over 52 weeks mirrors that of the 36 week position with Orthopaedics and General Surgery accounting for the vast majority of breaches.	**Number of patients waiting longer than 52 weeks** 	• The actions relating to > 52 week patients are the same as 36 week patients. • Specific challenge to make a stepped improvement in the number of long waiting patients over 100wks+. Emerging plans required by 9th May with middle of May with monitoring of improvement in June 2018.
Total waiting times Percentage of patients waiting less than 26 weeks from referral to treatment	Throughout 2017/18 the overall percentage of patients waiting less than 26 weeks from referral to treatment has been consistently around 86% and increased to 87.82% in March 2018.	**Percentage of patient waiting less than 26 weeks** 	• Plans as outlined in previous tables.

Description	Current Performance	Trend	Actions planned for next period
Diagnostics waiting times The number of patients waiting more than 8 weeks for specified diagnostics	In March 2018, there were 29 patients waiting over 8 weeks for specified diagnostics compared with 320 in March 2017. Echo Cardiogram had 27 breaches and Cystoscopy had 2 breaches in March 2018.	**Number of patients waiting longer than 8 weeks for diagnostics** 	• Additional lists secured for Cystoscopy will be cleared through the appointment of a locum Urology Consultant. • Endoscopy will be cleared to Nil in April and sustained through maximising backfill arrangements and utilising the capacity of the insourcing company.
Therapy waiting times The number of patients waiting more than 14 weeks for specified therapies	There has been significant improvement in Therapy waiting times over the last 12 months and there were no patients waiting over 14 weeks in March 2018. This is a reduction of 254 compared with March 2017.	**Number of patients waiting longer than 14 weeks for therapies** 	• Continuation of current plans to manage patients into early appointments to provide headroom for re-booking any late cancellations.

4.4 Cancer (WG Measures 77 and 78)

Description	Current Performance	Trend	Actions planned for next period
NUSC waiting times- Percentage of patients newly diagnosed with cancer, not via urgent route that started definitive treatment within 31 days of diagnosis	In March 2018 the percentage of patients starting treatment within 31 days was 93%. There were 9 breaches in total across the Health Board: • Brain/ CNS: 1 • Gynaecological: 2 • Lower GI: 1 • Lung: 1 • Sarcoma: 1 • Upper GI: 1 • Urological: 2	**Percentage of NUSC patients starting treatment within 31 days of diagnosis** 	• Review of surgical capacity/need for additional consultant surgeons for Gynaecology to be progressed. • Macmillan have agreed the Job Description to fund the Quality Improvement Manager vacancy. The post holder will play a key role in leading and delivering the Cancer Services Improvement Programme across ABMU Health Board.
USC waiting times- Percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within 62 days of receipt of referral	In March 2018 the percentage of patients starting treatment within 62 days was 88%. There were 17 breaches in total across the Health Board: • Breast: 2 • Gynaecological: 4 • Lung: 2 • Other: 2 • Upper GI: 2 • Urological: 5	**Percentage of USC patients starting treatment within 62 days of receipt of referral** 	• Bimonthly support and challenge meetings between MDT) Lead, Service Managers, Cancer Clinical Lead and Lead Service Director continue. • Breast one-stop clinics to commence from 1.5.2018 for NPTH/POW patients. • Undertake a review of outpatient capacity and demand for Gynae-oncology • Lower GI team at Morriston to commence pathway / Demand & Capacity work.

<table>
<tr><th>Description</th><th>Current Performance</th><th>Trend</th><th>Actions planned for next period</th></tr>
<tr>
<td>USC backlog- the number of patients with an active wait status of more than 53 days</td>
<td>End of March backlog by tumour site:
<table>
<tr><th>Tumour Site</th><th>53 - 62 days</th><th>63 ></th></tr>
<tr><td>Breast</td><td>9</td><td>4</td></tr>
<tr><td>Gynaecological</td><td>2</td><td>4</td></tr>
<tr><td>Haematological</td><td>2</td><td>2</td></tr>
<tr><td>Head and Neck</td><td>2</td><td>2</td></tr>
<tr><td>Lower GI</td><td>2</td><td>6</td></tr>
<tr><td>Lung</td><td>3</td><td>3</td></tr>
<tr><td>Other</td><td>1</td><td>0</td></tr>
<tr><td>Skin</td><td>1</td><td>0</td></tr>
<tr><td>Upper GI</td><td>3</td><td>4</td></tr>
<tr><td>Urological</td><td>8</td><td>21</td></tr>
<tr><td>Grand Total</td><td>33</td><td>46</td></tr>
</table>
</td>
<td>Number of patients with a wait status of more than 53 days
 
</td>
<td>

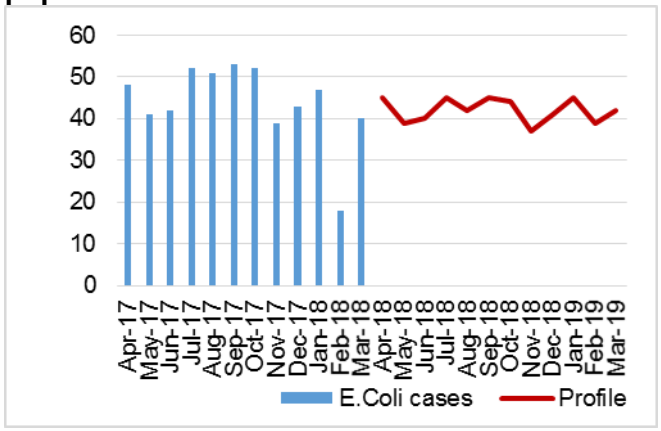
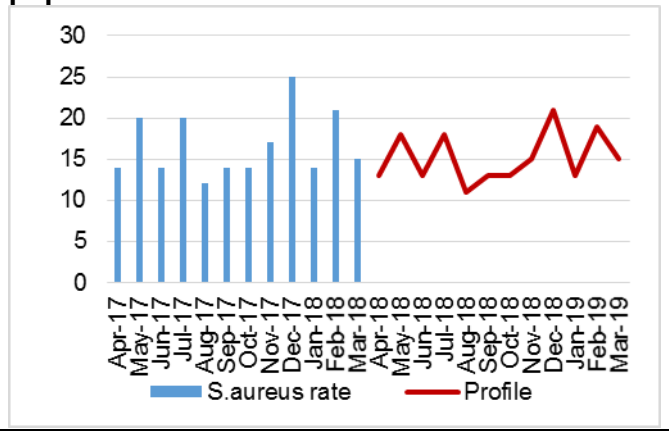
POWH Unit have enhanced tracking arrangements in Urology and Breast and are reviewing opportunities to further increase the tracking resource available
Further clinical engagement to consider potential improvements in the Urology cancer backlog in POWH Unit is planned

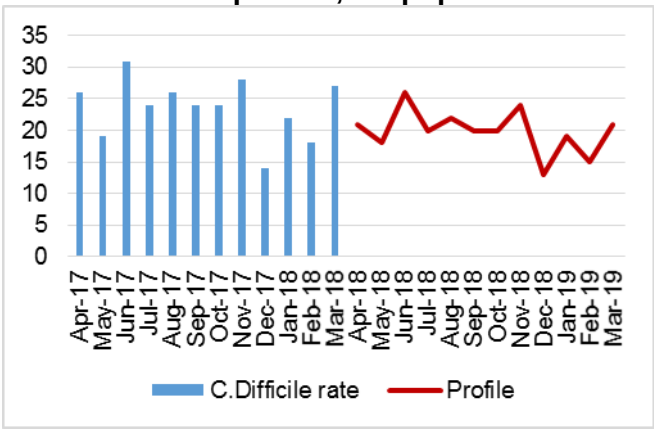
</td>
</tr>
<tr>
<td>USC First Outpatient Appointments
The number of patients at first outpatient appointment stage by days waiting</td>
<td>Week to week through March the percentage of patients seen within 14 days to first appointment/assessment ranged between 44% and 57%.</td>
<td>The number of patients waiting for a first outpatient appointment (by total days waiting)- March 2018
<table>
<tr><th></th><th>≤10</th><th>11-20</th><th>21-30</th><th>>31</th><th>Total</th></tr>
<tr><td>Breast</td><td>0</td><td>9</td><td>30</td><td>48</td><td>87</td></tr>
<tr><td>Gynaecological</td><td>15</td><td>15</td><td>10</td><td>7</td><td>47</td></tr>
<tr><td>Haematological</td><td>2</td><td>0</td><td>0</td><td>0</td><td>2</td></tr>
<tr><td>Head and Neck</td><td>24</td><td>20</td><td>2</td><td>3</td><td>49</td></tr>
<tr><td>Lower GI</td><td>5</td><td>25</td><td>3</td><td>0</td><td>33</td></tr>
<tr><td>Lung</td><td>4</td><td>2</td><td>0</td><td>0</td><td>6</td></tr>
<tr><td>Other</td><td>22</td><td>31</td><td>3</td><td>3</td><td>59</td></tr>
<tr><td>Skin</td><td>60</td><td>15</td><td>2</td><td>2</td><td>79</td></tr>
<tr><td>Upper GI</td><td>0</td><td>2</td><td>0</td><td>1</td><td>3</td></tr>
<tr><td>Urological</td><td>2</td><td>7</td><td>42</td><td>5</td><td>56</td></tr>
<tr><td>Total</td><td>134</td><td>126</td><td>92</td><td>69</td><td>421</td></tr>
</table>
</td>
<td>

Cancer Improvement Team have undertaking Demand & Capacity for USC first outpatient waits. Model in place for gastroenterology, breast and gynaecology Post-Menopausal Bleeding (PMB) pathway and available via the Cancer dashboard as live tools. Work programme to be agreed for the next cohort, likely Lower GI and Urology.

</td>
</tr>
</table>

4.5 Healthcare Acquired Infections (WG Measures 23 and 24)

Description	Current Performance	Trend	Actions planned for next period
E.coli bacteraemia- Rate of laboratory confirmed *E.coli* bacteraemias cases per 100,000 population	Over 2017/18, the Health Board average was 44 cases per month. The total number of cases between April 2017 and March 2018 was 526. By the end of March 2018, the Health Board was 174 cases above the expected cumulative number of cases for 2017/18.	***E.coli* bacteraemias cases per 100,000 population** 	• QI programmes: reducing peripheral cannulae and urinary catheters; review requirement incorporated within Board Rounds. • Ward-based training on the importance of hydration for prevention of Urinary Infections. • Revision of blood culture collection protocol. • Delivery Units working to improve numbers of clinical staff who have completed Aseptic Non Touch Technique (ANTT) training and been competency assessed.
S.aureus bacteraemias- Rate of laboratory confirmed *S.aureus* bacteraemias (MRSA & MSSA) cases per 100,000 population	For the months between April 2017 and March, the Health Board average decreased to 16 cases per month. The total number of cases in 2017/18 was 200. By the end of March, the Health Board was 95 cases above the expected cumulative number of cases for 2017/18.	***S.aureus* bacteraemias cases per 100,000 population** 	• QI programmes as above, and revision of blood culture collection protocol. • ANTT training improvements. • Deliver ward-based training to improve compliance with MRSA risk assessments and provide update on new MRSA decolonisation which has been introduced to improve compliance with treatment.

Description	Current Performance	Trend	Actions planned for next period
C.difficile- Rate of laboratory confirmed C.difficile cases per 100,000 population	Over 2017/18, the Health Board average was 23 cases per month. The total number of cases between April 2017 and March 2018 was 283. By the end of March 2018, the Health Board was 147 cases above the expected cumulative number of cases for 2017/18.	***C.difficile* cases per 100,000 population**  	• Implement a restricted Antimicrobial policy. • Appointment of Quality Improvement Clinical Leads in each Delivery Unit, who will have dedicated sessions and clear objectives to advise and support staff in their objective to reduce HAI. • Increase percentage of patients isolated within 2 hours' onset of unexplained diarrhoea. • Delivery Units to improve compliance with ensuring all single and multi-bedded source rooms are emptied temporarily to enable deep cleaning and high level decontamination following identification and isolation of *C. difficile.*Re-introduction of UVC. • Improve patient environments and reduce over-crowding

5. SUMMARY OF PERFORMANCE AGAINST WELSH GOVERNMENT PERFORMANCE MEASURES

A high level summary of each of the measures by Corporate Objective can be found in the following table. The detail of each of the measures which constitute the tables can be found in section 4 for the Targeted Intervention Priorities and section 6 for all other local and national measures.

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Corporate Objective 1: Promoting and Enabling Healthier Communities					
Staying Healthy	1	Percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks pregnancy	✓	↑ ●	
Staying Healthy	Local measure	Percentage of children up to date in schedule at 4th birthday	✗	↑ ●	No
Staying Healthy	2	Percentage of children who receive 3 doses of the '5 in 1' vaccine by age 1	✓	↓ ●	Yes *(page 38)*
Staying Healthy	3	Percentage of children who received 2 doses of the MMR vaccine by age 5	✗	↓ ●	Yes *(page 38)*
Staying Healthy	4	Percentage of children who are 10 days old within the reporting period who have accesses the 10-14 days health visitor contact component of the Healthy Child Wales Programme	✗	↓ ●	No
Staying Healthy	5	Uptake of the influenza vaccination among: • 65 years old and over • Under 65s in risk groups • Pregnant women • Health care workers	 ✗ ✗ ✗ ✓	 ↑ ● ↑ ● ↓ ● ↑ ●	Yes *(page 40)*
Staying Healthy	6	The rate of emergency hospital admissions for basket 8 chronic conditions per 100,000 of the health board population	✓	↓ ●	No
Staying Healthy	7	The rate of emergency hospital multiple readmissions (with a year for basket 8 chronic conditions per 100,000 of the health board population	✗	↑ ●	No
Staying Healthy	8	The percentage of adult smokers who make a quit attempt via smoking cessation services	✗	→ ●	Yes *(page 42)*
Staying Healthy	9	The percentage of those smokers who are validated as quit at 4 weeks	✓	↑ ●	Yes *(page 42)*
Safe Care	15	Rate of hospital admissions with any mention of intentional self-harm for children and young people per 1,000 population	✗	↑ ●	No
Dignified Care	66	Percentage of people with dementia in Wales age 65 years or over who are diagnosed (registered on a GP QOF register)	✓	↑ ●	No

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Individual Care	87	Rate of calls to the mental health helpline CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population	✓	↑ ●	No
Individual Care	88	Rate of calls to the Welsh dementia helpline by Welsh residents per 100,000 of the population (age 40+)	✗	↓ ●	No
Individual Care	89	rate of calls to the DAN 24/7 helpline by Welsh residents per 100,000 of the population	✗	↓ ●	No
Corporate Objective 2- Delivering Excellent Patient Outcomes, Experience and Access					
Staying Healthy	10	Percentage of people (age 16+) who found it difficult to make a convenient appointment with a GP	✗	↓ ●	No
Safe Care	16	Amenable mortality per 100,000 of the European standardised population	✗	↑ ●	No
Safe Care	19	The number of preventable hospital acquired thromboses	✓	↓ ●	No
Safe Care	20	Total antibacterial items per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)	✓	↑ ●	*No*
Safe Care	22	The rate of laboratory confirmed *E.Coli* bacteraemias cases per 100,000 population	✗	↑ ●	Yes *(page 46)*
Safe Care	23	The rate of laboratory confirmed *S.aueus* bacteraemias (MRSA & MSSA) cases per 100,000 population	✗	↑ ●	Yes *(page 48)*
Safe Care	24	The rate of laboratory confirmed *C.difficile* cases per 100,000 population	✗	↑ ●	Yes *(page 50)*
Safe Care	Local measure	% compliance with Hand Hygiene Audits	✓	↑ ●	Yes *(page 52)*
Safe Care	25	Non steroid anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-Pus (specific therapeutic group age related prescribing unit)	✓	↓ ●	*No*
Safe Care	31	Number of patients with grade 1,2,3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions	✓	↓ ●	Yes *(page 54)*
Safe Care	32	Number of patients with grade 3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in hospital per 100,000 hospital admissions	✗	↑ ●	Yes *(page 54)*

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Safe Care	Local measure	Number of patients with grade 1,2,3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in the community	✓	↓ ●	Yes *(page 56)*
Safe Care	Local measure	Number of patients with grade 3,4 suspected deep tissue injury and un-stageable pressure ulcers acquired in the community	✓	↓ ●	Yes *(page 56)*
Safe Care	Local measure	Total number of inpatient falls	✓	↓ ●	Yes *(page 58)*
Effective Care	37	Delayed transfer of care delivery per 10,000 LHB population-mental health (all ages)	✗	↑ ●	Yes *(page 60)*
Effective Care	38	Delayed transfer of care delivery per 10,000 LHB population- non mental health (age 75+)	✗	↑ ●	Yes *(page 60)*
Effective Care	39	Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death	✗	↓ ●	Yes *(page 62)*
Effective Care	40	Crude hospital mortality rate (74 years of age or less)	✗	→ ●	Yes *(page 64)*
Effective Care	43	Percentage of episodes clinically coded within one reporting month post episode month end date	✗	↑ ●	Yes *(page 66)*
Effective Care	44	Percentage of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	✓	↑ ●	No
Safe Care	Local measure	Percentage of completed discharge summaries	✓	↑ ●	Yes *(page 68)*
Effective Care	45	All new medicines must be made available no later than 2 months after NICE and AWMSG appraisals	✗		
Dignified Care	50	The average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	✗	↓ ●	No
Dignified Care	51	Percentage of patients who had their procedures postponed on more than one occasion for non clinical reasons with less than 8 days notice and are subsequently carried out within 14 calendar days or at the patient's earliest convenience	✓	↑ ●	Yes *(page 70)*
Dignified Care	52	Number of patients agreed 75 and over with an AEC (Anticholinergic Effect on Condition) of 3 or more for items on active repeat, as a percentage of all patients aged 75	*WG establishing data flows*		

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
		years and over			
Dignified Care	56	Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at their GP/ family doctor	✗	↓ ●	No
Dignified Care	57	Percentage of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care that they received at an NHS hospital	✓	↑ ●	No
Timely Care	60	Percentage of GP practices open during daily core hours or within 1 hour of daily core hours	✓	↑ ●	Yes *(page 72)*
Timely Care	61	Percentage of GP practices offering daily appointments between 17:00 and 18:30 hours	✗	↓ ●	Yes *(page 72)*
Timely Care	62	Percentage of P1 calls logged and patient started definitive clinical assessment within 20 minutes of the initial call being answered	*Currently establishing data source and accuracy of data*		
Timely Care	63	Percentage of P1 patients seen within 60 minutes following their clinical assessment or face to face triage			
Timely Care	64	Percentage of the health board population regularly accessing NHS primary dental care	✓	↑ ●	No
Timely Care	65	Percentage of patients waiting less than 26 weeks for treatment	✗	↓ ●	Yes *(page 74)*
Timely Care	66	The number of patients waiting more than 36 weeks for treatment	✗	↓ ●	Yes *(page 74)*
Timely Care	67	The number of patients waiting more than 8 weeks for a specified diagnostic *(Excluding Endoscopy)*	✗	↓ ●	Yes *(page 76)*
		The number of patients waiting more than 8 weeks for Endoscopy	✓	↓ ●	Yes *(page 78)*
Timely Care	68	The number of patients waiting for an outpatient follow-up (booked and not booked) who are delayed past their target date	✗	↑ ●	Yes *(page 80)*
Timely Care	69	Percentage of patients who are diagnosed with stroke who have a direct admission to an acute stroke unit within 4 hours	✗	↑ ●	Yes *(page 82)*
Timely Care	70	Percentage of patients who are diagnosed with stroke who are thrombolysed within 45 minutes (door to needle)	✗	↓ ●	No

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Timely Care	71	Percentage of patients who are diagnosed with stroke who receive a CT scan within 12 hours	✓	↑ ●	Yes (page 82)
Timely Care	72	Percentage of patients who are diagnosed with stroke who have been assessed by a stroke consultant within 24 hours	✗	↑ ●	Yes (page 82)
Timely Care	73	Percentage of emergency responses to red calls arriving within (up to and including) 8 minutes	✓	↑ ●	Yes (page 84)
Timely Care	74	Number of ambulance handovers over one hour	✗	↑ ●	Yes (page 84)
Timely Care	75	Percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge	✗	↓ ●	Yes (page 86)
Timely Care	76	Number of patients who spend 12 hours or more in all major and minor care facilities from arrival until admission, transfer or discharge	✗	↑ ●	Yes (page 86)
Timely Care	77	Percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within 31 days of diagnosis	✗	↓ ●	Yes (page 88)
Timely Care	78	Percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within 62 days of receipt of referral	✗	↑ ●	Yes (page 88)
Timely Care	79	Percentage of survival within 30 days of emergency admission for a hip fracture	✓	↑ ●	No
Timely Care	80	Percentage of mental health assessments undertaken within 28 days from the date of receipt of referral	✓	↑ ●	Yes (page 90)
Timely Care	81	Percentage of therapeutic interventions started within 28 days following an assessment LPMHSS	✓	↓ ●	Yes (page 90)
Individual Care	90	Percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)	✗	↓ ●	Yes (page 90)
Individual Care	91	All health board residents who have been assessed under part 3 of the mental health measure to be sent a copy of their outcome assessment report up to and including 10 working days after the assessment has taken place	✓	→ ●	Yes (page 90)

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Individual Care	92	Percentage of hospitals within a health board which have arrangements in place to ensure advocacy is available for all qualifying patients	✓	→ ●	Yes *(page 90)*
Timely Care	Local measure	Percentage of Urgent Assessment by the Child and Adolescent Mental Health Services (CAMHS) undertaken within 48 Hours from receipt of referral	✗	↑ ●	Yes *(page 92)*
Timely Care	Local measure	Percentage of routine Assessment by CAMHS undertaken within 28 days from receipt of referral	✗	↓ ●	Yes *(page 92)*
Timely Care	Local measure	Percentage of patients with Neurodevelopmental Disorders receiving a Diagnostic Assessment within 26 weeks	✗	↑ ●	Yes *(page 92)*
Timely Care	Local measure	Percentage of therapeutic interventions started within 28 days following assessment by LPMHSS	✗	↓ ●	Yes *(page 92)*
Timely Care	Local measure	Percentage of Health Board residents in receipt of CAMHS to have a valid Care and Treatment Plan (CTP)	✗	↓ ●	Yes *(page 92)*
Our staff & resources	96	Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product plus biosimilar	*WG establishing data flows*		
Our staff & resources	96	Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product plus biosimilar	-	-	No
Our staff & resources	98	Caesarean section rate	✗	↑ ●	No
Corporate Objective 3- Demonstrating Value and Sustainability					
Our staff & resources	93	Rate of patients who did not attend a GP appointment	*WG establishing data flows*		
Our staff & resources	94	Percentage of patients who did not attend a new outpatient appointment	✓	↓ ●	Yes *(page 95)*
Our staff & resources	95	Percentage of patients who did not attend a follow-up outpatient appointment	✓	↓ ●	Yes *(page 95)*
Corporate Objective 4 - Securing a Fully Engaged and Skilled Workforce					
Dignified Care	59	Percentage of GP practice teams that have completed mental health training in dementia care or other training as outlined under the Directed Enhanced Services for mental illness	✗	↓ ●	No

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Our Staff & Resources	100	Percentage of headcount by organisation who have had a PADR/medical appraisal in the previous 12 months	✗	↑ ●	Yes (page 98)
Our Staff & Resources	101	Percentage of staff who are undertaking a performance appraisal who agree it helps them improve how they do their job	✓	↑ ●	No
Our Staff & Resources	102	Overall staff engagement score- scale score method	✓	↑ ●	No
Our Staff & Resources	103	Percentage compliance for each completed Level 1 competency with the Core Skills and Training Framework by organisation	✗	↑ ●	No
Our Staff & Resources	104	Percentage of sickness absence rate of staff	✓	↓ ●	Yes (page 100)
Our Staff & Resources	105	Percentage of staff who would be happy with the standards of care provided by their organisation if a friend or relative needed treatment	✓	↑ ●	No
Corporate Objective 5 - Embedding Effective Governance and Partnerships					
Safe Care	26	Number of Patient Safety Solutions Wales Alerts that were not assured within the agreed timescale	-	-	No
Safe Care	27	Number of Patient Safety solution Wales Notices that were not assured within the agree timescale	✓	-	No
Safe Care	28	Percentage of serious incidents assured within the agreed timescales	✓	↑ ●	Yes (page 104)
Safe Care	29	Number of never events	✗	↑ ●	Yes (page 104)
Effective Care	46	Number of Health and Care Research Wales clinical research portfolio studies	✗	↓ ●	No
Effective Care	47	Number of Health and Care research Wales commercially sponsored studies	✓	↑ ●	No
Effective Care	48	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	✗	↓ ●	No
Effective Care	49	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	✗	↑ ●	No
Dignified Care	Local measure	Number of new formal complaints received	-	↑ ●	Yes (page 106)

WG Framework Domain	WG Measure no.	Performance Measure	Target attained	Trend	Report Card
Dignified Care	54	Percentage of concerns that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the concern was first received by the organisation	✖	↓ ●	Yes *(page 106)*
Dignified Care	Local measure	Percentage of acknowledgements sent within 2 working days	✔	→ ●	Yes *(page 106)*

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

Annual measures in particular do not lend themselves to having a dedicated report card and so these will be integrated into existing report cards where appropriate. The use of dedicated report cards for all national measures will give the Board greater understanding of current performance and actions planned to improve (or sustain) performance in 2018/19.

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

6.1 Promoting and Enabling Healthier Communities

The table starting on page 26 above sets out the assessed performance of the key metrics under this Corporate Objective. Due to the varied reporting frequencies for these measures the reporting periods are mixed within this section but do reflect the most up to date information available. The majority of measures are reported quarterly with quarter 3 for 2017/18 being the latest data available.

The detailed performance report cards provide further background analysis to this performance assessment and cards are in included within this section of the report starting on page 38.

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

Smoking during pregnancy (WG measure 1)

The measure relating to the percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks) is reported on an annual basis with 2016/17 being the latest published data. In 2016/17 ABMU achieved 4.8% compared with 4.7% in 2015/16. This is an annual improvement target, therefore the Health Board has achieved this measure however performance is significantly lower than the all-Wales position of 23.7%.

Confirmation has been received from the Health Board's Midwifery Service that all women are currently automatically referred to smoking cessation when booked at the beginning of the pregnancy. Different ways of working at currently being explored in order to target women who attend regular hospital appointments etc. to reiterate if they have not stopped smoking. In addition, there is also stop smoking support from pharmacy where women can be referred if they are inpatients. When published later in 2018/19 it is hoped that the 2017/18 data will continue to show an improved position.

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

The Healthy Child Wales Programme (HCWP) sets the strategic direction for Health Boards in Wales for the delivery of universal early intervention health services that are designed to address health inequalities and aims to ensure that children achieve their health potential. The programme was implemented in ABMU from 1st October 2016. The programme sets out universal provision for children and their families can expect from the Health Boards from maternity services to a child's 7th birthday

The Universal contacts cover three areas of intervention:

- Screening
- Immunisation
- Monitoring and supporting child development

One of the measures in the HCWP which is included in the NHS Wales Delivery Framework, is the percentage of children who are 10 days old within the reporting

period who have accessed the 10-14 days health visitor contact component. The latest published data for April- December 2017 (quarter 3) shows that ABMU achieved 53.5% which is lower than the all-Wales position of 83.1%. ABMU is the worst performing Health Board in quarter 3.

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

- The process for data collection is paper based and requires practitioners to update a lengthy form that is sent in the post to the Child Health Dept
- Practitioners are reporting that the contacts have been completed and the forms have been submitted to the child health departments but a relatively high number of forms have failed to be delivered. Meetings have been held across Delivery Units (Primary and community services and Singleton with Information Governance) to consider paper less options but the same is currently not viable due to the limitations of the system functionality and also demand and capacity pressures within Child Health department
- During end April/May there is an internal audit of completed Child Health data forms to review processes and compliance

Emergency hospital admissions and re-admissions (WG measures 6-7)
The 8 basket procedures included in the measure are:

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

The rationale behind this measure is that emergency admissions for chronic conditions will improve through the availability and quality of comprehensive services for integrated chronic conditions management resulting in a smooth and efficient patient pathway.
In January 2018 the rate of emergency admissions (for basket of 8 chronic conditions) improved compared with January 2018 but readmissions saw a deterioration when compared with January 2018. The Health Board is above the all-Wales average for both measures.

The following tables show how ABMU compares with the other Health Boards in Wales and historical activity trends.

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

LHB	Current	Same Period Comparison		
	Jan-18	Jan-17	Jan-16	Apr-11
Wales	1,108	↑ 1,234	↑ 1,166	↑ 1,244
ABM	1,274	↑ 1,314	↓ 1,184	↑ 1,372
AB	1,224	↑ 1,340	↑ 1,280	↑ 1,319
BCU	1,009	↑ 1,149	↑ 1,175	↑ 1,204
C&V	1,013	↑ 1,110	↑ 1,026	↑ 1,141
CTaf	1,405	↑ 1,715	↑ 1,558	↑ 1,560
HDda	1,159	↑ 1,328	↑ 1,232	↑ 1,346

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

LHB	Current	Same Period Comparison		
	Jan-18	Jan-17	Jan-16	Apr-11
Wales	231	↑ 252	↑ 243	↑ 269
ABM	265	↓ 264	↓ 252	↑ 297
AB	250	↑ 276	↑ 261	↑ 305
BCU	221	↑ 245	↑ 264	↑ 260
C&V	204	↓ 198	↓ 188	↑ 228
CTaf	320	↑ 392	↑ 344	↑ 361
HDda	222	↑ 258	↑ 237	↑ 267

Calls to helplines (WG measures 87-89)

These measures focus on three helplines available to Welsh residents which include the C.A.L.L. helpline; the DAN 24/7 helpline and Wales Dementia helpline. The Community Advice and Listening Line (C.A.L.L.) service offers emotional support and information/literature on Mental Health and related matters to people in Wales. The Wales Dementia helpline offers emotional support to anyone, of any age who is caring for someone with Dementia as well another family members of friends plus it supports those who have been diagnosed with Dementia. DAN 24/7 is a telephone drugs helpline providing a single point of contact for anyone in Wales wanting further information or help relating to drugs or alcohol.

The latest data available is quarter four 2017/18 which shows that there has been a significant increase in the uptake for the C.A.L.L. helpline but a reduction in uptake for the other two helplines when compared with quarter four 2016/17. For the uptake rates of the DAN 24/7 helpline, ABMU is above the all-Wales uptake rate (36.3 compared with 34.4). Whereas the uptake rate for the Wales Dementia helpline is lower than 2016/17 below the all-Wales rate (4.4 compared with 7.6).

Even though the uptake rate for C.A.L.L. has significantly improved from 83.2 in 2016/17 to 107.5, ABMU has the lowest uptake rate in Wales and is significantly below the all-Wales average of 173.9. The Health Board actively promotes the C.A.L.L. helpline through the use of leaflets and call cards which are made available in community sites and wards. Care co-ordinators also advise people they come into contact with about the helpline. In addition, as the helpline is for all people with any mental wellbeing concerns not just severe mental health difficulties, the helpline is featured in our Choose Well materials.

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

- Childhood vaccinations (WG measures 2 and 3)
- Influenza immunisation (WG measure 5)
- Smoking Cessation (WG measures 8 and 9)

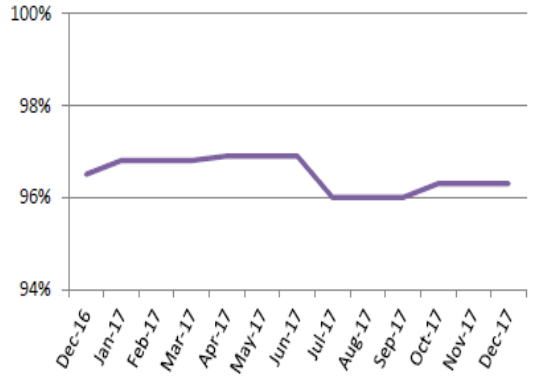
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

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

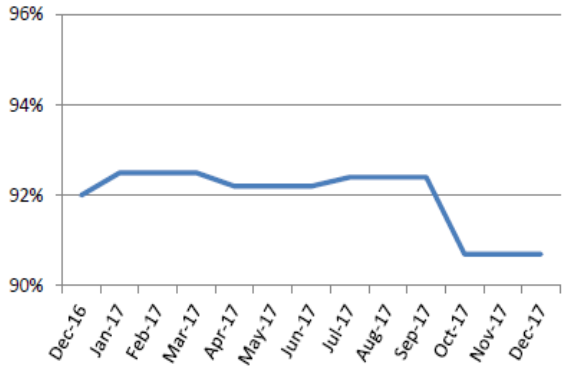
Corporate Objective : Promoting & Enabling Healthier Communities			Executive Lead : Sandra Husbands	
Period : Dec 17	IMTP Profile Target :	WG Target : 95%	Current Status : ✖	Movement : ⇩ ● Worsening

Current Trend: Dec 16- Dec 17

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



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



Benchmarking

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

LHB	Current	Same Period Comparison		
	Q3 17/18	Q3 16/17	Q3 15/16	Q3 14/15
Wales	95.8%	⇩ 96.2%	⇩ 96.9%	⇧ 95.1%
ABM	96.3%	⇩ 96.5%	⇩ 97.2%	⇧ 96.1%
AB	96.1%	⇩ 96.7%	⇩ 97.4%	⇩ 96.3%
BCU	96.5%	⇩ 96.6%	⇩ 96.7%	⇧ 94.9%
C&V	94.2%	⇩ 95.0%	⇩ 95.8%	⇧ 91.9%
CTaf	96.9%	⇩ 97.7%	⇩ 98.3%	⇩ 97.7%
HDda	93.9%	⇩ 94.8%	⇩ 97.3%	⇩ 94.6%
Powys	97.2%	⇧ 95.7%	⇧ 95.1%	⇧ 94.0%

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

LHB	Current	Same Period Comparison		
	Q3 17/18	Q3 16/17	Q3 15/16	Q3 14/15
Wales	89.9%	⇩ 90.7%	⇩ 91.9%	⇩ 93.0%
ABM	90.7%	⇩ 92.0%	⇩ 93.6%	⇩ 92.5%
AB	89.3%	⇩ 89.6%	⇩ 91.1%	⇩ 92.6%
BCU	91.8%	⇩ 92.8%	⇩ 94.4%	⇩ 94.4%
C&V	87.7%	⇩ 88.4%	⇩ 89.8%	⇩ 91.9%
CTaf	91.8%	⇩ 92.8%	⇨ 91.8%	⇩ 93.9%
HDda	87.2%	⇩ 88.6%	⇩ 90.3%	⇩ 92.4%
Powys	91.6%	⇧ 88.7%	⇧ 90.3%	⇩ 92.7%

Source : Vaccine Uptake in Children in Wales October to December 2017 (COVER 125)

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

How are we doing?

- Measure 1 - Although there is a small decrease in uptake rates, ABMU continues to achieve uptake rates which are consistently above 95%. All 3 Local Authorities (LA) are above 95% for this outcome measure. Uptake rates are higher in Bridgend LA (97.6%) and lowest in Swansea LA (95.7%)
- Measure 2 - During the last quarter we have seen a decrease in the number of children, who by the age of 5 years have received 2 doses of the MMR vaccine. Uptake of this vaccine varies between the 3 Local Authorities. During this reporting quarter uptake is highest in NPT LA (91.3%) and lowest in Swansea LA (89.9%). It is worth noting that Public Health Wales (PHW) have advised in the COVER report that ' vaccination uptake for children reaching 5 years of age is currently undergoing enhanced quality assurance checks. These figures should be interpreted with caution'

What actions are we taking?

- Health Visitors (HV's) receive weekly reports from the Child Health department, of the names of children who are currently on their caseload, who have missed immunisation appointments. This requires HV's to follow local and National guidance prior to instructing Child Health to re-appoint these children for their immunisations. The accuracy of the immunisation history held on the Child Health system is reliant on information forwarded by HV's and GP practices. At present there is no data linkage between the Child Health system to that of the GP systems.
- Health Visitor managers request a monthly report of children aged 18 months and 4.5 years who are recorded on the Child Health system with an outstanding MMR vaccination(s) for action as per national guidance
- The Healthy Child Wales programme ensures contact between the HV and family at 3.5 years and also requires the HV to hand over to the named school health nurse upon school entry if the child remains to have outstanding immunisations.
- Primary care managers are monitoring current waiting lists and cancelled clinics. There is an expectation that no practice should have a queue of children waiting for an appointment for their routine immunisations.
- The local Public Health Team (PHT) are working in collaboration with childcare settings to raise awareness of the importance of vaccinations amongst staff and parents.

What are the main areas of risk?

- In respect of Measure 1 - overall we are above 95% which is positive, however in view of cancelled immunisations clinics and waiting lists there is a risk that some resident children across ABMU are not in receipt of timely vaccinations, which could leave some children susceptible to a vaccine preventable disease.
- In respect of Measure 2 - overall we are below the 95% target which is required in order to achieve herd immunity. This is a risk given the cases of measles that have recently been confirmed in South East Wales. This risk could be increased further given the forthcoming events /concerts planned in the Swansea area, where a large number of people are expected to attend, possibly from areas which have had confirmed measles cases.

How do we compare with our peers?

- Measure 1 - during this reporting period ABMU are ranked fourth and above the Welsh average of 95.8%. The highest ranking Health Board achieved uptake rates of 97.2%.
- Measure 2 - ABMU is currently above the Welsh average (89.9%) and ranked third amongst the Welsh Health Boards. The highest ranking Health Board achieved uptake rates of 91.8%

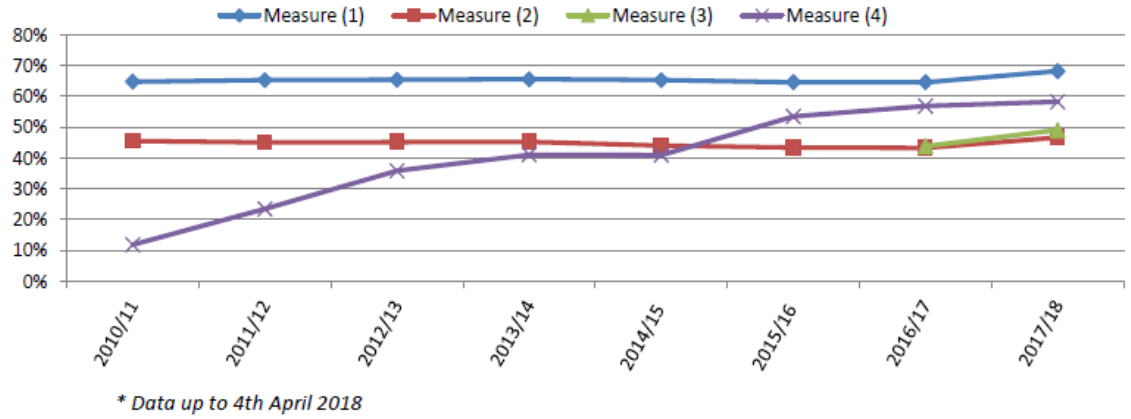
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

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

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

Current Trend: 2010/11 - 2017/18

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



Benchmarking

% uptake of the Seasonal Flu Vaccine

2017/18	ABM	AB	BCU	C&V	CTaf	HDdA	Powys	Wales
(1) 65+	68.2%	69.80%	70.60%	71.00%	67.70%	65.00%	66.3%	68.8%
(2) 6 months to 64 years @ Risk	46.7%	50.80%	51.60%	49.00%	46.80%	42.90%	47.9%	48.5%
(3) 2 to 3 Year Olds	49.1%	49.10%	54.30%	49.20%	53.00%	43.10%	56.9%	50.2%
(4) Health Care Workers	58.3%	*Current uptake for other Health Boards not available*						

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

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

How are we doing?

As of 4th April 2018 (IVOR)

- Measure 1. This season uptake has increased to 68.2% from 65.1% in 2016/17 with an additional 3,764 vaccinations given. Uptake by cluster ranges from 73.9% to 63.6%. Uptake by practice ranges from 84.3% to 59.2%. 12 practices achieved the 75% national target.
- Measure 2. Uptake has increased to 46.7% from 43.7% in 2016/17 with an additional 2,279 vaccinations given. Cluster uptake ranges from 51.8% to 39.9%. Practice uptake ranges between 76.7% and 28.9%. 11 practices achieved the 55% national target.
- Measure 3. Uptake has increased to 49.1% from 43.9% in 2016/17. Cluster uptake ranges from 57.5% and 34.2%. Practice uptake ranges between 90% and 27.3%. Uptake for 2 year olds is higher 52.5% than 3 year olds 45.8%, a trend seen across Wales.
- Measure 4. 58.5% of frontline staff have received the vaccine.

What actions are we taking?

- Campaign debrief and plans for the incoming season are underway
- In line with Joint Committee on Vaccination & Immunisation (JCVI) and Welsh Government advice ABMU is advocating each practice to order the adjuvanted TIV for patients aged 65 and older. Practices that haven't yet ordered are being followed up. The Primary Care Flu Planning Group will work with practices to overcome any issues faced due to the advised lateness in delivery of the vaccine.
- Chronic respiratory patient groups to be prioritised
- Engagement with Health Visitor Teams to support increase in 2 and 3 year old uptake and reduce variance between practices
- Explore opportunity to work with local Muslim community to better understand the barriers to vaccine uptake

What are the main areas of risk?

- Uptake amongst patients aged 6 months to 64 years at risk needs to improve as these patients are more vulnerable to the complications of flu.
- Overall uptake among 2 and 3 year olds has improved, but wide variance between practices remains. Vaccination uptake is higher in 2 year olds compared to 3 year olds.
- A multi-disciplinary review of the staff campaign has been undertaken and Public Health Wales has been informed of data collection issues that may have prevented ABMU reaching the Welsh Government target of 60% of frontline staff receiving the vaccination.

How do we compare with our peers?

Compared to other Welsh Health Boards ABMU is ranked:

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

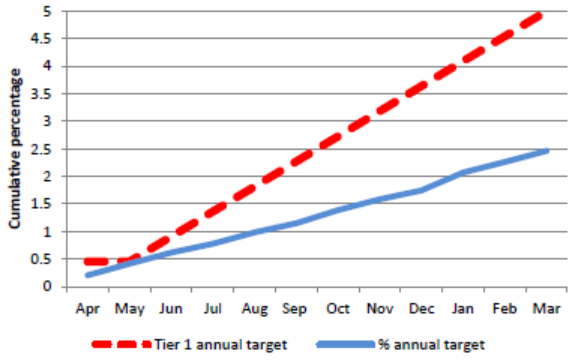
STAYING HEALTHY - PEOPLE IN WALES ARE WELL INFORMED AND SUPPORTED TO MANAGE THEIR OWN PHYSICAL AND MENTAL HEALTH

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

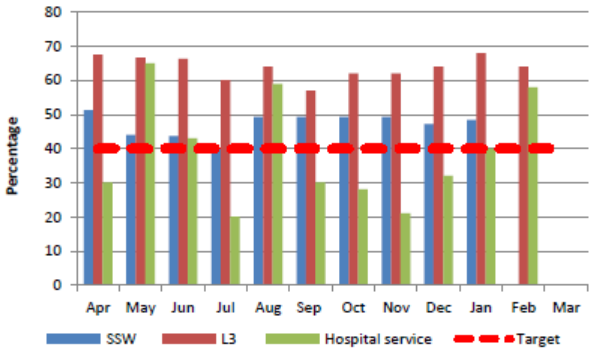
Corporate Objective : Promoting & Enabling Healthier Communities			Executive Lead : Sandra Husbands	
Period : Mar 2018	IMTP Profile Target : (1) 5% (2) 40%	WG Target : (1) 5% (2) 40%	Current Status :	Movement : Impr

Current Trend: 2017-2018 (monthly)

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



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



Benchmarking

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

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

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

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

How are we doing?

- To achieve the 5% smoking cessation target approximately 4,600 smokers need to be treated in ABMU stop smoking services per year, with an average of 383 smokers treated per month. ABMU has treated 2,260 smokers (monthly activity data) against the cumulative monthly target of 4,590 achieving 2.5% of the overall 5% target (expected trajectory performance by March 2018 is 5%). N.B this data is not fully reflective of all service data to year end, as hospital service data is not yet available for March 2018.
- Level 3 community pharmacy cessation services and Stop Smoking Wales have consistently achieved over the 40% target, for smokers that have a Carbon monoxide (CO) validated reading as quit at 4 weeks. The hospital service performance against this measure has varied, however the latest data shows improved performance and above the 40% target.
- The most recent data from the National Survey for Wales 2016/17 estimates that 21% of ABMU's population (aged 16+) smoke. This is higher than the Wales average of 19%. Smoking prevalence in ABMU's constituent counties are Bridgend 20.0%, Swansea 20.0% and NPT 24.6%.

What actions are we taking?

- An ABMU Cessation Services Steering group has been established, and agreement gained for governance and reporting of the group to ABMU Quality and Safety Forum and Committee
- A Tobacco Risk Register is in development. A review of ABMU cessation services is now to be undertaken as part of the national integration agenda and against minimum service standards being developed on an all-Wales basis. Scoping of this review is in progress.
- Phase 3 of the national integrated cessation system is in progress in line with actions within the Tobacco Control Action Plan for Wales. ABMU has participated in the all-Wales review of Cessation Services by Welsh Government. Broader work to create supportive smoke free environments is being scoped, including smoke free hospital sites, in line with Public Health Act requirements
- Following the Burden of disease workshop held between Primary care delivery unit and Public Health team, plans are being scoped for tobacco priorities for primary care, including a programme of work to increase referrals from primary care for smokers and targeted groups (pre-op; COPD etc.) into Help Me Quit services. A Pilot project has commenced with 2 Swansea clusters to increase referral to cessation services.
- National monthly meetings are being held to look at system wide improvements across Health Boards for maternal smoking, as part of Welsh Government's National improvement programme. The ABM maternal smoking working group is progressing work to improve compliance of NICE guidance; referral to cessation services and improve attrition in cessation services for pregnant smokers.

What are the main areas of risk?

- Measure 1 of the Cessation target not met in 2017/18. New cessation brand 'Help me quit' introduced in April 2017. Possible confusion for smokers and service referrers during transition period of current cessation services to the new brand, and impacting on numbers accessing support through services.
- Hospital cessation service does not currently see mental health in-patients and therefore there is an inequity of service provision. ABMU has no specialist MAMMS service for pregnant smokers in line with evidence and requirements of WG National Improvement programme
- Focus currently on cessation services and driving the demand to services, without addressing the broader supportive environments and wider determinants agenda. This work being scoped for progression in 2018/19.
- Commissioned pharmacies are now accredited, but not necessarily actively delivering the service. Service to be extended to 100 ABMU pharmacies in line with national funding. The projected numbers of pharmacies do not deliver the required number of treated smokers

How do we compare with our peers?

- The latest published quarterly data from Welsh Government shows that during Q1-2 2017/18 ABMU was above the all-Wales position for the percentage of resident smokers who are CO validated as successfully quitting at 4 weeks. ABMU is shown to have improved performance for this measure of the target compared to the same period in 2016/17.

6.2 Delivering Excellent Patient Outcomes, Experience and Access

The table which starts on page 26 above sets out the assessed performance of the key metrics under this Corporate Objective. For the majority of cases this data relates to January 2018. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 46.

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

New Treatment Fund (WG measure 45)

The Welsh Government launched the New Treatment Fund in January 2017. The fund provides an additional £16 million annually for Health Boards and Trusts in Wales to support the faster introduction of new medicines recommended by the National Institute for Health and Care Excellence (NICE) and the All Wales Medicines Strategy Group (AWMSG).

The New Treatment Fund requires the seven Health Boards and one NHS trust to make recommended medicines available as soon as is reasonably practicable and certainly within 60 days of the publication of the decision. The measure itself was created to reflect the New Treatment Fund requirements in WHC (2017) 001. Failure to be complaint would potentially jeopardise the Health Board's funding allocation. Compliance is reported on a monthly basis to Welsh Government and bi-monthly through the Health Board's Medicines Management Board.

The latest published data relates to April 2017 to September 2018 which shows that ABMU was 98.1% complaint, however the unpublished data up to March 2018 confirms that ABMU is 100% compliant as the only technology not yet provided access to is Strimvelis which is a Welsh Health Specialised Services Committee (WHSSC) commissioning responsibility and there are no patients eligible with ABMU at this point.

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

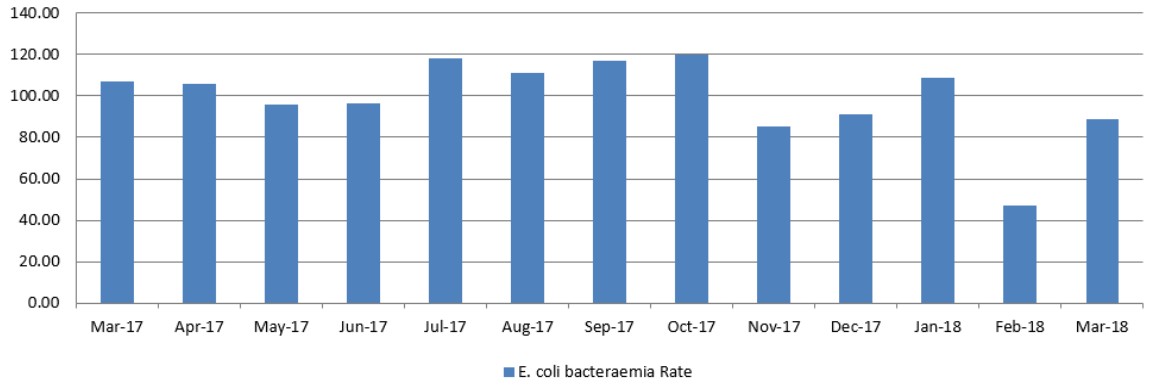
- Infection Control (WG Measure 22 to 24)
- Pressure Ulcers (Local Measure)
- Inpatient Falls (Local Measure)
- Mortality (WG Measures 39, 40 and 79)
- Delayed Transfers of Care (DTOCs) (WG Measures 37 and 38)
- Clinical Coding (WG Measures 43)
- Discharge Summaries (Local Measure)
- Postponed Operations (WG Measures 51)
- Primary Care Access (WG Measures 60, 61 and 64)

- Planned Care (WG Measures 65 to 67)
- Delayed Follow-ups (WG Measure 68)
- Stroke (WG Measures 69 to 72)
- Unscheduled Care (WG Measures 73 to 76)
- Cancer (WG Measures 77 and 78)
- Mental Health (WG Measures 80 to 92)
- Child and Adolescent Mental Health (CAMHS) (Local Measures)

SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM				
Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Angela Hopkins**	
Period : Mar 2018	**IMTP Profile Target :**	**WG Target : 67 per 100,000 population**	**Current Status :**	**Movement :** Improving

Current Trend: Mar 17 - Mar 18

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



Benchmarking

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

LHB	Apr 17 - Mar 18	Cumulative Number Against Mar 18 Reduction Expectation
Wales	82.84	+503
ABM	99.00	+172
AB	75.67	+88
BCU	75.59	+61
C&V	70.62	+56
Ctaf	91.58	+75
Hdda	118.06	+197

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected reduction by Mar 18

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

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

How are we doing?

- Over the 12 months of 2017/18, the Health Board average was approximately 44 cases per month. The total number of cases between April and March 2018 was 526; more than 170 cases above the expected cumulative number of cases for 2017/18.
- 40 cases of Escherichia coli (E. coli) bacteraemia were identified in March 2018.
- Local surveillance of all cases has identified that 70% of all cases were community-acquired infection.
- 30% of all cases were identified as being hospital acquired cases. The distribution of hospital acquired cases is as follows: Morriston – 42%, Singleton – 26%, Princess of Wales – 18%, Neath Port Talbot – 12%; Mental Health & Learning Disabilities – 2%; Primary Care & Community Services – 1%.
- There has been a 12% increase in the number of cases of E. coli bacteraemia identified within the Health Board between April and March 2018, compared with 2016/17.

What actions are we taking?

- There has been no national surveillance programme specific to E. coli bacteraemia in the past. 2017/18 was a year where the Health Board established baseline surveillance data, whilst additionally it is required to achieve a reduction.
- Analysis of local surveillance identified that in 48% of cases, the urinary tract was considered to be the source of the bacteraemia; in 51% of these cases, E. coli had been identified in urine samples; of the cases that were considered to have a urinary source, evidence of a urinary catheter was documented in 12% of cases (if a urinary catheter was in situ but not documented, or if a urinary catheter had been removed in the week prior to blood culture, catheter associated infections may have accounted for more cases). The source of the bacteraemia was unknown in 22% of cases; 12% of cases were documented to be associated with hepato-biliary sources.
- Delivery Units (DUs)will be expected to include in their annual plans how they will progress the number of staff who have been ANTT competence assessed – for 2018/19 financial year.
- A training package specific to prevention and correct identification of urinary tract infection been developed as a “bolt-on” to Standard Infection Control Precautions training, is being rolled out across the Health Board throughout 2018/19.
- Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters –into Q1, 2018/19.
- Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters in 6 wards – launched March 2018.

What are the main areas of risk?

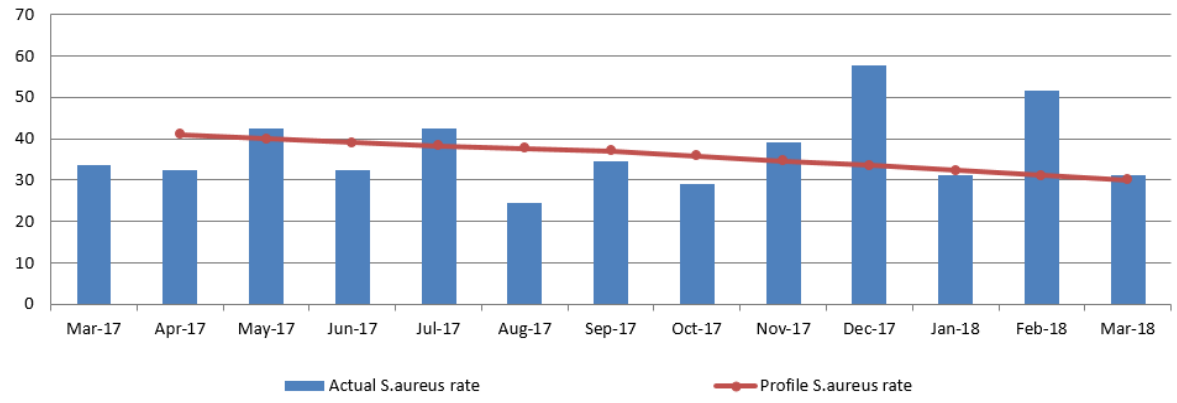
- A large proportion of E. coli bacteraemia is community acquired, with many patient related contributory factors, particularly in relation to urinary tract infection and biliary tract disease. As such, it will be a challenge to prevent a significant proportion of these.

How do we compare with our peers?

- ABMU has the second highest cumulative incidence of E. coli bacteraemia in comparison with the other major Welsh Health Boards. There has been an approximate 1% increase in cases across NHS Wales in 2017/18, compared with 2016/17.
- Wales has not achieved the 2017/18 reduction expectation.
- None of the six major health boards have achieved the 2017/18 reduction expectation.
- Four of the eight health boards (Betsi Cadwaladr UHB, Cardiff and Vale UHB, Cwm Taf UHB and Velindre NHST) have fewer cases in Apr 17 – Mar 18 compared to Apr 16 – Mar 17. One has remained the same (Powys THB).

SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM				
Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Angela Hopkins**	
Period: Mar 2018	**IMTP Profile Target : 30.0**	**WG Target : 20 per 100,000 population**	**Current Status :** ✖	**Movement :** ⇧ ● **Worsening**
Current Trend: Mar 17 – Mar 18				

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



Benchmarking

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

LHB	Apr 17 - Mar 18	Cumulative Number Against Mar 18 Reduction Expectation
Wales	30.13	+319
ABM	37.22	+92
AB	25.85	+41
BCU	28.60	+61
C&V	31.64	+59
Ctaf	33.88	+42
Hdda	34.14	+55

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected reduction by Mar 18

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

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

How are we doing?

- For the year, April to March 2017/18, the Health Board average was 17 cases per month. The total number of cases between April and March 2018 was 200. By the end of March, the Health Board had exceeded the maximum total number of cases to achieve the annual infection reduction expectation by more than 90 cases.
- In March, the Health Board had 15 cases of Staph. aureus (SA) bacteraemia; none of these was a case of MRSA bacteraemia. During 201/18, local surveillance identified that 99 of the 200 cases (49%) were hospital acquired infections; 101 (51%) were community acquired infections. Morriston accounted for 59% of the hospital acquired cases; Princess of Wales and Singleton hospitals accounted for 16% each of hospital acquired cases.
- There has been a 10% increase in the number of cases of Staph. aureus bacteraemia identified within the Health Board between April 2017 and March 2018, compared with 2016/17.

What actions are we taking?

- Delivery Units (DUs) will be expected to include in their annual plans how they will progress the number of staff who have been ANTT competence assessed – for 2018/19 financial year.
- Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters – ongoing during Q4, 2017/18 and into Q1, 2018/19.
- Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters in 6 wards – launched March 2018.

What are the main areas of risk?

- 51% of Staph. aureus bacteraemia is community acquired, with many patient related contributory factors, such as recreational infecting drug use, arthritis, chronic conditions, etc. As such, it is a challenge to prevent a significant proportion of these.
- Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
- Bed occupancy, which frequently is close to, or exceeds, 90%. Analysis by the Department of Health, reported in Tackling healthcare associated infections through effective policy action (BMA, June 2009), suggested that when all other variables are constant, an NHS organisation with an occupancy rate above 90 per cent could expect a 10.3% higher MRSA rate compared with an organisation with an occupancy levels below 85%.
- High bed turnover. In the same BMA report, the impact on MRSA rates of turnover intervals were suggested to have a greater impact on MRSA rates than bed occupancy levels.

How do we compare with our peers?

- ABMU continues to have the highest cumulative incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards. There has been an 11% increase in cases across NHS Wales in the 12 months of 2017/18, compared with the same period in 2016/17.
- None of the 6 major Health Boards achieved the 2017/18 reduction expectation.

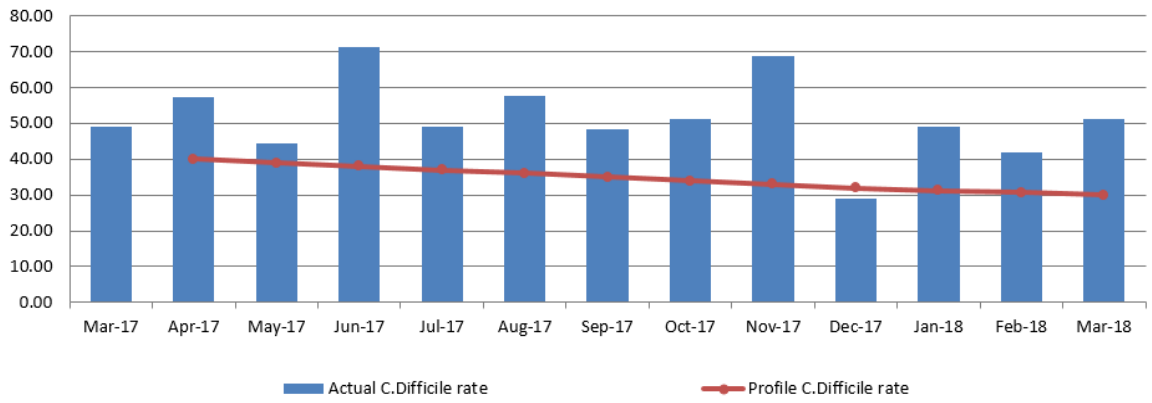
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Mar 2018	**IMTP Profile Target :** 30.0	**WG Target :** 26 per 100,000 population	**Current Status :** ✖	**Movement :** ⇩ ● Improving

Current Trend: Mar 17 - Mar 18

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



Benchmarking

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

LHB	Apr 17 - Mar 18	Cumulative Number Against Mar 18 Reduction Expectation
Wales	36.59	+334
ABM	52.52	+142
AB	36.81	+70
BCU	39.38	+94
C&V	25.72	0
Ctaf	18.78	-3
Hdda	40.66	+57

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected reduction by Mar 18

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

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

How are we doing?

- Public Health Wales (PHW) monthly data was not correct at time of initial publication; amendments have been sent to PHW from the Health Board. Local surveillance data is correct and will be used as the basis for this report. Over the 12 months of 2017/18, the Health Board average was approximately 24 cases per month. The total number of cases between April and March 2018 was 283. At the end of the March 2018, the Health Board was 147 cases above the expected cumulative number of cases for 2017/18.
- 27 cases of C. difficile infection were identified in ABMU in March 2018. Local surveillance identified that 19 of the 27 cases in March were hospital acquired infections.
- For the year 2017/18, local surveillance of all cases has identified that 78% of all cases were hospital-acquired infection (occurring more than 48 hours after admission), however, antimicrobial prescribing in Primary Care potentially contributes to an indeterminate proportion of these cases.
- The distribution of hospital acquired cases from April 2017 to March 2018 is as follows: Morriston – 43%; Princess of Wales – 31%; Singleton – 19%; Neath Port Talbot – 5%; Primary Care & Community – 1%; Mental Health & Learning Disabilities – 1%
- There had been a 24% increase in the number of cases of Clostridium difficile infection identified within the Health Board between April and March 2018, compared with 2016/17. The rate of increase April – November 2018 was 47%. The rate of increase slowed in the subsequent four months.

What actions are we taking?

- More restrictive antimicrobial guidelines are being amended currently, in preparation for implementation during Quarter 1, 2018/19. There is significant clinical concern amongst clinicians in Morriston regarding the increased use of alternative antibiotics due to their potential for harm (ototoxicity and nephrotoxicity) if the restrictive policy is implemented.
- Safe system of work protocol in relation to UVC completed. Updated training programme, based on new safe system, has been developed. The revised safe system of work and associated training have been sent to HSE before training commences. The introduction of UVC should occur within the next two months, but will be dependent on any challenge made by staff-side.
- The Medical Director has agreed funding for identified clinical leads for Infection Prevention and Antimicrobial Stewardship in the acute Delivery Units. Job Descriptions are being prepared in preparation to invite expressions of interest in April 2018.

What are the main areas of risk?

- Contributory factors: secondary care antibiotic prescribing; impact of high numbers of outliers on good antimicrobial stewardship; use of pre-emptive beds; suspension of enhanced decontamination technologies; lack of decant facilities which restricts ability to undertake deep-cleaning of clinical areas. The deep cleaning process is disjointed and depends on three separate staff groups to each play their part in the right timescale for the process to be effective and robust. This requires a redesign, moving all resourcing to one team. This will improve outcome and increase assurance.
- C. difficile spores may be found in 49% rooms of patients with C. difficile infection; 29% rooms of asymptomatic carriers.
- Studies have identified a correlation between peak incidence for Influenza and pneumonia and a subsequent peak in C. difficile incidence, approximately 9 weeks later, or with a 1-2 month lag (respectively). At the peak of seasonal influenza in 2018, the incidence was almost x4 more than the peak in 2017. The Health Board should anticipate increased incidence of C. diff between March and May 2018

How do we compare with our peers?

- ABMU ended the year with the highest cumulative incidence of C. difficile infection (approximately 53/100,000) in comparison with all other major Welsh Health Boards. Hywel Dda has the second highest incidence, at 40.66. More significantly, Cardiff & Vale UHB had an incidence of 25.72, which is less than half the rate in ABMU.
- There has been a 9% increase in cases across NHS Wales in the 12 months of 2017/18, compared with the same period in 2016/17.
- Wales has not achieved the 2017/18 reduction expectation.
- Provisionally, two of the six major Health Boards have achieved the reduction expectation (Cardiff and Vale UHB and Cwm Taf UHB).

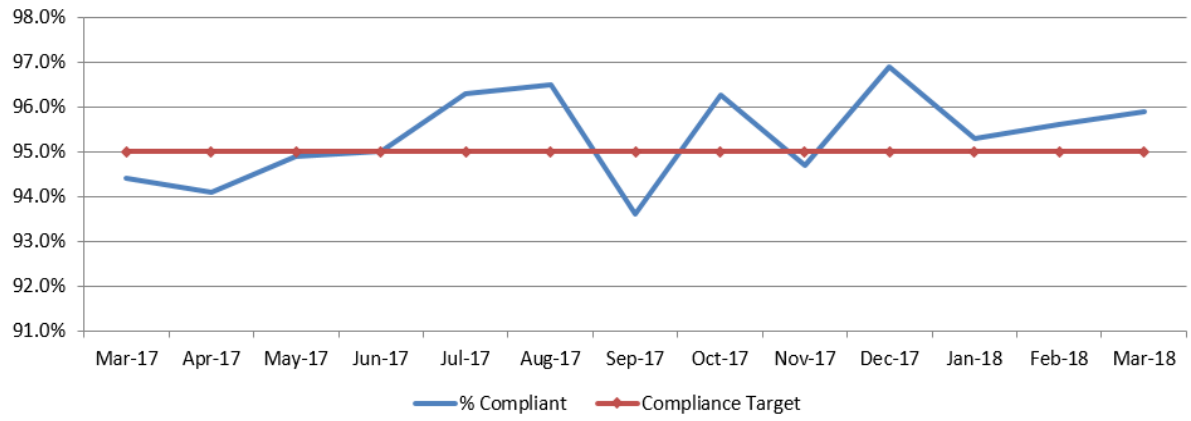
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % compliance with Hand Hygiene Audits

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

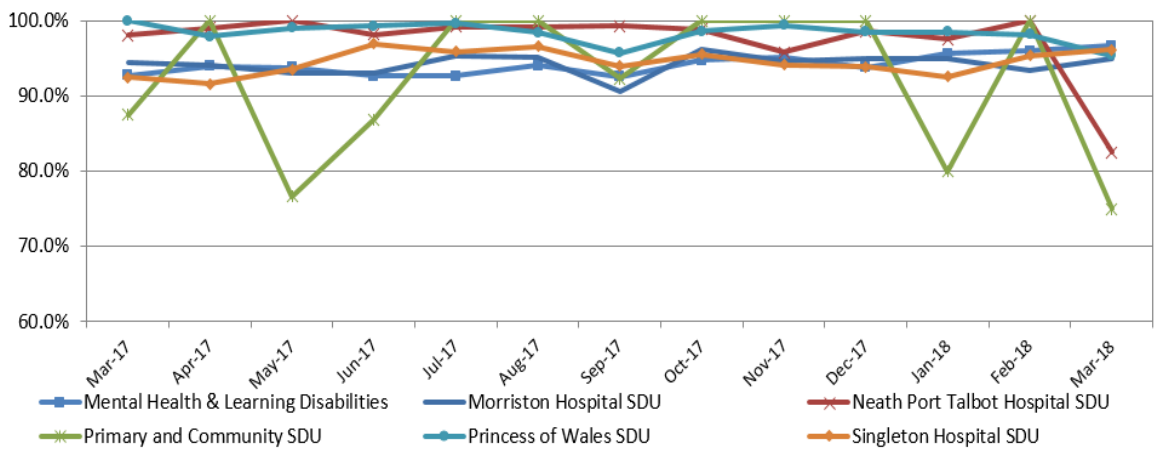
Current Trend: Mar 17- Mar 18

(1) % compliance with Hand Hygiene Audits



Benchmarking

(1) % compliance with Hand Hygiene Audits



Source : ABMU Care Matrix

Measure 1: % compliance with Hand Hygiene Audits

How are we doing?

- Compliance with hand hygiene (HH) for March 2018 was 95 %.
- For March 2018, 88 wards/units (62%) reported compliance ≥95%.
- 13 wards/departments (9%) reported compliance ≥90% ≤94%; 21 wards/units (15%) reported compliance ≤89%.
- 19 wards/departments had not uploaded the results of their audits undertaken in March 2018.
- Three of the six Service Delivery Units (SDU) reported compliance ≥95% (Mental Health & Learning Disabilities, Princess of Wales, and Singleton); Morriston reported compliance ≥90% in March 2018. Neath Port Talbot and Primary Care and Community Services reported compliance below 89%
- Results over time indicate there are challenges to achieving sustained improvements in compliance however, there are recognised limitations with self-assessment.

What actions are we taking?

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

What are the main areas of risk?

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

How do we compare with our peers?

- Data not available.

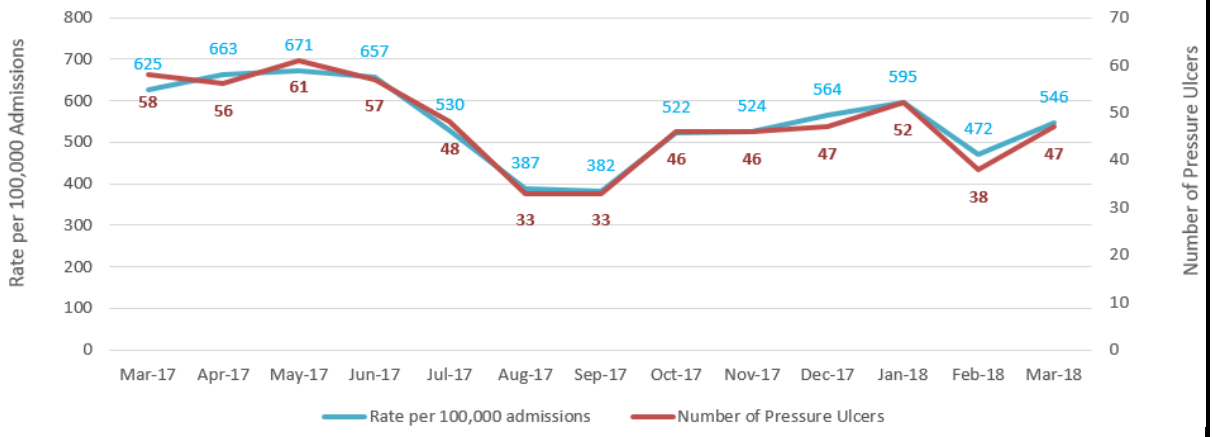
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

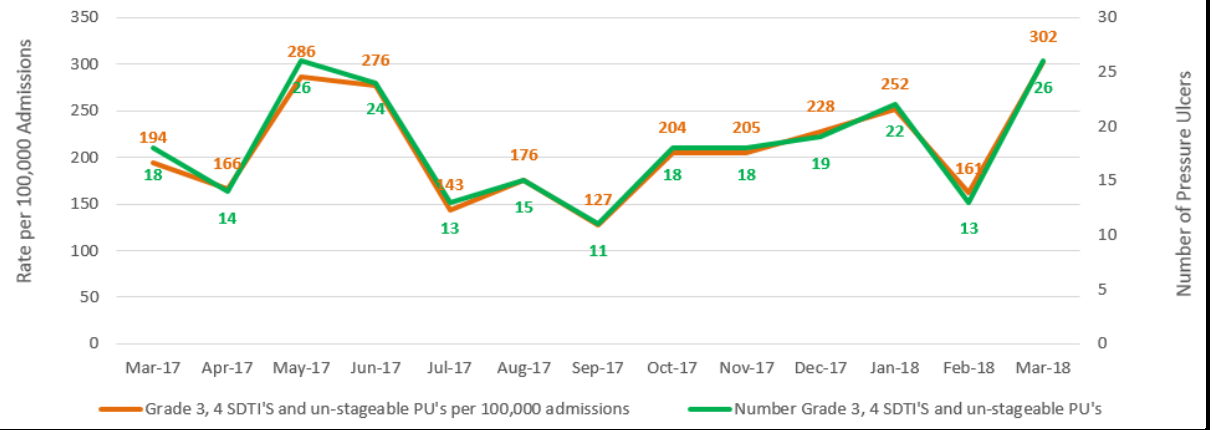
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Mar 2018	**IMTP Profile Target :** Reduce	**WG Target :** Reduce	**Current Status :** ✓	**Movement :** ↓ ● Impr

Current Trend: Mar 17 – Mar 18

(1) Total Pressure Ulcers acquired in hospital



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



Benchmarking

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

Source : PRESSURE ULCERS FROM DATIX and ADMISSIONS FROM MYRDDIN

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

How are we doing?

- The "In Hospital" acquired Pressure Ulcers are reported as a rate per 100,000 hospital admissions to comply with the requirements of the 2017/18 NHS Wales Delivery Framework. The number of pressure ulcer incidents is also included to enable comparison with the reported measure of per 100,000 admissions.
- There has been an increase in the rate of pressure ulcer development for inpatients during March 2018. The rate per 100,000 admissions has increased from 472 in February to 546 in March 2018. This reflects an increase of 9 pressure ulcer incidents, from 38 in February 2018 to 47 in March 2018.
- Device related pressure ulcers account for 5 of the reported pressure ulcers in March 2018.
- The rate of Grade 3+ pressure ulcers has increased from 161 per 100,000 admissions in February, to 302 per 100,000 admissions in March 2018.
- Of the 26 Grade 3+ pressure ulcer incidents reported in March, 6 were classified as deep damage and met the criteria for Serious Incident reporting.

What actions are we taking?

- The 4th quarter Pressure Ulcer Prevention Strategic Group meeting (PUPSG) was held in March 2018. PUPSG are continuing to work closely with Welsh Risk Pool to develop a Health Board Strategic Quality Improvement Plan. The plan will be informed by the outcome of the analysis of Serious Incidents (SI) reported pressure ulcers for 2017 -2018. The analysis will produce a heat-map of causal factors that will be used to identify and target work streams to reduce pressure ulcer risk.
- The Serious Incident Pressure Ulcer Causal Factor Analysis report will be presented to PUPSG at the next meeting in June 2018.
- Singleton Hospital is the pilot site for the development of a local strategic quality improvement plan. The plan will be presented to the PUPSG in June 2018.
- Pressure Ulcer Scrutiny Panel Development workshops are being rolled out across the Health Board to support and develop the skills of scrutiny panel members. The first workshop was held on April 17th, eight more sessions are planned ending on 18th May
- The new two step hierarchical pressure ulcer investigation and scrutiny process will go live on Datix at the end of May 2018 to coincide with the completion of the panel development workshops.
- Pressure Ulcer Peer Review Scrutiny Panels are held in all Service Delivery Units (SDU's) and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
- Datix scrutiny was conducted for March 2018 data, duplicate entries were identified and the data rectified to ensure Health Board reporting accuracy.

What are the main areas of risk?

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

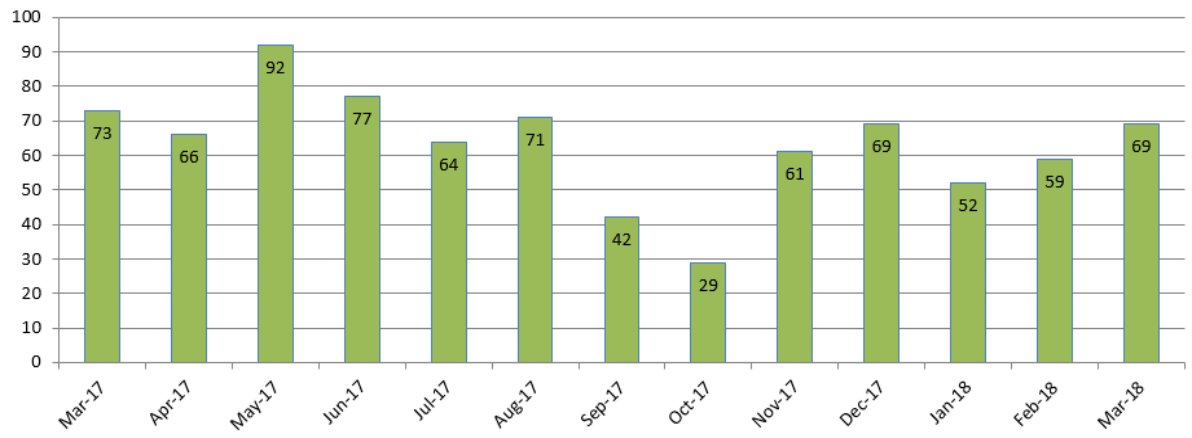
How do we compare with our peers?

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

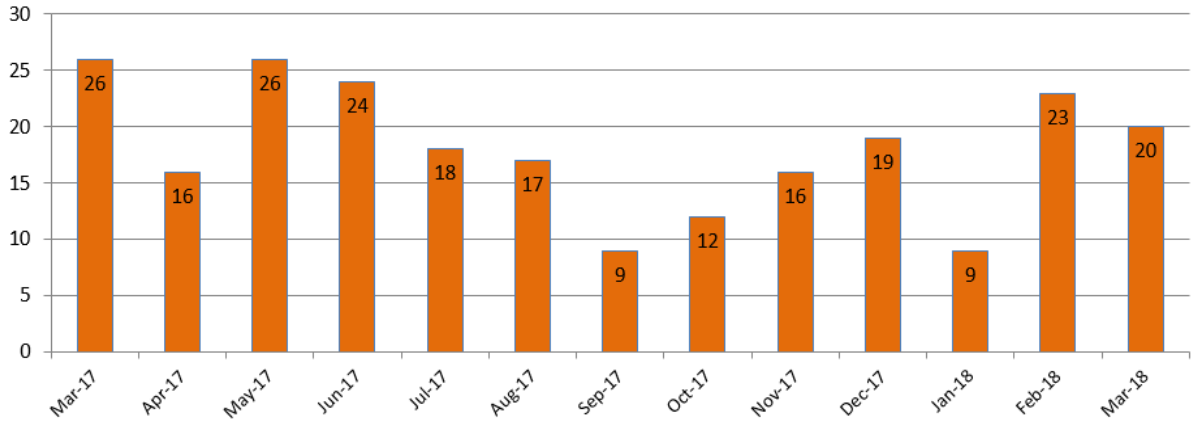
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM				
Measure 1: Total Number of pressure ulcers developed in the community. **Measure 2:** Number of grade 3, 4 suspected deep tissue injury and un-stageable pressure ulcers developed in the community.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

Current Trend: Mar 17 – Mar 18

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



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



Benchmarking

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

Source : PRESSURE ULCERS FROM DATIX

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

How are we doing?

- During March 2018, 69 incidents of pressure ulceration were reported in the community, this is an increase compared to the 59 incidents reported in February 2018.
- Of the pressure ulcers reported in March, 90% were recorded as superficial damage.
- Device related damage accounts for 4 pressure ulcers, of those, 3 were caused by devices owned by patients.
- There has been a decrease in the number of Grade 3+ pressure ulcers reported, from 23 in February to 20 in March 2018.
- Of the Grade 3+ pressure ulcers reported in March, 7 were considered deep damage and met the criteria for Serious Incident (SI) reporting.
- No Grade 4 pressure ulcers were reported.

What actions are we taking?

- The 4th quarter PUPSG meeting was held in March 2018. PUPSG are continuing to work closely with Welsh Risk Pool to develop a Strategic Quality Improvement Plan. The plan will be informed by the outcome of the analysis of SI reported pressure ulcers for 2017 -2018. The analysis will produce a heat-map of causal factors that will be used to identify and target work streams to reduce pressure ulcer risk.
- The Serious Incident Pressure Ulcer Causal Factor Analysis report will be presented to PUPSG at the next meeting in June 2018 .
- Pressure Ulcer Scrutiny Panel Development workshops are being rolled out across the Health Board to support and develop the skills of scrutiny panel members. The first workshop was held on April 17th, eight more sessions are planned ending on 18th May
- The new two step hierarchical pressure ulcer investigation and scrutiny process will go live on Datix at the end of May to coincide with the completion of the panel development workshops.
- Monthly Quality Improvement Pressure Ulcer meetings, chaired by the Head of Community Nursing provide assurance for effective pressure ulcer prevention and investigation of incidents. The learning from the panel is shared through the Nursing and Community Services Quality and Safety Group, the Unit Quality and Safety meeting and the Pressure Ulcer Prevention Strategic Group.
- Peer review scrutiny panels are held in Swansea, Bridgend and NPT localities, the frequency has been increased to weekly to proactively manage the risks identified. This will increase the number of pressure ulcer incidents scrutinised and enhance local accountability. The learning from each local panel is shared at the Unit Quality Improvement meeting.
- Education for pressure ulcer prevention and classification of pressure ulcers remains an ongoing priority. Bespoke sessions are delivered by TVN's to community staff, carer organisations and care homes on a rolling programme.
- The Governance team continue work to improve the validity of the Datix incident data to reduce errors and duplicate reports.

What are the main areas of risk?

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

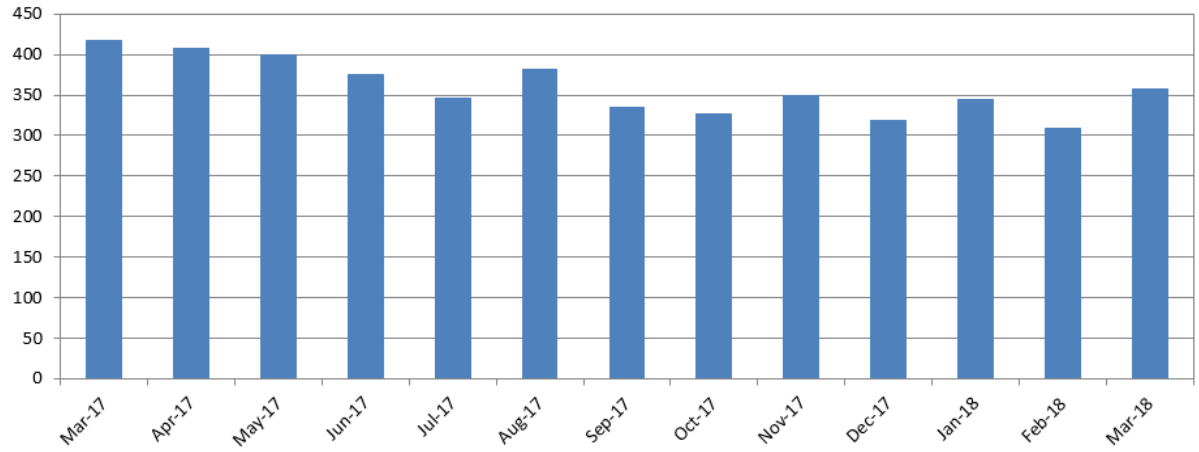
How do we compare with our peers?

No benchmark data available.

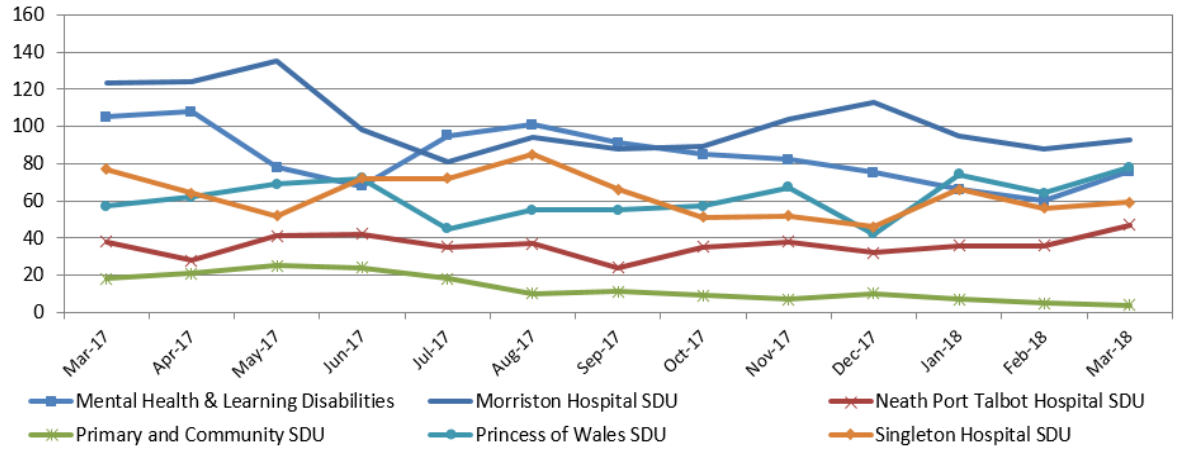
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM				
Measure 1: Total Number of Inpatient Falls				
Corporate Objective : Embedding Effective Governance and Partnerships			**Executive Lead : Angela Hopkins**	
Period : Mar 2018	**IMTP Profile Target : Reduce**	**WG Target : Reduce**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

Current Trend: Mar 17- Mar 18

(1) Number of Inpatient Falls



(1) Number of Inpatient Falls



Benchmarking

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

Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of Inpatient Falls

How are we doing?

- The number of falls reported via Datix in February showed a decrease of 35 from January, however there was an increase in March 2018 of 49. When comparing the data for January 2018 and February 2018 all Delivery Units (DUs) with the exception of Neath Port Talbot (NPT) reported a decrease in all falls recorded via Datix. When comparing the data for February 2018 to March 2018 all units with the exception of Primary and Community reported an increase in falls recorded via Datix.
- Whilst there was in month movement the 12 month movement continues to show an overall reduction.

What actions are we taking?

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

- The Falls policy is currently under further review following feedback from Corporate Nursing team. Baseline audits on the implementation of the new falls policy and associated documentation will be undertaken by the corporate nursing team in May 2018.
- All Delivery Unit's (DU's) have Falls Scrutiny panels, Primary and Community panels all agreed outcomes from the scrutiny panel will be presented to the FPMG to enable shared learning.
- The FPMG will undertake a training needs analysis has been completed, training package sent to members of FPMG for implementation from March 2018.
- Base line audit and review of all equipment relating to falls management was discussed at the February 2018 FPMG. The Health Board have purchased via Charitable Funds 60 high low beds with roll out took place in March 2018. Further work will be scheduled for April 2018 to review other equipment needs.
- Chair of FPMG has requested from HB manual handling lead an outline of the asset register to ensure accurate HB picture by March 2018, which has now been received. Further work will be scheduled in May/June 2018 to review overall equipment needs.
- FPMG membership will be reviewed in May 2018 (and monthly) going forward to establish if the group would benefit from more senior clinical representation. Work continues with the Datix user group to configure the system to collate and report accurately falls with harm versus falls without harm. Each Delivery Unit now collates this information monthly and reports into the FPMG group.

What are the main areas of risk?

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

How do we compare with our peers?

- Action plan has been developed as a result of National inpatient falls audit the results and action plan was shared in the April 2018 FPMG meeting.

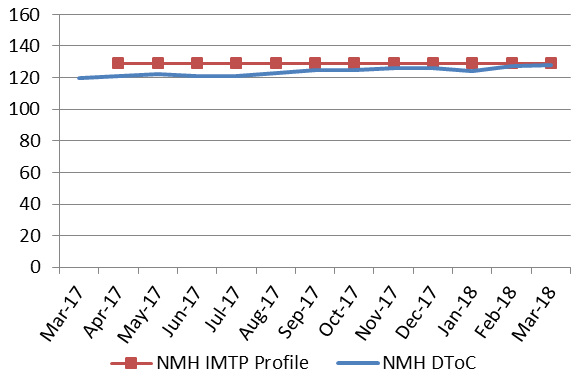
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

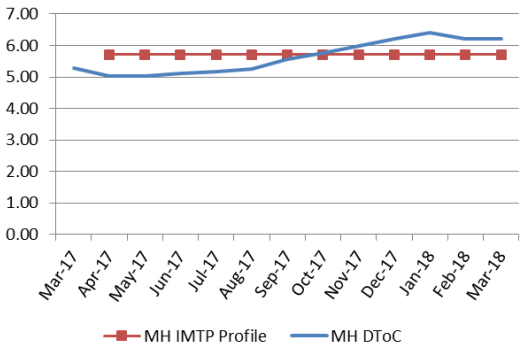
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period: Mar 2018	IMTP Profile Target : (1) 5.7 (2) 129.1	WG Target : Improve	Current Status :	Movement : W

Current Trend: Mar 17- Mar 18

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



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



Benchmarking

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

LHB	Current	Same Period Comparison		
	Feb-18	Feb-17	Feb-16	Feb-15
Wales	143.1	↑ 154.8	↑ 163.2	↑ 145.0
ABM	123.0	↓ 119.8	↓ 108.2	↓ 51.4
AB	182.1	↓ 165.3	↑ 187.8	↑ 198.3
BCU	154.7	↑ 208.2	↑ 182.7	↓ 137.9
C&V	149.3	↑ 182.1	↑ 271.4	↑ 260.6
CTaf	127.2	↑ 149.2	↑ 133.6	↑ 158.0
HDda	89.8	↓ 59.3	↓ 58.0	↓ 64.8
Powys	175.6	↑ 182.8	↑ 235.6	↑ 212.8

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

LHB	Current	Same Period Comparison		
	Feb-18	Feb-17	Feb-16	Feb-15
Wales	3.1	↑ 3.7	↑ 3.6	↑ 4.2
ABM	5.8	↓ 5.5	↓ 5.4	↓ 5.5
AB	2.0	↓ 1.7	↓ 1.7	↑ 3.1
BCU	3.0	↓ 3.0	↓ 2.6	↓ 2.6
C&V	2.3	↑ 5.4	↑ 5.0	↑ 5.5
CTaf	2.8	↑ 3.3	↑ 3.7	↑ 4.6
HDda	2.8	↑ 4.0	↑ 3.9	↑ 3.8
Powys	3.2	↓ 1.9	↑ 4.5	↑ 7.6

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

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

How are we doing?

- The total number of patients classified as a delayed transfer of care in March 2018 was 69. This was a reduction when compared with the 74 delayed transfers of care reported in February 2017, and a reduction when compared with the 71 delayed transfers of care reported in March 2017.
- The overall bed days associated with delayed transfers of care in March 2018 however was at the second highest reported level. The majority of this increase was experienced in mental health services, although the bed days lost in the non mental health and learning disability services also increased by 18% when compared with March 2017.

What actions are we taking?

- Implementation of good practice recommendations on effective discharge planning, with a particular focus on earlier and consistent communication with patients and families on the quality and safety benefits of earlier discharge.
- Joint work with Local Authorities (LA's) regarding options to support the provision of sustainable capacity in the community.
- Regular communication and escalation of delays with all heads of service regarding patients requiring local authority support for discharge.
- Supporting and promoting the UK wide #endpjparalysis campaign.
  Implementation of the discharge action plan agreed in response to the Wales Audit office discharge report and recommendations.

What are the main areas of risk?

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

How do we compare with our peers?

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

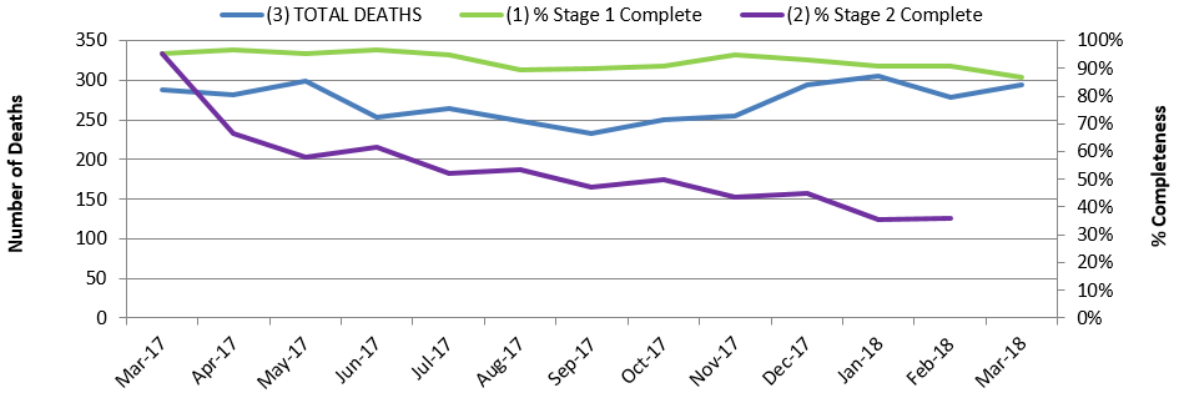
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

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

Current Trend: Mar 17- Mar 18

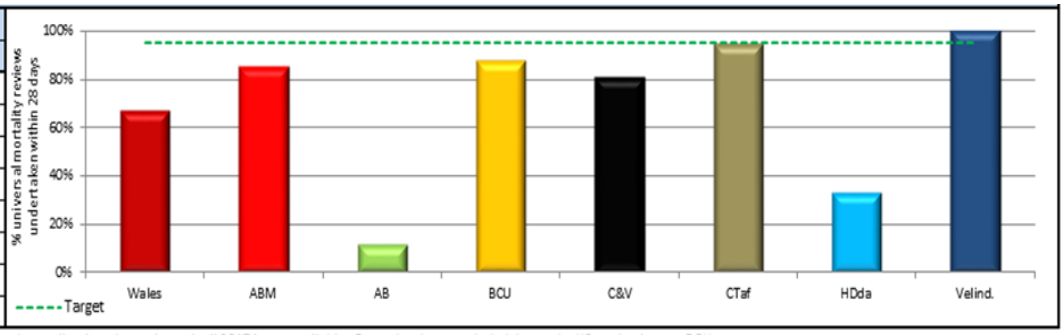
(1) % Universal Mortality Reviews (UMR) undertaken within 28 days of death,
(2) % Stage 2 Review forms completed,
(3) Number of Hospital Deaths of persons over the age of 16 *(Excluding Emergency Department)*



Benchmarking

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

LHB	Current Feb-18
Wales	66.9%
ABM	84.9%
AB	11.3%
BCU	87.2%
C&V	80.5%
CTaf	94.5%
HDda	32.7%
Velind.	100.0%



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

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

How are we doing?

- Welsh Government Mortality Review Performance - ABMU achieved 91.4% completion of UMRs within 28 days of death in January 2018. The Wales compliance was 64.1%
- The Health Board UMR rate in March 2018 was 86.7%, compared with 90.6% in February and 95.1 in March 2017
- Singleton and Neath Port Talbot Hospital (NPTH) achieved 100%, Princess of Wales Hospital (POWH) 98.7% and Morriston 76.1%. There were 39 missing UMR forms; 38 in Morriston and one in POWH.
- 20 deaths triggered a Stage 2 review in March compared with 14 in February
- Completion of Stage 2 reviews within 8 weeks (January deaths) was 47%. There are 80 outstanding Stage 2 reviews from April 2017 - March 2018. 40/80 (50%) from Morriston & 28/80 (35%) from POWH.
- Mental Health and Community data are unavailable via the eMRA application at present. This is being addressed by Informatics.
- Thematic (Stage 3) reviews - Nothing untoward was found in the majority of thematic reviews. Where a theme is identified, infection remains the most common, often pneumonia in elderly patients

What actions are we taking?

- Morriston Delivery Unit (DU) has revised its process of death certification to improve the quality and timeliness of certification and to ensure that a UMR is completed every time. The new process has now been implemented by the Patient Affairs Team. They are working with doctors across the DU to raise awareness of the change and reinforce the requirement to complete the UMR as part of the administration process when a patient dies.
- In Medicine at Singleton, all the Stage 2 reviews are discussed at their regular audit meetings.
- The MH&LD Delivery Unit is participating in the 3-part National pilot of the implementation of mortality reviews for people with mental health issues and learning disabilities. It has been piloted in the NPT Locality since January 2018.
- A new mortality reporting process has been developed based on the mortality dashboard. One of the Delivery Units presents their feedback and lessons learned at each Clinical Outcomes Group (COG) meeting
- A proposal to ensure that as many Stage 2 mortality reviews as possible as completed promptly following the patient's death to maximise learning was agreed at the Quality & Safety Committee in December and is now being implemented. Progress towards clearing the backlog of outstanding Stage 2 reviews has been good in Morriston and NPTH but not as good as anticipated in POWH and Singleton. The Unit Medical Directors (UMDS) have been asked to ensure that all outstanding Stage 2 reviews are completed by the end of May.

What are the main areas of risk?

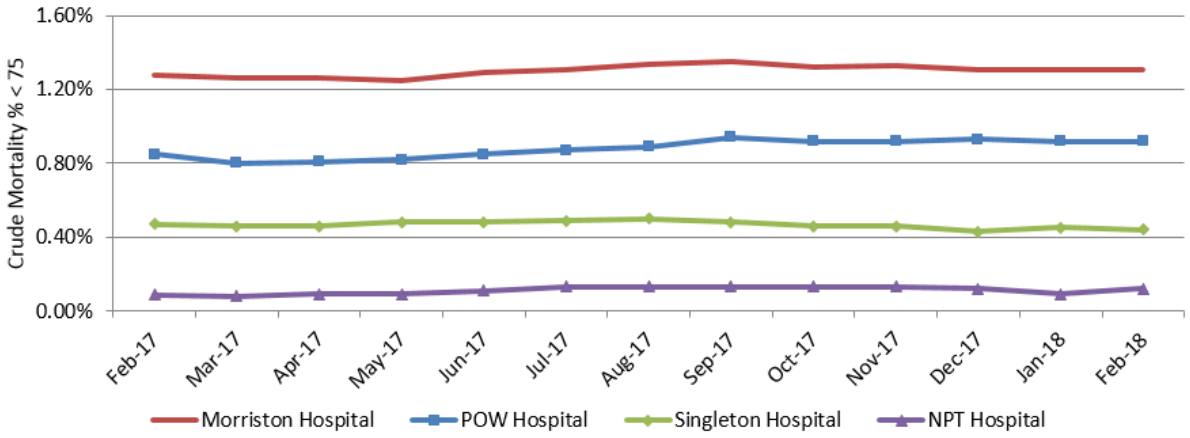
- Timeliness of Stage 2 completion. This is being addressed by a differential approach to backlog cases and current cases to ensure that in future the focus is on current learning.

How do we compare with our peers?

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

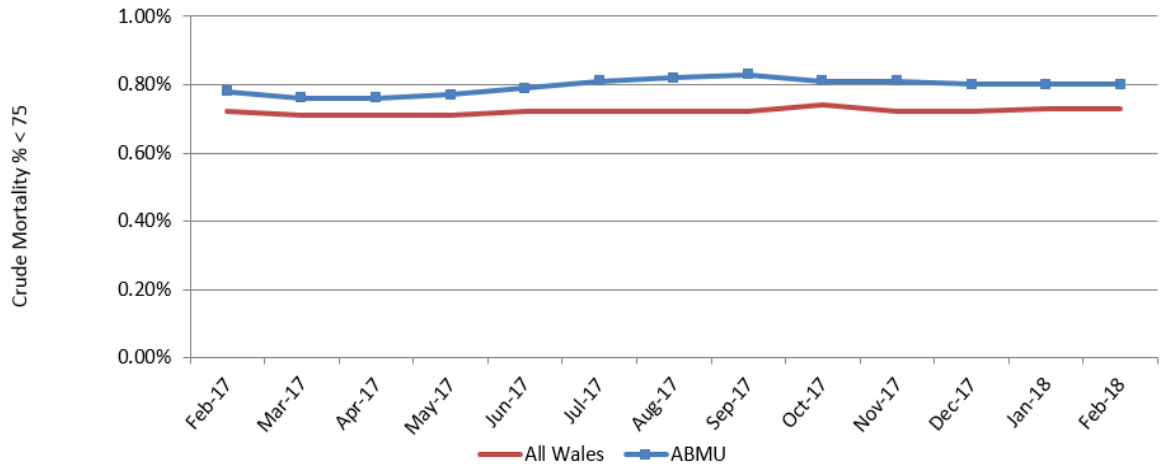
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE				
Measure 1: Crude hospital mortality rate (less than 75 years of age)				
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Hamish Laing**	
Period : Feb 2018	**IMTP Profile Target :**	**WG Target : 12 month reduction trend**	**Current Status :**	**Movement : Stable**
Current Trend: Dec 17- Dec 17				

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



Benchmarking

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



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

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

How are we doing?

- The ABMU Crude Mortality Rate for under 75s in the 12 months to February 2018 was 0.80%, compared with 0.78% for the same period last year
- Site level performance is as follows: (previous year in brackets) Morriston 1.30% (1.28%), Princess of Wales 0.92% (0.85%), Neath Port Talbot 0.12% (0.09%), Singleton 0.44% (0.47%). Site comparison is not possible due to different service models being in place.
- There were 103 in-hospital Deaths in this age group in March 2018 compared with 105 in March 2017: Morriston 58 (53), Princess of Wales Hospital 31 (27), Neath Port Talbot Hospital 2 (1), Singleton 12 (22).
- The number of deaths for Surgical and Elective cases remains consistently low for this age group.

What actions are we taking?

- A mortality report is considered by Clinical Outcomes Group (COG), chaired by the Executive Medical Director (EMD).
- Each Service Delivery Unit (SDU) continues to receive Mortality Reports enabling them to monitor mortality in the Unit, and to allow each Unit Medical Director to feedback learning from the mortality review process and review of fluctuations in their mortality data, to the Clinical Outcomes Group (COG). Delivery Units are requested to present to COG in rotation at the meeting. Singleton Hospital will present at March's COG.
- The Units are expected to continue to review Mortality data via the Mortality Dashboard. Information and analysis for Universal Mortality Reviews, Stage 2 mortality reviews and thematic mortality reviews undertaken by Unit Medical Director Process continues to be available on a daily basis via the Mortality dashboard
- Thematic, Stage 3 reviews of completed Stage 2 mortality reviews up to the end of March 2018 demonstrated that in the majority of cases nothing untoward was noted. Infections are still the most frequent theme, usually pneumonia in elderly patients
- A proposal to ensure that as many Stage 2 mortality reviews as possible are completed promptly following the patient's death to maximise learning was presented to the Quality & Safety Committee (Q&SC) in December and agreed. Good progress has been made in completing outstanding Stage 2 reviews in Morriston and NPTH but slower than anticipated in POWH and Singleton. Unit Medical Directors have been asked by the Exec MD to ensure that the backlog is completely cleared by the end of May.

What are the main areas of risk?

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

How do we compare with our peers?

- ABMU are above the all-Wales Mortality rate for the 12 months to February 18 – 0.80% compared with 0.73%.
- ABMU is the best Performing Health Board in respect of UMRs completed within 28 days of the patients death (94%). All-Wales compliance was (72%).

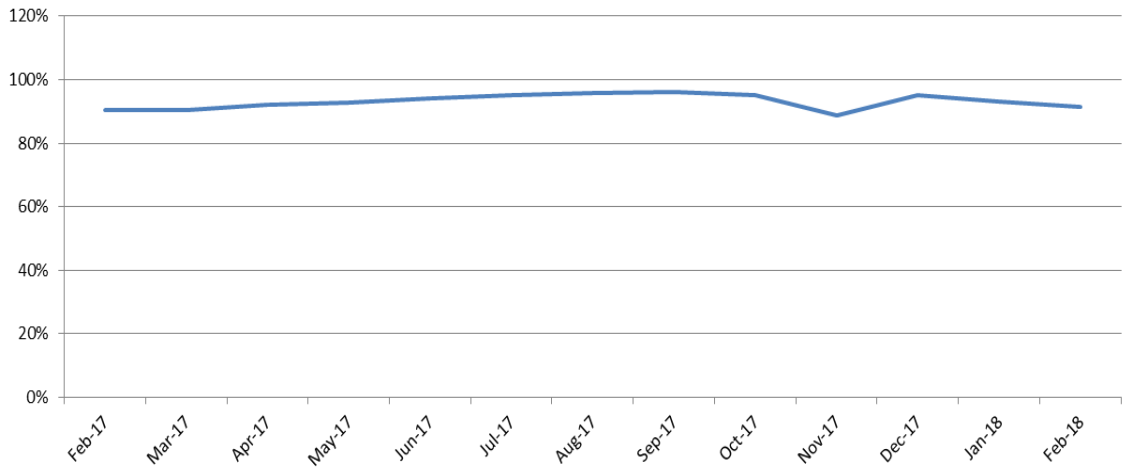
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead: Hamish Laing	
Period : Feb 2018	**IMTP Profile Target :**	**WG Target :** 95%	**Current Status :**	**Movement :** In

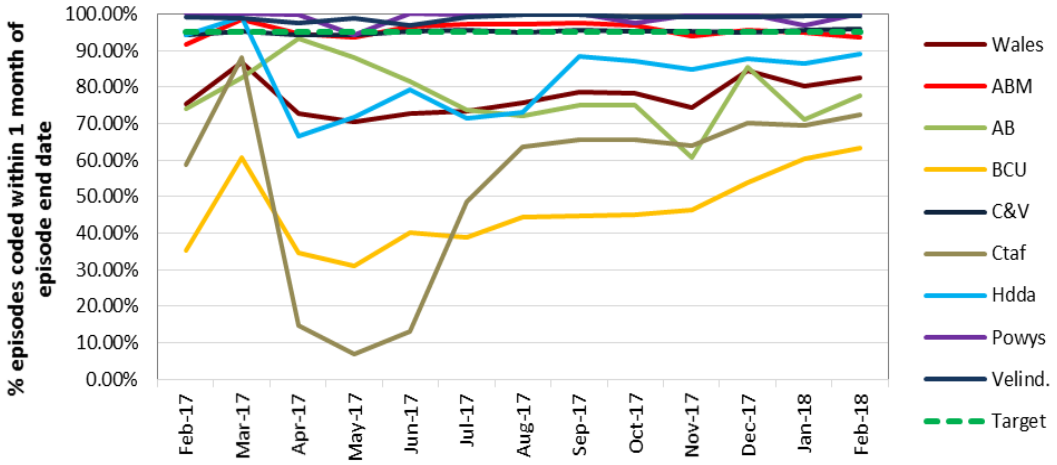
Current Trend: Feb 17- Feb 18

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



Benchmarking

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



Source : NWIS Clinical Coding Extract MARCH 2018

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

How are we doing?

- The department has achieved overall Coding completeness for 2017/2018 as follows: April - 99.39%, May - 99.22%, June - 99.36%, July - 99.09%, August - 98.96%, September - 98.92%, October is 99.03%, November is 97.85%, December is 97.87%, and January is 96.97% . This performance has been achieved as a result of considerable changes in working practices and integration with the Health Records Department
- The completeness within 30 days for February was 91.29%. This is less than January reported position of 93%, however staffing levels in the department remains a challenge
- The NHS Wales Informatics Service (NWIS) national audit team carried out coding accuracy audits across all four main acute hospital sites during 2017. The Health Board has now received the full audit report and findings. The percentage compliance for the Health Board has improved from 90.2% to 93% in accuracy. ABMU compares favourably with peers and is the highest ranked Health Board. The accuracy rate will provide assurance of the quality of the coding completed during the period, particularly as during this time there has also been a considerable improvement in efficiency and coding completeness target. The findings and recommendations will be incorporated into the Clinical Coding audit and development plans for 2018/19.

What actions are we taking?

- From November 2017 the central Informatics Clinical Coding has taken on responsibility for Clinical Coding in Mental Health, this will address compliance issues previously reported. The all-Wales benchmarking data has been updated to include up to August 2017 and demonstrates a significant improvement for ABMU from the previous positon of 40% compliance in August 2016. The ABMU position will improve further in 2018.
- Continued training of the 6.5 WTE permanent staff which will address the completeness in month once staff are trained and competent - end of 2018.
- Experienced coders are undertaking overtime to support the overall performance and effectiveness of the clinical coding service.

What are the main areas of risk?

- Maintaining the productivity levels in 2017/18 whilst the trainee Coders are still training and the contract coders are no longer employed and the availability of the Health Records in a timely manner.

How do we compare with our peers?

- The indicator above is now showing performance against the new target introduced for 2016/17 - 95% complete within 1 month (shown as a snapshot). ABMU is the top performing Health Boards.

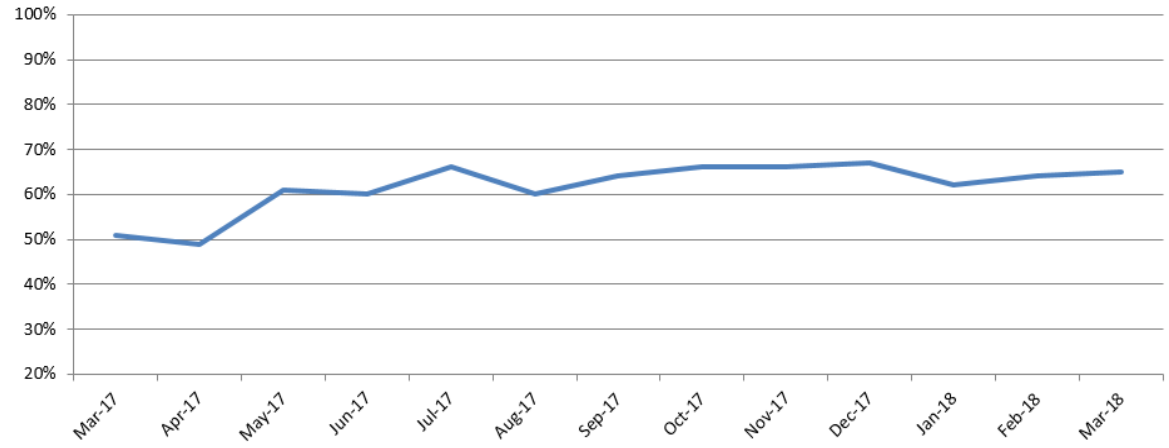
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % of completed discharge summaries

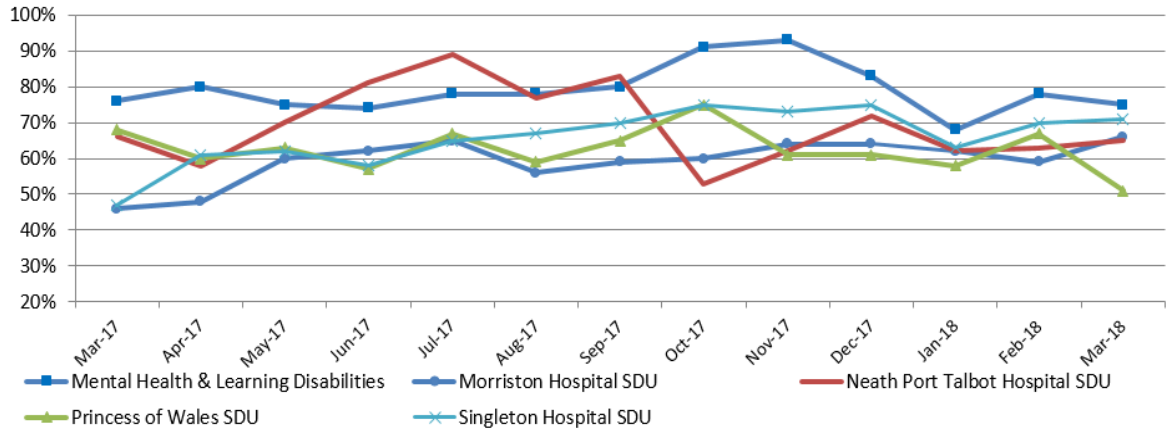
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Mar 2018	**IMTP Profile Target :** Improve	**Local Target :** 100%	**Current Status :**	**Movement :** Improving

Current Trend: Mar 17- Mar 18

(1) % of completed discharge summaries ABMU



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



Benchmarking

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

Source : ETOC Dashboard

Measure 1: % of completed discharge summaries

How are we doing?

- Performance in this quality priority has improved on a Health Board-wide basis in March 2018 (65%) compared with January (62%) & February (64%) but has still not returned to the 67% achieved in December 2017.
- There continues to be performance variance between Service Delivery Units (51%-75%).
- This month the performance has improved in 3/5 Delivery Units, and declined in the remaining two.
- Morriston achieved 66% in March, the highest rate since reporting began in January 2017 and 20% higher than March 2017.
- Mental Health & Learning Disabilities was the best performer achieving 75%, closely followed by Singleton (71%)
- The most significant drop in performance was in Princess of Wales Hospital (POWH), 51% in March compared with 67% in February.

What actions are we taking?

- The Executive Medical Director (EMD) has asked Unit Medical Directors (UMDs) to consider how, and by whom, discharge summaries are completed and to invite members of the clinical teams other than doctors to contribute to them to ensure the highest quality and timely summary gets to the patient's GP.
- The Executive MD and the relevant UMDs will be meeting with T&O Leads at Morriston and POWH to emphasise the need to prioritise discharge summaries.
- Morriston's 6 month Discharge Improvement Programme has now ended but performance continues to show improvement. The dip in performance in February has been reversed. Where services are struggling due to gaps in doctors' rotas, other approaches to completing the eToC are being explored (Nurse Practitioners/ Physicians' Associates). The Morriston UMD is working with IT and Informatics to explore the possibility of sending automated emails to individual consultants if an eToC has not been completed within 48hrs. The UMD is having targeted discussions with T&O and Burns & Plastics teams to support them to improve performance
- Singleton was the best performing hospital in March. Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician' Associate role could improve communication.
- Sickness absence amongst the Medical team at Neath Port Talbot Hospital has impacted on completion of eToCs but there was a slight improvement in March. Discharge summary performance is monitored and discussed at monthly Medical Consultant meetings.
- The primary measure being used in POWH is % discharge summaries completed within 24hrs of discharge. There have been notable improvements on individual wards although overall performance in POWH remains low (51%).

What are the main areas of risk?

- Risk to patient care and the need for readmission.

How do we compare with our peers?

- ABMU is the only Health Board to publish its performance

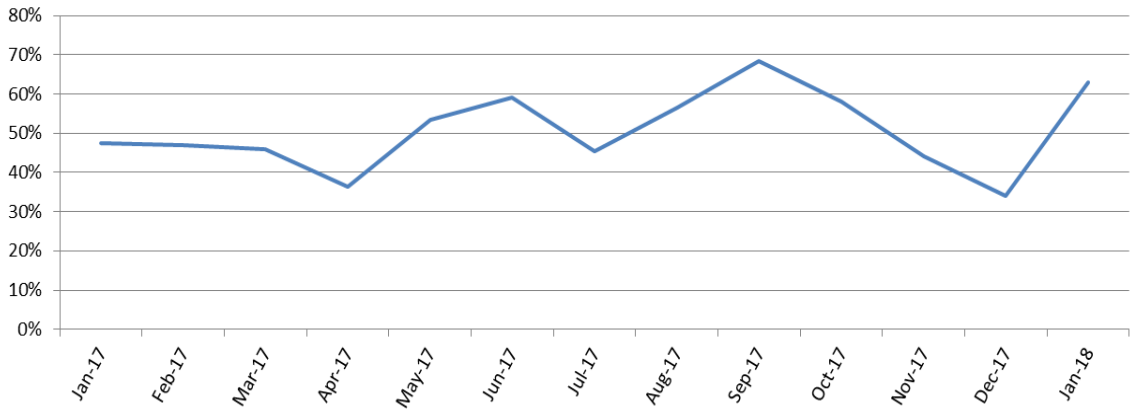
DIGNIFIED CARE - PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead: Chris White	
Period : Jan 2018	IMTP Profile Target : Improve	WG Target : Improve	Current Status : ✓	Movement : ↑ Imp

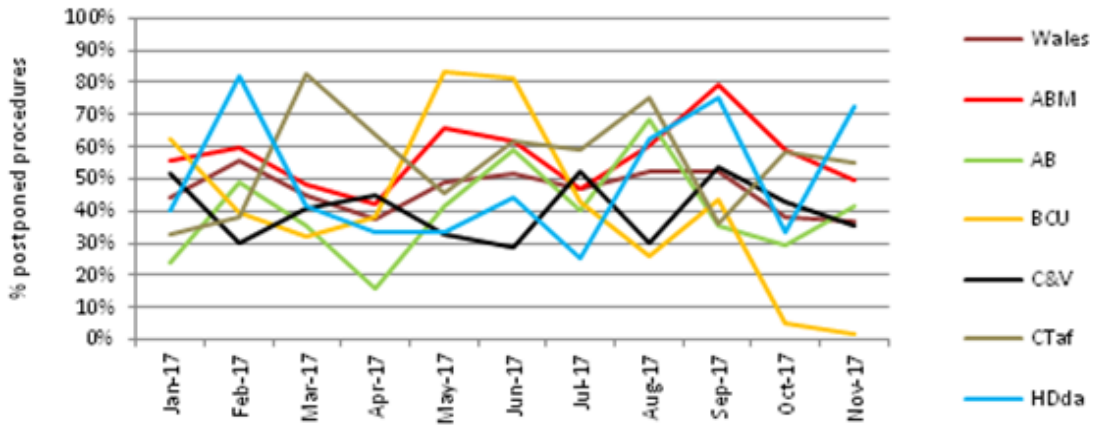
Current Trend: Jan 17 – Jan 18

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



Benchmarking

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



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

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

How are we doing?

- Percentages continue to fluctuate month on month due to the relatively small numbers involved.
- It is important to note that the data only represents those patients who have had their procedure within 14 days of their last postponed appointment and does not capture those patients who have chosen to have their procedure undertaken at their earliest convenience as Myrddin is currently unable to record this. 14 days does not constitute a reasonable offer under the Referral to Treatment (RTT) rules.
- Out of the 73 patients in January 2018 who had their procedure postponed on more than one occasion, 46 had their procedure carried out within the proceeding 14 days.

What actions are we taking?

- Escalate the development work required within the Myrddin Patient Administration System (PAS) to enable the health board to appropriately record and measure whether the appointment offered to undertake the procedure is at the patients earliest convenience. An update will be provided on the timescales for this work by May 2018.

What are the main areas of risk?

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

How do we compare with our peers?

- As at the end of November 2017, which is the latest published data available at the time of writing this report, ABMU performance was 49.3% compared with the all-Wales performance of 36.9%. ABMU is above the all-Wales position for this measure and the third best performing Health Board.

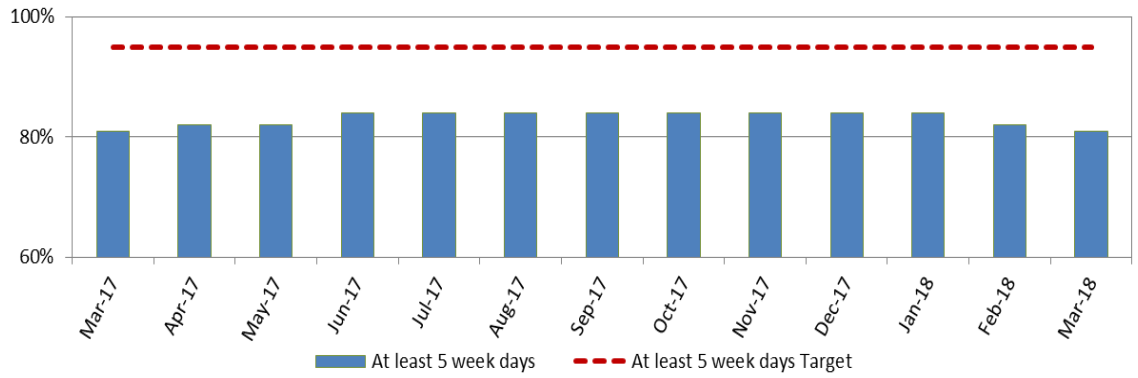
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

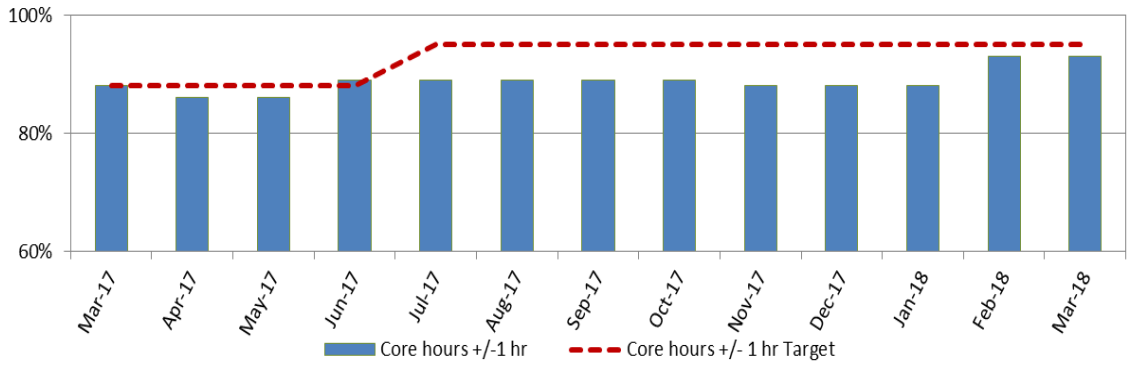
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target : (1) 95% (2) 95%	WG Target : (1) 95% (2) 95%	Current Status: ✗	Movement : ⇧ ● Imp

Current Trend: Mar 17- Mar 18 18

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



(2) % GP practices open during the daily core hours or within 1 hour of daily core hours



Benchmarking

LHB	5 days a week				core hours or within 1 hour			
	Current	Previous			Current	Previous		
	2017	2016	2015	2014	2017	2016	2015	2014
Wales	84%	⇧ 84%	⇧ 79%	⇧ 79%	87%	⇧ 85%	⇧ 82%	⇧ 80%
ABM	78%	⇩ 79%	⇨ 78%	⇧ 69%	90%	⇧ 85%	⇧ 85%	⇧ 73%
AB	97%	⇩ 99%	⇧ 95%	⇧ 93%	99%	⇩ 99%	⇧ 93%	⇧ 92%
BCU	69%	⇨ 69%	⇧ 55%	⇧ 63%	78%	⇧ 74%	⇧ 73%	⇧ 73%
C&V	92%	⇨ 92%	⇩ 94%	⇩ 94%	88%	⇨ 88%	⇧ 83%	⇧ 83%
CTaf	95%	⇩ 95%	⇧ 93%	⇧ 93%	90%	⇩ 90%	⇩ 93%	⇩ 93%
HDda	80%	⇧ 75%	⇧ 65%	⇧ 65%	73%	⇩ 74%	⇧ 65%	⇧ 67%
Powys	100%	⇨ 100%	⇧ 94%	⇧ 94%	100%	⇨ 100%	⇨ 100%	⇨ 100%

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

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

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

How are we doing?

- As at March 2018 55/68 (81%) practices are offering appointments between 17.00 and 18.30 at least 5 nights per week.
- 63/68 (93%) practices are now open during daily core hours or within 1 hour of daily core hours. This is a good improvement over January 2018 of 88%.

What actions are we taking?

- The Unit's access and sustainability forum continues to meet with the aim of driving forward improved and sustainable primary care general medical services, the meeting frequency has been increased to bi-monthly.
- The practice support/primary care team has worked with over 18 practices who are experiencing sustainability issues.
- Five sets of practices have been supported through a discretionary framework to merge, thereby ensuring ongoing access to more sustainable General Medical Services. Three mergers have been completed and two are currently being progressed.
- The primary care team has completed a desk top analysis of current access arrangements by practice and written to all practices who are not meeting the level 1 standards as agreed with the local medical committee.
- A refreshed submission has been made to Welsh Government on access arrangements. Discussion have commenced with the LMC on the revision of the current access standards.
- Access data has been utilised as one of the criteria to score practices under the GMS governance arrangements is forming part of the visiting programme. Detailed discussions have been held with two practices to date.
- Clusters continue to be supported to discuss access and sustainability as part of their cluster development plans. Pro- active work has taken place to support clusters to expand multi-disciplinary teams in accordance with the transforming primary care model in Wales. Pacesetter funds have been awarded for a pilot of expanding physician associates in primary care and 5 placements will be offered during 18/19.
- 25% of practices are utilising some form of telephone triage – the telephone first model has been finalised and self-assessment work will take place next year aligning to the national survey results.

What are the main areas of risk?

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

How do we compare with our peers?

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

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

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

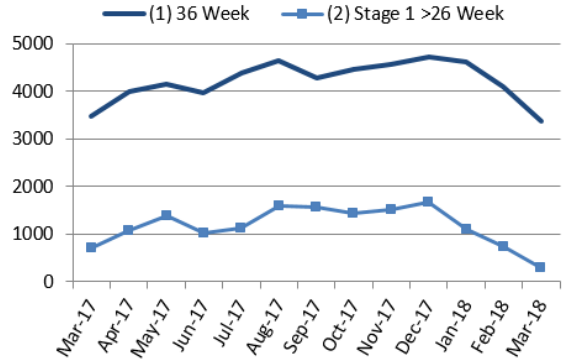
Measure 2: Number of patients waiting more than 26 weeks for first OP appointment

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

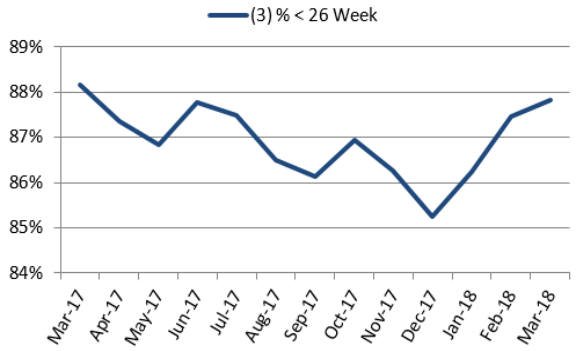
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target :	WG Target : (1) 0 (2) 0 (3) 95%	Current Status :	Movement : Improving

Current Trend: Mar 17 – Mar 18

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

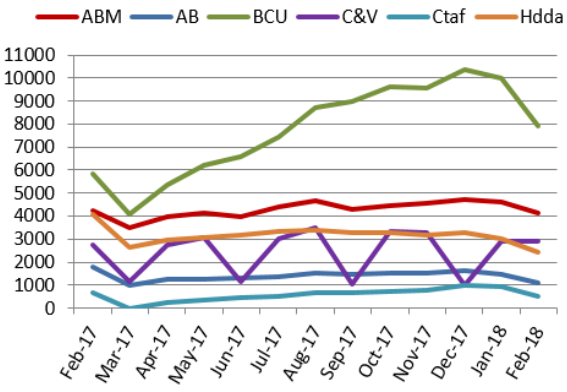


(3) % patients waiting less than 26 weeks for referral to treatment (RTT)

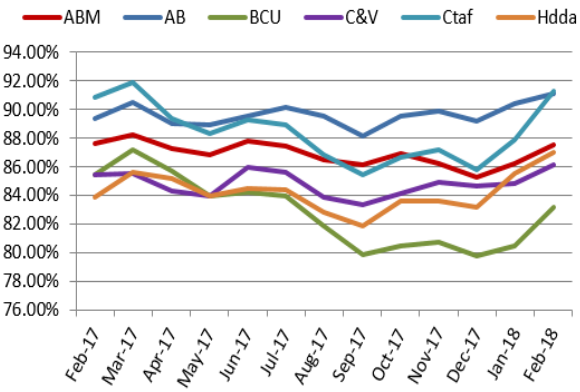


Benchmarking

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



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



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

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

How are we doing?

- In March 2018 there are 292 patients waiting over 26 weeks for a new outpatient appointment. This was an in-month reduction of 412 compared with February 2018 (732 to 292) and is contained within Oral/Maxillo Facial (OMF), Gynaecology and Restorative Dentistry.
- There are 3,363 patients waiting over 36 weeks for treatment in March 2018 compared with 3,485 in March 2017, this is an improvement of 122. There was also an in-month reduction of 748 compared with February 2018. ENT, General Surgery, Oral/ Maxillo Facial (OMF) and Orthopaedics collectively account for 3,157 of the over 36 weeks at March 2018. 97% of the patients waiting over 36 weeks are in the treatment stage of their pathway.
- 1,729 patients are waiting over 52 weeks in March 2018 which is 36% more patients than in March 2017 but 3% less patients than February 2018.
- The overall Health Board RTT target saw an improvement in March 2018 from 87.46% to 87.82%.

What actions are we taking?

- The RTT Delivery Plans for 2018/19 have been received from each Service Delivery Unit. Assurance meetings are scheduled through April/May to test the specialty plans submitted. When concluded the trajectories will be signed off and form part of the Unit accountability letters to be issued at the end of May.
- The focus at the weekly RTT meetings is now on Quarter 1 delivery. A range of immediate actions have been agreed in addition to those solutions identified within Unit plans to sustain the March position. A high level summary of these include:-
    - Morriston and Princess of Wales (POW) to confirm plans to clear new outpatient risk areas in Plastic Surgery, Paediatric Orthopaedics and Gynaecology. Plans by 25th April.
    - POW to explore potential for outsourcing Orthopaedics capacity. Update required by 25th April.
    - Morriston and POW to develop plans, through clinical discussion, for addressing long waiting patients >52wks to reduce overall size of the patient cohort and condense the tail end. Updates required on 25th April and 2nd May re: emerging plans.
    - POW to work with Swansea Gynaecology team to seek additional support. Action already underway.
    - Singleton to secure all internal WLIs and confirm a plan to clear Gastroenterology. Update required by 25th April.
    - Singleton to confirm patient numbers to be treated with outsourced Providers for Ophthalmology. Update required by 25th April.
    - Morriston and Singleton to maximise insourced Providers for Orthopaedics and Ophthalmology. Action already underway.

What are the main areas of risk?

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

How do we compare with our peers?

- As at the end of February 2018, which is the latest published data available, ABMU was above the all-Wales position for the percentage of patients waiting less than 26 weeks for referral to treatment (RTT) (87.5% compared with 87.3%) however, was the second worst Health Board in Wales for the number of patients waiting over 36 weeks.

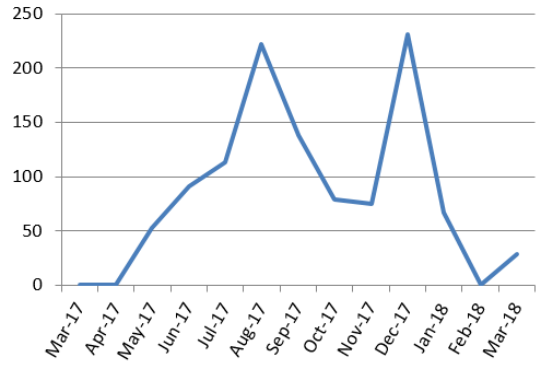
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

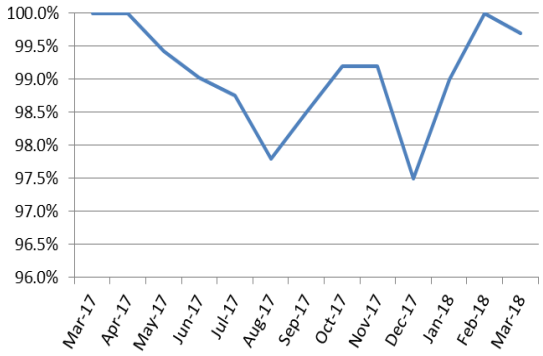
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target : (1) 0 (2) 100%	WG Target : (1) 0 (2) 100%	Current Status : ✗	Movement : ↓ ● Worsening

Current Trend: Mar 17- Mar 18

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

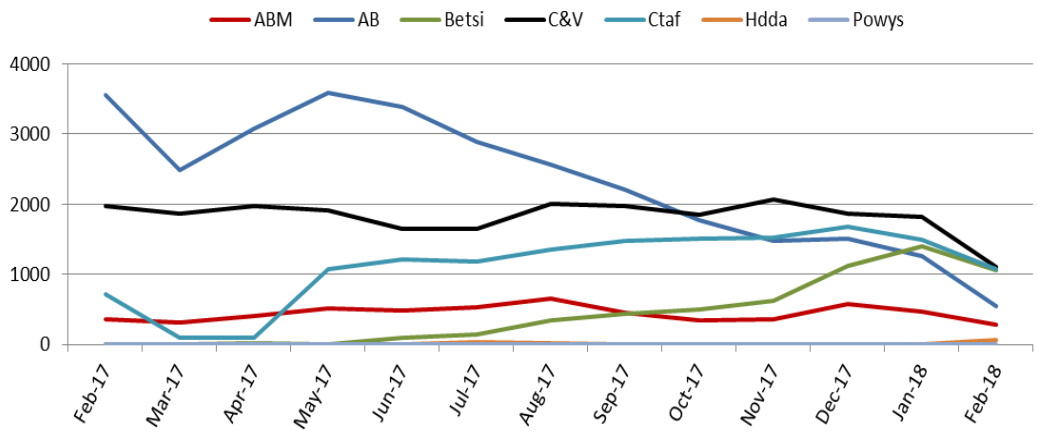


(2) % patients waiting less than 8 weeks for specific diagnostics (excluding Endoscopy & Cardiac)



Benchmarking

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



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

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

How are we doing?

- There were 29 patients waiting over 8 weeks for reportable diagnostics as at the end of March 2018.
- 27 breaches were for Echo Cardiograms in Morriston Hospital and 2 breaches were in Cystoscopy in Princess of Wales Hospital.
- All of the other diagnostic areas maintained a zero breach position in March 2018.

What actions are we taking?

- Cystoscopy at Princess of Wales (POW) - the 2 breaches were Consultant specific cases and could not be accommodated within the capacity available. There has been significant sickness amongst the already fragile clinical team. Additional capacity has been secured through the appointment of a Locum Urology Consultant who is focussing on the routine work, allowing the substantive Consultants to concentrate on the urgent and non-urgent suspected cancer work. Additional support is also being provided by the Urology Consultants in Swansea and the General Surgery Consultants within the POW Unit. The Unit has been asked to quantify the ongoing risk and provide a plan with mitigating actions by the 25th April.
- Echocardiograms at Morriston - 27 reported as late breaches after month end. These had not been escalated as a potential risk through the Unit into the weekly RTT meetings. The failure to manage the cases was a culmination of system, staffing, process and communication issues. Full assurance of escalation and remedial measures have been requested from the service with confirmation that April will be clear. Maternity leave is due to commence in May, the Unit has been asked to quantify the gap for May and June and provide a plan with mitigating actions by the 25th April.

What are the main areas of risk?

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

How do we compare with our peers?

- At the end of February 2018, which is the latest published data available at the time of writing this report, ABMU was the second best performing Health Board excluding Powys.

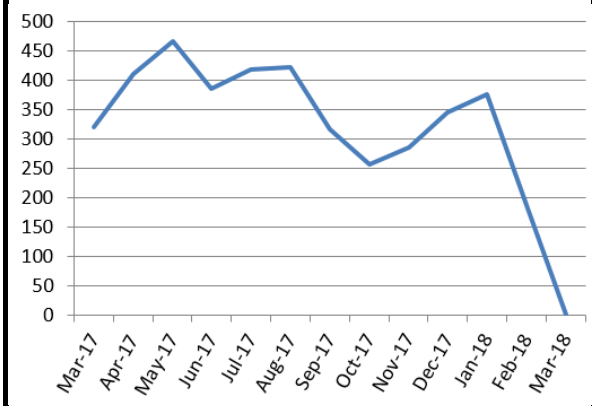
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

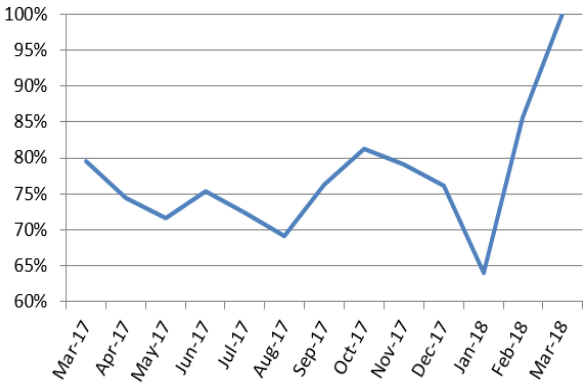
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period: Mar 2018	**IMTP Profile Target :** (1) 0 (2) 100%	**WG Target :** (1) 0 (2) 100%	**Current Status :** ✓	**Movement :** Improving

Current Trend: Mar 17 – Mar 18

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

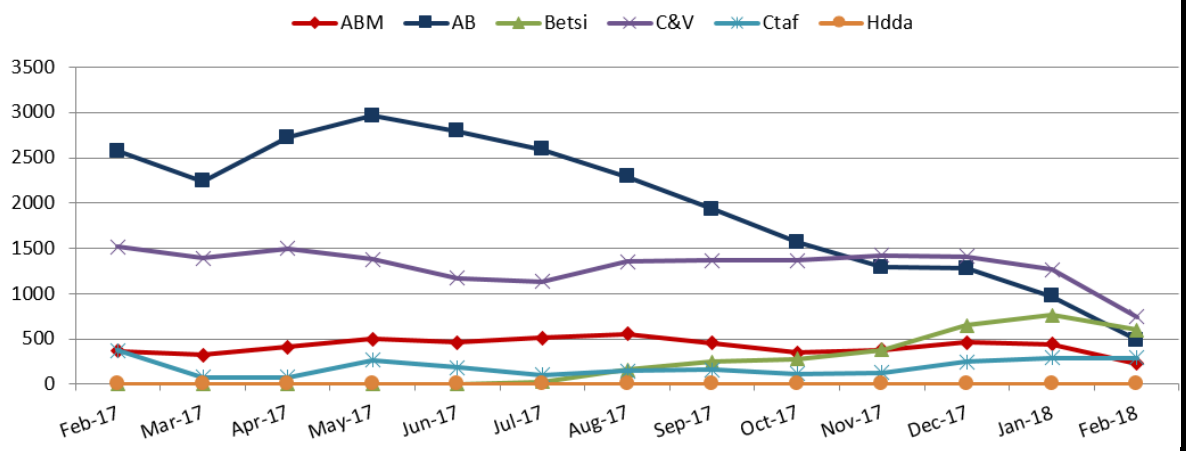


(2) % patients waiting less than 8 weeks for Endoscopy



Benchmarking

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



Source : NHS STATS WALES APRIL 2018

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

How are we doing?

- ABMU Health Board has achieved zero position for patients waiting over 8 weeks for Endoscopy as at the end of March 2018.
- Endoscopy continues to see a significant increase in urgent suspected cancer referrals. The majority of these continue to be in the area of Lower Gastroenterology referrals internally from surgical specialties.
- DNA rates continue to remain low at 3%.

What actions are we taking?

- Utilising all available capacity with an average of 30 backfill lists being undertaken per month across 2 sites - current agreement for funding until end of June 2018.
- Working closely with colleagues in the NHS Wales Delivery Unit to review demand and capacity plans and ongoing review weekly to ensure that capacity is being maximised on all sites.
- Ongoing additional insourcing support until the end of June 2018 from Medinet to maintain the zero position
- Development of alternative diagnostic pathway in partnership with Radiology (CT colongraphy)
- Continued focus on effective triage of referrals
- Partnership working with Hywel Dda underway. Currently benchmarking points per list and early discussions are underway to see if clinical cross cover for staffed sessions in ABMU can be facilitated.
- Singleton Endoscopy Unit refurbishment has now been completed and the unit is now JAG compliant.

What are the main areas of risk?

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

How do we compare with our peers?

- ABMU endoscopy performance continues to be good in comparison with the rest of Wales, although performance has improved for some previously under performing Health Boards.

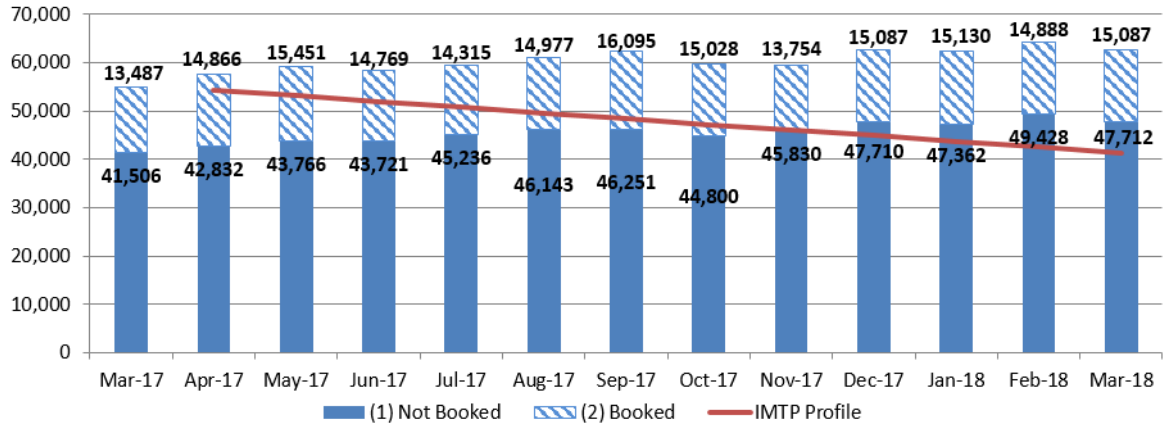
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target : 41,280	WG Target : Reduction	Current Status :	Movement : Wo

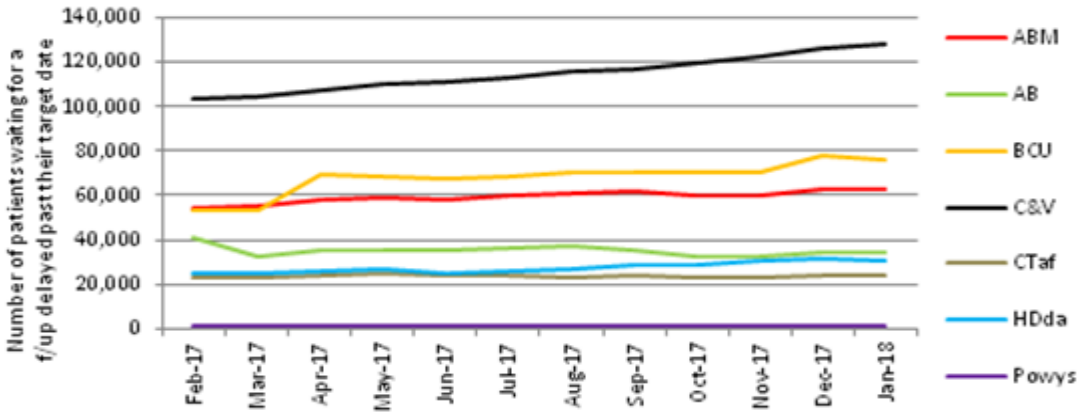
Current Trend: Mar 17 – Mar 18

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



Benchmarking

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



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

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

How are we doing?

- The number of patients waiting for a follow up appointment delayed past their target date (booked and non-booked) has increased from 54,993 (Mar 2017) to 62,799 (Mar 2018).
- Delayed Follow Up (Not Booked): In-month performance has slightly improved with a decrease in the number of not booked patients waiting for a follow up appointment delayed past their target date from 49,428 to 47,712. There are 15% more delayed follow up not booked with the same period 12 months ago (41,506 to 47,712).
- Delayed Follow Up (Booked): In-month performance has slightly deteriorated with an increase in the number of booked patients waiting for a follow up appointment delayed past their target date from 14,888 to 15,087. There are 12% more delayed follow ups booked compared with the same period 12 months ago (13,487 to 15,087). In March 2018 the Health Board is 21,519 higher than the IMTP profile.

What actions are we taking?

- Each Delivery Unit has developed a plan which is overseen by the Outpatient Improvement Group (OIP) and reported to the Planned Care Supporting Delivery Board. The expectation is that the plans are regularly monitored through local delivery mechanisms and OIP to ensure the expected IMTP profile for 2018/19 is delivered and to provide assurance that those highest risk patients are being addressed and ensure that patients are not being harmed.
- The plans have identified a number of actions to improve the Delayed Follow Up position with the expectation that the following are delivered by the 30th June 2018:
    - Identify the highest Delayed Follow Up specialties and undertake mass administrative and clinical validation to 'clean' the waiting lists and remove duplicates, errors and patients who no longer require a follow up appointment. This will have a resource requirement, a costed proposal being developed via the Outpatient Improvement Group.
    - Patient Initiated Follow Up appointments: already implemented in Rheumatology. Evaluate and roll out across specialties across the Health Board.
    - Review adherence to the RTT guidance for follow ups and DNA process to ensure consistent application across the Health Board.
    - Embed the national Planned Care Programme follow up guidelines and recommendations for Ophthalmology, ENT, Orthopaedics, Urology and Dermatology.
    - Advanced Practitioner led virtual follow up clinics. Increased support and advice to primary care to increase the management of patients in primary care with consequent reduction in new outpatient appointments – planned that this would allow for this new outpatient capacity to be converted to follow up to address the Delayed Follow Up backlog.
- The Wales Audit Office (WAO) has undertaken a follow-up audit to the 2015 review. Focus was given to assurance, scrutiny and reporting mechanisms; clinical risks on longest waiting patients; underlying issues for follow up backlog. A report has been received from the WAO highlighting that that there is a need for greater clinician engagement in the recording of clinical risks associated with delayed follow up appointments; there are insufficient mechanisms in place to routinely report these clinical risks to the Board; and that issues persist with the management of the FUNB list. Recommendations of the report will be addressed through OIP.
- A FUNB 'Deep Dive' was undertaken at the Performance & Finance Committee on 23rd February 2018 with the aim to explore recent performance and the actions being undertaken to improve the Health Board position. A further analysis planned for the meeting in April 2018.

What are the main areas of risk?

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

How do we compare with our peers?

- From February 2017 to January 2018: ABMU, BC, C&V, and HD positions have deteriorated; AB position has improved; CT position stable.

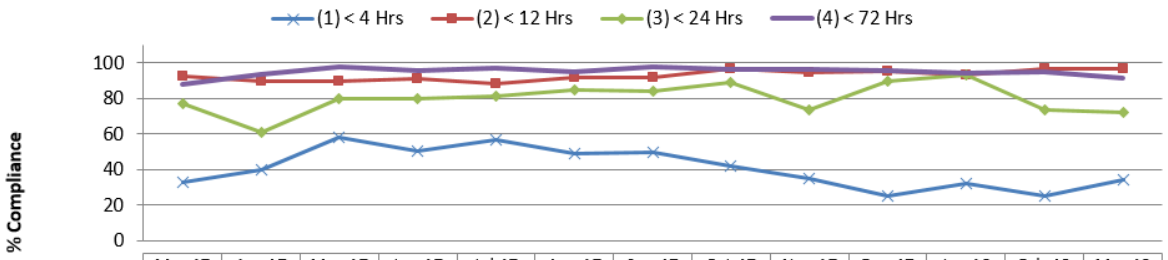
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target : (1) 72% (2)95% (3)75% (4)97%	WG Target : (1) 60.2%, (2) 94.3%, (3) 82.9%	Current Status :	Movement : Imp

Current Trend: Mar 17- Mar 18

72 Hour Pathway Care Indicators



	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
(1) < 4 Hrs	32.9	40.0	58.2	50.5	56.5	48.8	49.5	41.8	35.2	25.3	32.4	25.0	34.1
(2) < 12 Hrs	92.7	90.0	89.8	90.8	88.4	91.9	91.9	96.7	94.5	95.4	93.2	96.4	96.7
(3) < 24 Hrs	76.8	61.1	79.6	79.8	81.2	84.9	83.8	89.0	73.6	89.7	93.2	73.8	72.5
(4) < 72 Hrs	87.8	93.3	98.0	95.4	97.1	95.3	98.0	96.7	96.7	95.4	94.6	95.2	91.2

Benchmarking

72 Hour Care Indicators Mar 18	AB	ABM	BCU	C&V	CTaf	HDda
1. < 4 Hours Care Indicators	24.4%	34.1%	29.0%	48.6%	45.1%	69.6%
2. < 12 Hours Care Indicators	97.6%	96.7%	95.0%	97.3%	96.1%	100.0%
3. < 24 Hours Care Indicators	69.5%	72.5%	71.0%	75.7%	45.1%	79.7%
4. < 72 Hours Care Indicators	78.0%	91.2%	96.0%	94.6%	86.3%	92.8%

Thrombolysis Indicators Mar 18	AB	ABM	BCU	C&V	CTaf	HDda
1. Access						
1a - % All Strokes Thrombolsyed	9.8%	18.7%	10.0%	18.9%	5.9%	15.9%
2b - % Eligible Patients Thrombolsyed	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%
2. Time						
1a - Door-to-Needle <= 30 mins	12.5%	0.0%	0.0%	0.0%	0.0%	9.1%
2b - Door-to-Needle <= 45 mins	12.5%	5.9%	10.0%	14.3%	0.0%	36.4%
3c - Onset to-Needle <= 90 mins	0.0%	11.8%	0.0%	0.0%	0.0%	27.3%
4d - % with Pre and Post NIHSS Score	100.0%	88.2%	100.0%	100.0%	100.0%	100.0%

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

Source : ALL WALES PERFORMANCE SUMMARY (APRIL 2018) + ACUTE STROKE QUALITY IMPROVEMENT MEASURES NHS WALES DELIVERY UNIT REPORT

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

How are we doing?

- Performance in 3 of the 4 measures has improved in 2017/18 and delivered against the IMTP profile in a significant number of months
- Progress was sustained in these areas for the majority of the year but the dip in March on all measures other than the 4 hour bundle is a reflection of the wider unscheduled care pressures.
- Delivery against the 4 hour bundle is significantly adrift of the agreed IMTP profile despite an encouraging improvement in performance in Q1 that was not sustained through the rest of the year
- The number of confirmed stroke admissions in 2017/18 increased by 14% when compared to 2016/17.
- Support is being provided by the Delivery Unit to review the stroke pathway and to identify opportunities for targeted improvement
- The out of hours period is a risk as a result of reduced staffing capacity or non-availability of services on a 24/7 basis. Solutions are being explored to improve the identification and assessment of stroke patients who arrive overnight.
- Staff sickness during March also impacted on capacity at times - and affected the 72 hour bundle in particular.

What actions are we taking?

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

Morriston

- Increase the number of protected ringfenced stroke beds and improved governance arrangements to support the ringfenced protocol.
- Planned increase in medical cover from July which should improve timeliness of assessment.
- Stroke CNS capacity will be reinstated to full establishment from April and following staff induction this should support improvement in the stroke pathway.

Princess of Wales

- The team of the day is in place for the clinical nurse specialists and junior doctors to ensure ongoing focus on the pathway.
- The planned relocation of the TIA clinic in the next few months will release clinical nurse specialist time to support patient flow.
- Reviewing stroke pathway with the support of the Delivery Unit - to identify and address any barriers.

ABMU wide

- Improved and ongoing communication and awareness of the stroke pathway within hospital units and between services.
- Ongoing planning in terms of working towards the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from national funding to fund a dedicated project manager to support this work.
- Review the rehabilitation pathway to identify opportunities to support the provision of early supported discharge for stroke patients.

What are the main areas of risk?

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

How do we compare with our peers?

- Performance against the 4 hour bundle continued to be the main challenge for ABMU Health Board in March, and in line with a number of other Health Board was affected by the significant unscheduled care pressures experienced in March 2018. The Health Board thrombolysis rates were amongst the highest in March. Performance against the remaining 3 bundles was generally comparable with other Health Board on the 12, 24 and 72 hour bundles.

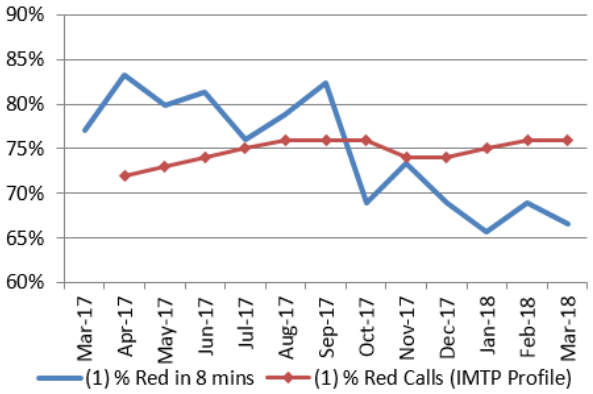
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

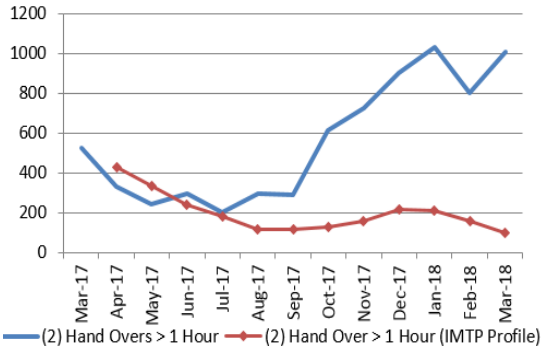
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target : (1) 76% (2) 100	WG Target : (1)65% (2) 0	Current Status:	Movement : W

Current Trend: Mar 17 – Mar 18

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

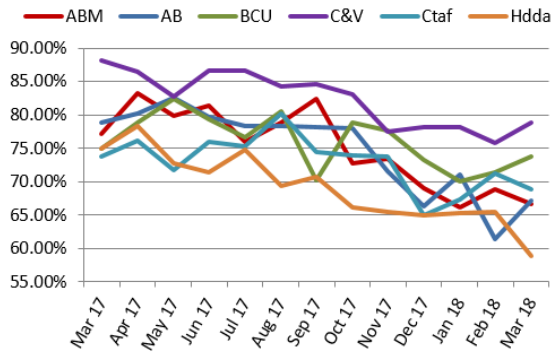


(2) Number of patients waiting more than 1 hour for an ambulance handover

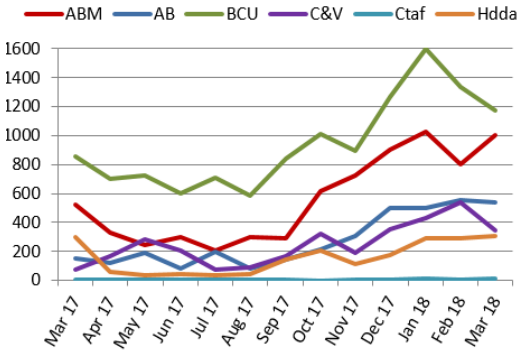


Benchmarking

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



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



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

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

How are we doing?

- The Health Board's Category A (Red response) was 66.6% in March 2018, against the National shared target of 65%. Response times for the most urgent calls reduced from 68.9% in February 2018, and also from 77.1% in March 2017. The number of patients conveyed to hospital in the red (life threatening) category in March 2018, was the highest ever recorded.
- 1 hour ambulance handover performance in March 2018 deteriorated when compared with March 2017, with a 92% increase in > 1 hour delays for these comparative months.
- March 2018 experienced a 10.7% reduction in overall ambulance arrivals at our hospital front doors when compared with March 2017 as a result of the joint work programme with WAST. When comparing March 2018 with March 2017 categories of patients conveyed to hospital, there has been a 25% increase in red (life threatening calls), a 12% reduction in amber calls, and a 25% reduction in green calls. This suggests that the acuity and complexity of patients arriving at ED by ambulance is increasing, whilst the lower acuity calls are continuing to be redirected to appropriate alternative pathways and services.

What actions are we taking?

- The Health Board continues to work closely with WAST to ensure that patients are directed to the most appropriate service or pathway of care that best meets their needs.
- An Executive to Executive meeting took place in April to review the changing pattern of ambulance demand within ABMU Health Board and to explore additional opportunities to further improve the unscheduled care pathway to reflect this change.
- Continued development of pathways, models of care and the workforce to reduce health care professional requests for an emergency ambulance response. This includes closer links between WAST with our District nursing service to redirect suitable patients. Trialling a dedicated mental health response/ community psychiatric nurse response car to jointly support the appropriate management of community mental health patients.
- Evaluating the impact of joint ABMU/WAST tests of change implemented over the winter - and if evaluations are successful to develop proposals to support the upscaling of capacity to deliver alternative models of care on a sustainable basis across the Health Board.

What are the main areas of risk?

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

How do we compare with our peers?

- March 2018 was one of the most challenging periods across the health and care system in terms of patient flow,and had a significant impact on ambulance response and patient handover times.
- In line with other Health Boards in Wales, ABMU performance against the Category A - Red calls target struggled in March, and at 66.7% was below the all-Wales average performance of 69.4% for the month. However unlike the majority of other Health Boards the >1 handover delays showed an upward (deteriorating) trend.

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

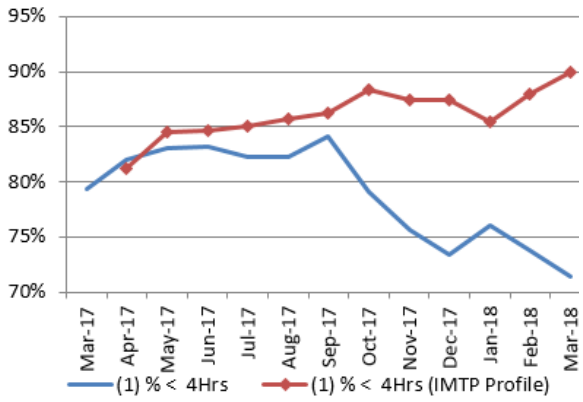
Measure 1: % new patients spending no longer than 4 hours in an Emergency Department

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

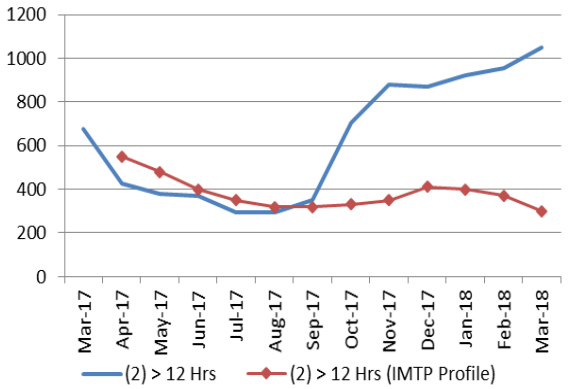
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target : (1) 90% (2) 300	WG Target : (1) 95% (2) 0	Current Status :	Movement : W

Current Trend: Mar 17- Mar 18

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



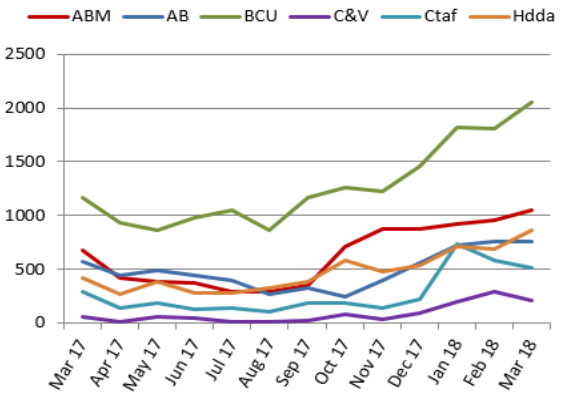
(2) Number of patients spending more than or equal to 12 hours in A&E



Benchmarking

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

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



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

Measure 1: % new patients spending no longer than 4 hours in an Emergency Department
Measure 2: Number of patients spending more than or equal to 12 hours in A&E

How are we doing?

- Unscheduled care performance against the 4 hour target in March 2018 was 71.43%. This position has deteriorated when compared with February 2018 (73.81%), and when compared with March 2017 (75.7%).
- 1,051 patients stayed over 12 hours in our Emergency Departments (ED's) during March 2018, which represented a 55% increase when compared with March 2018.
- The overall number of patients attending the Emergency departments and minor injuries units decreased by 6% compared with March 2017 with the majority of the decrease associated with a reduction in attendance at our minor injuries units, with Singleton and NPT hospitals experiencing a 20% and 9% reduction respectively.
- However the month experienced some significant variation in demand across the days of the week/month. The early part of March saw our Emergency Departments and front door services experiencing significant increased demand on particular days following the snow and the aftermath of the adverse weather conditions.

What actions are we taking?

- The ongoing and increased focus on implementation of the SAFER flow bundle to support patient flow, reducing un-necessary stays in hospital and increasing avoidable admissions. Supporting and promoting the national #endpjparalysis campaign between April and July to support earlier and more timely patient discharge, and to raise awareness of staff and the general public on the impact of unnecessary or avoidable hospital stays on patient outcomes.
- Working with partners in Local Authorities on arrangements to develop more sustainable models of care to support patient flow.
- Evaluating and developing new models of care between the ambulance service and primary and community care services to support patients at home - see ambulance report.
- Implementation of Quarter 1 USC improvement plans with a particular focus on frailty services and ambulatory care models.
- Implementation of the action plan developed following Breaking the Cycle to support sustainable improvement in patient flow and safety.

What are the main areas of risk?

- Capacity gaps in Care Homes, Community Resource Teams. Capacity and fragility of private domiciliary care providers , leading to an increase in the number of patients in hospital who are 'discharge fit' and increasing length of stay
- Workforce - with ongoing challenges in general nursing and medical roles in some key speciality areas such as the Emergency Department (ED) and out of hours services.
- Peaks in demand/patient acuity above predicted levels of activity.
- The impact of infection on available capacity and patient flow.

How do we compare with our peers?

- The Health Board's 4 hour performance was 71.4% in March 2018, compared with the all-Wales 4 hour performance of 75.6% for this period.
- In ABMU 93% of all patients were assessed, treated and transferred from the Emergency Department within 12 hours, compared with the All Wales position of 93.5%.

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

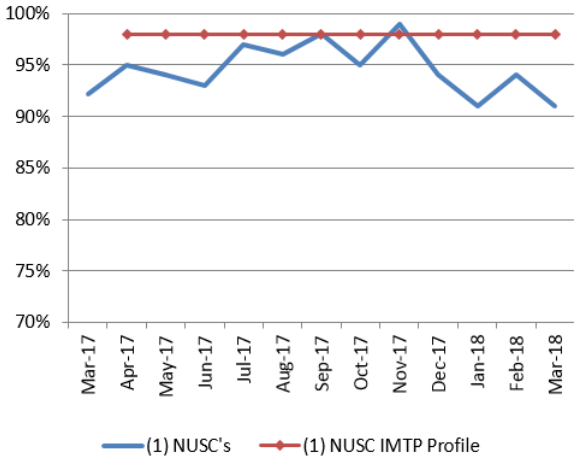
Measure 1: % of patients newly diagnosed with cancer not via the urgent route that started definitive treatment within 31 days

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

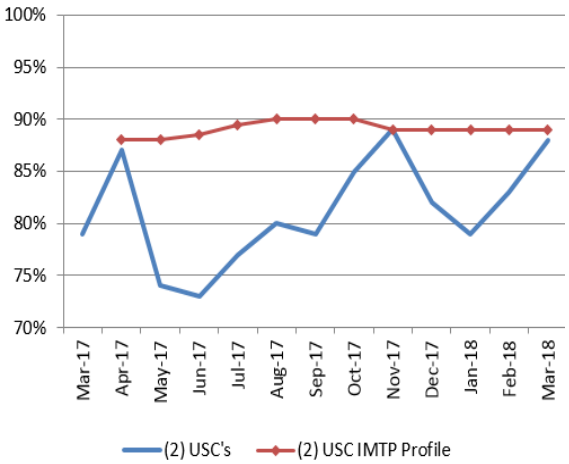
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	IMTP Profile Target: (1) 98% (2) 89%	WG Target : (1) 98% (2) 95%	Current Status :	Movement : Imp

Current Trend: Mar 17- Mar 18

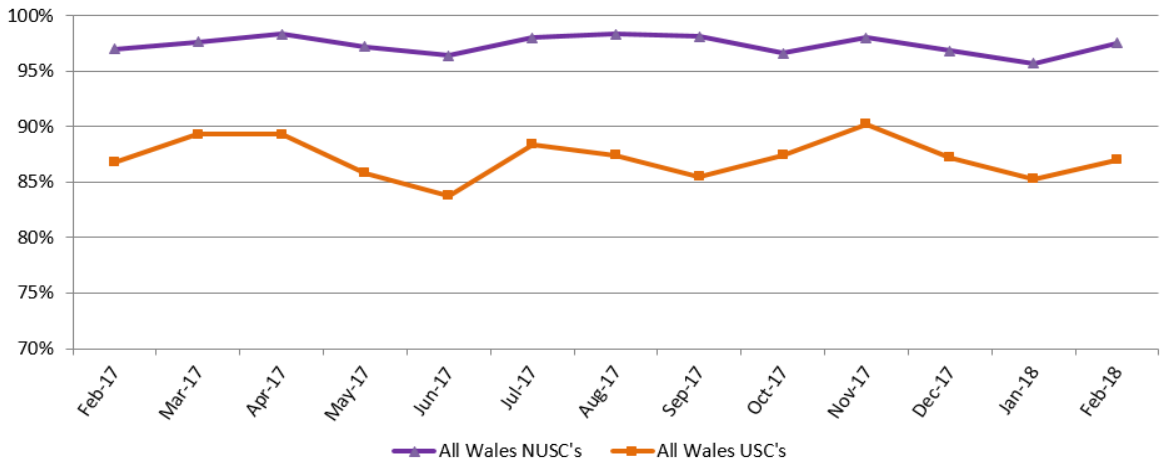
(1) % of patients newly diagnosed with cancer not via the urgent route that started treatment within 31 days



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



Benchmarking



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

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

How are we doing?

- NUSC performance for March 2018 is 91% (10 breaches).
- USC performance for March 2018 is 88% (17 breaches).
- USC referrals received by the Health Board remain high during Q4. The monthly average during the 13 months February 17 to February 18 is 1749. 1748 referrals were received in February.
- Backlog reduced through February 2018 however increased again through March 2018.

What actions are we taking?

- Gynaecology theatre timetable revised to increase theatre capacity and opportunity for backfill within Gynae-oncology service.
- Post-Menopausal Bleeding (PMB) pathway under review with aim to improve waiting times for diagnostics, which will reduce overall wait from referral to treatment.
- Centralisation of Breast outpatient work to Neath Port Talbot Hospital will be complete in May.
- Additional haematology backfill and Waiting List Initiative (WLI) clinics arranged to ensure patients requiring USC appointments are seen within target.
- All theatre lists reviewed. Additional weekend WLI theatres arranged to accommodate USC and NUSC patients.
- Breast waiting list initiatives being held on weekends.
- First outpatient waits for OMF patients are being monitored to ensure they are reducing and working towards a local target of 8 working days.
- Radiotherapy service improvement radiographer has commenced in post and from March will be working to support the service to reduce waits and support escalation of treatment dates to deliver treatment in target. Also the LINAC replacement programme is currently underway.
- Additional endoscopy lists undertaken to keep waits to a minimum
- Close monitoring of diagnostic waits in radiology, especially plain film to enable escalation and completion of investigations sooner.
- Extending the contract of the current agency locum Urology Consultant at Princess of Wales Hospital.
- Review of CT biopsy provision to increase capacity.
- Demand and Capacity work undertaken for USC Breast outpatients.
- Introduction of electronic booking forms in radiotherapy have helped reduce administrative delays. Consultants have been provided with remote access for planning and localisation. A service improvement radiotherapist monitoring CT SIM booking is now liaising with consultants to ensure treatment slots are not wasted. The service improvement lead for Cancer Services is also working with the department to review processes and improve efficiency.

What are the main areas of risk?

- Unscheduled Care pressures are having an impact on bed capacity although site management processes aim to minimise impact on cancer cases.
- Continued growth in demand and therefore the backlog
- On-going challenges to appoint to vacant posts and time lag in developing new workforce models
- Delays to diagnostic endoscopy service
- Growing waiting times in Chemotherapy and radiotherapy –pressures around vacancies / planned maternity leave / changes in NICE guidance.
- Ongoing issues with delivery of Urological services at Princess of Wales Hospital
- Delays in Gynaecological diagnostic pathway and theatre capacity
- Ongoing issues with delivery of Breast services
- There will be 3 Gynaecology Consultants on long term sick from the end of March – one of these is part of triumvirate of Consultants that operate on cancer patients post MDT which will reduce surgical capacity.

How do we compare with our peers?

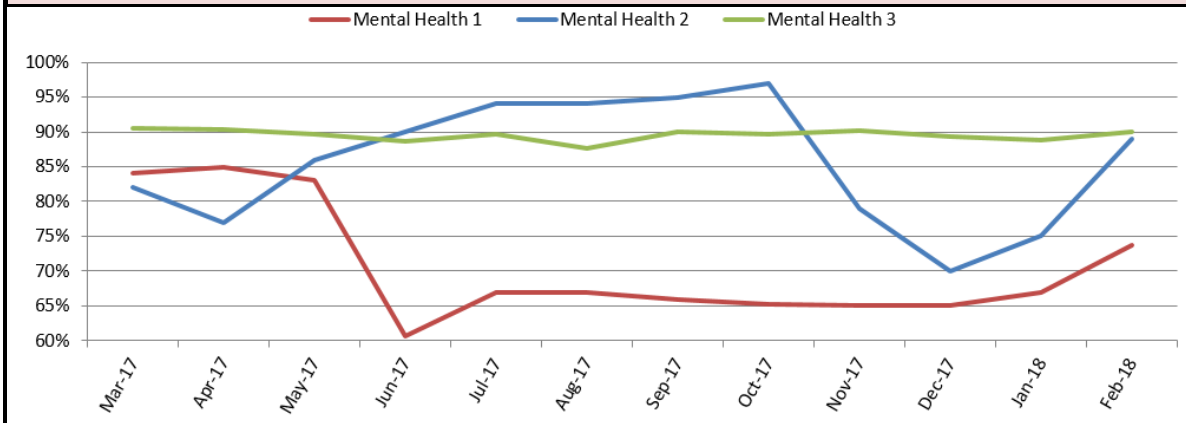
- USC performance continues to struggle in comparison with other Health Boards, demonstrating the lowest performance of all Health Boards. In contrast however, second to Betsi-Cadwalader UHB, ABMU has the highest volumes of USC patients treated per quarter

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

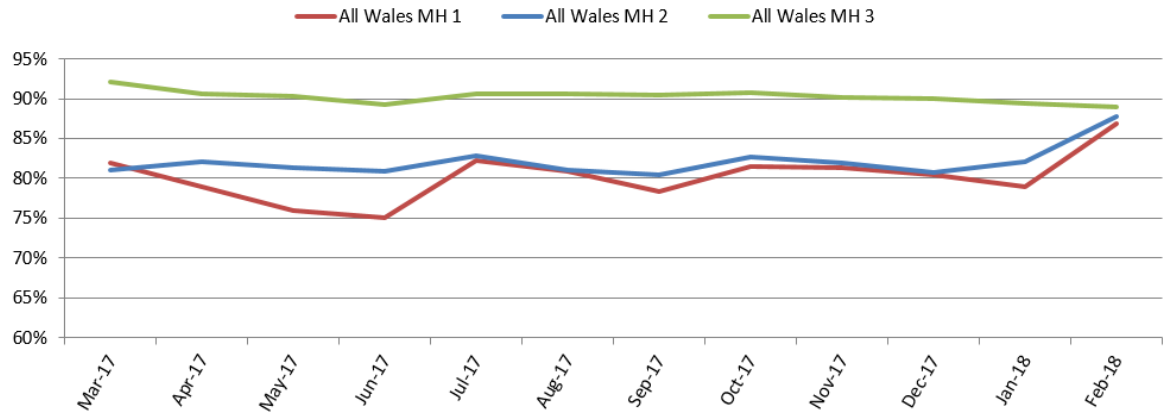
Measure 1: % of assessment by the Local Primary Mental Health Support Service (LPMHSS) undertaken within 28 days from receipt of referral
Measure 2: % of therapeutic interventions started within 28 days following an assessment by LPMHSS
Measure 3: % of Health Board residents in receipt of secondary Mental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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period: Feb 2018	**IMTP Profile Target :** (1) 90% (2) 85% (3) 85%	**WG Target :** (1) 80% (2) 90% (3) 90%	**Current Status :**	**Movement :** Worsening

Current Trend: Feb 17 – Feb 18



Benchmarking



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

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

How are we doing?

- Mental Health 1 - ABMU met the target for 3 of the 12 months shown. The data submitted to WG includes CAMHS data, which is collated by Cwm Taf HB. Agreement was reached to allow for the commencement of CAMHS data reporting from June 2017. However, the assimilation of CAMHS data into the reporting framework has seen a negative impact to the assessment target. If we exclude CAMHS data from our submission, we were 95% compliant in February. It should be noted that actual waiting time is irrespective of weekends and bank holidays.
- Mental Health 2 - intervention levels met the target 8 of the 12 months shown. There was a slight dip from November to January as a result of the change in analysing CAMHS intervention data in Cwm Taf. We achieved target in the number of interventions in February, including and excluding CAMHS data. Meeting the target does not tell you how many people are waiting or the length of longest waits, but we manage and monitor the lists locally. Of note, from the 1st of January 2018 each Health Board is responsible to report the new "Access to Psychological Therapies in Specialist Adult Mental Health Services", which will impact on Part 1 intervention data.
- Mental Health 3 - This data covers Adult, Older People, CAMHS and Learning Disability Services. ABMU met the target from 8 of the 12 months shown. The percentage of Care and Treatment Plans reported for February was slightly under target. An audit of CTP's has taken place to capture service user's experience of care and treatment planning.

What actions are we taking?

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

What are the main areas of risk?

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

How do we compare with our peers?

February 2018
- All-Wales MH1 measure ranged from 73.8% to 95.9% 73.8% ABM
- All-Wales MH2 measure ranged from 75.4% to 95.2% 70.4% ABM
- All-Wales MH3 measure ranged from 85.4% to 92.5% 89.0% ABM

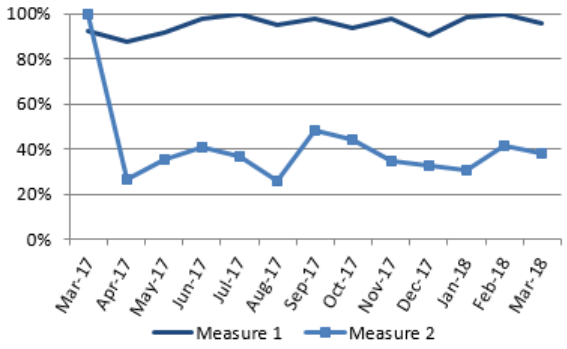
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

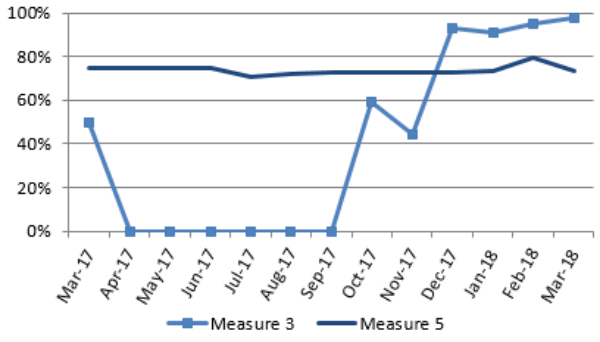
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Siân Harrop-Griffiths	
Period : Mar 2018	IMTP Profile Target :	WG Target : (1, 2, 3, 4) 100% (5) 90%	Current Status : ✖	Movement : ⇩ Worsening

Current Trend: Mar 17 – Mar 18

(1) % of Urgent Assessments undertaken within 48 Hours from receipt of referral, (2) % of Routine Assessments undertaken within 28 days from receipt of referral.



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



Benchmarking

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
% of urgent assessments undertaken within 48 hours from receipt of referral	⇩ 94.0%	⇧ 97.8%	⇩ 90.5%	⇧ 98.2%	⇧ 100.0%	⇩ 96.0%
% of routine assessments undertaken within 28 days from receipt of referral	⇩ 44.0%	⇩ 34.5%	⇧ 32.6%	⇩ 30.4%	⇧ 41.7%	⇩ 38.3%
% of patients with NDD receiving diagnostic assessment and intervention within 26 weeks	⇧ 59.0%	⇩ 44.0%	⇧ 93.0%	⇩ 91.0%	⇧ 95.0%	⇧ 98.0%
% of therapeutic interventions started within 28 days following assessment by LPMHSS	⇨ 100.0%	⇩ 59.0%	⇧ 71.0%	⇨ 71.0%	⇧ 88.1%	⇩ 81.8%
% of Health Board residents in receipt of CAMHS who have a Care and Treatment Plan	⇨ 73.0%	⇩ 72.5%	⇧ 72.8%	⇧ 73.2%	⇧ 79.3%	⇩ 73.2%

Source : Cwm Taf Health Board

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

How are we doing?

- Measure 1: 100% of urgent assessments by CAMHS undertaken within 48 hours from receipt of referral - whilst there has been slight deterioration compliance has been consistent over the last 12 months with 96% compliance achieved at the end of March.
- Measure 2: Performance against measure 2 - assessments undertaken within 28 days from receipt of referral deteriorated between October 2017 to January 2018, but have improved significantly from January to March 2018. Efforts have been made by Cwm Taf UHB to hold waiting list clinics to address backlogs, but these did not start until late March, due to staff being utilised to address NDD waiting list backlogs. By 19th April 2018 the position had started to improve across ABMU, with 53.4% achievement against measure 2, with Bridgend at 67.4% compliance, NPT at 93.8%, and Swansea at 43.4%. Average waiting times for specialist CAMHS have reduced significantly, with an average wait of 4.9 weeks across ABMU. Cwm Taf did not achieve the Welsh Government target set at 80% for Measure 2 by end of March 2018 for the ABMU population.
- Measure 3: The Welsh Government target of 80% of NDD Assessments to be carried out within 26 weeks was achieved at the end of March with 98% compliance.
- Measure 4: 81.8% target achieved (relates to specialist CAMHS only) - whilst performance has deteriorated slightly between February & March a significant improvement has been achieved since November when compliance dropped to 59%. This position will continue to be monitored.
- Measure 5: Compliance of 73.2% reported in March- A decline in the number patients on the measure.

What actions are we taking?

- **NDD -** Slippage from 2017/18 from Integrated Care Funding has been utilised to carry out waiting list initiative clinics to reduce the backlog, and a sustainable plan for demand and capacity is being developed. To support the long term sustainability of the service additional substantive staff are being recruited, and a consultant psychiatrist and nurse practitioner are anticipated to be in post by June 2018.
- **Specialist CAMHS** - ABMU Health Board continues to scrutinise performance and improve governance as commissioner of CAMHS. CAPA was introduced by the CAMHS Network in September across ABMU and this model should support the long term sustainability of the Service, because more robust demand and capacity assessments can be undertaken once local data is available following implementation of CAPA. Waiting list initiative clinics have commenced in Bridgend. The service had been working towards delivery of the 80% target for compliance against the 28 day S-CAMHS target by the end of March 2018, but failed to do so for the ABM population. Cwm Taf have highlighted that compliance will be met by September 2018. Ongoing detailed scrutiny of the performance of Specialist CAMHS is ongoing, with at least monthly meetings as well as more detailed service based discussions as required. The performance of the CAMHS Network and the risk caused by long waiting times has been included on the Health Board's risk register.

What are the main areas of risk?

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

How do we compare with our peers?

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

6.3 Demonstrating Value and Sustainability

The table on page 26 above sets out the assessed performance of the key metrics under this Corporate Objective. All of the available data relates to November 2017. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 95.

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

- DNA Rates (WG Measures 94 and 95)

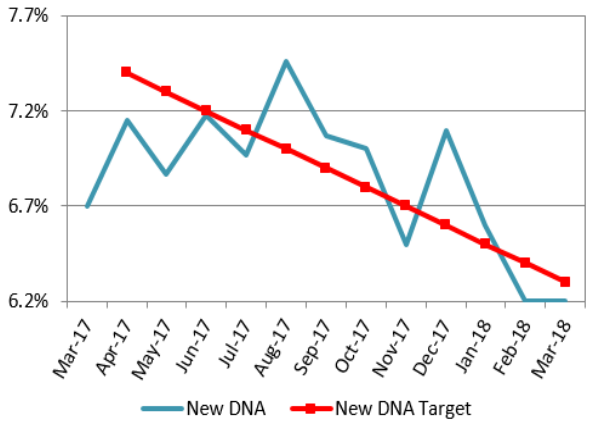
OUR STAFF AND RESOURCES: PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

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

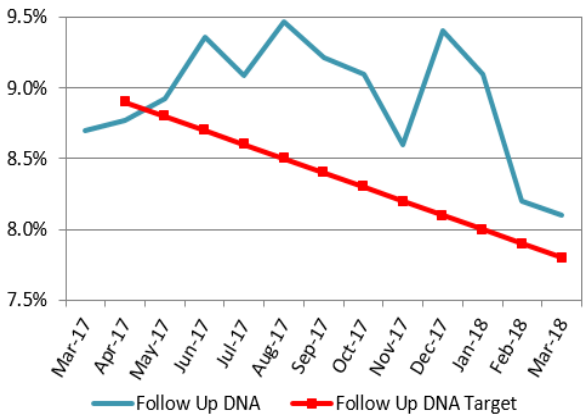
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Mar 2018	**IMTP Profile Target :** (1) 6.3% (2) 7.8%	**WG Target :** 12 month reduction trend	**Current Status :** ✓	**Movement :** Improving

Current Trend: Jan 17 - Jan 18

(1) % New Outpatient that Did Not Attend



(2) % Follow Up Outpatient that Did Not Attend



Benchmarking

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

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

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

How are we doing?

- New Outpatient DNA: From Mar 2017 - Mar 2018 performance has improved from 6.7% to 6.2%. In month performance has remained stable at 6.2%.
- Follow-Up DNA: From Mar 2017 - Mar 2018 performance has improved from 8.7% to 8.1%. In month performance has improved from 8.2% at February 2018.

What actions are we taking?

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

What are the main areas of risk?

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

How do we compare with our peers?

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

6.4 Securing a Fully Engaged and Skilled Workforce

The table which starts on page 26 above sets out the assessed performance of the key metrics under this Corporate Objective. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 98.

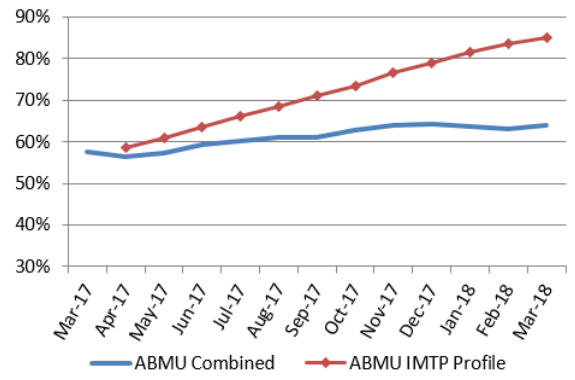
Further detail on current performance and proposed actions going forward can be found for the following measures via dedicated report cards:

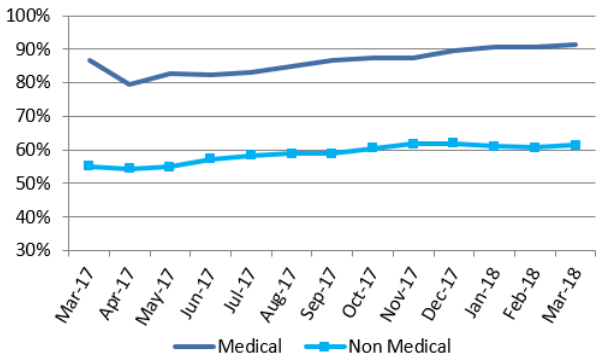
- Appraisals (WG Measure 100)
- Sickness absence (WG Measure 104)

TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE				
Measure 1: % staff (medical & non medical) undertaking performance appraisals				
Corporate Objective : Securing a Fully Engaged and Skilled Workforce			**Executive Lead : Kate Lorenti**	
Period : Mar 2018	**IMTP Profile Target : 85%**	**WG Target : 85%**	**Current Status :**	**Movement : Imp**

Current Trend: Jan 17- Jan 18

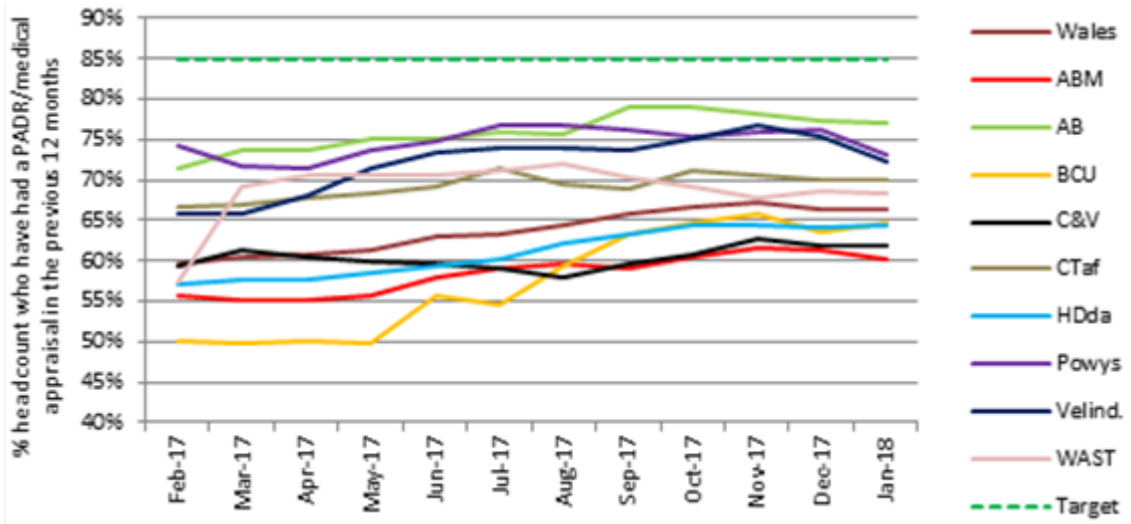
(1) % staff undertaking performance appraisals





Benchmarking

(1) % staff undertaking performance appraisals



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

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

How are we doing?

Medical:

- Excluding any exemptions (new starters, absences e.g. long term sickness, maternity leave etc.) the appraisal rate for the rolling period to March 2018 was 91%.
- Appraisals undertaken have continued to improve since April.
- The dip in April 2017 reflects a change in the 'denominator', the number of doctors employed / contracted and 'connected' to the Health Board increased from 1255 to 1335. This varies throughout the year but for consistency, the statistics are based on numbers at the beginning of April each year.

Non Medical:

- Reporting figures demonstrate an increase in PADR compliance- Jan 2017 55.73% to March 2018 61.46%
- From the 6 Service Delivery Units (SDUs): Mental Health & Learning Disabilities (MHLD) 84.71%, Morristion Delivery Unit (MSDU) 61.9%, Neath Port Talbot (NPT) 72.71%, Primary & Community Care (PCC) 79.13%, Princess of Wales (POW) 58.56%, Singleton Delivery Unit (SSDU) 54.14%
- The lowest PADR Compliance is with Informatics 11.36% which is a significant decrease in compliance (previously 18%)

What actions are we taking?

Medical:

- Maintain current performance levels through continuing engagement with Unit Medical Directors, undertaking quarterly exception management process, providing doctors with training and advice.
- There have been further enhancements since the new version was launched in August 2017 to improve functionality in line with identified changes/developments.
- Unit based Appraisal Leads have been identified for NPT, POW & MH&LD (MH & SH tbc), once formally appointed they will drive appraisal quality forward and maximise delivery of appraisal benefits.

Non Medical:

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

What are the main areas of risk?

Medical:

- If doctors fall behind on appraisal timescales for revalidation: stress for doctor; diversion of doctor's and management time /resource; potential delayed revalidation; ultimately, consequences for licence to practise if fail to engage.
- Poor quality appraisals - lack of personal/service development and progression; continuation of sub-optimal practices; resistance to change.
- Ensuring new starters and ad hoc doctors are engaged with the annual appraisal process, and relevant information received from previous RO (Responsible Officer).

Non Medical:

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

How do we compare with our peers?

- **Medical:** Stats from the RSU (Revalidation Support Unit) show appraisals undertaken from 1st April 2017 - 31st December 2017 in ABMU as 61% of the baseline total number of doctors (based on appraisals completed) this is in line with other Health Boards within Wales.
- **Non Medical**: ABMU remains in line with other Health Boards across Wales. Risk areas which are much lower than the national average remain as Estates, Facilities and Informatics.

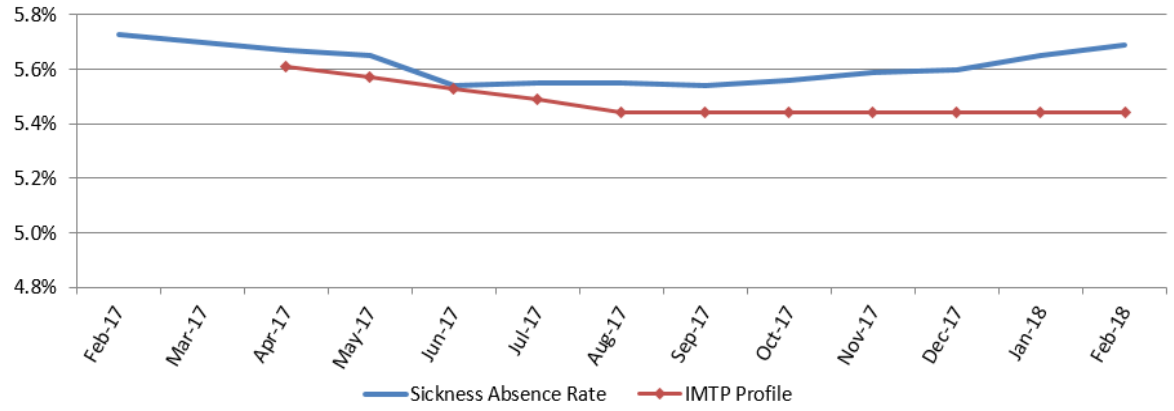
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

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

Corporate Objective : Securing a Fully Engaged and Skilled Workforce			Executive Lead : Kate Lorenti	
Period : Feb 2018	**IMTP Profile Target :** (1) 5.44%	**WG Target :** Reduction	**Current Status :** ✓	**Movement :** ↓ ● Imp

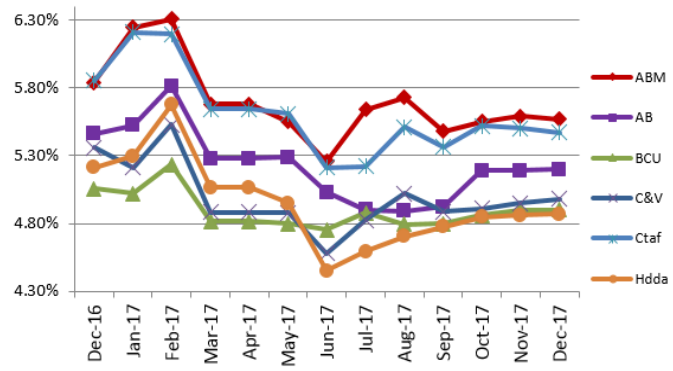
Current Trend: Feb 17 – Feb 18

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



Benchmarking

In-Month Sickness Absence Rates



% workforce sickness absence (Rolling 12 months)

LHB	Current	Same Period Comparison		
	Dec-17	Dec-16	Dec-15	Dec-14
Wales	5.13%	↑ 5.15%	↑ 5.30%	↑ 5.56%
ABM	5.57%	↑ 5.60%	↓ 5.45%	↑ 5.71%
AB	5.20%	↑ 5.26%	↑ 5.42%	↑ 5.48%
BCU	4.90%	↓ 4.85%	↓ 4.89%	↑ 5.24%
C&V	4.98%	↓ 4.87%	↑ 5.31%	↑ 5.74%
CTaf	5.47%	↑ 5.61%	↑ 5.67%	↑ 6.04%
HDda	4.87%	↑ 5.19%	↑ 5.62%	↑ 5.41%
Powys	4.59%	↑ 4.60%	↓ 4.06%	↑ 4.74%
PHW	3.96%	↓ 3.45%	↑ 4.04%	↓ 3.64%
Velind.	3.85%	↓ 3.56%	↑ 4.09%	↓ 3.70%
WAST	6.84%	↑ 7.12%	↑ 6.97%	↑ 8.33%

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

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

How are we doing?

Rolling 12 month performance:

- Mar 16- Feb 17= 5.71%
- Feb 17- Jan 18= 5.64%
- Mar 17 – Feb 18 = 5.69%

In Month performance:

- Jan 18= 6.75%
- Feb 18= 6.47% (was 5.96% in Feb 17)

- Whilst four out of six units improved their in month sickness performance, only MH and LD improved their rolling 12-month performance, this resulted in an increase in the overall rolling 12-month performance.
- Short-term sickness (STS) improved by 0.15% in February 2018 compared to the previous month however, levels of STS remain above 2% due to cold/flu related absence, which has seen 3275 more fte days lost in Jan and Feb combined, compared with the combined total for Nov and Dec. We anticipate this reducing in March.
- Long-term sickness reduced by 0.12% to 4.3% compared to the previous month. Stress and other mental health illnesses remains our top reason for absence, accounting for just under 27% of all absence in February 2018.

What actions are we taking?

- Standardised process and methodology for Long Term sickness scrutiny being piloted.
- Commencing provision of training opportunities in 'Mental health in the workplace for managers'.
- Commencing provision of training opportunities in HSE work related stress risk assessment.
- Development of an evaluation of the Wellbeing Champion network.
- Review of information received from a Trust in England that has taken a "different approach" to sickness absence management and reduced cumulative sickness by 0.5% in a 12 month period to under 4%.
- Review of medical staff sick absence reporting and actions taken.

What are the main areas of risk?

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

How do we compare with our peers?

- The latest 12 month cumulative differential between ABMU and the all-Wales performance is 0.44%.
- The latest differential between our monthly sickness absence rates and the all-Wales average is 0.47%.

6.5 Embedding Effective Governance and Partnerships

The table which starts on page 26 above sets out the assessed performance of the key metrics under this Corporate Objective. For the majority of cases this data relates to January 2018. The detailed performance report cards provide further background analysis to this performance assessment. The cards are in included within this section of the report starting on page 103.

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

Health and Care Research Wales (WG Measures 46 to 49)
This measure is reported quarterly and the latest available information is quarter 3 for 2017/18. The table below shows the performance in 2017/18 (Q1-3) compared with 2016/17. As these are annual improvement measures, the table below confirms that two of the four measures were achieved in 2017/18.

Measure	2016/17 (Q1-Q3)	2017/18 (Q1-Q3)	Variance
No. Health and Care Research Wales CRP Studies	99	85	-14
No. Commercially sponsored studies	27	38	+11
No. patients recruited into Health and Care Research Wales CRP Studies	1,822	1,492	-330
No. patients recruited into commercially sponsored studies	128	223	+95

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

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

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

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

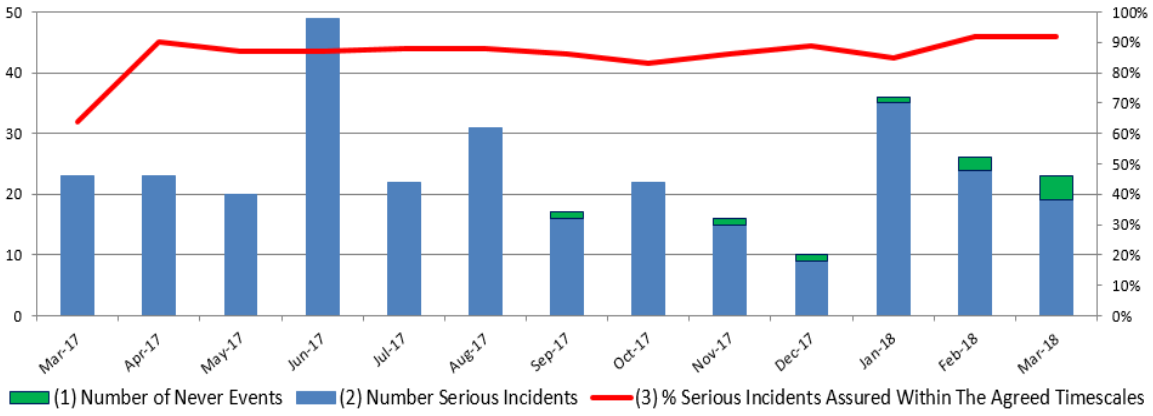
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

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

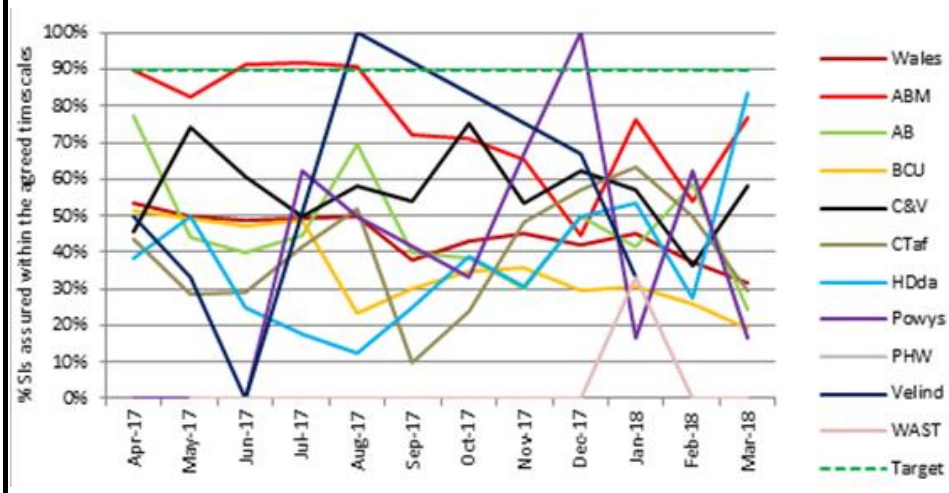
Current Trend: Mar 17 - Mar 18

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



Benchmarking

(3) Serious Incidents Assured Within The Agreed Timescales



Mar-18	
Wales	7
ABM	4
AB	1
BCU	1
C&V	1
Ctaf	0
Hdda	0
Powys	0
PHW	0
Velind	0
WAST	0

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

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

How are we doing?

- Total number of incidents reported in March 2018 was 2,285. This compares to 2,095 incidents reported in March 2017, an increase of 190 incidents for the month of March (increase of 9%).
- 19 Serious Incidents (SI) were reported to Welsh Government (WG) in March 2018 representing 0.8% of all incidents. In comparison, 23 SI's were reported to WG in March 2017, a decrease of 4 incidents. Of the 19 new serious incidents reported to WG, 12 (63%) related to pressure ulcer incidents (grade 3 and above), 2 (11%) related to patient falls, 1 (5%) related to maternity care, 2 (11%) related to communication, 1 (5%) related to Medication and 1 (5%) related to therapeutic processes.
- In terms of severity of incidents, the percentage of incidents resulting in severe harm for March 2018 was 0.2% (total incidents reported 2,285). The Health Board's target for incidents resulting in severe harm is 0.5% of the total number of incidents reported.
- Four Never Events were reported in March 2018.
- Performance against the WG target of closing SI's within 60 working days for March 2018 was 92% against the WG target of 80%
- Welsh Government performance data is not aligned to the Health Board data and the Health Board is working with WG to support their update on the cases.

What actions are we taking?

- Performance against the WG target to gain assurance on the reports within 60 working days (80%), remains consistently above the 80% target since April 2017. All submitted closure forms received assurance by WG in March 2018 evidencing continued improvement in the quality of forms submitted.
- The SI Team continues to trial the new reflective methodology approach to review serious incidents managed by the SI Team. Presentations promoting the approach are being undertaken across the Health Board to help promote an organisational learning culture.

What are the main areas of risk?

- Maintaining Welsh Government 80% target closure date whilst ensuring quality of investigation reports and robust learning from the incidents.
- Work is commencing on standardising fall related investigations. This is being done to coincide with the upcoming relaunch of the
- Health Board's fall prevention and management policy.
- Work is on-going to complete all ongoing Never Event investigations (10 in total) so that all learning and subsequent action plans can be implemented.
- Differences between WG data and Health records is a concern which will be addressed directly with Improving Patient Safety at WG.

How do we compare with our peers?

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

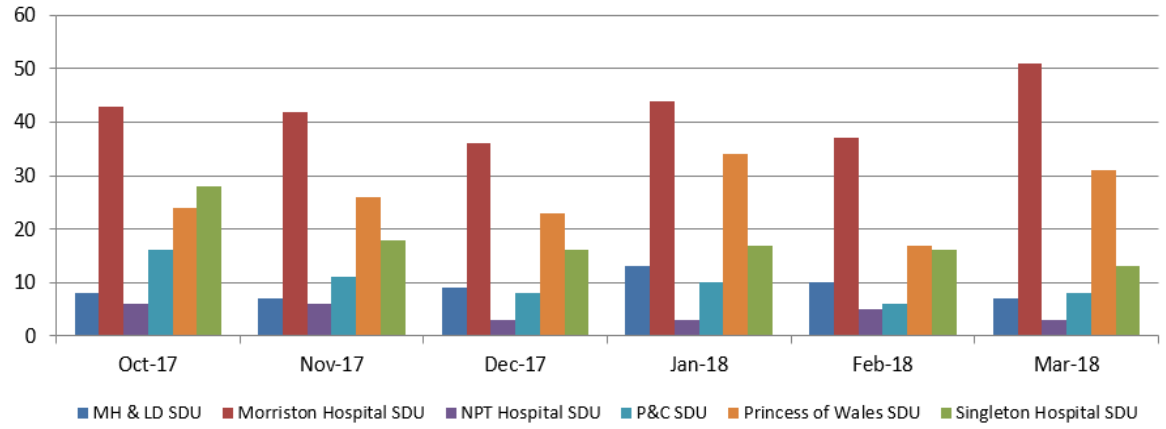
DIGNIFIED CARE - PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

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

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

Current Trend: Oct-17- Mar 18

(1) Number of new formal complaints received.



(2) % of responses sent within 30 working days

% of responses sent within 30 working days	2017											2018	
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
MH & LD SDU	50%	71%	55%	44%	71%	86%	100%	64%	75%	71%	88%	60%	50%
Morriston Hospital SDU	74%	86%	86%	93%	86%	88%	78%	84%	86%	75%	88%	76%	58%
NPT Hospital SDU	80%	40%	50%	80%	100%	57%	50%	78%	83%	83%	67%	100%	100%
Princess of Wales SDU	94%	95%	96%	100%	83%	83%	81%	68%	67%	62%	64%	93%	60%
P&C SDU	42%	50%	46%	55%	56%	88%	67%	60%	75%	82%	100%	75%	88%
Singleton Hospital SDU	69%	77%	63%	60%	81%	65%	81%	83%	79%	72%	73%	75%	53%
Health Board Total	**71%**	**80%**	**75%**	**77%**	**82%**	**80%**	**80%**	**76%**	**78%**	**73%**	**80%**	**80%**	**61%**

(3) % of acknowledgements sent within 2 working days

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

Benchmarking

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

Source : COMPLAINTS MODULE FROM DATIX

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

How are we doing?

- The Health Board received 115 formal complaints in March 2018, an increase of 11 (11% increase) compared to March 2017.
- The overall Health Board response rate for responding to concerns within 30 working days was 61% for February 2018, below the Welsh Government target of 80%.
- The Health Board continues to consistently maintain the 2 day acknowledgement target at 100%.
- Patient Advice Liaison Service (PALS) activity for the period April 2017 - March 2018, identified 3,496 contacts of which 3.2% (115) converted to formalised complaints.

What actions are we taking?

- Performance of the 30 day response target is addressed consistently at all Service Delivery Unit (SDU) performance reviews. The dip in the March performance is being explored but service demands including a period of 'business continuity' where all resources are targeted at direct patient care service delivery are likely to be contributing factors.
- SDU's identify trends and themes from their formal complaints for discussion at each local Quality and Safety meeting and formal reporting through the Health Boards' Assurance and Learning Group where themes, trends and Health Board actions can be identified and shared for learning. A recurring theme in complaints received continues to be communication. A training programme for communication for all staff grades continues in all SDU's by the Patient Experience Training officer, with further SDU discussions during attendance at Concerns and Redress Group (CRAG).
- Currently there are 38 open Ombudsman investigation cases; Morriston 15, Princess of Wales 11, Singleton 7, Mental Health & Learning Disabilities 3 and ; Primary Care and Community Service 2. Recurring themes from the Ombudsman investigations are discharge process, communication, record keeping and poor complaint handling. The Corporate Concerns function has recently embarked on a re-structure one of the aims of the re structure is to support improvement in the Units and ensure consistency across all of the SDU's in terms of the way the Health Board investigates and responds to complaints. In addition, the Health Board continues to liaise closely with the Ombudsman Improvement Officer and the Community Health Council to discuss on-going investigations. Trends and themes deriving from these interactions will be developed into training and awareness sessions to improve across the Health Board.

What are the main areas of risk?

- Improve Quality of Complaint responses while achieving the 30 day response rate target, and decrease the number of Ombudsman cases.

How do we compare with our peers?

- No monthly all-Wales data to compare.

7. NHS DELIVERY FRAMEWORK SELF ASSESSMENT TEMPLATES

The NHS Wales Delivery Framework contains the national measures that the Health Board reports performance against. The vast majority of the measures in the framework are quantitative with established data flows making the data readily available and reportable (see section 5 of this report). However, there are a number of measures that have dedicated self-assessment reporting templates that are required to be submitted to Welsh Government on an annual or bi-annual basis.

The latest submission to Welsh Government of the reporting templates was in April/ May 2018. Copies of the submitted templates have been included in this report as set out below.

7.1 Accessible Communication and Information

NHS Organisation	Abertawe Bro Morgannwg University Health Board
Date of Report	April 2018
Report Prepared By	Alison Clarke Sian Jones

The All Wales Standard for Accessible Communication and Information for People with Sensory Loss sets out the standards of service delivery that people with sensory loss should expect when they access healthcare. These standards apply to all adults, young people and children.

Reporting Schedule: Progress against the organisation's action plan for the current operational year is to be reported bi-annually. This form is to be submitted on 31 October and 30 April.

Does the organisation have an action plan in place to implement the All Wales Standard for Accessible Communication & Information for People with Sensory Loss? Yes the Health Board has an action plan. The All Wales Standards provide the focus for positive action and also highlighted the current gaps for our services users and stakeholders with sensory loss. Our Sensory Loss Standards Group comprises representation from NHS clinical and managerial staff, voluntary organisations and patient representatives.	

Update on the Actions to Implement the All Wales Standards for Accessible Communication & Information for People with Sensory Loss:

Needs Assessments	Key Actions Achieved during 2018-19	Risks to Delivery	Corrective Actions
All public & patient areas should be assessed to identify the needs of people with sensory loss	AUDIT: The Sensory Loss Standards Group has a sub-group which undertakes audits with staff and service users to check progress against the standards and to communicate gaps in current provision so that the audited departments can take corrective action. Discussions with the Beacons Centre in Swansea has led to engagement with this practice and agreement to implement the audit at the centre.	To date audits have focussed on secondary care settings. Engagement with primary care settings is in development. Capacity of staff and time required to undertake the audit.	Review of the current audit tool in collaboration with service users, third sector and the Health Board.
All public information produced by organisation should be assessed for accessibility prior to publication.	Patient experience feedback analysed and learning from this translated into improved signage in hospital.	Cost	Larger font required for hospital signage – signs replaced

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
Health Prevention (Promotion Screening, SSW, Flu Vaccination, Bump Baby & Beyond). Priority areas include:			
➢ Raising staff awareness	During ante natal and the birth visit the Healthy Child Wales programme (HCSP) assesses all the medical and		

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	social needs of both parents including sensory loss. A Care plan is developed to ensure clients have access to interpreters/sign language. Staff have had training in delivering the HCWP. Staff awareness raising takes place at professional meetings and skills training sessions.		
➢ Ensuring all public information is accessible for people with Sensory loss	Staff use texting as well as other forms of communication to ensure clients understand information and interventions provided. Information leaflets provided by Public Health Wales are given to all parents/carers of eligible children re: Fluenz programme.	If interpreters are not available. No braille information is currently available re: Fluenz or Height, Weight and Vision Screening programmes, or the Child Measurement Programme.	Staff ensure resources are available by planning and booking interpreters for planned appointments. Public Health Wales informed of this requirement.
➢ Accessible appointment systems	Home visits by the Health Visitor allow for two way communication of appointments. Ongoing appointments are discussed and acceptable ways for clients negotiated to ensure they have an understanding of appointments.	If interpreter not available. If information cannot be produced in an appropriate accessible format.	Staff ensure resources are available by planning and booking interpreters' sign language staff for planned appointments. Support sought from Third sector partners where information is available in an accessible format.

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	ABMU is part of a National Task & Finish Group for school entry hearing screening.		
➢ Communication models	Health Board staff work in collaboration with Specialist teachers/classroom assistants in Units and support School Nurses as necessary if the parents or pupil has a sensory loss issue. Texting appointment details and alerts.	No teacher available.	Re-arrange school visit.
Primary and Community Care. Priority areas include:			
➢ Raising staff awareness	Sensory Loss Awareness training, following discussion at ABMUHB's Sensory Loss Accessibility Working Group has been identified to be of high importance. Discussion is underway to facilitate the provision of electronic and direct learning and awareness to frontline staff. There is the ambition that 'sensory loss champions' could be identified to support staff or service users when required. All Podiatry & Orthotic staff are aware of interpreter service, central		

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	resource e-mail address and central telephone line and signpost patients with sensory loss accordingly. All Maesteg Hospital A&C staff have undertaken an e-learning module on sensory loss. All Chronic Pain & MCAS Staff are aware of interpreter service. Audiology staff have regular 'deaf awareness' training, and interpreter services are used routinely A presentation was given in the Therapies & Health Sciences Conference on the 27th February 2018 on the piloting of the Primary Care based Audiology Service. Details of this pilot was shared with a wider audience of Health Care Professionals. ABMU has implemented a Primary Care Based Audiology Service utilising new pathways and audiologists with enhanced skills.		

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	The Primary Care based Audiology Service has been submitted for the ABMU Chairman's Awards. Tracey Good and Marcia Morgan attended the 'Protected Time for Learning' for GP's in the Bridgend area on 30th January 2018 to raise awareness of the Accessible Information Standard The pilot of a BSL video to support reception staff meet and greet deaf people was discussed in the All Wales Senior Officers Meeting. This is being developed by the NHS Centre for Equality and Human Rights and will be evaluated for its effectiveness at 6 and 12 month intervals. The video will be made available to the Health Board.	Health Board not being able to access the resource via YouTube.	Advise of a different platform that will be required in order for staff to be able to access.
➢ Accessible appointment systems	Evidence provided of services offering communication via telephone, text and e-mail for appointments i.e. Audiology patients are able to communicate via text, email and		

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	telephone. Speech & Language Therapy offer appointments by telephone and post only. There is no access to text messaging. Podiatry and Orthotics do not currently use text service, however currently exploring options to communicate by text. Chronic Pain uses phone, text and e-mail. MCAS uses phone and e-mail. Text will be available from October 2018.		
➢ Communication models	Services have access to British Sign Language Interpreters to support service users. Evidence of services having developed and implemented communication for appointments via telephone, text and e-mail. MCAS will be using text service from October 2018. **Loop systems** are available in: All Audiology Clinics and Cwmavon Health Centre.	No loop systems currently available in Community Clinic sites; Dyfed Road hub and Speech & Language Therapy.	Raise awareness of this in annual plan and risk assessment.

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	Speech & Language Therapy has access to interpreters and employs a generic e-mail account. Loop systems in Podiatry and Orthotics are widely available including hospital sites and Port Talbot Resource Centre. Chronic Pain & MCAS are mostly community based and a portable hearing loop system is available for use. Maesteg Hospital has a hearing loop.		
Secondary Care. Priority areas include:			
➢ Raising staff awareness ➢ Accessible appointment systems ➢ Communication models	ACCESSIBLE APPOINTMENT LETTERS: The Health Board is continues to work in collaboration with service users with visual impairment to develop a method to receive large print outpatient appointment letters. The appointment letter will be put into PDF format and then e-mailed to the patient. 1500 patients with sight loss were identified on the Patient Administration System and they have been invited to participate in the pilot. Printed appointment letters continue to be used during the pilot and	Some patients may not have an e-mail address so would be unable to participate in the pilot.	Active support and involvement of the IM&T department has been secured and the pilot will be evaluated to inform future action.

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	patient feedback is supporting the delivery of the project. Work continues on this pilot with regular feedback at Sensory Loss group meeting. ACCESSIBLE CONSULTATIONS: ABMU carried out a successful Face Time trial using iPads to provide real-time signing for deaf people whose first language is British Sign Language and who are receiving care in hospital. The Face Time trial was developed as part of ABMU's wider mobilisation project, which involves using new technology to improve contact between the health board, staff and patients. When it is made more widely available it will not replace face to face interpretation but will instead be an extension of the existing service. This opportunity has been extended to a pilot within Neath Port Talbot Outpatient Department.	Access to the appropriate technology and awareness of the service across all hospital sites and clinical areas.	The use of Social Media, Internet and Intranet to communicate this alternative approach and its success placing patient experience at the centre of the evaluation. Awareness raising of this innovative practice will be cascaded via the Sensory Loss group to Delivery Units.

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	SENSORY LOSS AWARENESS MONTH: The Sensory Loss Group is co-ordinating the planning of activities across the Health Board for the national campaign 'It Makes Sense' – Sensory Loss Awareness Month during November 2018. ABMU HB hosted a high profile event the national launch of the 'It Makes Sense Sensory Loss Awareness month on the 23rd November 2017. The Cabinet Secretary for Health, Wellbeing & Sport, Vaughan Gething AM gave a keynote address. The event also served as an opportunity to introduce the new Accessible Information Standard. HEARING LOOPS: A mapping exercise of the availability of hearing loops across the Health Board has been undertaken. Data. ENGAGEMENT: ABMU continues to engage with a range of stakeholders on the development and implementation of its work programme. This includes local	Ability to sustain raising awareness and maintaining awareness of the standards and best practice.	Organise awareness raising events and increase use of social media in collaboration with our third sector partners, service users and community groups to raise and sustain awareness to achieve further improvement.

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	representatives from disability access groups, RNIB Cymru, British Deaf Association, Deaf Blind Cymru and Action on Hearing Loss Cymru. The ongoing engagement takes place through ABMU's Sensory Loss Standards Group, Disability Reference Group and Stakeholder Reference Group. Outpatient departments access British Sign Language Interpreters via Oracle to support service users. British Sign Language interpreters are integral to the success of the Sensory Loss Working Group and are invited to attend the meeting to support and facilitate engagement of the service users present at the meeting to support and facilitate engagement of the service users present at the meeting. A volunteer service for adult hearing aid users is being developed in ABMU in partnership with Action on	Older premises do not have hearing loops. Awareness of staff of the use of the system.	Sufficient loop systems available at all sites across ABMUHB and staff awareness of the use of the hearing loop systems. Continue to procure BSL interpreters so that there is an identified demand for the provider to ensure supply of highly skilled interpreters.

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	Hearing Loss. The plan is to deliver a nationally agreed pathway for battery provision and ongoing hearing aid maintenance, including self management, battery management and volunteer peer support.	Availability of skilled BSL interpreters.	

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
Emergency & Unscheduled Care. Priority areas include:			
➢ Raising staff awareness ➢ Communication models	IN-HOURS/OUT OF HOURS: Wales Council for Deaf People shares information with the Health Board in relation to accessing interpreters in an emergency situation.	Out of Hours Service support may not always be as comprehensive as in-hours.	Raise awareness of other models to improve communication in times of emergency including the WAST app.
Concerns & Feedback (CF). Areas include:			
➢ Highlighting current models of CF in place which would support individuals with sensory loss to raise a concern or provide feedback	Texting, braille version information on how to raise a concern. Easy read leaflets on how to raise a concern and information on Putting Things Right for concerns. Audio version on how to raise a concern. Using suitable font for corresponding with complainants with visual issues.		

Standards of Service Delivery	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	A British Sign Language video version of the patient complaints information leaflet is available on the ABMU HB website for BSL users to access to support them in raising a concern. Let's Talk, one of ABMU's feedback mechanisms, includes a text message and email service to notify the HB of issues / provide the HB with positive and negative feedback on its services.		
➢ Highlight any CFs received in sensory loss and actions taken	Received an action taken in conjunction with the needs of the complainant	Increased font size used to communicate.	

Patient Experience*	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
Mechanisms are in place to seek and understand the patient's experience of accessible communication and information	The All Wales survey is used to seek and understand the patient experience of accessible communication and information. Representatives from BDA Wales, Action on Hearing Loss Cymru, Deaf Blind Cymru and RNIB Cymru		Any concernsare identified and logged on Datix. 'You said – We Did' forms are also completed and reported in Quality and Safety forums in each Unit.

Patient Experience*	Key Actions Achieved during 2017-18	Risks to Delivery	Corrective Actions
	comprise the membership of ABMU's Sensory Loss Group. Patient stories are presented at the meeting to help us understand their experiences of using our services. The BDA and RNIB are also represented on ABMU's Disability Reference Group. People with sensory loss are actively engaged in department audits relating to the Sensory Loss standards and their experiences communicated to staff. Sensory Loss Training is to be provided for staff in the Informatics Department to support future work/developments relating to making appointment letters more accessible to people with sensory loss and more effective methods of communication. This training will be provided by the RNIB and Deafblind Cymru. It is anticipated that this training will take place in April 2018.		

Patient Experience*	**Key Actions Achieved during 2017-18**	**Risks to Delivery**	**Corrective Actions**
	Key Themes		**Corrective Actions**
The key themes to emerge from patient experience feedback (both positive and negative)	Difficulty in reading hospital signs, text too small. Difficulty seeing as corridor was too dark. There is a continued requirement to provide information in a more accessible format e.g. large, bold print, with appropriate contrast. Departments should provide more accessible information and a variety of ways in which the service can be contacted.		Signs were made larger. Estates arranged for the corridor lights to be kept on. IT Department is piloting large print appointment letters. This would be an interim measure until a national solution is implemented. Advised to include other contact details in patient letters.
* **Patient experience mechanism and themes to be documented in this return applies specifically to patients with sensory loss who have accessible communication and information needs**. There is a requirement in the NHS Delivery Framework for NHS organisations to provide an update on patient experience for all patients (not just for those with accessible communication or information needs). This is to be reported on a separate proforma entitled 'Evidence of how organisations are responding to patient feedback to improve services' and links to the NHS Framework for Assuring Service User Feedback.			

7.2 Advancing Equality and Good Relations

NHS Organisation	Abertawe Bro Morgannwg University Health Board
Date of Report	16 April 2018
Report Prepared By	Jane Williams

The Public Sector Equality Duty seeks to ensure that equality is properly considered within the organisation & influences decision making at all levels. To meet the requirements of the Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011 Health Boards & NHS Trusts must consider how they can positively contribute to a fairer society through advancing equality & good relations in their day-to-day activities. The equality duty ensures that equality considerations are built into the design of policies & the delivery of services and that they are kept under review. This will achieve better outcomes for all.

Reporting Schedule: Progress against the organisation's plan is to be reported bi-annually. 31 October and 30 April.

Does the organisation have a Strategic Equality Plan (SEP) in place, setting out how tackling inequality and barriers to access improves the health outcomes and experience of patients, their families and carers?	**Yes**
Does the SEP include equality objectives to meet the general duty covering the following protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race (including ethnic or national origin, colour or nationality), religion or belief (including lack of belief), marriage and civil partnership, sex, sexual orientation?	**Yes**

Update on the actions implemented during the current <u>operational year</u> to advance equality & good relations in the health board's day to day activities

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
Planning & Performance Management			
IMTPs clearly demonstrate how the NHS organisation meets the duties associated with equality & human rights and the arrangements for equality impact assessment.	Ensure we meet the commitment within our Annual Plan 2017/18 to assess the equality impact of proposed service change.		Equality impact assessment has been integrated into the work of the newly formed Capacity Redesign Workstream.
Steps have been taken, where possible, to align equality impact & health needs assessments to ensure they take account of the 'protected characteristics' & utilise specific data sets & engagement activity.	Develop an Area Plan for Western Bay.	The equality impact assessment for the Western Bay Population Assessment 2017 identified that there is greater insight into the care and support needs of some people with protected characteristics than others. Further research is needed to address the data gaps.	A task and finish group met in August to start progressing the development of the Western Bay Joint Area Plan. Work has commenced on pulling out the identified priorities in the population assessment.
IMTPs set out how equality impact assessment is embedded into service change plans & informed by the findings from engagement & consultation and other evidence.	Continue to undertake equality impact assessment on proposed service changes and use the results of our assessments to inform decision making.	Equality training is being arranged for the Board to ensure that newly appointed Members receive the necessary briefing.	Refresher training was provided for service delivery units undertaking equality impact assessment on 7.11.2017 and 9.11.2017. Equality training was delivered for Board Members on 30.11.2017 as part of the statutory and mandatory training for newly appointed Independent Members. Equality impact assessment training was

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
			delivered on 22.02.2018 as part of the Board development session.
Service plans include clear measurable objectives for reducing health inequalities & are aligned to the equality priorities set out in the Strategic Equality Plan.	Engage with the public and partners to develop a strategic framework for mental health		Engagement undertaken to inform the Health Board and Local Authorities' Strategic Framework for Adult Mental Health. 105 people gave their experiences face-to-face and another 170 through questionnaires.

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
Governance			
The Health Board/NHS Trust receives assurance that processes are in place to identify Equality impact, undertake engagement and that mitigating actions are clearly set out. Committee or Sub-committees confirm that equality impact assessments inform decision making.	Review the reporting arrangements to provide assurance on equality.		Reporting arrangements to be considered as part of the overall review of the Board Sub Committee structure.
The Health Board/NHS Trust ensures that equality considerations are included in the procurement, commissioning and contracting of services.	Deliver equality training to the Procurement Team.	Two training sessions were held in the Procurement offices at an agreed time and date to overcome the risk of low numbers of staff being released for training.	All members of the Procurement Team attended equality and human rights training delivered by the NHS Centre for Equality and Human Rights on 23.08.2017.

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
Quality and safety			
Each service change programme/plan as a minimum includes: equality implications, including positive and negative impacts on patients, public and staff and mitigating actions to reduce any anticipated negative impact.	Integrate equality impact assessment into the work of the newly formed Capacity Redesign Workstream.	Capacity Redesign Workstream identified the need for refresher training and support for teams undertaking equality impact assessment.	Equality impact assessment training was provided for service delivery units on 7.11.2017 and 9.11.2017. Coaching was offered to the teams undertaking equality impact assessments and time was set aside to provide support on an individual basis.
Equality is clearly linked to quality initiatives and are informed by the needs assessment findings, the risk register, and the challenges and improvement priorities set out in the Annual Quality Statement.	Engage with the public and partners to develop a strategic framework for mental health. This action supports the delivery of our equality objective for mental health services. This area is in our top ten quality priorities.	Targeted engagement ensured the inclusion of groups who may experience barriers in accessing the events. We held a separate engagement session with the Deaf Club. We had representatives from the Ethnic Youth Support Team (EYST) and the African Community Centre attending sessions. We also held a separate session with the Swansea Mental Health Voluntary Sector Forum which was attended by several BME representatives.	We ran listening events with the local Councils in June/July 2017 for mental health service users to feedback their experiences. This will help develop our mental health services to ensure they meet the needs of everyone. 105 people gave their direct experiences, including people from the BME community, children & young people, older people and people with a physical disability.
Workforce			
There is evidence that employment information informs policy decision making and workforce planning.	Complete the working longer readiness tool.	The tool is assisting us to identify areas for development in relation to the issues that working longer presents and to develop plans to mitigate risks around these issues.	A Working Group completed the NHS Wales 'The ageing workforce checklist to assess organisational readiness'.

	Key Actions Planned	Risks to Delivery & Corrective Actions	What was achieved
Numbers of staff who have completed mandatory equality and human rights training 'Treat Me Fairly' (TMF)			11,168

Relevant Strategies and Guidance

- Equality and Human Rights Commission Wales (EHRC) https://www.equalityhumanrights.com/en/commission-wales
- Making Fair Financial Decisions: Guidance for Decision-makers - Equality and Human Rights Commission
- EHRC's "Is Wales Fairer?" 2015
- Welsh Government Equality Objectives 2016
- Organisations Revised Strategic Equality Plans 2016 - 20
- EIA Practice Hub – NHS CEHR/WLGA 2015 – http://www.eiapractice.wales.nhs.uk/home
- The Essential Guide to the Public Sector Equality Duty: An Overview for Public Authorities in Wales (EHRC)
- Homeless and Vulnerable Groups

7.3 Improving the Health and Well-being of Homeless & Specific Vulnerable Groups

Health Board	ABMU
Date of Report	April 4th 2018
Report Prepared By	Tony Kluge Cluster Development Manager. Debra Morgan, Planning and Partnerships Support Manager. 01792 601825/ 01792 601876

Health Boards are expected to have in place assessments and plans to identify and target the health & well-being needs of homeless & vulnerable groups of all ages in the local area. Vulnerable groups are people identified as: homeless, asylum seekers & refugees, gypsies & travellers, substance misusers, EU migrants who are homeless or living in circumstances of insecurity.

Reporting Schedule: Progress against the Health Board's action plan is to be reported bi-annually. This form is to be submitted on 31 October and 30 April to cover the period April 2017 to March 2018.

Standards	**Key Actions Achieved** April to September 2017	**Key Actions Achieved** October 2017 to March 2018	**Risks to Delivery**	**Corrective Actions**
1. Leadership The Health Board demonstrates leadership driving improved health outcomes for homeless and vulnerable groups.	A multi agency approach has been adopted across ABMU linked to key geographical areas in implementing the standards set out in the Welsh Government's '*Standards for Improving the Health and Wellbeing of Homeless People and Specific Vulnerable Groups'* The Health and Housing Strategic Group has received input on the feasibility Study for the Liverpool City Region undertaken by Crisis related to the Housing First Model.	.	• Lack of Multi agency involvement / Communication • Systems not 'joined up'	Developing and strengthening the work and profile of HHAVGAP across Swansea, Neath Port Talbot and Bridgend is currently under discussion Recommendations developed during the vulnerability workshop held on December 6th are currently being discussed and progressed through

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
	The Health and Housing Group is currently planning a workshop on Vulnerability to consider local issues and best practice in relation to vulnerability. This will involve Community and Partnership involvement and supporting vulnerability across ABMU.	The Health and Housing Strategic Group held a workshop focussing on Vulnerability on December 6th 2017. The event was well attended by representatives from Health and Local Authorities including Housing Staff and representatives from the Third Sector. The event culminated in a series of recommendations (including a series of quick wins and longer term strategy development) that have been collated and fed back to the Health and Housing strategy Group to take forward and implement.		the Health and Housing Strategy Group.

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
2. Joint Working The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders to improve health and contribute to the prevention of homelessness.	The HHAVGAP Steering Group continues to meet quarterly in Swansea. Meetings took place on June 21st and September 6th. Updates were received at these meetings from EYST (Ethnic Youth Support Team) related to the 'Supporting Asylum Seekers Project' based in the City Cluster GP Network. The project aims to offer support to Asylum Seekers accessing primary health care services with language issues and access concerns. The project started in April 2017 and by June 21st ,14 patients were being supported across 5 practices in the City. Feedback was also given on the work undertaken by the BME Carers/Young Carers support worker. This post was funded by Western Bay Carers Partnership Board. The work started in April 2017. By June 21st, 7 BME Carers have been identified and supported. Other GP networks are hoping to follow suit with regard to funding similar initiatives. The Penderi GP Cluster Network is hoping to fund an	The HHAVGAP Group continues to meet quarterly in Swansea. Meetings took place on December 13th and March 28th. Updates and discussion took place at these meetings related to the development of the Homelessness Strategy for Swansea. A draft strategy is currently being worked on and will be circulated for consultation in May. The final strategy will be published and in place by October. A survey has been developed by the Community Health Council which has been shared across ABMU to seek the views of Vulnerable Patients. The Questionnaire is	• Increasing demand • Lack of funding/resource • Lack of multi agency involvement • Systems not 'joined up'	Membership of the HHAVGAP steering group continues to develop and expand as additional third sector organisations and other interested parties join the group. Innovative use of Cluster Network funds to support Vulnerable Groups locally continues to prove to be effective. Repetition of events to highlight services offered across the Third Sector, Health and Social Care to be progressed eg: Service Weaving

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
	Asylum Seeker Support Worker and is keen on adopting an English for Health Project to improve spoken English in health care settings in relation to health conditions. The Local Authority has delivered a presentation on the work undertaken by Local Area Coordinators in Swansea. New vulnerable groups are emerging and being identified eg: Hoarders. There is a need for health and Social Care Staff to be trained in relation to supporting this group. A joint event event focussing on the support offered by the Third Sector and Health to support Vulnerable Groups was recently held in Swansea. The event culminated in a better understanding of provision and possible referral routes for patients. On April 28th a Service Weaving Event was held in Manselton. The event focussed on co production in homelessness and to effective working with Gypsy Travellers was attended by a range of organisations. It provided an opportunity for	aimed at the Vulnerably Housed and the Homeless. The report is currently being compiled and will be shared at the next HHAVGAP meeting scheduled for June 2018. Mind Cymru briefed the group on a project undertaken on 'Improving Access for Vulnerable Migrants'. Links with HHAVGAP were cited as very useful regarding developing the project and report. A need has been identified to share support for Complex Needs (including Mental Health) more effectively. HHAVGAP are considering an event focussing on sharing information		

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
	organisations to discuss, share and understand the support offered and to break down any existing barriers. The event was a success and it is planned to repeat the 'service weaving' approach at regular intervals.	and available resources later in the year. Moves have been made to look at effectively supporting vulnerable patients in the Secure Estate. Links with the 'Preventing Reoffending Team' at Swansea Prision are being forged to further develop this work. A Service Weaving Event focussing on co production in Homelessness was held at Christwell Church in Manselton on February 2nd. The event followed on from previous successful Co production events and was attended by staff and organisations representing Health,		

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
		Local Authority, Housing and the Third Sector. The event afforded an opportunity to receive a presentation on the 'Night Shelter' offered as part of the Hope Project run by Swansea Churches and allowed sectors to share information and gain a better understanding of the range of existing support and services for vulnerable people.		
3. Health Intelligence The Health Board works in partnership with the Local Authority, service users, third sector and stakeholders and demonstrates an understanding of the profile and health needs of homeless people & vulnerable groups in their area.	A comprehensive needs assessment was completed in 2016 that has identified key local actions. This has provided useful baseline data to base developments on. As previously mentioned health intelligence is continually strengthened by the contributions made to the HHAVGAP Steering Group.	Health Intelligence is continually strengthened by the contributions made to the HHAVGAP Steering Group. This	• Lack of resources/accurate and timely information and data • Lack of multi agency/partnership involvement • Systems/pr	Continued expansion of membership adds to the intelligence provided to the partnership. Following meetings with the Local Authority Housing Department an 'aide memoire' has been produced and distributed to Swansea Networks to provide support to front

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
	In March the Local Authority Housing Department delivered an overview of the work being done to support Gypsy Travellers in official and unofficial sites in Swansea. Links with Health were further discussed and partnerships strengthened. The HHAVGAP group have since developed an 'aide memoire' based on Travelling to Better Health' that can be used by front line staff to help improve cultural awareness and good practice when working with gypsy travellers.	information is continually fed to the appropriate Senior Manager to ensure that any operational issues can be addressed effectively. The document based on Travelling to Better Health has been finalised and shared with GP Practices in Swansea and members of the HHAVGAP Group. At a recent meeting it was agreed that useful resources will be shared by SCVS on a website that the group can access. Information has been gathered on organisations that can offer 'cultural awareness' training. It is hoped that such	ocesses not 'joined up;	line health staff in relation to working effectively with gypsy travellers. Discussions are taking place regarding cascading this resource across ABMU.

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
		training can be incorporated into future Protected Learning Time Sessions for GPs and front line staff and other organisations/services. GP Cluster Networks are looking to/ have developed initiatives based on the Population profiles of their network and issues identified in Cluster Development Plans. Eg: Asylum Seeker Support/ English for Health initiatives		

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
4. Access to Healthcare Homeless and vulnerable groups have equitable access to a full range of health and specialist services.	Health Services for Homeless and Vulnerable Groups continue to be delivered at Orchard Street Clinic in Swansea. The service is also offered at the Access Point in the Strand. Close links have been developed with local partner agencies and the service is flexible in its approach to provision for patients. GP practices continue to participate in the enhanced service to provide support for Asylum Seekers and refugees who are part of the Syrian relocation scheme. The Homelessness nurse and Mental Health Nurse provide enhanced health provision linked to Abertawe Medical Practice based in the City Centre. The Penderi Network continues to fund enhanced health support for local Women's Refuges. The service continues to develop and grow and the network has agreed to fund the service for another year. The HHAVGAP Group in Swansea is planning to actively promote the availability of Language Line to	The key actions noted for April to September 2017 have continued during October 2017-March 2018. Case Studies continue to be presented at HHAVGAP meetings as a 'reality check' to determine where services are performing well and where improvements could be made. Any issues raised are fed back to the appropriate manager/organisation. The HHAVGAP Group in Swansea has developed posters to actively promote Language Line and encourage patients to ask for the service at the front desk. These posters will be rolled out to Primary Care	• Increase in demand • Access to interpretation and translation services	Health Service for Homeless and Vulnerable Groups is delivered out of Orchard Street Clinic and Access Point. The service is offered on a flexible basis to suit the needs of individual patients.

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
	speakers of other languages at practices across the City. It is also planned to develop access information in other languages in collaboration with SCVS. This has been factored into the local action plan. BME Access Cards for individuals whose first language is not English or Welsh have not yet been formally launched to date. (However some Syrian Refugee families have been issued with them by the British Red Cross). An implementation plan for this scheme is currently in development. The Penderi GP Cluster Network is planning to commission services to increase literacy for health among non English speakers. The City Cluster Network have commissioned Third Sector support for Asylum Seekers to help with access to health care services locally. The Penderi Cluster Network is also planning to commission Asylum Seeker Support to improve access and understanding of health care services. Action plan was reviewed at the	practices in the near future. Access information for speakers of other languages has been shared by Aneurin Bevan Health Board. ABMU is planning on reproducing this information with the support/endorsement of ABHB. EYST has recently applied for funding to support and extend the Asylum Seeker Support project in Primary Care to both the City and Penderi Networks. The Penderi Cluster Network has also invested in developing an English for Health Project focussing on helping speakers of other languages		

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
	Steering Group meetings held on December 13th and March 28th Case studies are routinely presented at steering group meetings. Concerns are fed back to the team/organisation to ensure that quality and service improvement issues are tackled appropriately. This is followed up by inviting relevant staff to steering group meetings to discuss issues raised.	improve health related communication and understanding of services and access.		Access issues remain a standing agenda item at Steering Group meetings. Case studies are also presented. Concerns are routinely fed back to appropriate teams/Managers to ensure quality and improvement issues are addressed.
5. Homeless & Vulnerable Groups' Health Action Plan (HaVGHAP) The Health Board leads the development, implementation & monitoring of the HaVGHAP (as an element of the Single Integrated Plan & regional commissioning strategies) in partnership with the Local Authority, service	A local health action plan is in place that is regularly reviewed by the HHAVGAP Steering Group in Swansea. The action plan was reviewed at the Steering Group meetings held on June 21st and September 6th. Key priorities were identified in the Complex Needs Workshop held in May 2016. . These priorities were flagged under the headings of Housing, Health, Communication and Joint working.	A local health action plan is in place that continues to be regularly reviewed by the HHAVGAP Group in Swansea. This action plan was reviewed at the Steering Group meetings held on December 13th and March 28th. The Health and Housing Strategy	• Systems/processes not joined up • Lack of partnership/ multi agency working	Vulnerability Workshop held by Strategic Health and Housing Group will help inform best practice and discussions going forward.

Standards	Key Actions Achieved April to September 2017	Key Actions Achieved October 2017 to March 2018	Risks to Delivery	Corrective Actions
users, third sector & other stakeholders.	The Health and Housing Strategy Group is planning a Vulnerability Workshop across ABMU which will help determine the way forward with regard to further developments supporting vulnerable groups across the area. This workshop is planned for December.	Group held a workshop on December 6th which focussed on Vulnerability issues across ABMU HB and allowed an opportunity to share best practice and identify gaps in provision. Recommendations coming out of the workshop are currently being further developed and actioned via the Health and Housing Strategy Group.		

7.4 Safeguarding Children

Reporting Schedule	Mar-18
Health Board/Trust	ABMU Health Board
Date of Report	23/04/2018
Completed By	Jodie Denniss
E-mail Address	Jodie.Denniss@wales.nhs.uk

One of the most important principles of safeguarding is that organisations must ensure that they do everything they can to protect adults and children from abuse and neglect. As a result, NHS staff should complete safeguarding training to an appropriate level for their job role. This data return applies to all NHS health care settings - primary care, secondary care & community care.
Reporting Schedule: To be reported bi-annually. This form is to be submitted on 21 April (for data collected at 31 March).

Update should be taken from the ESR ESRBI: NHS Compliance Dashboard - Summary Tab	**Data at 31 March 2018**			**Update on issues impacting delivery or reporting**
	Total number of staff employed in assignment status group	**Total number of staff who have completed safeguarding training**	**Percentage of staff who have completed safeguarding training**	
Safeguarding children mandatory training *ESR Field: NHS|CSTF| Safeguarding Children –Level 1 - 3 Years*	**16273**	**7711**	**47.39%**	

	Data at 31 March 2018			Update on issues impacting delivery or reporting
	Total number of staff employed in assignment status group	**Total number of staff who have completed safeguarding training**	**Percentage of staff who have completed safeguarding training**	
Safeguarding children additional training required – level 2 *ESR Field: NHS|CSTF| Safeguarding Children –Level 2 - 3 Years*	**N/A**	**1259**		There are ongoing challenges in terms of being able to analyse percentage compliance with Level 2 & 3 , at present only data for attendance would be available; there is ongoing work with the Service Delivery Units around training needs analysis to identify the numbers of staff in all satff groups who would require this training
Safeguarding children additional training required – level 3 *ESR Field: NHS|CSTF| Safeguarding Children – Level 3 - 3 Years*		**19**		As above; in addition it has recently been highlighted that there are discrepancies when extracting training figures from ESR - this has been escalated by the Learning Development team to the ESR team
Safeguarding children additional training required – other				
Please provide examples of the type of safeguarding training that has taken place				

Safeguarding Adults

Reporting Schedule	Mar-18
Health Board/Trust	ABMU Health Board
Date of Report	
Completed By	
E-mail Address	

One of the most important principles of safeguarding is that organisations must ensure that they do everything they can to protect adults and children from abuse and neglect. As a result, NHS staff should complete safeguarding training to an appropriate level for their job role. This data return applies to all NHS health care settings - primary care, secondary care & community care. Reporting Schedule: To be reported bi-annually. This form is to be submitted on 21 April (for data collected at 31 March).

Update should be taken from the ESR ESRBI: NHS Compliance Dashboard - Summary Tab	Data at 31 March 2018			Update on issues impacting delivery or reporting
	Total number of staff employed in assignment status group	**Total number of staff who have completed safeguarding training**	**Percentage of staff who have completed safeguarding training**	
Safeguarding adult mandatory training *ESR Field: NHS|CSTF| Safeguarding Adults - Level 1 - 3 Years*	**16273**	**8447**	**51.91%**	
Safeguarding adult additional training required – level 2 *ESR Field: NHS|CSTF| Safeguarding Adults - Level 2 - 1Year*	**N/A**	**1197**	**7.36%**	There are ongoing challenges in terms of being able to analyse percentage compliance with Level 2 & 3 , at present only data for attendance would be available; there is ongoing work with the Service Delivery Units around training needs analysis to identify the numbers of staff in all satff groups who would require this training
	Data at 31 March 2018			**Update on issues impacting delivery or**

Update should be taken from the ESR ESRBI: NHS Compliance Dashboard - Summary Tab	**Total number of staff employed in assignment status group**	**Total number of staff who have completed safeguarding training**	**Percentage of staff who have completed safeguarding training**	**reporting**
Safeguarding adult additional training required – level 2 *ESR Field: NHS|CSTF| Safeguarding Adults – Level 2 - 3 Years*	**N/A**			As above; in addition it has recently been highlighted that there are discrepancies when extracting training figures from ESR - this has been escalated by the Learning Development team to the ESR team
Safeguarding adult additional training required other		**4041**		This data relates to Prevent Awareness training

Please provide examples of the type of safeguarding training that has taken place
In addition to the above, ABMU Health Board provide 'Ask & Act' training in line with the 5 year local training plan that is submitted to Welsh Government. As of 31st March 2018, 80% (11268) staff have completed Group 1 training. Group 2 training commenced in the initial pilot and implementation is continuing within individual Service Delivery Units; to date, 1026 staff have completed this training**.**

7.5 Implementation of the Welsh Language Guidance as Defined in 'More Than Just Words'

NHS Organisation	Abertawe Bro Morgannwg University Health Board
Date of Report	16/10/2017 18/04/2018
Report Prepared By	Carol Harry

Each Health Board and Trust is expected to put in place actions to deliver the strategic framework for Welsh language services in health, social services and social care: 'More Than Just Words'. This has been developed to meet the care needs of Welsh speakers, their families or carers. Actions to deliver the framework are to cover both primary and secondary care sectors.

Reporting Schedule: Progress against actions to deliver More Than Just Words is to be reported bi-annually. This form is to be submitted on 31 October and 30 April.

Update on the actions to deliver the More than Just Words Strategic Framework

Priority Area	**Yes or No**	**Supporting Evidence**		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
Population Needs Assessment The organisation has identified the Welsh language needs of its population and has used it to plan services.	Yes	The health board in partnership with its three Local Authorities has developed a chapter of its population needs assessment under the Social Services and Wellbeing (Wales) Act 2015. This seeks to identify the needs of the ABMU population for services to be provided in Welsh. The findings from this will be	Not relevant as completed	

<table>
<tr><th rowspan="2">Priority Area</th><th rowspan="2">Yes or No</th><th colspan="3">Supporting Evidence</th></tr>
<tr><th>Key Actions Achieved</th><th>Risk to Delivery</th><th>Corrective Actions</th></tr>
<tr><td></td><td></td><td>taken forward as part of our Annual Plan/IMTP.
Population Assessment for the Western Bay region, was launched in April 2017 and will be repeated in 2021 (being refreshed during that time) allowing Western Bay partners to incorporate new information and to ensure progress is monitored effectively.</td><td>Needs to be addressed over the coming years.</td><td></td></tr>
<tr><td>Welsh Language Skills

The organisation has identified the Welsh language skill levels of its workforce and is using this information to plan services.</td><td>No</td><td><table>
<tr><td>Headcount @ 04/10/17</td><td>16030</td></tr>
<tr><td>Headcount @ 04/10/17 who have added Welsh Competency detail in ESR</td><td>2596</td></tr>
<tr><td>% @ 04/10/17 who have completed Welsh Language Competency detail in ESR</td><td>16.19%</td></tr>
<tr><td>Headcount @ 05/04/18</td><td>16009</td></tr>
<tr><td>Headcount @ 05/04/18 who have added Welsh Competency detail in ESR</td><td>2761</td></tr>
</table></td><td>Staff need access to computers to input information. Digital Skills Strategy approved at Health Board meeting in March 2017 which will seek to help address this

As with all Health Boards ABMU have serious clinical staffing shortage issues, meaning additional hours to get through the workload and not breach waiting lists, therefore difficulty in accessing time to complete courses,</td><td>Free 10 hour Welsh Language on-line course available for staff, with ABMU having the largest number of staff from all the organisations in Wales registering to do the course, therefore, in turn the number of staff possessing some Welsh language skills will increase.

Staff are continually being encouraged to input Welsh Language skills into ESR system. Delivery Units undertaking assessments of Welsh Language skills at local level as ESR data incomplete.</td></tr>
</table>

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		% @ 05/04/18 who have completed Welsh Language Competency detail in ESR: 17.25% Staff can register their Welsh language skills via ESR but at present it is not possible for every staff member to do so as not all staff have access to an ABMU computer. To address this it's now possible for staff to access ESR via their own Tablets/mobile phones. As not all staff will naturally do so we are having to collect data at local level.	Mandatory or Voluntary:- **526 in total** registered for the free 10hour Welsh language course, but **only 33** have actually completed the course. Constant changes of staff 'mean our records need to be regularly updated	ABMU has put into place a Bilingual Skills Strategy which aims to increase the number of Welsh speaking staff in the workforce.
Where there are gaps in Welsh language skills the organisation has ensured that vacancies are advertised as 'Welsh language essential'.	No No		Difficulties continue in recruiting to some professions even prior to any requirement that candidates be Welsh speaking Workforce colleagues are re-enforcing the need to implement the Bilingual Skills Strategy to ensure we seek to increase the number of Welsh speaking staff in our workforce	See above, Bilingual Skills Strategy in place.

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	Risk to Delivery	Corrective Actions
How many members of staff have undertaken a course to learn Welsh or to increase their confidence to speak Welsh during this operational year?				278 have registered for 10hr free Welsh online course 526 have registered for the 10 hr free Welsh online course but only 33 have completed the course to date. There was no set deadline for completion.

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	Risk to Delivery	Corrective Actions
Patient Preference The organisation has processes in place to ensure that the language preference of patients is noted and services are actively offered in Welsh.	Yes	The Myrddin system is used by health boards to collect of this information. Staff are aware of the need to record the patient's preferred language. Currently this all-Wales system does not require language choice to be completed as a mandatory field. Not all NHS IT systems are	Whilst we actively endeavour to offer Welsh language services to those service users' staff are not always able to act in accordance with the individual's language preference in clinical situations as we have very low numbers of bilingual staff. In such situations it may simply not be practical or clinically safe, and could lead to delay in service	It is inevitable given the size and complexity of the organisation (two million patient contacts each year) that the provision of a bilingual member of staff will not always be possible. However staff are encouraged to learn everyday phrases that they can use in conversation with the patient, as often a word of comfort is all that is needed. We continue to promote the free

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		compatible with each other therefore language preference is not always known by other departments who may become involve in patient care. Where patient facing systems are in place we endeavour to ensure language requirements are met. E.g. outpatient self- checking in system in Outpatients at Morriston Hospital offers patients a choice of whether to transact in Welsh or English. In ABMU's Health & Care Standards Annual Audit Report, the 'Dignified Care' standard requires that service users receive full information about their care which is accessible, understandable and in a language and manner sensitive to their needs to enable and support them to make an informed decision about their care as an equal partner. ABMU's Compliance	provision. When this arises the position would be explained to the patient and the risks of not proceeding at that point fully Communicated.	10hr on-line Welsh language course. We are about to update the functionality on the self-check-in kiosks and introduce patient calling screens which are displayed bilingually. A bilingual text reminder service regarding future outpatients has been piloted and is due to be launched.

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		around this and knowing how to access Welsh speaking staff has increased to 98% in 2017. A Bi-Lingual appointment reminder texting service has been launched by ABMU in phases across all main ABMU Specialities. The default first text received is Bi-Lingual, and from that point forward the patient may specify whether they wish to receive further texts in Welsh/English as they so wish. By the end of March 2018, we have achieved the following % in our letters being sent bilingually: 57% of our Outpatient Appointment letters. 100% of our Partial Booking letters. 100% of our Referral		

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
	Yes	Acknowledgement letters. 29% of Inpatient & Day case confirmation letters. We are committed to achieving 100% by December 2018. Changes were made to the system during **Thursday 1st February 2018** and the system switched on so that all but one category of letters were available bilingual. Referral Acknowledgment, Day case & Inpatient confirmations and also Outpatient confirmations are all now available in new double sided bilingual letters'		
How many patients have been asked their language preference and have had this preference noted on their records?			419 Registered on Myrddin It is part of our normal processes to ascertain language preference 533 Registered on Myrddin	

Priority Area	Yes	Supporting Evidence

	or No	Key Actions Achieved	Risk to Delivery	Corrective Actions
Commissioned and Contracted Services The organisation ensures that Welsh language considerations are included in the commissioning and contracting of services including primary care services	Yes	The Health Board is on the point of awarding the next Local Framework for the appointment of Contractors and Consultants. For each commission under this Framework a call of Contract will be completed and this document includes the following as a standard clause:- *The Employer has a Welsh Language Scheme which sets out its various commitments in terms of bilingualism. A copy of the Scheme can be accessed via the website at www.abm.wales.nhs.uk To assist the Employer in delivering upon these important commitments it is important that the Contractor ensures that any materials/signage on display to the public will be bilingual and meet the requirements of the Scheme in terms of their size, layout, format, quality and prominence. In addition, where there is likely to be a direct interface with the public (either by telephone, email, letters or face to face*	All contractors and consultants appointed will have to comply with this requirement.	

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		contact), the relevant provisions of the Employer's Welsh Language Scheme must be observed. Advice regarding compliance can be obtained via the Employer's Welsh Language Officer on 01639 683351. The Commissioned and Contracted Services element of the NHS Delivery Framework remains unchanged, as the standard clause is included within documents provided to potential Contractors and Consultants		
Sharing Best Practice Best practice in providing Welsh language services is shared with all relevant staff in the organisation and the organisation also shares best practice with other health boards and trusts.	Yes	Our Welsh Language Scheme sets out how we aim to deliver services bilingually and this is available to staff via our intranet and is continually promoted via our Welsh Language Officer and local Welsh Language Champions in our delivery units. Clwb Clonc' has been developed	We want to continually improve the quality of the services people receive and ensure that they are treated with dignity and respect. We are therefore seeking to offer Welsh Language services without service users having to ask for them. Public services are operating	ABMU was represented at the More Than Just Words Showcase Awards Event during October 2017 which provided an opportunity to listen to both local and international speakers. We have publicised details of the award winning projects on our Welsh Language Resources intranet page to encourage staff to network innovative ideas and

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		at Neath Port Talbot Hospital enabling staff who have some Welsh language skills to practice in an informal setting gaining confidence in their Welsh language skills We continue to encourage celebration of Welsh language services by promoting a Welsh category in the annual Chairman's Awards. Welsh Government has asked all Health Boards to establish new Regional Forums to work jointly with other relevant organisations and discuss the best approach to achieving the targets within the More Than Just Words Strategic Framework. A Regional Forum has been established and Cwm Taf & Abertawe Bro Morgannwg University Health Boards will work collaboratively with representatives of relevant organisations to accomplish	within very tight and challenging financial constraints and therefore. Whilst we continue to promote the availability of the 10hr on-line free Welsh Language course to staff (with the largest sign-up of any public sector organisation in Wales during the first month of its launch) we do not have sufficient resources to backfill staff wishing to progress to residential courses to further improve their language skills.	schemes. Our Welsh Language Officer has recently promoted Shwmae Day at local hospital within ABMU. ABMU staff have worked in partnership with their Learning and Development team and Careers Wales at Swansea Careers Festival (involving around 2,000 children and staff from local schools and FEIs). This has given us the chance to promote why there is the need for staff with Welsh language skills in health care to help us deliver an improved patient experience for Welsh speaking service users in terms of safety, dignity and respect. Now the final Welsh Language Standards have been received we will be working with Welsh Language Commissioner's

Priority Area	Yes or No	Supporting Evidence		
		Key Actions Achieved	**Risk to Delivery**	**Corrective Actions**
		elements of the follow-up strategic framework's action plan.		office to discuss any issues with implementation and lead-in times. The Welsh Language Officer has been working with Swansea University and Coleg Cymraeg Cenedlaethol and local Higher Education facilities promoting and participating in taster sessions as to what students can expect if they study Nursing and Midwifery through the medium of Welsh.