GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

*Positively Influencing the Health & Wellbeing of the Citizens of Wales*

*Dylanwadu'n Gadarnhaol ar Iechyd a Lles Dinasyddion Cymru*

# INTEGRATED PERFORMANCE DASHBOARD

# MAY 2019


# Executive Summary

Background

At the end of the calendar year 2017 the Welsh Government issued a consultation proposing that responsibility for healthcare services in the Bridgend County Borough Council (CBC) area should transfer to Cwm Taf University Health Board (Cwm Taf) from Abertawe Bro Morgannwg University Health Board (ABMU); moving the health board boundary accordingly. Following due process, the outcome of the consultation was that the Health Board boundary be changed in accordance with the proposal; the change to take effect from 1 April 2019.

Performance Dashboard – May 2019

This is the first performance dashboard to be produced by the Health Board providing performance reporting for Cwm Taf Morgannwg University Health Board. This dashboard is the May 2019 iteration, the dashboard wherever possible provides April reporting data.

The dashboard has been redesigned with distinct sections that show performance for Cwm Taf University Health Board (as was), Bridgend and Cwm Taf Morgannwg University Health Board.

For ease of reading the following terms have been used:

| | |
|---|---|
| Cwm Taf University Health Board | has been referred to as "CT" |
| Bridgend | has been referred to as Morgannwg or "M" |
| Cwm Taf Morgannwg University Health Board | has been referred to as "CTM" |

The nomenclature N/A is used to show that data is "not available"

The following colour coding has been used for graphical representation where possible:

| | |
|---|---|
| CT | Light Blue |
| CTM | Dark Blue (Corporate Blue) |
| Wales | Red |
| Morgannwg | Green |

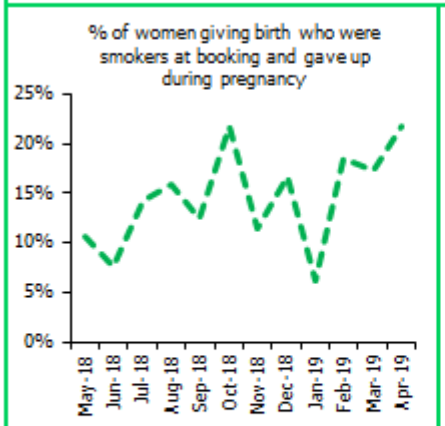
Performance Data

Where performance data is available for CT, M and/or CTM this has been incorporated into this dashboard, where data is not currently available or as yet, not reported, this has been highlighted within the appropriate section. As far as is possible data for Morgannwg has been quality assured, however, data should be used with due caution.

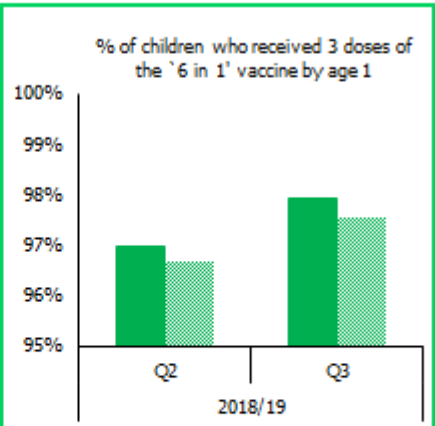
## Table of Contents

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

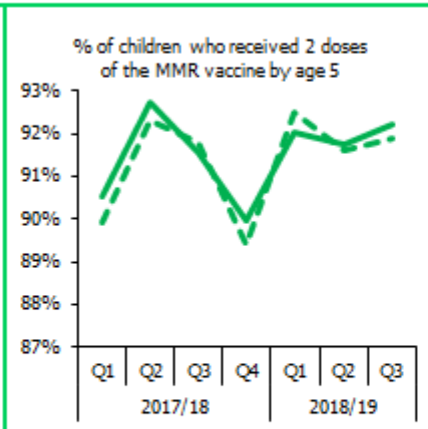
**Key: Cwm Taf Morgannwg** — **Cwm Taf** - - - **or** ■ **Morgannwg**



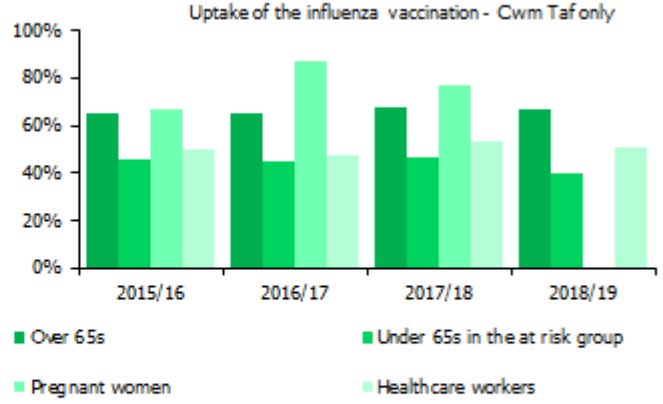

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 21.67% | N/A | N/A |



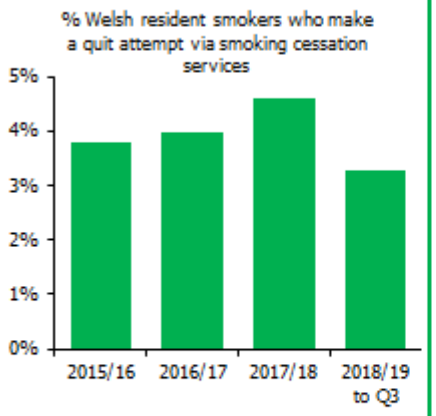

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 98.0% | 96.6% | N/A |



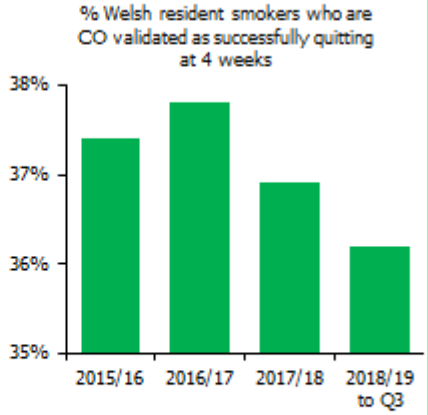

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 91.9% | 93.0% | N/A |




| Current Position | CT | M | CTM |
|---|---|---|---|
| Over 65's | 67.1% | N/A | N/A |
| Under 65's at risk group | 40.0% | N/A | N/A |
| Pregnant women | N/A | N/A | N/A |
| Healthcare workers | 50.9% | N/A | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 3.3% | N/A | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 36.2% | N/A | N/A |

**Indicator 1: Of those women who had their initial assessment and gave birth within the same health board, the percentage of pregnant women who gave up smoking during pregnancy (by 36-38 weeks of pregnancy)**

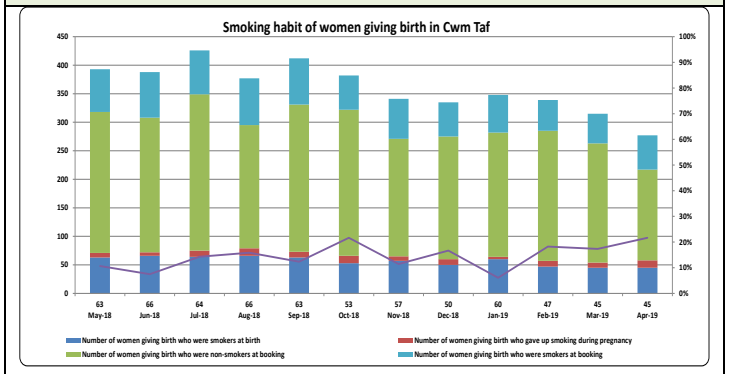
| | |
|---|---|
| Outcome: My children have a good healthy start in life | Executive Lead: Director of Public Health |
| Period: May 2018 to Apr 2019 | Target: Annual Improvement |

## Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

## How are we doing, what actions are we taking?

**How are we doing?**

- Progress is continuing in relation to the work being undertaken to address the challenges of smoking in pregnancy within CTUHB in line with reducing the low birth weight and the more recent 1000 lives campaign to reduce the stillbirth rate continues to be a priority going forward in particular the universal offer of CO readings at booking.
- MAMSS (Models for Access to Maternal Smoking Cessation Support) MAMSS is now a core service for the whole of Cwm Taf run by two WTE MWSs – MAMSS is not yet in Bridgend – smokers continue to be referred on opt out basis as per NICE PH26 guidance.

**What actions are we taking?**

- The Families' First project plan was not approved 2018/19 and also funding from Flying start Merthyr was not renewed for 2019-20 however, all areas in Cwm Taf now have access to MAMSS smoking cessation support.
- CO monitoring is now being carried out on all women at each "routine" antenatal appointment and also if a woman attends the Day Assessment Unit (DAU) with a view to readdressing smoking in pregnancy (MECC) and ensuring the safety of our pregnant women with regards to Carbon monoxide that they are being unknowingly exposed to.
- PHW continue to explore other funding streams to assist with expansion of service to the new area of our Health Board.
- Awaiting collaboration of Bridgend smoking cessation data and service information.

**What are the areas of risk?**

- Cessation of services that have proven improved health outcomes for the women and their unborn/babies.
- Two tiered smoking cessation service in CTMUHB maternity service.

## Benchmarking: how do we compare?

| | ABMU | AB | BCU | C&V | HDd | Powys |
|---|---|---|---|---|---|---|
| 2017/18 | 4.40% | 63.50% | 7.40% | 18.50% | 21.90% | 31.30% |
| 2016/17 | 4.80% | 46.00% | 10.70% | 21.40% | 26.80% | 10.30% |
| 2015/16 | 4.70% | 32.70% | 15.80% | 7.10% | 69.20% | 2.90% |

| | CT | Morgannwg | CTM | | | Wales |
|---|---|---|---|---|---|---|
| 2017/18 | 26.50% | | | | | 27.10% |
| 2016/17 | 25.10% | | | | | 23.70% |
| 2015/16 | 25.00% | | | | | 22.90% |

% of women giving birth who were smokers at booking and gave up during pregnancy

| | CT | M | CTM |
|---|---|---|---|
| Apr-18 | 29.55% | | |
| May-18 | 10.67% | | |
| Jun-18 | 7.50% | | |
| Jul-18 | 14.29% | | |
| Aug-18 | 15.85% | | |
| Sep-18 | 12.35% | | |
| Oct-18 | 21.67% | | |
| Nov-18 | 11.43% | | |
| Dec-18 | 16.67% | | |
| Jan-19 | 6.15% | | |
| Feb-19 | 18.52% | | |
| Mar-19 | 17.31% | | |
| Apr-19 | 21.67% | | |

**Source: Local: MITS Team/Information Team**

## Indicator 2: Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1
## Indicator 3: Percentage of children who received 2 doses of the MMR vaccine by age 5

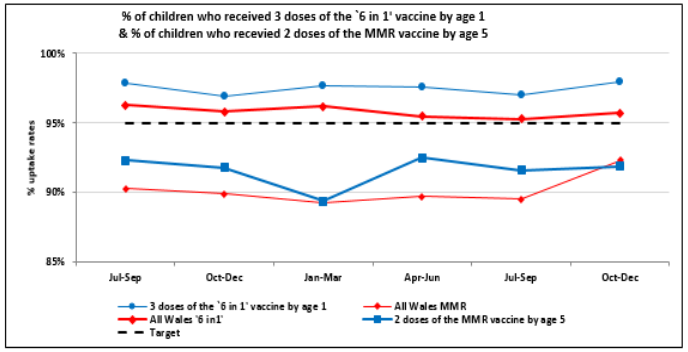
| Outcome: My children have a good healthy start in life | Executive Lead: Director of Public Health |
|---|---|
| Period: Q1 2017/18 – Q3 2018/19 | Target: 95% |

### Current Performance:

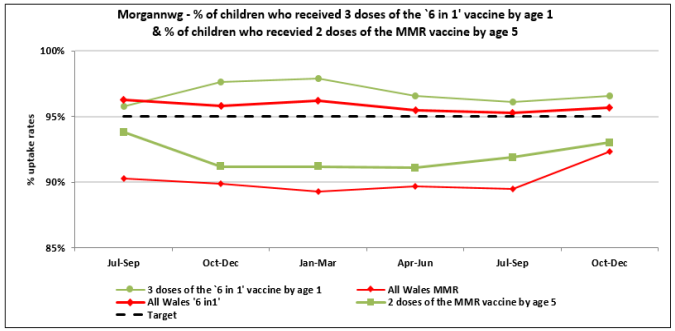
Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

**How are we doing?**

Indicator 2: Uptake for CTUHB during Oct-Dec 2018 98.0% remains above target, a 1.0% increase; was 97.0% during Jul-Sep 2018 (Source: COVER 128 & 129 reports; *Note that uptake of pertussis is used as a proxy for the 6 in 1 primary at 1 year*).

Indicator 3: Uptake for CTUHB during Oct-Dec 2018 91.9% remains below target despite a 0.3% increase; was 91.6% during Jul-Sep 2018 (Source: COVER 128 & 129 reports).

*Note: WHC (2017) 039 introduced the hexavalent ("6 in 1") vaccine, adding hepatitis B into the routine immunisation schedule, for babies born on or after 1 August 2017.

**What actions are we taking?**

Pilot Sept-March 2019 - Missed 2 immunisation appointments documentation is being highlighted to Health Visiting Service from Child health to improve uptake in children who have incomplete immunisations up to age 5. Plans for a focus group to meet to look at time scales: 1. That health visitors need to respond by, 2. For the pilot's completion/point of evaluation.

The School Nursing service has plans to devise a letter to send to parents at the school entry health review (4 years old rising 5) where immunisations are outstanding, particularly MMR.

Child Health printing off lists of children with incomplete immunisations status by age 5. Lists are being sent to Health visitors and GPs.

**What are the areas of risk?**

Potential of outbreaks in local area if stats remain below 95% target

Confirmed outbreak of Mumps in England by PHE (March 2019 – Confirmed outbreak of Mumps in Cardiff by PHW (April 2019 – BBC Wales News)

### Benchmarking: how do we compare?

Percentage of children who received 2 doses of the MMR vaccine by age 5

| | ABMU | | | AB | | | BCU | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2018/19 | | | 2018/19 | | | 2018/19 | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec |
| 2 doses of the MMR vaccine by age 5 | 91.2% | 90.0% | 91.1% | 89.7% | 90.3% | 91.9% | 91.0% | 90.7% | 95.6% |
| | C&V | | | HDd | | | Powys | | |
| | 2018/19 | | | 2018/19 | | | 2018/19 | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec |
| 2 doses of the MMR vaccine by age 5 | 87.9% | 86.3% | 91.2% | 85.6% | 88.6% | 91.0% | 88.9% | 87.7% | 90.9% |
| | CT | | | Morgannwg | | | CTM | | |
| | 2018/19 | | | 2018/19 | | | 2018/19 | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec |
| 2 doses of the MMR vaccine by age 5 | 92.5% | 91.6% | 91.9% | 91.1% | 91.9% | 93.0% | n/a | n/a | n/a |
| | All Wales | | | | | | | | |
| | 2018/19 | | | | | | | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | | | | | | |
| 2 doses of the MMR vaccine by age 5 | 89.7% | 89.5% | 92.3% | | | | | | |
| Target | 95% | 95% | 95% | | | | | | |

Percentage of children who received 3 doses of the `6 in 1' vaccine by age 1

| | ABMU | | | AB | | | BCU | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2018/19 | | | 2018/19 | | | 2018/19 | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec |
| 3 doses of the `6 in 1' vaccine by age 1 | 95.2% | 95.7% | 95.9% | 96.2% | 95.8% | 95.9% | 95.5% | 95.0% | 96.6% |
| | Cardiff & Vale | | | Hywel Dda | | | Powys | | |
| | 2018/19 | | | 2018/19 | | | 2018/19 | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec |
| 3 doses of the `6 in 1' vaccine by age 1 | 94.7% | 94.4% | 94.1% | 93.8% | 94.6% | 94.1% | ot know | 94.5% | 94.9% |
| | CT | | | Morgannwg | | | CTM | | |
| | 2018/19 | | | 2018/19 | | | 2018/19 | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec | Apr-Jun | Jul-Sep | Oct-Dec |
| 3 doses of the `6 in 1' vaccine by age 1 | 97.6% | 97.0% | 98.0% | 96.6% | 96.1% | 96.6% | n/a | n/a | n/a |
| | All Wales | | | | | | | | |
| | 2018/19 | | | | | | | | |
| | Apr-Jun | Jul-Sep | Oct-Dec | | | | | | |
| 3 doses of the `6 in 1' vaccine by age 1 | 95.5% | 95.3% | 95.7% | | | | | | |
| Target | 95% | 95% | 95% | | | | | | |

**How do we compare with our peers?**

- Indicator 2: Uptake was 95.7% for Wales during Oct-Dec 2018 (a 0.4% increase; was 95.3% during Jul-Sep 2018), so CTUHB (98.0%) continues to slightly exceed this by 2.3% (Source: COVER 128 & 129 report)
- Indicator 3: Uptake was 92.3% for Wales during Oct-Dec 2018 (a 2.8% increase; was 89.5% during Jul-Sep 2018), so CTUHB (91.6%) slightly fell short of this by 0.7% (Source: COVER 128 & 129 Report) (*PHW has been working closely with Powys Health Board on a data quality project looking into irregularities in data that have been identified. A problem with one of the algorithms meant that when a child left a health board, not all of the data went with them. A fix has been rolled out and PHW is looking to work with CTUHB in the future to carry out similar audits. PHW has explained that this fix will mean that percentage uptake will increase in the areas that were involved*).

Source: Public Health Wales Health Protection Division: http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=54144

## Indicator 5: Uptake of the influenza vaccination among: (a) 65 year olds and over; (b) under 65s in risk group; (c) pregnant women; (d) health care workers

| Outcome: I am healthy and active and do the things to keep myself healthy | Executive Lead: Director of Public Health | | | |
|---|---|---|---|---|
| Period: Seasons 2015/16 – 2018/19 | Target: (a) 75% | (b) 55% | (c) 75% | (d) 60% |

### Current Performance:

Cwm Taf Morgannwg

See table below

Cwm Taf

| Uptake of influenza vaccination a | CT | M | CTM | All Wales |
|---|---|---|---|---|
| | 2019/20 | | | |
| | as at 24 April 2019 | | | |
| Over 65s | 67.1% | 69.4% | 67.9% | 68.2% |
| Under 65s in the at risk group | 40.0% | 41.0% | 40.3% | 44.0% |
| Pregnant women* | | | | |
| Healthcare workers** | | | | |
| No of pregnant women immunised | 1006 | | | |

Morgannwg

See table above

### How are we doing, what actions are we taking?

***Cwm Taf Primary Care*** - as at 23 April 2019
Uptake in those 65 years and older in CTUHB was 67.1% (68.2% Wales average). Uptake in those under 65 years with clinical risk in CTUHB was 40.0% (44.0% Wales average) (*see note 1*)
***Cwm Taf Staff*** Uptake among staff with direct patient contact (*to end of Mar 19*) was 50.9% (55.0% Wales average). Uptake among total staff (*to end of February 2019*) was 48.0% (53.4% Wales average).

**What actions are we taking?**

- Distinction between strategic and operational immunization groups, and separation of community and staff flu plans should improve oversight and engagement.
- Fluenz pilot from 2016/17 to vaccinate 3 year olds within LA nursery schools instead of by GP's increased uptake; an evaluation of 2017/18 season is underway. Pilot programme has continued for 2018/19 while awaiting evaluation.
- Communication to practices that Fluenz is available to from hospital pharmacy in CTUHB.
- Continue to promote 'It's not too late to be vaccinated',
- Learning from the 2017/18 staff campaign will be incorporated into an updated staff flu plan for 2018/19.
- Staff Flu vaccination workshop planned for May 2019 to evaluate the 2018/19 programme and plan for 2019/20, further engaging with members of the Board and Senior Managers.
- An enhanced service for vaccinating care home staff is now in place.
- GP practices and clusters are now receiving personalised reports to incentivise further uptake efforts.
- Facilitation of vaccine transfer between practices to enable practices who have run out of to continue vaccinating where there is need.
- 36 peer vaccinators have been trained to undertake staff flu vaccinations in the areas of work.
- The Immunisation Team have collaborated with Public Health to ensure Peer Vaccinators and staff flu are incorporated into as many IMTP plans in the health board as possible
- An incentive has been agreed and is in use so that staff received a voucher for a free tea/coffee in the HB, a pen and a lanyard when they have their flu vaccination.
- Occupational Health have extra funding to input staff flu data onto Cohort (50% of forms were not on their system when first figures sent to PHW).
- Communication to staff in a variety of formats that it's not too late to be vaccinated including posters and intranet comms.

### Benchmarking: how do we compare?

| | ABMU | | | AB | | | BCU | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2015/16 | 2016/17 | 2017/18 | 2015/16 | 2016/17 | 2017/18 | 2015/16 | 2016/17 | 2017/18 |
| Over 65s | 64.6% | 65.0% | 68.2% | 67.7% | 68.1% | 69.8% | 68.7% | 68.7% | 70.6% |
| Under 65s in the at risk group | 43.4% | 43.7% | 46.7% | 49.4% | 49.7% | 50.8% | 49.3% | 49.3% | 51.6% |
| Pregnant women* | 44.1% | 81.5% | 93.3% | 43.7% | 69.8% | 72.5% | 50.3% | 75.3% | 65.2% |
| Healthcare workers** | 54.6% | 57.4% | 58.5% | 41.4% | 52.1% | 58.0% | 43.2% | 50.3% | 55.1% |
| No of pregnant women immunised | 1980 | 1851 | 1911 | 2476 | 5422 | 2621 | 3673 | 3579 | 3878 |

| | C&V | | | HDda | | | Powys | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2015/16 | 2016/17 | 2017/18 | 2015/16 | 2016/17 | 2017/18 | 2015/16 | 2016/17 | 2017/18 |
| Over 65s | 68.9% | 69.0% | 71.0% | 63.9% | 63.4% | 65.0% | 64.3% | 63.9% | 66.3% |
| Under 65s in the at risk group | 48.3% | 48.3% | 49.0% | 43.2% | 42.3% | 42.9% | 44.2% | 46.0% | 47.9% |
| Pregnant women* | 51.8% | 87.2% | 77.2% | 42.7% | 87.5% | 54.8% | 53.5% | 85.7% | 100.0% |
| Healthcare workers** | 46.8% | 53.0% | 64.7% | 52.8% | 47.0% | 60.6% | 60.1% | 64.0% | 65.4% |
| No of pregnant women immunised | 2602 | 2659 | 2614 | 1278 | 1208 | 1265 | 643 | 617 | 647 |

| | CT | | | Morgannwg | | | CTM | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2015/16 | 2016/17 | 2017/18 | 2015/16 | 2016/17 | 2017/18 | 2015/16 | 2016/17 | 2017/18 |
| Over 65s | 65.0% | 64.9% | 67.7% | | | | | | |
| Under 65s in the at risk group | 45.9% | 45.2% | 46.8% | | | | | | |
| Pregnant women* | 66.7% | 57.4% | 69.8% | | | | | | |
| Healthcare workers** | 50.4% | 47.2% | 53.1% | | | | | | |
| No of pregnant women immunised | 1003 | 971 | 986 | | | | | | |

| | All Wales | | |
|---|---|---|---|
| | 2015/16 | 2016/17 | 2017/18 |
| Over 65s | 66.6% | 66.7% | 68.8% |
| Under 65s in the at risk group | 46.9% | 46.9% | 48.5% |
| Pregnant women* | 47.1% | 76.8% | 72.7% |
| Healthcare workers** | 47.3% | 51.5% | 57.9% |
| No of pregnant women immunised | 13655 | 13410 | 13922 |

**Cwm Taf's position is comparable with peers.**

**What are the areas of risk?**

- Persisting myths around immunisation in the community.
- Delay in Delivery of QIV vaccine and staggered deliveries of aTIV
- Capacity within primary care to increase vaccination uptake.
- Attaining the increased 60% healthcare worker target for 2019/20 represents an additional challenge requiring high levels of directorate support.

Source: Public Health Wales Health Protection Division: http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=34338 http://nww.immunisation.wales.nhs.uk/ct-ivor http://nww.immunisation.wales.nhs.uk/ct-gp-flu)

## Indicator 6: The percentage of adult smokers who make a quit attempt via smoking cessation services

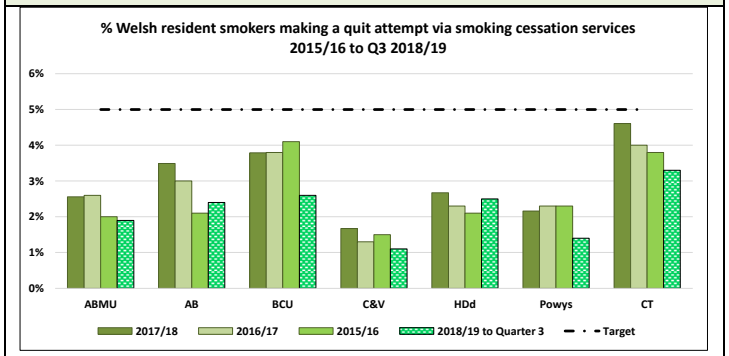
| | |
|---|---|
| Outcome: I am healthy and active and do the things to keep myself healthy | Executive Lead: Director of Public Health |
| Period: 2018/19 | Target: 5% Annual Target |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

Data pertaining to Welsh resident smokers making a quit attempt via smoking cessation is available on a quarterly basis.

The number of Welsh resident smokers treated by smoking cessation services during 2017/18 was 14,783 with an estimated number of Welsh resident smokers standing at 476,057 giving an estimated All Wales percentage of 3.11%. The equivalent figures for Cwm Taf were 2,325 of 50,413 ie 4.61%.

To achieve 5% during 2018/19 we required 2,500 smokers to be treated via the range of available cessation services. Provisional available data to Quarter 1-3 shows a total of 1701 treated smokers via the following cessation services:

Stop Smoking Wales – 364
Level 3 Community Pharmacy – 1174
MAMSS – 117
Secondary Care Service – 46

**What actions are we taking?**
Two year funding has been secured from the RHIG (National Respiratory Health Implementation Group) to develop a secondary care smoking cessation service. Overall progress on service implementation is reported quarterly to CTUHB Respiratory Planning and Delivery Group. The service commenced in Q4 of 2017/18. Client outcome data is included from Q1 2018/19.

A review of the actions identified in the recently updated Tobacco Control Delivery Plan for Wales 2017-2020 is underway.

**What are the areas of risk?**
Options are being considered to maintain service funding for MAMSS and the secondary care smoking cessation service.

### Benchmarking: how do we compare?

| % Welsh resident smokers who make a quit attempt via smoking cessation services | | | | | | |
|---|---|---|---|---|---|---|
| | ABMU | AB | BCU | C&V | HDd | Powys |
| 2018/19 to Quarter 3 | 1.9% | 2.4% | 2.6% | 1.1% | 2.5% | 1.4% |
| 2017/18 | 2.6% | 3.5% | 3.8% | 1.7% | 2.7% | 2.2% |
| 2016/17 | 2.6% | 3.0% | 3.8% | 1.3% | 2.3% | 2.3% |
| 2015/16 | 2.0% | 2.1% | 4.1% | 1.5% | 2.1% | 2.3% |
| Target | 5.0% | 5.0% | 5.0% | 5.0% | 5.0% | 5.0% |

| | CT | Morgannwg | CTM | | | Wales |
|---|---|---|---|---|---|---|
| 2018/19 to Quarter 3 | 3.3% | | | | | |
| 2017/18 | 4.6% | | | | | |
| 2016/17 | 4.0% | | | | | |
| 2015/16 | 3.8% | | | | | |
| Target | 5.0% | 5.0% | 5.0% | | | |

**How do we compare with our peers?**
Options are being considered to maintain service funding for MAMSS and the secondary care smoling cessation service.

Source: Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Indicator 7: The percentage of those smokers who are CO-validated as quit at 4 weeks

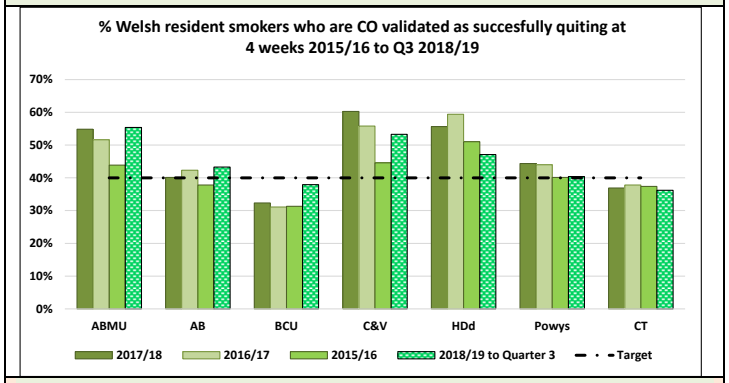
| | |
|---|---|
| Outcome: I am healthy and active and do the things to keep myself healthy | Executive Lead: Director of Public Health |
| Period: 2018/19 | Target: 40% Annual Target |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

Data pertaining to Welsh resident smokers CO-validated as quit at 4 weeks is available on a quarterly basis. The Quarter 1-3 figure 2018/19 provisional validation rates are 36.2%

The number of Welsh resident smokers CO-validated as quit at 4 weeks during 2017/18 was 6,363 with an estimated number of Welsh resident smokers treated at 14,783 giving an estimated All Wales percentage of 43.04%. The equivalent figures for Cwm Taf were 858 of 2,325 i.e. 36.9%.

**What actions are we taking?**

An All Wales Client handbook has now been developed. This will be used by all services who are supporting residents to quit.

### Benchmarking: how do we compare?

% Welsh resident smokers who are CO validated as successfully quitting at 4 weeks (target 40% end of financial year)

| | ABMU | AB | BCU | C&V | HDd | Powys |
|---|---|---|---|---|---|---|
| 2018/19 to Quarter 3 | 55.4% | 43.3% | 37.9% | 53.3% | 47.1% | 40.4% |
| 2017/18 | 54.8% | 40.1% | 32.4% | 60.3% | 55.6% | 44.4% |
| 2016/17 | 51.6% | 42.3% | 31.1% | 55.8% | 59.4% | 44.0% |
| 2015/16 | 43.9% | 37.8% | 31.3% | 44.6% | 51.0% | 40.1% |
| Target | 40.0% | 40.0% | 40.0% | 40.0% | 40.0% | 40.0% |

| | CT | Morgannwg | CTM | | | Wales |
|---|---|---|---|---|---|---|
| 2018/19 to Quarter 3 | 36.2% | | | | | |
| 2017/18 | 36.9% | | | | | |
| 2016/17 | 37.8% | | | | | |
| 2015/16 | 37.4% | | | | | |
| Target | 40.0% | 40.0% | 40.0% | | | |

**How do we compare with our peers?**

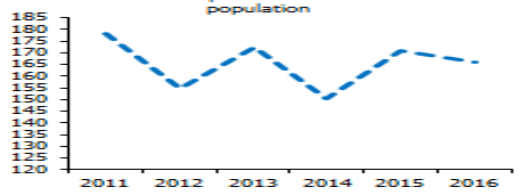
The Health Board's performance for 2018/19 is currently below the All Wales target of 40%.

Source: Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

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

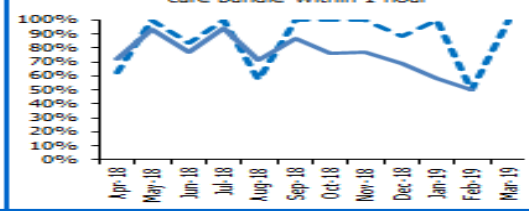
**Key: Cwm Taf Morgannwg** — **Cwm Taf** – – – **or** ■ **Morgannwg** ▭ **N/A - data not currently available**

### Amenable mortality per 100,000 of the European standardised population



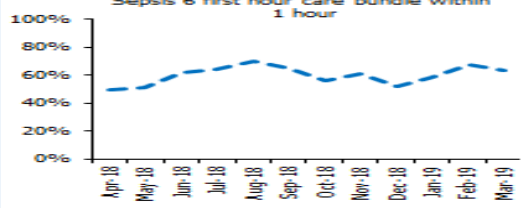

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 166.2 | N/A | N/A |

### % in-patients with positive sepsis screening received Sepsis 6 first hour care bundle within 1 hour



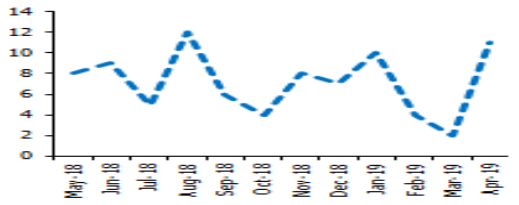

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 100.0% | N/A | N/A |

### % patients presented at ED with positive sepsis screening received Sepsis 6 first hour care bundle within 1 hour



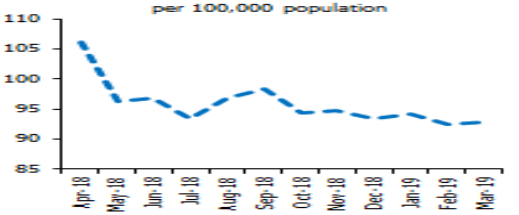

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 67.4% | N/A | N/A |

### Number of potentially hospital acquired thromboses



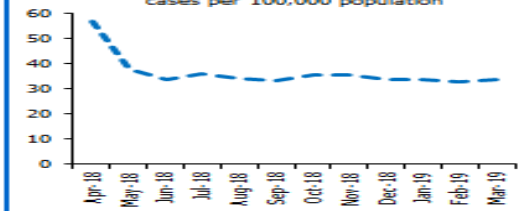

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 2 | N/A | N/A |

### Cumulative rate of laboratory confirmed E.coli bacteraemia cases per 100,000 population



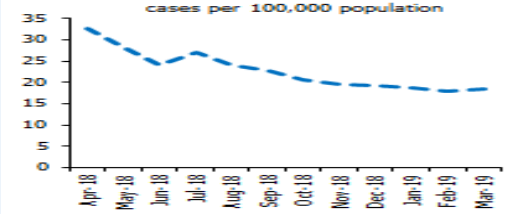

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 92.95 | N/A | N/A |

### Cumulative rate of laboratory confirmed S.aureus bacteraemia cases per 100,000 population



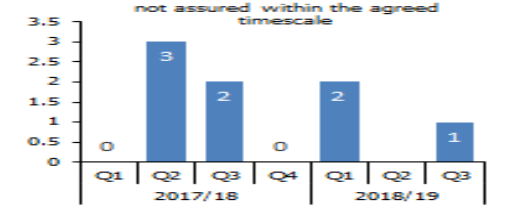

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 33.77 | N/A | N/A |

### Cumulative rate of laboratory confirmed C.difficile bacteraemia cases per 100,000 population



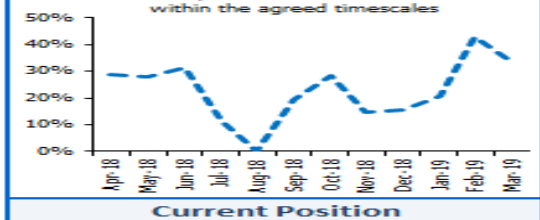

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 18.39 | N/A | N/A |

### Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale



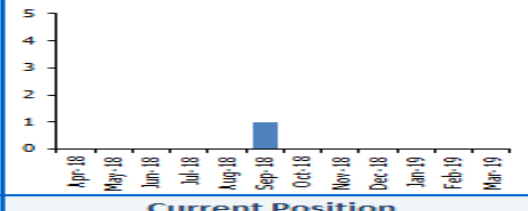

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 1 | N/A | N/A |

### Of the serious incidents due for assurance, the % which were assured within the agreed timescales



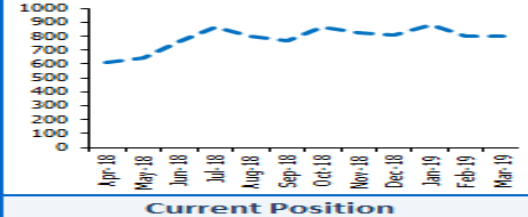

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 33.3% | N/A | N/A |

### Number of new never events



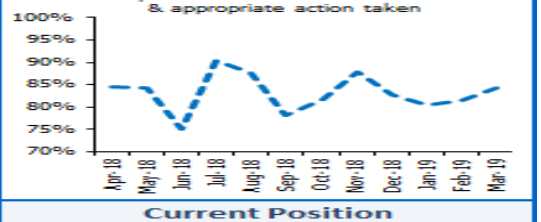

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 0 | N/A | N/A |

### Total Incidents recorded



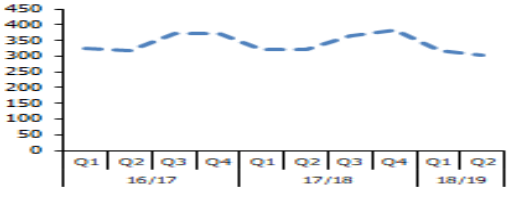

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 803 | N/A | N/A |

### % Compliance with Nutrition Score completed within 24 hrs of admission & appropriate action taken



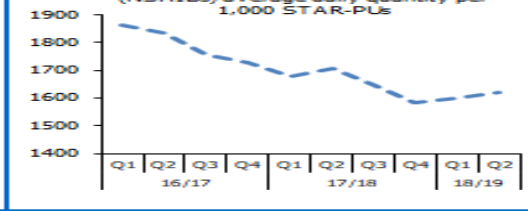

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 84.21% | N/A | N/A |

### Total antibacterial items per 1,000 STAR-PUs




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 303.3 | N/A | N/A |

### Non steroid anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-PUs




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 1621 | N/A | N/A |

## Indicator 12: Amenable mortality per 100,000 of the European standardised population

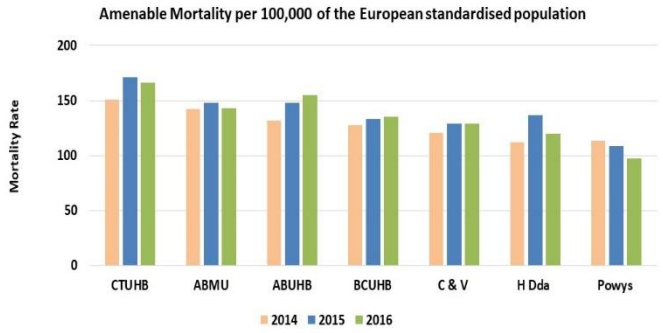
| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Medical Director |
|---|---|
| Period: 2014 to 2016 | Target: Annual Reduction |

### Current Performance:

Cwm Taf Morgannwg

Not currently available

Cwm Taf




Morgannwg

Not currently available

### How are we doing, what actions are we taking?

Age-standardised amenable mortality rates for the highest ranked health boards in Wales by sex, 2016[1,2,3]

| Males | | | Females | | |
|---|---|---|---|---|---|
| Health Boards | Mortality rate per 100,000 population | Rank | Health Boards | Mortality rate per 100,000 population | Rank |
| Cwm Taf University | 188.9 | 1 | Cwm Taf University | 144.4 | 1 |
| Aneurin Bevan University | 181.1 | 2 | Aneurin Bevan University | 129.6 | 2 |
| Betsi Cadwaladr University | 165.6 | 3 | Abertawe Bro Morgannwg University | 123.7 | 3 |
| Abertawe Bro Morgannwg University | 163.6 | 4 | Betsi Cadwaladr University | 105.7 | 4 |
| Cardiff and Vale University | 156.2 | 5 | Cardiff and Vale University | 104.5 | 5 |
| Hywel Dda University | 150.1 | 6 | Hywel Dda University | 90.9 | 6 |
| Powys Teaching | 118.7 | 7 | Powys Teaching | 77.5 | 7 |

Source: Office for National Statistics

1. Age-standardised mortality rates are expressed per 100,000 population and standardised to the 2013 European Standard Population. Age-standardised mortality rates are used to allow comparison between populations which may contain different proportions of people of different ages.
2. Figures for Wales exclude deaths of non-residents.
3. Figures are for deaths registered in the calendar year 2016.

The Health Board continues to improve process around mortality to ensure improving performance.

### Benchmarking: how do we compare?

**Age-standardised amenable mortality rates (with 95% confidence intervals) by cause and constituent country of the UK, 2014-2016** [1,2,3,4,5]

| | | Wales | | | |
|---|---|---|---|---|---|
| Cause | Year | Rate per 100,000 population | Lower 95% confidence interval | Upper 95% confidence interval | Number of deaths |
| All causes | 2014 | 128.9 | 124.9 | 133.0 | 3,999 |
| | 2015 | 140.6 | 136.4 | 144.8 | 4,409 |
| | 2016 | 138.1 | 134.0 | 142.2 | 4,403 |
| Cardiovascular diseases | 2014 | 58.6 | 55.9 | 61.3 | 1,821 |
| | 2015 | 61.1 | 58.3 | 63.8 | 1,919 |
| | 2016 | 60.2 | 57.5 | 62.9 | 1,922 |
| Infections | 2014 | 2.9 | 2.4 | 3.6 | 90 |
| | 2015 | 3.9 | 3.2 | 4.6 | 121 |
| | 2016 | 3.3 | 2.7 | 4.0 | 106 |
| Injuries | 2014 | 1.3 | 0.9 | 1.7 | 40 |
| | 2015 | 1.7 | 1.3 | 2.3 | 54 |
| | 2016 | 1.5 | 1.1 | 2.0 | 47 |
| Neoplasms | 2014 | 31.1 | 29.1 | 33.0 | 959 |
| | 2015 | 30.6 | 28.7 | 32.6 | 955 |
| | 2016 | 29.3 | 27.4 | 31.2 | 928 |
| Other | 2014 | 9.9 | 8.8 | 11.0 | 307 |
| | 2015 | 10.9 | 9.7 | 12.0 | 337 |
| | 2016 | 10.5 | 9.4 | 11.6 | 334 |
| Respiratory Diseases | 2014 | 25.2 | 23.4 | 26.9 | 782 |
| | 2015 | 32.4 | 30.4 | 34.4 | 1,023 |
| | 2016 | 33.2 | 31.2 | 35.2 | 1,066 |

National Statistics

[1] Figures are for deaths registered in each calendar year.

[2] Deaths of non-residents are excluded in figures Wales.

Across the seven Welsh Health Boards, Cwm Taf University had the highest rate of amenable mortality for both males and females, while Powys Teaching Health Board had the lowest. For males, only Powys Teaching had a statistically significant lower rate than the Wales estimate of 164.5 deaths per 100,000 males.

For females, both Powys Teaching and Hywel Dda University had statistically significantly lower amenable mortality rates compared with Wales, while Cwm Taf University had a significantly higher rate.

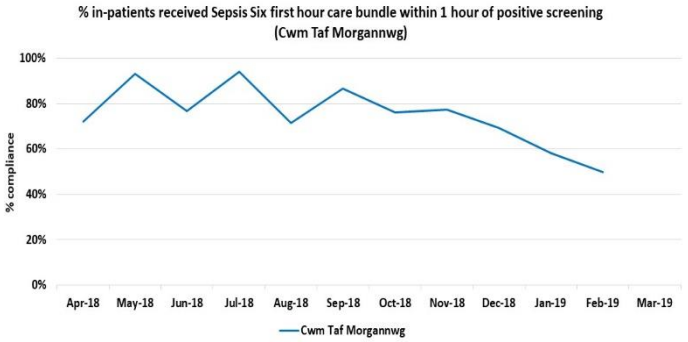
Source: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/avoidablemortalityintheuk

## Indicator 13: Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening

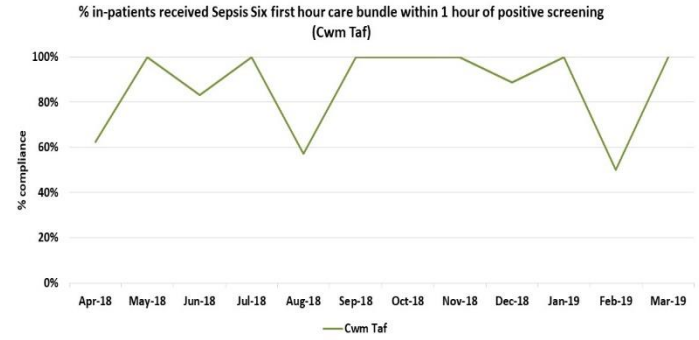
| | |
|---|---|
| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Medical Director |
| Period: Apr 2018 to Mar 2019 | Target: 12 month improvement trend |

### Current Performance:

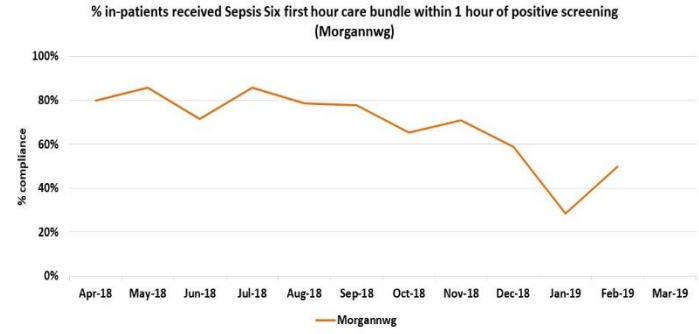
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

Sepsis compliance metrics are reported to Welsh Government on a monthly basis. Outreach input is now a formal part of the doctor and nurse orientation programme.

Outreach team continue to promote the work of the RRAILS and AKI groups to improve patient safety and care and there is now 24/7 cover for the whole Health Board. Suspicion of infection leads to sepsis screening and delivery of sepsis 6 of which compliance is measured by the Outreach team.

There is a well-attended multi-disciplinary quarterly group engaged with the national programme.

Working with maternity to produce sepsis guideline and working with District Nursing team to provide NEWS charts and observation equipment.

Education of all frontline HCPs via a mix of induction, rolling programmes and ward based targeted training.

Establishment of DRIPS meetings in both ED's to regularly review response to acute deterioration.

Risks are:

- Engagement of staff who are increasingly finding difficulty in being released from clinical areas for training.
- Outreach team has no capacity to provide teaching when clinical areas take priority.

### Benchmarking: how do we compare?

% of inpatients with a positive sepsis screening who have eceived all elements of the Sepsis Six first hour care bundle within one hour of positive screening

| | CTUHB | ABMU | ABUHB | BCUHB | C & V | H Dda |
|---|---|---|---|---|---|---|
| Apr-18 | | 32.2% | 60.0% | | | |
| May-18 | | 27.9% | 50.0% | | | |
| Jun-18 | 83.3% | 16.3% | 61.3% | 100.0% | 68.8% | 93.9% |
| Jul-18 | 100.0% | 36.9% | 61.1% | | | |
| Aug-18 | 57.1% | 18.3% | 32.3% | 100.0% | 61.3% | 90.3% |
| Sep-18 | 100.0% | | | | | |
| Oct-18 | 100.0% | 57.1% | 42.4% | 100.0% | 77.8% | 100.0% |
| Nov-18 | 100.0% | | | | | |
| Dec-18 | 88.9% | 52.6% | 52.6% | 100.0% | 71.4% | 84.6% |
| Jan-19 | 100.0% | | | | | |
| Feb-19 | 50.0% | 42.9% | | 100.0% | 50.0% | 93.1% |
| Mar-19 | 100.0% | | | | | |

**Not all hospitals/wards may be included in the data supplied by health boards**

**April 2019 data**
**(PoW data – only outreach figures are included)**

| Inpatients (excluding patients currently in critical care beds) | April 2019 |
|---|---|
| The number of patients identified as positive to sepsis screening requiring a new response in a 24 hour period | 27 |
| Number who received all six elements of the sepsis bundle within 1 hour | 22 |
| % compliance | 81.48 |
| Number of patients who received a positive screening for sepsis but did not receive a diagnosis of sepsis | |

| Emergency | April 2019 |
|---|---|
| The number of patients identified as positive to sepsis screening requiring a new response in a 24 hour period | 31 |
| Number who received all six elements of the sepsis bundle within 1 hour | 21 |
| % compliance | 67.74 |
| Number of patients who received a positive screening for sepsis but did not receive a diagnosis of sepsis | 1 |

Source: Local Clinical Audit

## Indicator 14: Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening

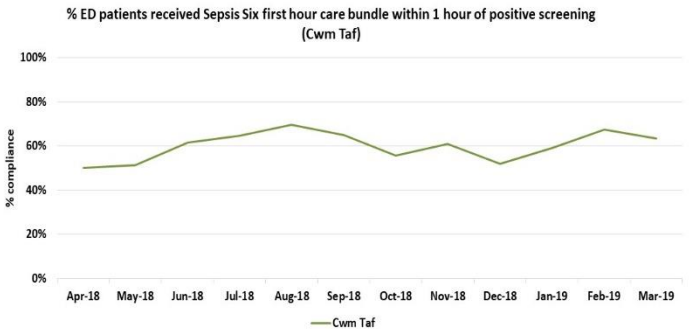
| | |
|---|---|
| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Medical Director |
| Period: Apr 2018 to Mar 2019 | Target: 12 month improvement trend |

### Current Performance:

Cwm Taf Morgannwg

Data not available as the Princess of Wales Hospital Emergency Department do not currently collate data

Cwm Taf




Morgannwg

Data not currently collated by Princess of Wales Hospital Emergency Department

### How are we doing, what actions are we taking?

Sepsis compliance metrics are reported to Welsh Government on a monthly basis. Outreach input is now a formal part of the doctor and nurse orientation programme.

Outreach team continue to promote the work of the RRAILS and AKI groups to improve patient safety and care and there is now 24/7 cover for the whole Health Board. Suspicion of infection leads to sepsis screening and delivery of sepsis 6 of which compliance is measured by the Outreach team.

There is a well-attended multi-disciplinary quarterly group engaged with the national programme.

Working with maternity to produce sepsis guideline and working with District Nursing team to provide NEWS charts and observation equipment.

Education of all frontline HCPs via a mix of induction, rolling programmes and ward based targeted training.

Establishment of DRIPS meetings in both ED's to regularly review response to acute deterioration.

**What are the areas of risk?**

Engagement of staff who are increasingly finding difficulty in being released from clinical areas for training.

Outreach team has no capacity to provide teaching when clinical areas take priority.

### Benchmarking: how do we compare?

% of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the `Sepsis Six' first hour care bundle within one hour of positive screening

| | CTUHB | ABMU | ABUHB | BCUHB | C & V | H Dda |
|---|---|---|---|---|---|---|
| Apr-18 | | 37.8% | 62.2% | | | |
| May-18 | | 58.0% | 61.7% | | | |
| Jun-18 | 61.6% | 34.2% | 62.4% | 29.7% | 61.6% | 95.5% |
| Jul-18 | 64.7% | 43.8% | 66.7% | | | |
| Aug-18 | 69.6% | 36.4% | 59.8% | 39.6% | | 91.6% |
| Sep-18 | 65.0% | | | | | |
| Oct-18 | 55.8% | 75.0% | 69.0% | 71.4% | | 95.0% |
| Nov-18 | 60.9% | | | | | |
| Dec-18 | 52.0% | | 65.3% | 63.8% | | 94.2% |
| Jan-19 | 59.0% | | | | | |
| Feb-19 | 67.4% | | | 48.6% | | 87.9% |
| Mar-19 | 63.5% | | | | | |

**Not all hospitals/wards may be included in the data supplied by health boards**

Source: Local Clinical Audit

## Indicator 15: The number of potentially preventable hospital acquired thrombosis

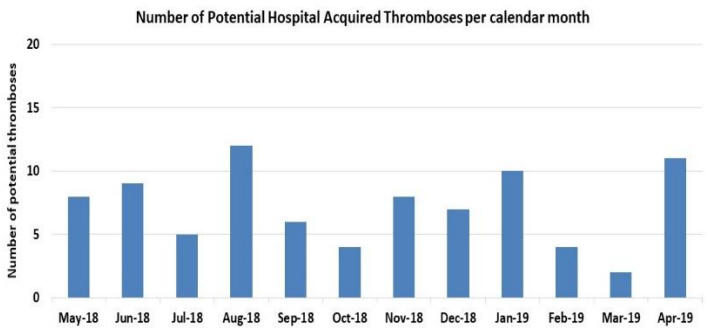
| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Medical Director |
|---|---|
| Period: 2017/18 to Qtr 1 2018/19 | Target: 4 Quarter Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

The pharmacy team continue to hold awareness and training sessions as well as a continuation of a number of improvement projects.

VTE risk assessment compliance is monitored via monthly Pharmacy audits with immediate feedback provided to the Ward Sister.

The RCAs are informing learning and improvement with regards to prescribing and administration timeliness.

Qlik Sense App developed to allow close monitoring of potential HATs.

Clinical Directors with MDTs to ensure completion of the VTE risk assessments and prophylaxis, prescribing and administration as per local guidelines. To monitor via local Quality and Safety meetings and feedback learning to the VTE Steering group.

The Clinical Audit Facilitator who has taken responsibility for the management of the VTE/HAT process is establishing meetings with the lead clinicians to review all HAT cases.

### Benchmarking: how do we compare?

| Number of potentially preventable hospital acquired thromboses (HAT) - 4 quarter | 2018/19 | 2017/18 | | | |
|---|---|---|---|---|---|
| | Q1 | Q1 | Q2 | Q3 | Q4 |
| Cwm Taf | 0 | 5 | 4 | n/a | 1 |
| Abertawe Bro Morgannwg | 0 | 1 | 2 | | 0 |
| Aneurin Bevan | 4 | 6 | 3 | | 3 |
| Betsi Cadwaladr | 4 | 5 | 0 | | 2 |
| Cardiff & Vale | 2 | 0 | 6 | | 0 |
| Hywel Dda | 6 | 1 | 2 | | 3 |
| Powys | 0 | 0 | 0 | | 0 |

Source: Local Clinical Audit/Local Information Team

## Indicator 16: Total antibacterial items per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)

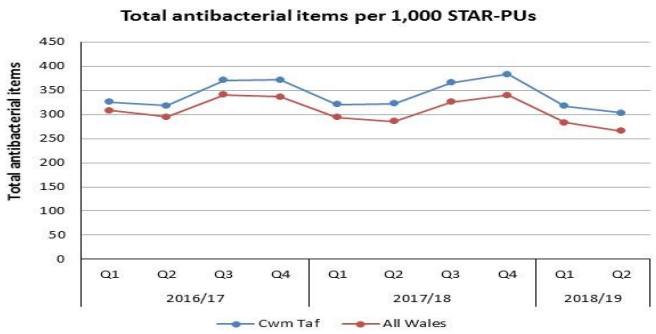
| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Director of Primary, Community and Mental Health |
|---|---|
| Period: 2016/17 to 2018/19 | Target: 4 Quarter Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

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### How are we doing, what actions are we taking?

CTUHB have the highest prescribing rates of antimicrobials in primary care in Wales and are not reducing at the rate of other HBs. However CTUHB have introduced prescribing guidelines to improve the choice of antimicrobials prescribed and this has demonstrated improvement e.g. compliance with the new primary care UTI treatment guidelines is good with current audited practices achieving around 70% compliance.
Recent data in FY 2018 has shown a reduction in volume of prescribing:

| Table MM01: Indicator | 2017/18 Quarterly trend | CTUHB Position in Wales (1st = best performing HB) | | Cwm Taf change June Quarter 2017 v 2018 |
|---|---|---|---|---|
| | | June Quarter 2017 | June Quarter 2018 | |
| Antibacterial items per 1,000 PU | ▼ | 7th | 7th | -1.19% |
| 4c antimicrobial items per 1,000 patients | ▼ | 7th | 7th | -0.93% |

CT have established an AM stewardship group within the HB governance structure. There is an agreed & monitored action plan for both primary and secondary care led and delivered by the antimicrobial pharmacists.

**Actions include:**
new prescribing guidelines accessible via phone APPs and a quick reference guideline for GPs.

GP practice audits of antimicrobial prescribing with feedback and recommended tailored actions, clinical and public engagement with an outcome of behaviour change via education and training to GPs & community nurses and "antibiotic myth busting" public education sessions which has been recognised as best practice and was a finalist in the international Antibiotic Guardian Awards 2018.

High volumes of antimicrobial prescribing are associated with increased levels of antimicrobial resistance and can contribute to HCA infections.

### Benchmarking: how do we compare?

| 4 Quarter Reduction Trend | | Total antibacterial items per 1,000 STAR-PU's (specific therapeutic group age related prescribing unit) | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
| 2018/19 | Q1 | **317.1** | 307.4 | 227.8 | 274.7 | 263.1 | 287.9 | 233.2 |
| | Q2 | **303.3** | 288.9 | 263.6 | 256.9 | 243.7 | 266.1 | 222.3 |
| 2017/18 | Q1 | 321.1 | 311.0 | 294.0 | 290.0 | 273.0 | 297.0 | 250.0 |
| | Q2 | 322.0 | 299.0 | 287.0 | 277.0 | 268.0 | 293.0 | 251.0 |
| | Q3 | 366.0 | 346.0 | 331.0 | 307.0 | 309.0 | 335.0 | 274.0 |
| | Q4 | 382.9 | 363.7 | 339.1 | 324.7 | 316.5 | 353.0 | 281.7 |
| 2016/17 | Q1 | 332.5 | 340.3 | 313.2 | 322.7 | 290.4 | 319.3 | 261.8 |
| | Q2 | 318.0 | 310.0 | 292.0 | 298.0 | 273.0 | 301.0 | 248.0 |
| | Q3 | 371.0 | 356.0 | 339.0 | 340.0 | 315.0 | 345.0 | 282.0 |
| | Q4 | 371.8 | 348.1 | 339.0 | 335.1 | 311.1 | 345.3 | 284.4 |

**CTUHB are 7th in Wales, however the continued increase in the volume of prescribing has shown a decrease in more recent data in 2018.**

Source: Welsh Government Delivery and Performance Website

## Indicator 18: Cumulative rate of laboratory confirmed *E.coli* bacteraemia cases per 100,000 population

| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Director of Nursing |
|---|---|
| Period: Apr 2018 to Mar 2019 | Target: 67 per 100,000 population |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

**Cwm Taf UHB E.coli bacteraemia 2018/19 reduction expectation results**

| Maximum numbers to achieve 2018/19 FY reduction expectation | | Actual 2018/19 FY numbers |
|---|---|---|
| Maximum number for FY | <201 | 278 Actual number for FY |
| Maximum average number per month | <17 | 23 Actual average number per month |
| Maximum rate/100,000 population | 67.00 | 92.95 Actual rate/100,000 population |

**Cwm Taf UHB maximum cumulative monthly numbers of E.coli bacteraemia required to achieve the 2018/19 reduction expectation and actual cumulative monthly number and rate**

| | Maximum cumulative monthly number to achieve reduction expectation | Actual cumulative monthly numbers | Difference between maximum and actual cumulative monthly numbers | Actual cumulative monthly rate/100,000 population |
|---|---|---|---|---|
| Apr | <17 | 26 | 10 | 105.77 |
| May | <34 | 48 | 15 | 96.03 |
| Jun | <51 | 72 | 22 | 96.56 |
| Jul | <67 | 93 | 27 | 93.03 |
| Aug | <84 | 121 | 38 | 96.52 |
| Sep | <101 | 147 | 47 | 98.03 |
| Oct | <117 | 165 | 49 | 94.10 |
| Nov | <134 | 189 | 56 | 94.53 |
| Dec | <151 | 211 | 61 | 93.64 |
| Jan | <168 | 236 | 69 | 94.12 |
| Feb | <184 | 253 | 70 | 92.44 |
| Mar | <201 | 278 | 78 | 92.95 |

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Data not currently available

### How are we doing, what actions are we taking?

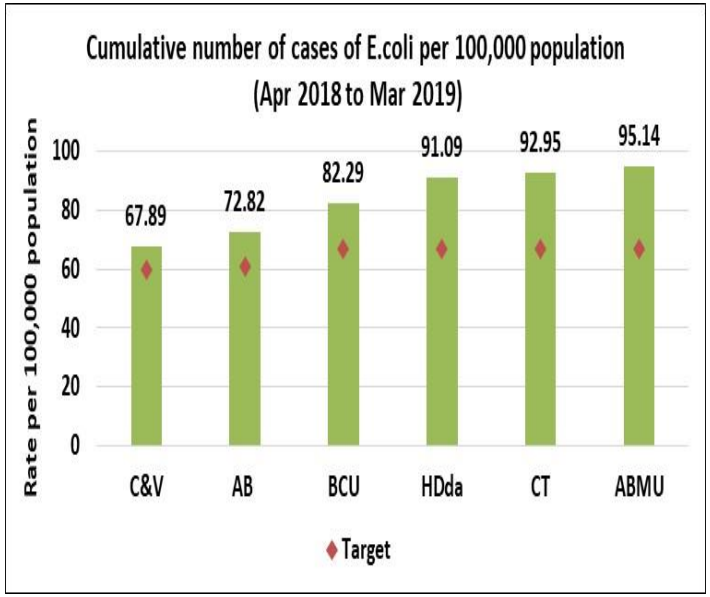
The Cwm Taf 2018/19 reduction expectation for E.coli bacteraemia is to achieve a rate of less than or equal to 67.00 per 100,000 population. This equates to an average of less than 17 E.coli bacteraemia per month and less than 201 for the whole financial year.

At the end of the 2018/19 reduction expectation period, the rate of E.coli bacteraemia in Cwm Taf UHB is 92.95 per 100,000 population. This equates to an average of 23 per month and based on the current trajectory, a total of 278 for the FY. Cwm Taf has not achieved the 2018/19 reduction.

The IPC team are discussing all E.coli bacteraemia weekly to identify preventable sources. A collaborative has been formed to identify interventions in primary and secondary care which will support the reduction expectation.

Poor antimicrobial stewardship, poor hand hygiene and poor management of invasive devices.

### Benchmarking: how do we compare?




**None of the Health Boards have achieved the required reduction for 2018/19. However, Cardiff & Vale UHB is best performing with a rate of 67.89 per 100,000 population.**

Source: Public Health Wales (WHAIP)

## Indicator 19: Cumulative rate of laboratory confirmed *S.aureus* bacteraemia (MRSA & MSSA) cases per 100,000 population

| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Director of Nursing |
|---|---|
| Period: Apr 2018 to Mar 2019 | Target: 20 per 100,000 population |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

**Cwm Taf UHB S.aureus bacteraemia 2018/19 reduction expectation results**

| Maximum numbers to achieve 2018/19 FY reduction expectation | | Actual 2018/19 FY numbers | |
|---|---|---|---|
| Maximum number for FY | <60 | 101 | Actual number for FY |
| Maximum average number per month | <5 | 8 | Actual average number per month |
| Maximum rate/100,000 population | 20.00 | 33.77 | Actual rate/100,000 population |

**Cwm Taf UHB maximum cumulative monthly numbers of S.aureus bacteraemia required to achieve the 2018/19 reduction expectation and actual cumulative monthly number and rate**

| | Maximum cumulative monthly number to achieve reduction expectation | Actual monthly numbers | Difference between maximum and actual cumulative monthly numbers | Actual cumulative monthly rate/100,000 population |
|---|---|---|---|---|
| Apr | <5 | 14 | 10 | 56.95 |
| May | <10 | 19 | 10 | 38.01 |
| Jun | <15 | 25 | 11 | 33.53 |
| Jul | <20 | 36 | 17 | 36.01 |
| Aug | <25 | 43 | 19 | 34.30 |
| Sep | <30 | 50 | 21 | 33.34 |
| Oct | <35 | 62 | 28 | 35.36 |
| Nov | <40 | 71 | 32 | 35.51 |
| Dec | <45 | 77 | 33 | 34.17 |
| Jan | <50 | 85 | 36 | 33.90 |
| Feb | <55 | 90 | 36 | 32.89 |
| Mar | <60 | 101 | 42 | 33.77 |

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Data not currently available

### How are we doing, what actions are we taking?

The Cwm Taf 2018/19 reduction expectation for S.aureus bacteraemia is to achieve a rate of less than or equal to 20.00 per 100,000 population. This equates to an average of less than 5 S.aureus bacteraemia per month and less than 60 for the whole financial year.

At the end of the 2018/19 reduction expectation period, the rate of S.aureus bacteraemia in Cwm Taf UHB is 33.77 per 100,000 population. This equates to an average of 8 per month and based on the current trajectory, a total of 101 for the FY. Cwm Taf has not achieved the 2018/19 reduction.

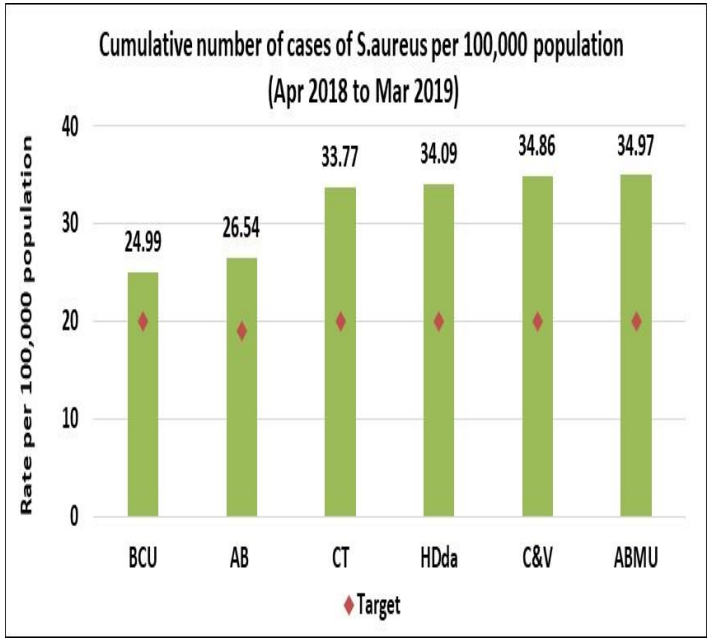
All MRSA bacteremias are investigated by the IPCT and a RCA is performed for all line related bacteremias.

Improvement work is being carried out to improve compliance with MRSA screening in our A&E departments and admission wards.

60% of the MSSA bacteraemia are identified <48 hours post admission.

Poor antimicrobial stewardship. Poor hand hygiene. Poor compliance with MRSA screening and management of invasive devices. Poor hand hygiene.

### Benchmarking: how do we compare?




**None of the Health Boards have achieved the required reduction for 2018/19, however Betsi Cadwaladr is currently best performing with a rate of 24.99 per 100,000 population.**

Source: Public Health Wales (WHAIP)

## Indicator 20: Cumulative rate of laboratory confirmed *C.difficile* bacteraemia cases per 100,000 population

| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Director of Nursing |
|---|---|
| Period: Apr 2018 to Mar 2019 | Target: 18 per 100,000 population |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

**Cwm Taf UHB C.difficile 2018/19 reduction expectation results**

| Maximum numbers to achieve 2018/19 FY reduction expectation | | Actual 2018/19 FY numbers | |
|---|---|---|---|
| Maximum number for FY | <54 | 55 | Actual number for FY |
| Maximum average number per month | <5 | 5 | Actual average number per month |
| Maximum rate/100,000 population | 18.00 | 18.39 | Actual rate/100,000 population |

**Cwm Taf UHB maximum cumulative monthly numbers of C.difficile required to achieve the 2018/19 reduction expectation and actual cumulative monthly number and rate**

| | Maximum cumulative monthly number to achieve reduction expectation | Actual cumulative monthly numbers | Difference between maximum and actual cumulative monthly numbers | Actual cumulative monthly rate/100,000 population |
|---|---|---|---|---|
| Apr | <5 | 8 | 4 | 32.54 |
| May | <9 | 14 | 6 | 28.01 |
| Jun | <14 | 18 | 5 | 24.14 |
| Jul | <18 | 27 | 10 | 27.01 |
| Aug | <23 | 30 | 8 | 23.93 |
| Sep | <27 | 34 | 8 | 22.67 |
| Oct | <32 | 36 | 5 | 20.53 |
| Nov | <36 | 39 | 4 | 19.51 |
| Dec | <41 | 43 | 3 | 19.08 |
| Jan | <45 | 47 | 3 | 18.74 |
| Feb | <50 | 49 | 0 | 17.90 |
| Mar | <54 | 55 | 2 | 18.39 |

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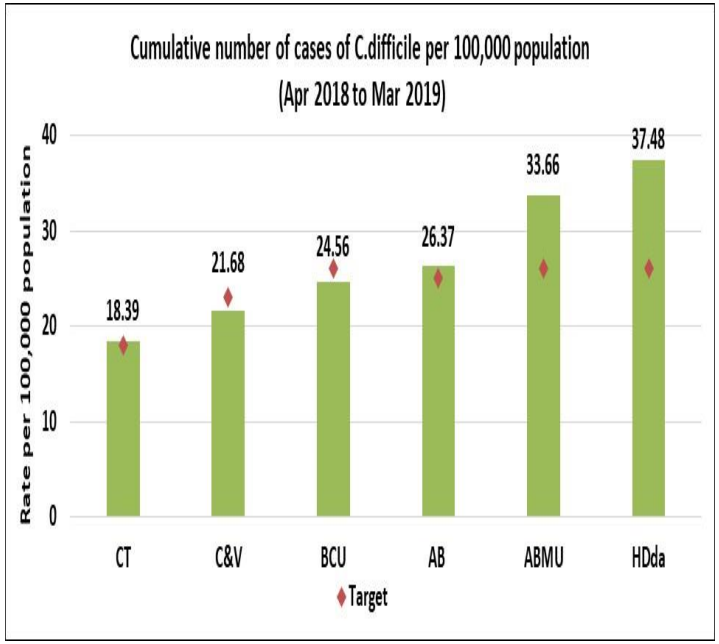
Data not currently available

### How are we doing, what actions are we taking?

The Cwm Taf 2018/19 reduction expectation for C.difficile bacteraemia is to achieve a rate of less than or equal to 18.00 per 100,000 population. This equates to an average of less than 5 C.difficile bacteraemia per month and less than 54 for the whole financial year.

At the end of the 2018/19 reduction expectation period, the rate of C.difficile in Cwm Taf UHB is 18.39 per 100,000 population. This equates to an average of 5 per month and 55 for the whole FY. Cwm Taf UHB has not achieved the 2018/19 reduction expectation.

### Benchmarking: how do we compare?




**Although Cwm Taf did not meet the reduction expectation it has the lowest rate of C.difficile out of all the other health boards in Wales.**

Source: Public Health Wales (WHAIP)

## Indicator 21: Non steroid anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-PUs (specific therapeutic group age related prescribing unit)

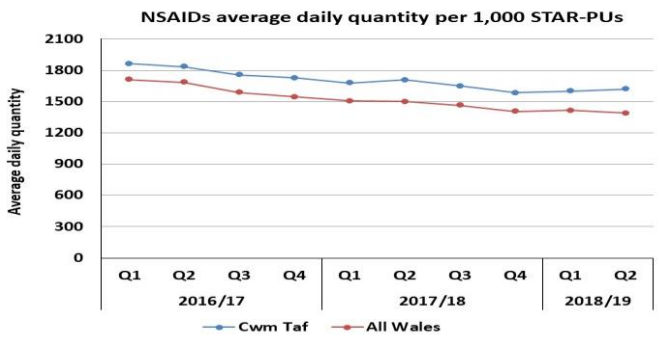
| | |
|---|---|
| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Director of Primary, Community and Mental Health |
| Period: 2016/17 to 2018/19 | Target: 4 Quarter Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

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Data not currently available

### How are we doing, what actions are we taking?

CTUHB have the highest prescribing volumes of NSAIDS per STAR PU in Wales. This volume has shown a consistent year on year reduction. However, the choice of NSAID prescribed has a high compliance with current guidance.

The HB have incorporated this into practice work plans over a number of years, including QOF audit. Although this is no longer a prescribing indicator for 2018-19 it will still be incorporated into the prescribing team work plan.

NSAIDS have been shown to be the medicine group most likely to cause an adverse drug reaction requiring hospital admission due to such events as gastrointestinal bleeding and peptic ulceration.

### Benchmarking: how do we compare?

| 4 Quarter Reduction Trend | | Non-steriod anti-inflammatory drugs (NSAIDs) average daily quantity per 1,000 STAR-PU's (specific therapeutic group age related prescribing unit) | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
| 2018/19 | Q1 | **1601** | 1517 | 1411 | 1419 | 1201 | 1437 | 1282 |
| | Q2 | **1621** | 1479 | 1402 | 1376 | 1154 | 1405 | 1289 |
| 2017/18 | Q1 | 1679 | 1571 | 1508 | 1495 | 1309 | 1577 | 1376 |
| | Q2 | 1709 | 1559 | 1487 | 1501 | 1284 | 1553 | 1392 |
| | Q3 | 1650 | 1541 | 1464 | 1461 | 1249 | 1511 | 1337 |
| | Q4 | 1584 | 1496 | 1407 | 1405 | 1195 | 1430 | 1278 |
| 2016/17 | Q1 | 1863 | 1768 | 1715 | 1691 | 1608 | 1714 | 1619 |
| | Q2 | 1834 | 1732 | 1680 | 1674 | 1561 | 1723 | 1587 |
| | Q3 | 1756 | 1631 | 1594 | 1565 | 1462 | 1615 | 1489 |
| | Q4 | 1728 | 1602 | 1543 | 1524 | 1387 | 1589 | 1414 |

**Cwm Taf have the highest ADQ of NSAID prescribing in Wales. This has reduced consistently (-8.6% from 2016/17 to 2017/18) over the years in line with similar reductions across Wales.**

Source: Welsh Government Delivery and Performance Website

## Indicator 22: Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale

| | |
|---|---|
| Outcome: I am safe and protected from harm through high quality care, treatment and support | Executive Lead: Director of Nursing |
| Period: Q1 2017/18 to Q1 2018/19 | Target: Zero |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

Number of Patient Safety Solutions Wales Alerts and Notices that were not assured within the agreed timescale

| Target is Zero | | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
|---|---|---|---|---|---|---|---|---|
| 2018/19 | Q1 | 2 | 2 | 1 | 1 | 0 | 1 | 0 |
| 2017/18 | Q4 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| | Q3 | 2 | 3 | 3 | 3 | 2 | 2 | 2 |
| | Q2 | 3 | 2 | 3 | 3 | 2 | 3 | 2 |
| | Q1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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Data not currently available

### How are we doing, what actions are we taking?

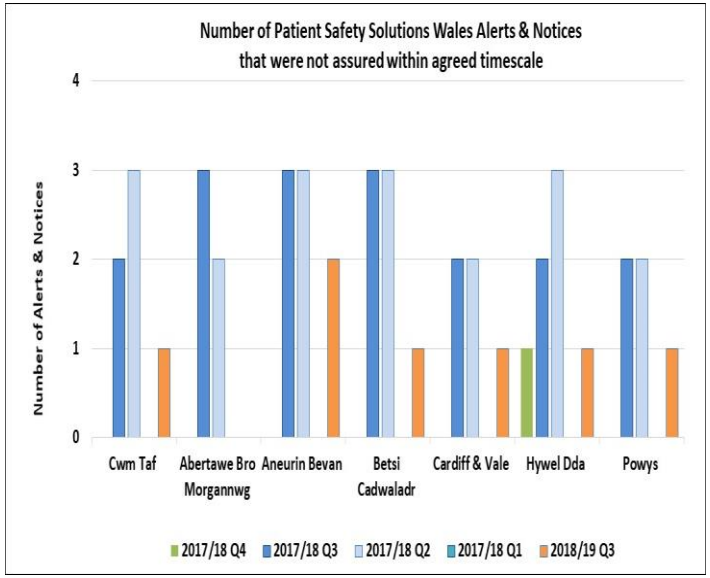
Previously reported alerts and notices as two separate measures. This has been amended so that they are reported within the same measure for 2018/19. Previously reported monthly. The 2018/19 measure is to be reported quarterly.

Patient Safety Solutions (after April 2014) Alerts and Notices.
Current position is:
Alerts: A total of 8 Alerts have been received. The Health Board is compliant with 7 (87.5%) of these Alerts. The compliance deadlines for the one outstanding alert is 30th October 2017.
Notices: A total of 47 notices have been issued. The Health Board is non-compliant with 2 notices outside of timescale.

Alerts: non-compliant outside of the timescale for completion
PSA008 – Nasogastric tube misplacement continuing risk of death and severe harm. Compliance deadline 30th October 2017. The procedure has been approved and competency based training added into the guidance. Standardisation of GBUK tubes completed. LocSSIP training arranged for 21/09/2018. Included on annual audit plan.

Notices: 2 non-complaint outside of timescale for completion
PSN030 – The safe storage of medicines: Cupboards
Areas of non-compliance have been identified and actions taken to minimise the risk. Storage and Security of medicines procedure updated and a delivery plan for modernisation of medicines storage is being developed.
PSN043 - The Health Board has in place comprehensive multi-disciplinary guidelines, which incorporate the All Wales guidance.
A Training Plan is in place to ensure that staff will be appropriately trained in Tracheostomy management.

### Benchmarking: how do we compare?




**Cwm Taf is comparable with the other Health Boards in Wales.**

Source: Welsh Government Delivery and Performance Website [http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data](http://www.patientsafety.wales.nhs.uk/safety-solutions-compliance-data)

**Indicator 23: Of the serious incidents due for assurance, the percentage which were assured within the agreed timescales**
**Indicator 24: Number of new never events**

Outcome: I am safe and protected from harm through high quality care, treatment and support

Executive Lead: Director of Nursing

Period: Apr 2018 to Mar 2019

Target Indicator 23: 90%

Target Indicator 24: Zero

## Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

| Period | Serious Incidents | Never Events |
|---|---|---|
| Apr-18 | 28.6% | 0 |
| May-18 | 27.8% | 0 |
| Jun-18 | 31.4% | 0 |
| Jul-18 | 11.1% | 0 |
| Aug-18 | 0.0% | 0 |
| Sep-18 | 19.4% | 1 |
| Oct-18 | 28.2% | 0 |
| Nov-18 | 14.6% | 0 |
| Dec-18 | 15.4% | 0 |
| Jan-19 | 20.5% | 0 |
| Feb-19 | 42.9% | 0 |
| Mar-19 | 33.3% | 0 |

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| Period | Serious Incidents | Never Events |
|---|---|---|
| Apr-18 | 93.0% | 0 |
| May-18 | 82.0% | 0 |
| Jun-18 | 82.0% | 0 |
| Jul-18 | 71.0% | 0 |
| Aug-18 | 100.0% | 0 |
| Sep-18 | 100.0% | 0 |
| Oct-18 | 100.0% | 0 |
| Nov-18 | 100.0% | 0 |
| Dec-18 | 100.0% | 0 |
| Jan-19 | 88.0% | 0 |
| Feb-19 | 67.0% | 0 |
| Mar-19 | N/A | N/A |

## How are we doing, what actions are we taking?

As at the 7th March 2019 within the Health Board there were 40 closure forms outstanding outside of timescale.

It should be noted, that whilst the formal process of completing the closure form has not been undertaken, for the majority of incidents the investigations have been concluded. The never events reported by Cwm Taf UHB have been fully investigated and action plans to address the learning identified.

Quarter 1, 2018/19 - 92 serious incidents and no never
Quarter 2, 2018/19 - 120 serious incidents and one never
Quarter 3, 2018/19 - 109 serious incidents and no never events during this quarter.
Quarter 4, 2018/19 (01/01/19 to 28/02/19) - 41 serious incidents and no never events

Weekly meetings are held with the Patient Safety Improvement Managers to monitor progress with the submission of closure forms. Information presented in this meeting is included in the weekly Concerns Report provided to the Executive Leads.

A dedicated administrative resource is aligned to the serious incident process to ensure robust implementation and monitoring of notifications and closures.
In addition, recent developments have been implemented in relation to Datix (risk management system used to report incidents) which supports the monitoring of serious incidents. This enables identification of barriers to completion and targeted action being taken as required.

The main areas of clinical risk are being addressed through the Quality Delivery Plan. The remaining risk is that of organisational reputation in view of overdue closures.

## Benchmarking: how do we compare?

Of the Serious Incidents due for assurance, the % which assured in agreed timescale - Target 90%

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
|---|---|---|---|---|---|---|---|
| Apr-18 | 28.6% | 51.4% | 36.8% | 21.1% | 66.7% | 50.0% | 0.0% |
| May-18 | 27.8% | 69.6% | 64.3% | 18.3% | 42.1% | 55.6% | 0.0% |
| Jun-18 | 31.4% | 38.1% | 47.1% | 15.5% | 53.3% | 21.4% | 21.4% |
| Jul-18 | 11.1% | 73.3% | 52.0% | 25.3% | 42.4% | 81.3% | 25.0% |
| Aug-18 | 0.0% | 86.7% | 64.0% | 17.3% | 25.0% | 69.0% | 33.3% |
| Sep-18 | 19.4% | 21.4% | 35.7% | 10.8% | 65.5% | 48.1% | 22.2% |
| Oct-18 | 28.2% | 50.0% | 47.2% | 24.8% | 69.0% | 63.0% | 0.0% |
| Nov-18 | 14.6% | 88.2% | 50.0% | 25.3% | 69.2% | 52.0% | 20.0% |
| Dec-18 | 15.4% | 88.9% | 29.4% | 20.7% | 50.0% | 35.3% | 0.0% |
| Jan-19 | 20.5% | 48.7% | 18.4% | 17.0% | 60.4% | 26.7% | 50.0% |
| Feb-19 | 42.9% | 56.0% | 21.7% | 33.8% | 19.5% | 36.0% | 0.0% |
| Mar-19 | 33.3% | 34.8% | 50.0% | 17.1% | 27.0% | 31.3% | 22.2% |

Number of new Never Events - Target Zero

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
|---|---|---|---|---|---|---|---|
| Apr-18 | 0 | 0 | 0 | 0 | 2 | 0 | 0 |
| May-18 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Jun-18 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| Jul-18 | 0 | 0 | 1 | 1 | 0 | 0 | 0 |
| Aug-18 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Sep-18 | 1 | 0 | 0 | 2 | 1 | 0 | 0 |
| Oct-18 | 0 | 0 | 1 | 1 | 1 | 1 | 0 |
| Nov-18 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dec-18 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Jan-19 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Feb-19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mar-19 | 0 | 1 | 0 | 0 | 1 | 0 | 0 |

The Welsh Government has identified the submission of closure forms as a specific risk for the Health Board which is being closely monitored to ensure improvement.

Source: Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649 /Qliksense Datix App/Local Datix

## Local Measure: Number of incidents and severity reported

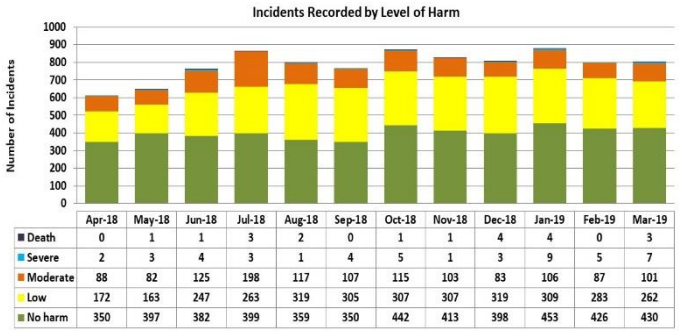
| Outcome: I am safe and protected from abuse and neglect | Executive Lead: Director of Nursing |
|---|---|
| Period: Apr 2018 to Mar 2019 | Target: Reduction |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




| | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Death | 0 | 1 | 1 | 3 | 2 | 0 | 1 | 1 | 4 | 4 | 0 | 3 |
| Severe | 2 | 3 | 4 | 3 | 1 | 4 | 5 | 1 | 3 | 9 | 5 | 7 |
| Moderate | 88 | 82 | 125 | 198 | 117 | 107 | 115 | 103 | 83 | 106 | 87 | 101 |
| Low | 172 | 163 | 247 | 263 | 319 | 305 | 307 | 307 | 319 | 309 | 283 | 262 |
| No harm | 350 | 397 | 382 | 399 | 359 | 350 | 442 | 413 | 398 | 453 | 426 | 430 |

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Data not currently available

### How are we doing, what actions are we taking?

A high reporting of no and low harm incidents is indicative a robust safety culture within an Organisation. Moderate incidents reported within the Health Board are currently slightly above the Welsh average – this partly due to an inaccuracy in reporting.

Data quality issues identified within the information is being addressed through:

Daily monitoring of moderate and severe incidents is undertaken by the Corporate Team to identify inaccuracies and correct reported incidents.

Training is provided across the Health Board to ensure accurate reporting of patient safety incidents, which includes category and severity. Additional training is provided to responsible managers to ensure timely review of incidents and that appropriate action is taken.

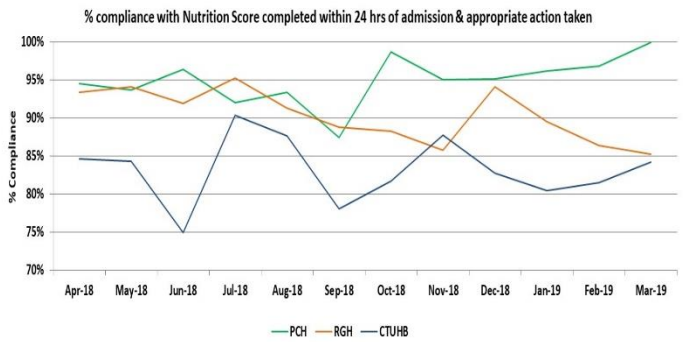
Inaccurate reporting which results in being unable to identify trends and real risks which need urgent action to address.

### Benchmarking: how do we compare?

**Benchmark not available**

Source: Local Datix

| Indicator 25: Nutrition and hydration (hydration data is not currently available) | |
|---|---|
| Outcome: I am safe and protected from abuse and neglect | Executive Lead: Director of Nursing |
| Period: Apr 2018 to Mar 2019 | Target: To be confirmed |

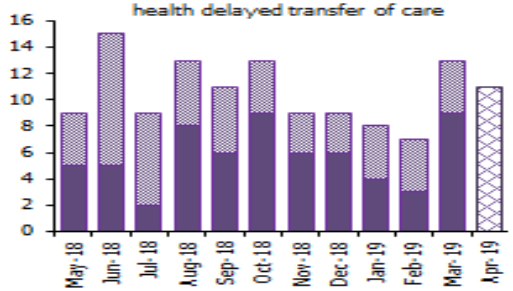
| Current Performance: | How are we doing, what actions are we taking? | Benchmarking: how do we compare? |
|---|---|---|
| Cwm Taf Morgannwg<br><br>Data not currently available<br><br>Cwm Taf<br><br>  <br><br><br>Morgannwg<br><br>Data not currently available | The Health Board is committed to providing and promoting good nutritional care, as nutrition and hydration are vital aspects of patient care. Early detection and management of nutritional risk across community and secondary care promotes well-being and supports better patient outcomes and improved recovery rates.<br><br>A significant amount of work continues to be undertaken within the health board on nutrition and hydration and the audit results shows evidence of this ongoing commitment to meeting the nutritional needs of patients. However, we do recognise that we do not get it right for every patient and there is still work to do.<br><br>Nursing staff not having time to complete the nutrition e-learning. | **Benchmark not available** |

Source: Local / Qlik

## EFFECTIVE CARE – People in Wales receive the right care and support locally as possible and are enabled to contribute to making that care successful

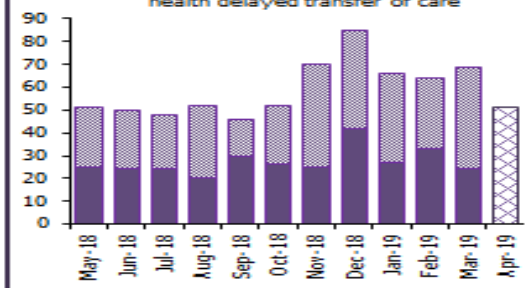
**Key: Cwm Taf Morgannwg** or **Cwm Taf** or **Morgannwg** | **N/A - data not currently available**

Number of health board mental health delayed transfer of care



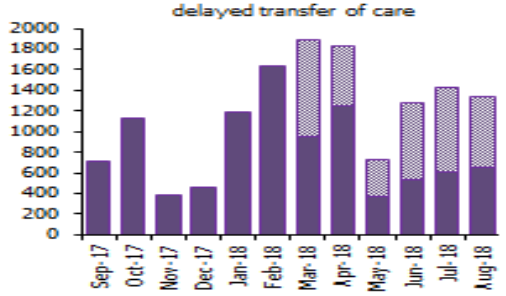
| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 9 | N/A | N/A |

Number of health board non-mental health delayed transfer of care



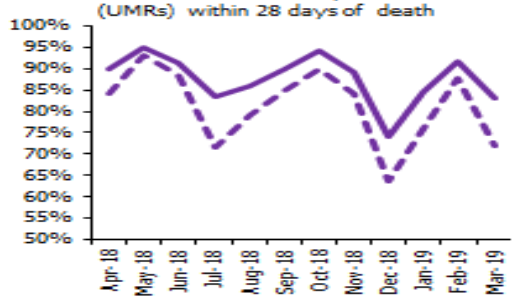
| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 24 | N/A | N/A |

Number of hours lost to critical care delayed transfer of care



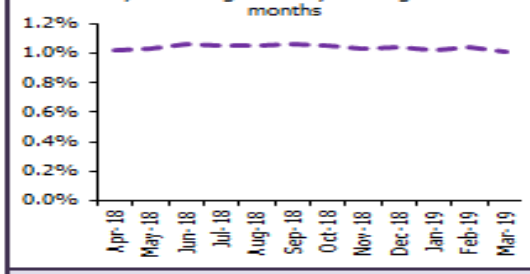
| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 660.1 | 686 | 1346.1 |

% of universal mortality reviews (UMRs) within 28 days of death



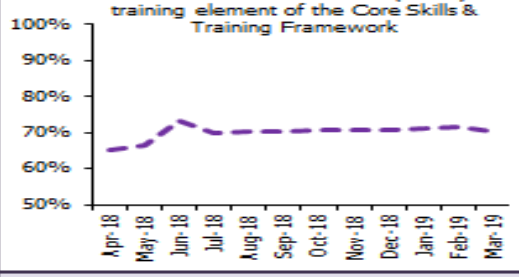
| Current Position | | |
|---|---|---|
| CT | POW | CTM |
| 71.8% | 98.8% | 83.2% |

Crude hospital mortality rate (74 years of age or less) - rolling 12 months



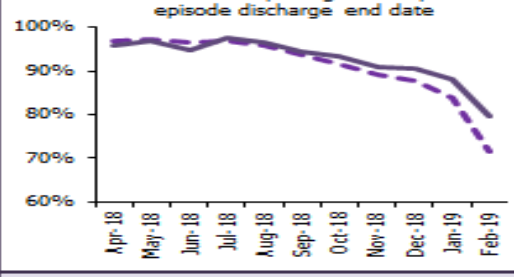
| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 1.04% | N/A | N/A |

% compliance of the completed level 1 Information Governance (Wales) training element of the Core Skills & Training Framework



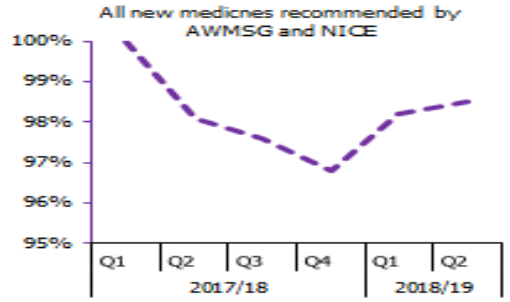
| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 70.50% | N/A | N/A |

% of episodes clinically coded within one month reporting month post episode discharge end date



| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 73.4% | N/A | N/A |

All new medicnes recommended by AWMSG and NICE



| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 98.5% | N/A | N/A |

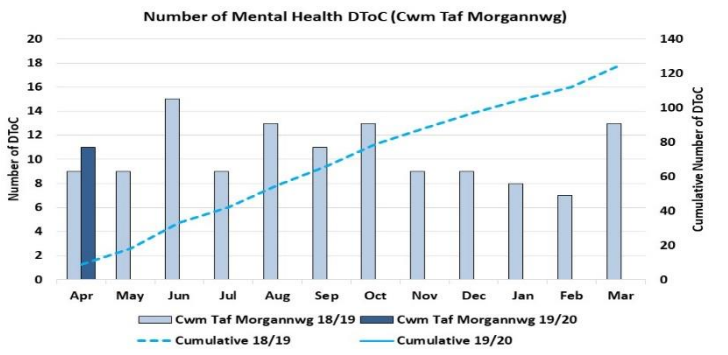
| Health & Care Research Wales | | |
|---|---|---|
| CT | M | CTM |
| 2018/19 (Q1 to Q2) | 2018/19 (Q1 to Q2) | 2018/19 (Q1 to Q2) |
| **No. of CRP Studies** | | |
| 44 | N/A | N/A |
| **No. of CS Studies** | | |
| 3 | N/A | N/A |
| **No. of patients recruited CRP Studies** | | |
| 2156 | N/A | N/A |
| **No. of patients recruited CS Studies** | | |
| 7 | N/A | N/A |

## Indicator 30: Number of health board mental health delayed transfer of care (rolling 12 months)

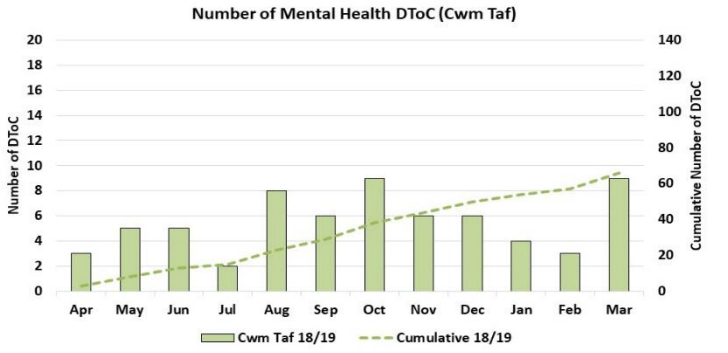
| | |
|---|---|
| Outcome: Health care and support are delivered at or as close to my home as possible | Executive Lead: Director of Primary, Community and Mental Health |
| Period: Apr 2018 to Apr 2019 | Target: 12 month reduction trend |

### Current Performance:

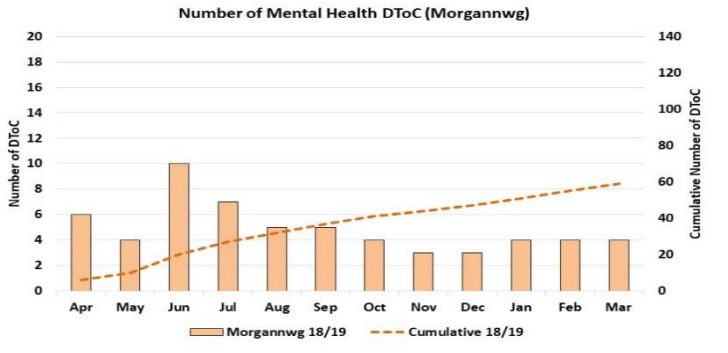
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

The 2019/20 target is a 12 month reduction trend.

This month's position (April) shows 11 delays to transfers of care.

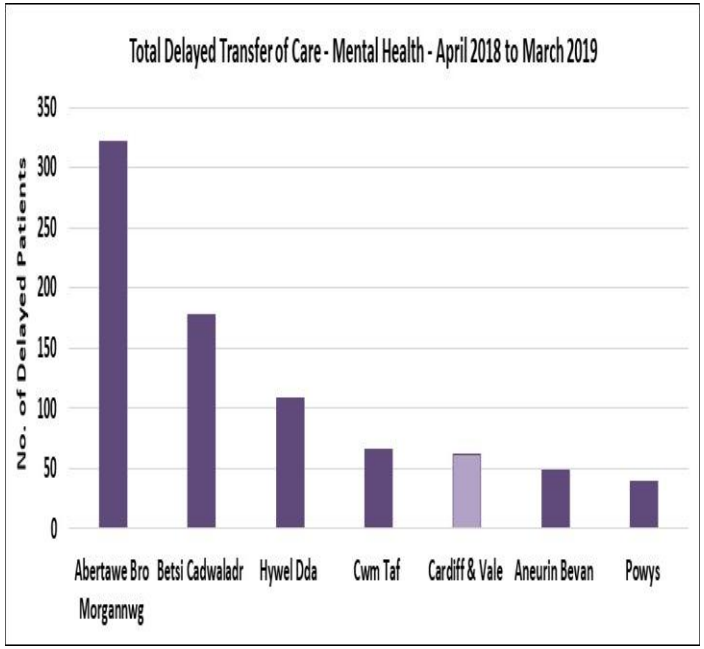
There are 6 delays in adult / rehabilitation services, 4 people are awaiting housing and 2 specialist placement availability. There are 5 delays in older peoples services, 2 people have delays due to mental capacity processes, 2 are waiting for EMI residential place availability in care home of choice and relates to engagement in a financial assessment.

All patients with a status of having a delayed transfer of care has progress towards discharge reviewed weekly by Senior Nurses and progress or issues are reported through to the Directorate team. Where necessary lack of progress is escalated to Local Authority Service Managers by ADO when required. A newly developed decision making Matrix for S117 placements in place with RCT is having a positive impact on reducing funding related delays.

Choice related issues continue to cause delays but not for a significant number of people, delays related to capacity assessment processes are starting to emerge more frequently and are being monitored to understand any themes. It is unusual to have so many people awaiting mainstream or adapted housing and this is anticipated to resolve quickly.

### Benchmarking: how do we compare?

| Number of health board mental health delayed transfer of care | | | | | | | |
|---|---|---|---|---|---|---|---|
| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
| Mar-18 | 6 | 25 | 3 | 15 | 12 | 7 | 3 |
| Apr-18 | 3 | 28 | 4 | 19 | 9 | 18 | 3 |
| May-18 | 5 | 22 | 2 | 19 | 8 | 14 | 2 |
| Jun-18 | 5 | 30 | 2 | 17 | 4 | 13 | 2 |
| Jul-18 | 2 | 27 | 5 | 17 | 4 | 8 | 3 |
| Aug-18 | 8 | 30 | 3 | 15 | 4 | 4 | 2 |
| Sep-18 | 6 | 29 | 3 | 14 | 3 | 4 | 2 |
| Oct-18 | 9 | 28 | 7 | 15 | 3 | 12 | 3 |
| Nov-18 | 6 | 26 | 3 | 15 | 3 | 4 | 1 |
| Dec-18 | 6 | 25 | 3 | 13 | 8 | 8 | 4 |
| Jan-19 | 4 | 29 | 3 | 13 | 6 | 5 | 4 |
| Feb-19 | 3 | 26 | 6 | 11 | 5 | 10 | 6 |
| Mar-19 | 9 | 21 | 7 | 10 | 5 | 8 | 7 |
| Rolling 12 mths | 66 | 321 | 48 | 178 | 62 | 108 | 39 |



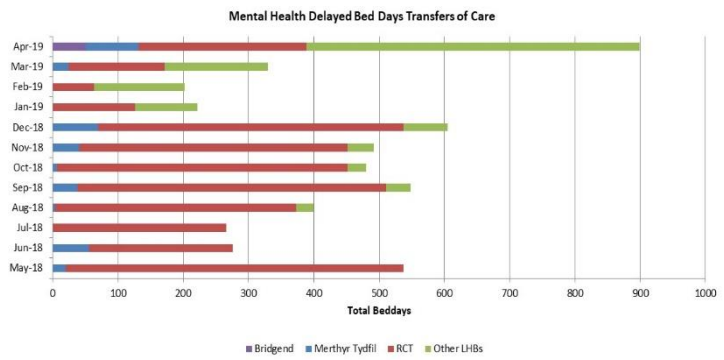

Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Indicator 30 continued: Number of health board mental health delayed transfer of care

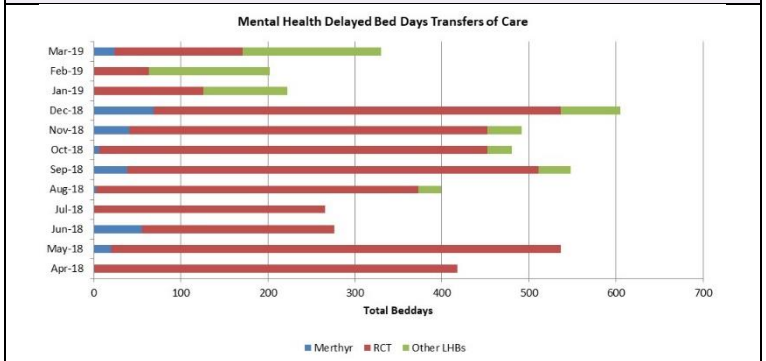
| Outcome: Health care and support are delivered at or as close to my home as possible | Executive Lead: Director of Primary, Community and Mental Health |
|---|---|
| Period: May 2018 to Apr 2019 | Target: 12 month reduction trend |

### Current Performance:

Cwm Taf Morgannwg




Cwm Taf (not updated from 1st April 2019)




Morgannwg

Data not available

### How are we doing, what actions are we taking?

Total delayed bed days in April was 899. One patient, a Swansea resident has had a lengthy delay waiting for specialist housing which has contributed to a significant rise in total bed day delays.

All DToC patients' status is reviewed weekly by Senior Nurses and progress or issues report through to the Directorate team as above.

Where necessary lack of progress is escalated to LA service managers by ADO when required.

A newly developed decision making Matrix for S117 placements in place with RCT is having a positive impact on reducing funding related delays and no delays related to funding of care packages was seen this month.

### Benchmarking: how do we compare?

**Benchmark not available**

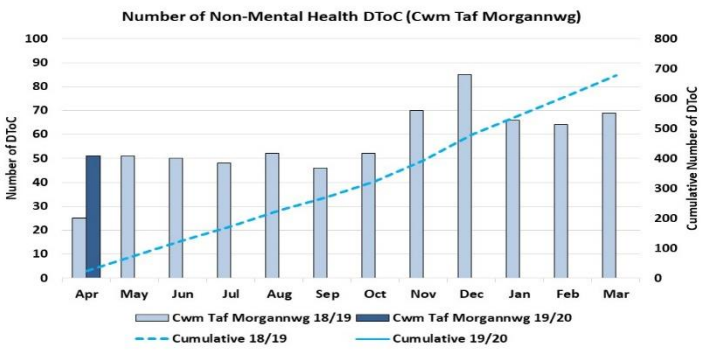
Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Indicator 31: Number of health board non-mental health delayed transfer of care (rolling 12 months)

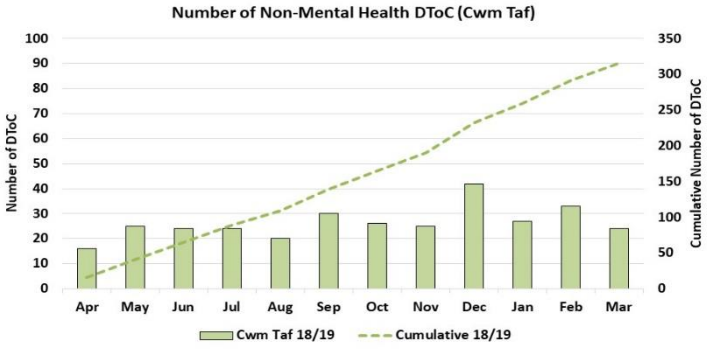
| Outcome: Health care and support are delivered at or as close to my home as possible | Executive Lead: Chief Operating Officer |
|---|---|
| Period: Apr 2018 to Apr 2019 | Target: 12 month reduction trend |

### Current Performance:

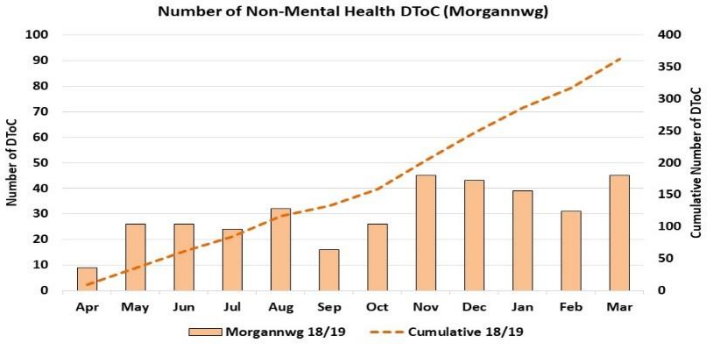
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

Cumulatively Cwm Taf are just outside the 5% target this month and this is attributed to the hike in the December figures. The Health Board continues to work with both Local authorities to address and reduce the DToC, with an overall decrease this month.

Robust monitoring processes are in place.

Continued joint working between health and local authority colleagues.

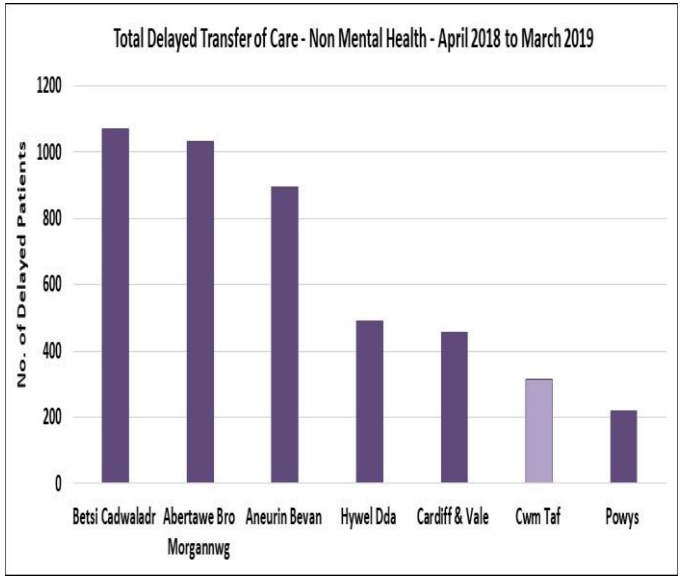
Capacity within the domiciliary care sector, had improved following the Christmas period and our delays in this area have fluctuated over recent months with an increase again this month and this seem to be in specific geographical areas. Both local authorities are working with the providers to improve the market and are using alternative options.

Awaiting homes of choice continue to be recorded despite vacancies in the area. There is a joint pilot scheme looking to address this in one of our community hospitals but this is in its infancy.

Legal issues for those without capacity remains a challenge as does Choice issues and engagement of patients, families and carers.

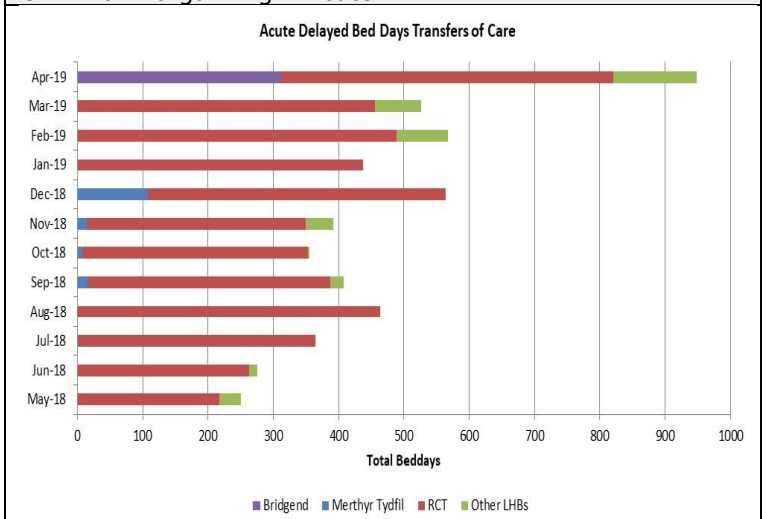
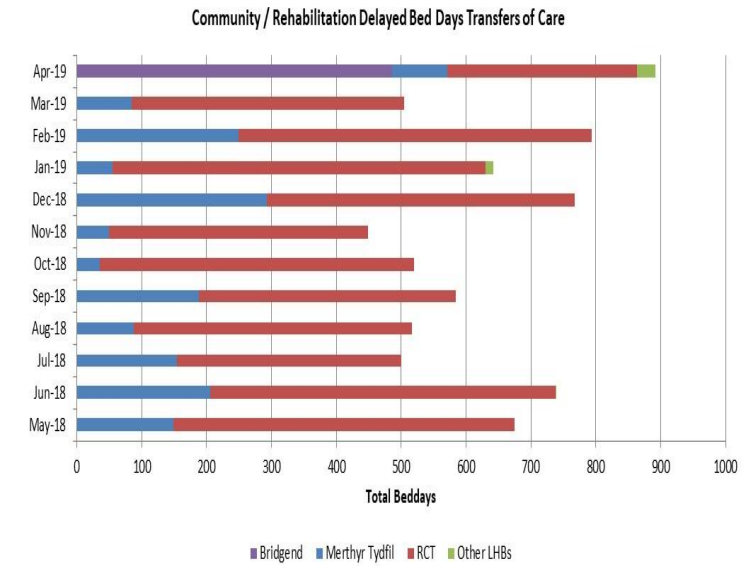
### Benchmarking: how do we compare?

| Number of health board non-mental health delayed transfer of care | | | | | | | |
|---|---|---|---|---|---|---|---|
| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
| Mar-18 | 10 | 44 | 87 | 98 | 35 | 37 | 15 |
| Apr-18 | 16 | 34 | 89 | 114 | 39 | 54 | 17 |
| May-18 | 25 | 64 | 73 | 104 | 37 | 49 | 15 |
| Jun-18 | 24 | 75 | 60 | 103 | 47 | 43 | 22 |
| Jul-18 | 24 | 74 | 53 | 111 | 43 | 32 | 17 |
| Aug-18 | 20 | 85 | 61 | 95 | 37 | 29 | 6 |
| Sep-18 | 30 | 69 | 73 | 111 | 26 | 53 | 12 |
| Oct-18 | 26 | 84 | 86 | 105 | 37 | 36 | 20 |
| Nov-18 | 25 | 125 | 97 | 79 | 35 | 44 | 14 |
| Dec-18 | 42 | 117 | 65 | 58 | 43 | 40 | 18 |
| Jan-19 | 27 | 104 | 74 | 52 | 39 | 34 | 18 |
| Feb-19 | 31 | 87 | 69 | 76 | 44 | 44 | 29 |
| Mar-19 | 24 | 112 | 95 | 60 | 32 | 31 | 32 |
| Rolling 12 mths | 314 | 1030 | 895 | 1068 | 459 | 489 | 220 |




Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

| Indicator 31 continued: Number of health board non-mental health delayed transfer of care (rolling 12 months) | |
|---|---|
| Outcome: Health care and support are delivered at or as close to my home as possible | Executive Lead: Chief Operating Officer |
| Period: May 2018 to Apr 2019 | Target: 12 month reduction trend |

| Current Performance: | How are we doing, what actions are we taking? | Benchmarking: how do we compare? |
|---|---|---|
| Cwm Taf Morgannwg – Acute<br>  <br><br>Cwm Taf Morgannwg – Community / Rehabilitation<br>  <br> | The number of delayed bed days remains high and equates to a small number of complex patients and legal challenges.<br><br>The Health Board continues to work closely with each of the local authorities to ensure any delays are kept to a minimum.<br><br>Availability of community placements remains a challenge for those with complex and specialist needs.<br><br>Stimulating and developing the domiciliary care market to reduce delays for vulnerable patients to be discharged with an adequate and sustainable package of care. | **Benchmark not available** |

Source: Local/Information Team/http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Local Measure: Critical Care – Delayed transfer of care

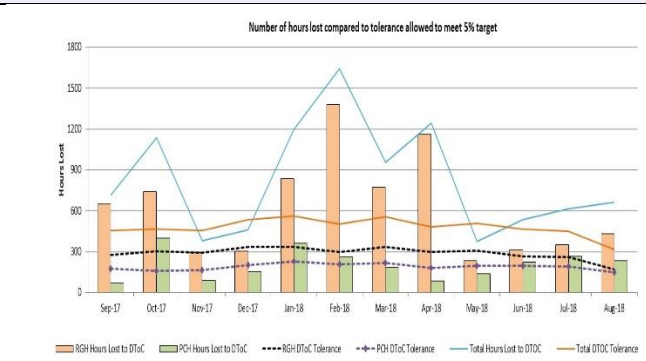
| Outcome: Health care and support are delivered at or as close to my home as possible | Executive Lead: Chief Operating Officer |
|---|---|
| Period: Sep 2017 to Aug 2018 | Target: 5% |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

From a critical care perspective the delays are calculated on a basis of total number of delayed hours as a percentage of the total number of hours used. The expected level of DToC by the National Critical Care Network is no more than 5%.

The main actions to be taken to keep DToC's 5% target is to ensure patient flow is working well. It is proven that when beds are available on the wards to discharge patients DToC reduces. We have now put Critical Care on the Emergency Pressures Escalation Chart so it highlights the visibility of critical care capacity.

Ensuring that patient flow is maintained so that we do not have any DToC's in the units.

### Benchmarking: how do we compare?

**Benchmark not available**

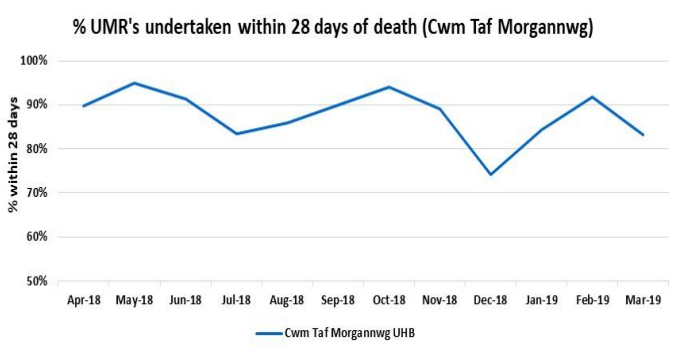
Source: Welsh Government

## Indicator 32: Percentage of universal mortality reviews (UMRs) undertaken within 28 days of a death

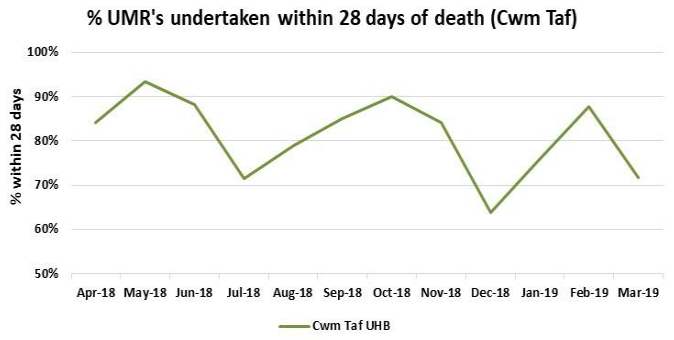
| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Medical Director |
|---|---|
| Period: Apr 2018 to Mar 2019 | Target: 95% |

### Current Performance:

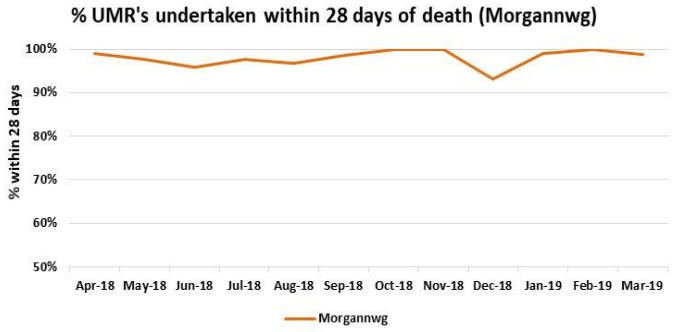
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

Performance dipped during March but overall has improved since December 2018 after the expected drop in performance in which was as a result of the increased number of in-hospital deaths during the winter and the unavailability of reviewers over the holiday period as a result of both bank holiday, annual leave and clinical cover for colleagues.

The implementation of the Mortality Module on Datix is progressing as planned, which will link with the Qlik Sense business intelligence tool to add value to our reporting mechanisms to Directorates and other clinical areas.

It is anticipated that at some point in the future, Stage 1 Mortality Review will become a function of the Medical Examiners Department.

### Benchmarking: how do we compare?

| % Universal Mortality Reviews undertaken within 28 days of death - 95% target | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Velindre |
| Feb-18 | 94.5% | 84.9% | 11.3% | 87.2% | 80.5% | 32.7% | 100.0% |
| Mar-18 | 75.9% | 85.7% | 0.5% | 91.1% | 80.4% | 25.6% | 100.0% |
| Apr-18 | 84.7% | 92.5% | 16.2% | 88.3% | 74.4% | 33.5% | 100.0% |
| May-18 | 93.3% | 94.4% | 17.8% | 88.1% | 72.9% | 34.0% | 100.0% |
| Jun-18 | 88.3% | 90.3% | 31.6% | 90.4% | 69.7% | 34.4% | 100.0% |
| Jul-18 | 72.2% | 94.6% | 7.0% | 96.2% | 65.2% | 47.4% | 100.0% |
| Aug-18 | 79.8% | 91.7% | 16.7% | 86.9% | 70.7% | 39.5% | 100.0% |
| Sep-18 | 85.0% | 94.6% | 43.2% | 87.7% | 66.2% | 81.7% | 100.0% |
| Oct-18 | 86.3% | 98.8% | 39.8% | 85.8% | 71.1% | 84.0% | 100.0% |
| Nov-18 | 84.2% | 99.1% | 24.9% | 90.7% | 72.7% | 88.0% | 100.0% |
| Dec-18 | 63.8% | 93.5% | 16.6% | 87.8% | 71.3% | 78.7% | 100.0% |
| Jan-19 | 75.7% | 97.3% | 18.0% | 82.7% | 82.0% | 87.6% | 100.0% |
| *Powys has been excluded due to HB not having any DGH's* | | | | | | | |

**As expected performance dipped compared to it's Welsh Peers during December and January, but is expected to compare favourably from February onwards**

Source: Local Data Mortality Team

## Indicator 33: Crude hospital mortality rate (74 years of age or less)

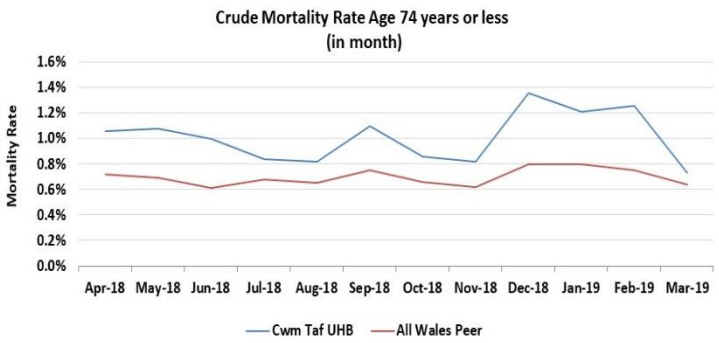
| | |
|---|---|
| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Medical Director |
| Period: Mar 2018 to Feb 2019 | Target: 12 Month Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

In order to provide a more up to date position for mortality index, the graphs represent the position from an extrapolation of local data from CHKS. Crude mortality is now the only measure of in-hospital death rates as RAMI has been removed from the Outcomes Framework with effect from April for 2016.

The metric had changed from total crude mortality to crude mortality age 75 years and less 2016/17 and from the 2017/18 Outcomes Framework measures age 74 or less.

There are currently a number of specific quality improvement projects being undertaken:

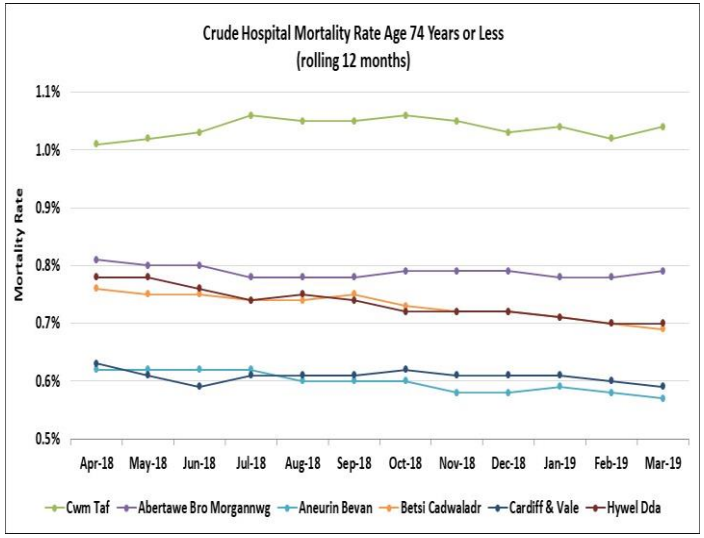
The systematic medical record reviews on the acute sites are continuing on a weekly basis. The process is evolving in readiness for the medical examiner system when introduced.

The systematic reviews of deaths in community hospitals commenced on a fortnightly basis (currently a monthly basis due to small numbers).
Mortality reviews are regularly undertaken at both acute A&E depts.

Mortality reviews follow a three stage process whereby Stage 1 is to screen out the expected deaths and Stage 2 is for more detailed review of unexpected deaths which could either prove to be unavoidable or proceed to Stage 3 for potential learning and improvement.

The All Wales Mortality Review Group is producing a new set of mortality indicators in line with the recommendations submitted to the Minister by Professor Stephen Palmer in 2015.

### Benchmarking: how do we compare?




Cwm Taf does have higher crude mortality rates than Welsh Peers.

Source: CHKS

## Indicator 33 continued: Crude hospital mortality rate (74 years of age or less)

| | |
|---|---|
| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Medical Director |
| Period: Mar 2018 to Feb 2019 | Target: 12 Month Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

Cwm Taf Crude Mortality Rates by Age Profile

| Period | 0 to 40 years | | | | 41 to 74 years | | | | 75+ years | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Deaths | Spells | Cwm Taf | All Wales | Deaths | Spells | Cwm Taf | All Wales | Deaths | Spells | Cwm Taf | All Wales |
| Apr-18 | 0 | 2363 | 0.00% | 0.08% | 53 | 2618 | 2.02% | 1.22% | 120 | 1427 | 8.41% | 5.79% |
| May-18 | 2 | 2498 | 0.08% | 0.08% | 57 | 2979 | 1.91% | 1.16% | 92 | 1460 | 6.30% | 4.44% |
| Jun-18 | 3 | 2574 | 0.12% | 0.07% | 52 | 2945 | 1.77% | 1.03% | 87 | 1317 | 6.61% | 4.70% |
| Jul-18 | 2 | 2682 | 0.07% | 0.08% | 45 | 2933 | 1.53% | 1.16% | 81 | 1425 | 5.68% | 4.52% |
| Aug-18 | 1 | 2375 | 0.04% | 0.08% | 42 | 2856 | 1.47% | 1.10% | 85 | 1473 | 5.77% | 4.47% |
| Sep-18 | 2 | 2429 | 0.08% | 0.09% | 54 | 2659 | 2.03% | 1.28% | 95 | 1316 | 7.22% | 4.80% |
| Oct-18 | 4 | 2899 | 0.14% | 0.10% | 47 | 3009 | 1.56% | 1.11% | 99 | 1433 | 6.91% | 4.72% |
| Nov-18 | 0 | 3019 | 0.00% | 0.04% | 48 | 2772 | 1.73% | 1.12% | 124 | 1427 | 8.69% | 5.04% |
| Dec-18 | 3 | 2425 | 0.12% | 0.08% | 65 | 2580 | 2.52% | 1.41% | 122 | 1356 | 9.00% | 6.05% |
| Jan-19 | 5 | 2674 | 0.19% | 0.10% | 62 | 2851 | 2.17% | 1.35% | 140 | 1478 | 9.47% | 5.83% |
| Feb-19 | 2 | 2469 | 0.08% | 0.09% | 64 | 2760 | 2.32% | 1.26% | 122 | 1348 | 9.05% | 5.27% |
| Mar-19 | 2 | 2744 | 0.07% | 0.10% | 40 | 2998 | 1.33% | 1.17% | 105 | 1380 | 7.61% | 5.15% |

Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

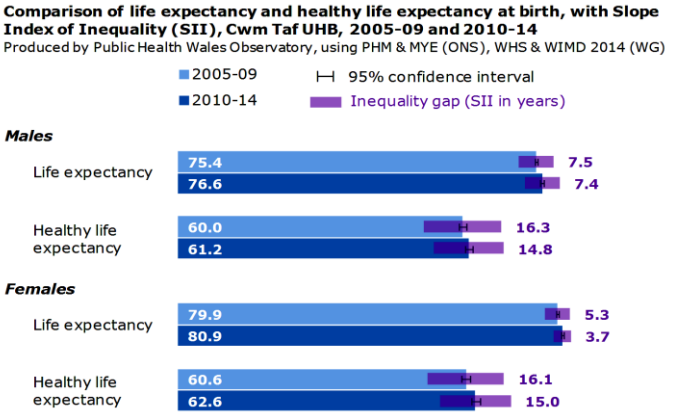
0-40 years: the Health Board is on par with the All Wales mortality with very few deaths.

41-74 years: the Health Board reports higher % mortality than All Wales. Investigation of individual patients indicates this relates to those with a diagnosis of cancer, drug & alcohol related deaths. A high proportion of patients are coded with pneumonia (lung diseases), stroke & palliative care.

75 years and over: Deaths include pneumonias (lung diseases), stroke, heart failure, palliative care, sepsis and other age related diseases are observed. Cwm Taf's population has higher rates of deprivation associated with higher rates of crude mortality as well as having greater rates of co-morbidities.

Contributory factors are lifestyle issues like obesity, smoking, alcohol and drug use which are more prevalent in the Cwm Taf population. The ratio of emergency care to elective care is higher in Cwm Taf and it is known that emergency care has higher risks and mortality. There are also a higher proportion of patients presenting with later stage cancer. 65% of deaths in Cwm Taf take place in hospital compared to an All Wales average of 55.9% therefore further improvement is still required to support patients who wish to die outside of hospital. To address the contributory factors all Cwm Taf UHB local delivery plans have specific areas to address lifestyle issues and support early recognition and speedier management of illness, particularly in cancer.

### Benchmarking: how do we compare?

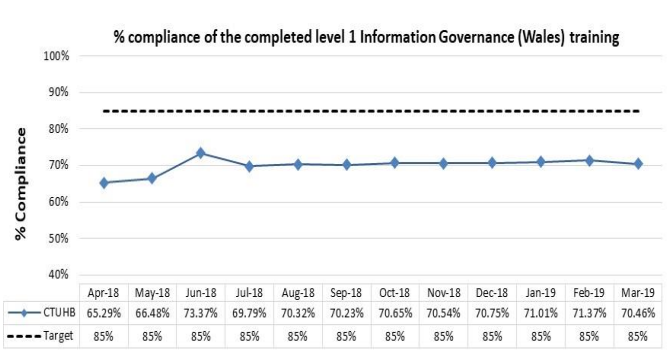



The Measuring Inequalities (2016) report shows that at a population level people are living longer and longer in good health in Wales as a whole. However, the report also indicates at a national level that the difference between life expectancy between the most and least deprived areas of Wales shows no sign of reducing. This is called the Slope Index of Inequalities (SII).

The graph above compares life expectancy and healthy life expectancy for Cwm Taf. It provides a comparison between the time periods 2005/09 and 2010/14 and the variation in the Slope Index of Inequalities (SII). In Cwm Taf, it is a very positive sign that life expectancy and healthy life expectancy (2010-2014) have improved since the previous report (2005-2009). The inequality gap between the most and least deprived has narrowed across all of the parameters and this has not been seen in other parts of Wales. However, we still remain below the Wales averages and for male life expectancy in Rhondda Cynon Taf, the inequality gap has increased since the previous report from 7.4 years to 7.8 years demonstrating the variations within Cwm Taf.

Source: CHKS

| Indicator 34: Percentage compliance of the completed Level 1 Information Governance (Wales) training element of the Core Skills and Training Framework | |
|---|---|
| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Director of Workforce and Organisational Development |
| Period: Apr 2018 to Mar 2019 | Target: 85% |

| Current Performance: | How are we doing, what actions are we taking? | Benchmarking: how do we compare? |
|---|---|---|
| Cwm Taf Morgannwg<br><br>Data not currently available<br><br>Cwm Taf<br><br>  <br><br>Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19<br>CTUHB 65.29% 66.48% 73.37% 69.79% 70.32% 70.23% 70.65% 70.54% 70.75% 71.01% 71.37% 70.46%<br>Target 85% 85% 85% 85% 85% 85% 85% 85% 85% 85% 85% 85%<br><br>Morgannwg<br><br>Data not currently available | Overall the compliance with the IG training continues to improve. Figures are monitored at the Information Governance Group via the standard key performance indicators report. These figures are also submitted to the Quality, Safety & Risk Committee. In addition to this, training compliance is presented at the directorates Clinical Business Meetings to try and increase the uptake of this mandatory training.<br><br>We continue to hold monthly classroom sessions, promote the E-learning package and the requirement for training is also highlighted at the Corporate Induction session for new starters.<br><br>Areas of high risk are directorates that have high involvement with medical records, sensitive information and access to clinical systems. We monitor the trends where incidents occur – targeted areas of risk include, CAMHS and Mental Health.<br><br>Where incidents occur, enforcement action can be considered by the regulatory bodies (which can include a monetary penalty) where these have an effect on an individual. We continue to work towards the 85% target and will routinely monitor progress as set out above. | **Benchmark not available** |

Source: Local/ESR

## Indicator 35: Percentage of episodes clinically coded within one reporting month post episode discharge end date

| | |
|---|---|
| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Director of Planning and Performance |
| Period: Apr 2017 to Feb 2019 | Target: 95% in month (98% at Year End-Final Submission) |

### Current Performance:

Cwm Taf Morgannwg

| 2018/19 Clinical Coding Completeness | | | |
|---|---|---|---|
| **Period** | **FCE's** | **% coded** | **% uncoded** |
| April | 12721 | 95.9% | 4.1% |
| May | 13380 | 96.9% | 3.1% |
| June | 13467 | 94.9% | 5.1% |
| July | 13337 | 97.4% | 2.6% |
| August | 12436 | 96.5% | 3.5% |
| September | 12126 | 94.5% | 5.5% |
| October | 14386 | 93.2% | 6.8% |
| November | 13614 | 90.9% | 9.1% |
| December | 12002 | 90.6% | 9.4% |
| January | 13781 | 88.2% | 11.8% |
| February | 12494 | 79.5% | 20.5% |
| March | | | |
| **Total** | **143744** | **92.6%** | **7.4%** |

Cwm Taf

| 2018/19 Clinical Coding Completeness report run WPAS 26/03/2019 | | | | |
|---|---|---|---|---|
| **Period** | **FCE's** | **% coded** | **% uncoded** | **Reported (frozen)** |
| April | 8513 | 96.7% | 3.3% | 71.9% |
| May | 9033 | 97.2% | 2.8% | 70.7% |
| June | 9000 | 96.5% | 3.5% | 62.4% |
| July | 9335 | 96.8% | 3.2% | 64.5% |
| August | 8637 | 95.7% | 4.3% | 63.0% |
| September | 8297 | 93.7% | 6.3% | 61.9% |
| October | 9527 | 91.7% | 8.3% | 63.3% |
| November | 9194 | 89.0% | 11.0% | 65.2% |
| December | 8207 | 87.7% | 12.3% | 72.5% |
| January | 9076 | 83.8% | 16.2% | 70.8% |
| February | 8464 | 71.4% | 28.6% | 65.9% |
| March | | | | |
| **Total** | **97283** | **91.0%** | **9.0%** | **66.5%** |

Morgannwg

| 2018/19 Clinical Coding Completeness | | | |
|---|---|---|---|
| **Period** | **FCE's** | **% coded** | **% uncoded** |
| April | 4208 | 94.3% | 5.7% |
| May | 4347 | 96.3% | 3.7% |
| June | 4467 | 91.7% | 8.3% |
| July | 4002 | 98.9% | 1.1% |
| August | 3799 | 98.4% | 1.6% |
| September | 3829 | 96.0% | 4.0% |
| October | 4859 | 96.2% | 3.8% |
| November | 4420 | 95.0% | 5.0% |
| December | 3795 | 96.8% | 3.2% |
| January | 4705 | 96.7% | 3.3% |
| February | 4030 | 96.5% | 3.5% |
| March | | | |
| **Total** | **46461** | **96.0%** | **4.0%** |

### How are we doing, what actions are we taking?

Coding completeness figures this month are presented in three separate ways due to the boundary change, Cwm Taf Morgannwg, Cwm Taf, and Morgannwg.

Cwm Taf Coding department has given a warm welcome to the staff from the Princess of Wales, and we are all looking forward to working as one big team. The coders at the Princess of Wales Hospital bring experience and knwoledge which will be of benefit to our trainee members at Cwm Taf. The Coding Manager and the Coding Supervisor has visited all three coding offices to meet with staff, and promote good working relations.

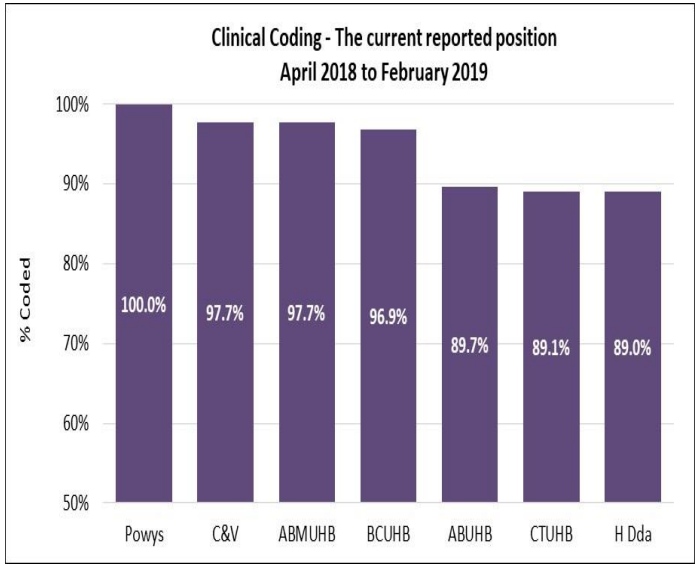
Over the next eight weeks we will focus our attention on reaching the National Coding Target of 95% within 1 month of discharge, an the yearly improvement in accuracy measuers. It was agreed that Princess of Wales will contine to give supoort to Swanse Bay (ABMU) in reaching their 95% coding target, untill the end of the 2018/2019 financial year.

NWIS have set up a small group of codign managers to assist with the testing of Data aquality indicators that will will be reported on a Dashboard on a monthly basis. The indicators with be derived form the Clinical Coding National Standards. It was felt that highlighting potential errors through a Dashboard whould have a much bigger effect on improving Organisations Coded Data, along side the annual audits undertaken by the classifications team at NWIS, we are hoping that Welsh Data will be the most robust in Britain.

Overtime and contract clinical coding will continue through to 30th June 2019 or untill we have exhausted all of the extra funding provided to clear the uncoded backlog for 2018/19.

We are currently waiting for a start date for the newly appointed Band 4 Annex U trainee Clinical Coder to be based at the Royal Glamorgan Hospital. The appointed Administration Assistant for Prince Charles hospital will be joining us in May. We will also be shortlisting for a coding Supervisor this week to be based at Prince Charles Hospital.

### Benchmarking: how do we compare?




Cwm Taf strives to improve their coding position with the contract coders and a small amount of overtime albeit with a large proportion of trainee coders insitu and the possibility of 1 extra trainee we will endevevour to improve our position.

Source: Local WPAS / NWIS

## Local Measure: Clinical Coding Quality

| | |
|---|---|
| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Director of Planning and Performance |
| Period: Apr 2017 to Feb 2019 | Target: Annual Improvement |

### Current Performance:

Cwm Taf Morgannwg

Not currently available

Cwm Taf

| Data Quality Indicator | 2017/18 | | 2018/19 *(Apr 18 - Feb 19)* | |
|---|---|---|---|---|
| Source CHKS (report run 28/09/2018) | CTUHB | All Wales | CTUHB | All Wales |
| Data Quality & Completeness Indicator | 95.17% | 91.41% | 86.05% | 90.59% |
| Blank Primary Diagnosis | 1.33% | 5.36% | 10.96% | 6.06% |
| Unacceptable Primary Diagnosis | 0.00% | 0.01% | 0.00% | 0.01% |
| Diagnosis Non-Specific | 14.54% | 15.27% | 14.63% | 15.34% |
| Sign or Symptom as a Primary Diagnosis | 13.89% | 10.99% | 13.73% | 11.18% |

Morgannwg

Not currently available

### How are we doing, what actions are we taking?

The table outlines Cwm Taf's position in comparison with rest of Wales in relation to some key data quality indicators. Coding completeness is the main contributor to the quality index however the quality index is based on three elements :

**Data Quality** – The data quality for the coded episodes for Cwm Taf is currently at 86.5% compared to the Welsh peers at 90.59%, we are continuing to improve Data Quality, and coding completeness internally with the help form Overtime and Contracting, also with the help from the data quality report produced by NWIS.

**Corrective** – The reporting of Diagnosis Non–specific performance indicator for Cwm Taf has improved again this from 14.46% now at 14.63%, which is lower than the all Wales at 15.34%

**Coding Richness** – accuracy of Primary Diagnosis, Cwm Taf is still looking to improve the amount of Signs and Symptoms being coded in a primary position; Cwm Taf are still recording higher levels of Signs and Symptoms at 13.73% in comparison to our peers at 11.18%,
We are continuing to monitor utilising the increased functionality in CHKS iCompare and in addition the development of a new Qlik app.

**Unacceptable Diagnosis-** Cwm Taf currently has not recorded any diagnosis that contravine Gender/Age/Standard.

### Benchmarking: how do we compare?

Utilising CHKS reports, Cwm Taf's position is compared to All Wales peer group. There is the ability within the reports to compare to wider peer groups e.g. the forty top performing organisations who submit data to CHKS.

**Unfortunately Cwm Taf is struggling with a high percentage of backlog of coding compared to all of our peers. We are optormistic this will improve as our trainees become more compitent, and with the additional staff from Princess of Wales Hospital.**

Source: CHKS

**Indicator 37: All new medicines recommended by AWMSG and NICE, including interim recommendations for cancer medicines, must be made available where clinically appropriate, no later than two months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation**

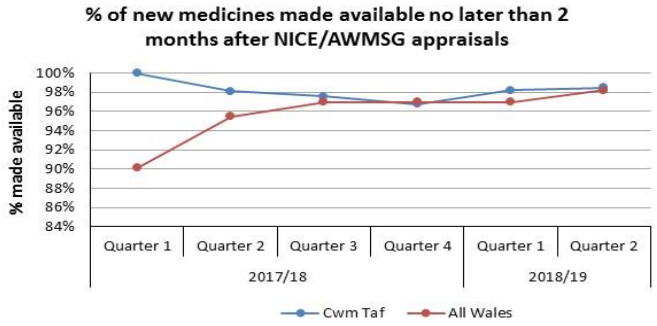
| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Director of Primary, Community and Mental Health |
|---|---|
| Period: 2017/18 & 2018/19 | Target: 100% |

## Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

## How are we doing, what actions are we taking?

CTUHB have implemented the vast majority of new medicines within the 60 day target set by WG.

Exceptions to this target have been where there is no clear commissioning pathway, as use within CTUHB is not appropriate.

CTUHB have implemented the vast majority of new medicines within the 60 day target set by WG.

Exceptions to this target have been where there is no clear commissioning pathway, as use within CTUHB is not appropriate.

New technologies or medicines which require wider resources to implement their use can take longer to process.

## Benchmarking: how do we compare?

% of new medicines recommended by NICE/AWMSG made available, where clinically appropriate, no later than 2 months from the publication of the appraisal

| Target is 100% | | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
|---|---|---|---|---|---|---|---|---|
| 2018/19 | Quarter 1 | 98.2% | 100.0% | 99.1% | 99.1% | 95.5% | 99.1% | 93.6% |
| | Quarter 2 | 98.5% | 100.0% | 99.3% | 99.3% | 96.3% | 99.3% | 94.8% |
| 2017/18 | Quarter 1 | 100.0% | 97.6% | 82.9% | 95.1% | 90.2% | 97.6% | 100.0% |
| | Quarter 2 | 98.1% | 98.1% | 98.1% | 98.1% | 90.7% | 98.1% | 87.0% |
| | Quarter 3 | 97.6% | 100.0% | 98.8% | 98.8% | 93.9% | 98.8% | 91.5% |
| | Quarter 4 | 96.8% | 100.0% | 98.9% | 98.9% | 93.7% | 98.9% | 91.6% |

**We compare favourably with our peers, as not all medicines are appropriate to be prescribed or used within CTUHB i.e require commissioning from specialist centres.**

Source: Welsh Government Delivery and Performance Website

**Indicator 38: Number of Health and Care Research Wales clinical research portfolio studies**
**Indicator 39: Number of Health and Care Research Wales commercially sponsored studies**
**Indicator 40: Number of patients recruited in Health and Care Research Wales clinical research portfolio studies**
**Indicator 41: Number of patients recruited in Health and Care Research Wales commercially sponsored studies**

| Outcome: Interventions to improve my health are based on good quality and timely research and best practice | Executive Lead: Medical Director |
|---|---|
| Period: 2018/19 | Target: AS PER TABLE |

## Current Performance:

### Cwm Taf Morgannwg

Data not currently available

### Cwm Taf

| | Health and Care Research Wales Indicator | 2017/18 | 2018/19 (Cumulative) Q1 | Q2 | Q3 | Q4 | % Annual Improvement Target | Annual % Change |
|---|---|---|---|---|---|---|---|---|
| 38 | Number of Clinical Research Portfolio Studies | 64 | 38 | 44 | 55 | | 10% | -14.06% |
| | *2017/18 Data for comparison* | | *22* | *39* | *52* | *64* | | |
| 39 | Number of Commercially Sponsored Studies | 7 | 3 | 3 | 5 | | 5% | -28.57% |
| | *2017/18 Data for comparison* | | *2* | *3* | *5* | *7* | | |
| 40 | Number of patients recruited Clinical Research Portfolio Studies | 2324 | 1269 | 2156 | 2883 | | 10% | 24.05% |
| | *2017/18 Data for comparison* | | *193* | *507* | *1115* | *2324* | | |
| 41 | Number of patients recruited Commercially Sponsored Studies | 36 | 6 | 7 | 13 | | 5% | -63.89% |
| | *2017/18 Data for comparison* | | *9* | *19* | *24* | *36* | | |

### Morgannwg

**Data not currently available**

## How are we doing, what actions are we taking?

Performance indicators for research are set by the Research and Development Department, WG. Organisations are expected to increase the number of studies open and adopted onto the clinical research portfolio (CRP) by 10% per annum and commercial studies by 5% and also the number of participants recruited to CRP and commercial studies by 10% and 5% respectively. Local Support and Delivery funding is provided to organisations to develop their own research infrastructure to support, deliver, promote and encourage high quality research. Funding is based on research activity for the previous three rolling years (activity based funding) i.e. the number of open CRP studies, number of participants recruited to CRP studies, number of Chief Investigators affiliated to the organisation and the number of clinical research fellows within the organisation.

During 2017/18, CTUHB exceeded the KPIs for the number of open CRP and commercial studies and for the number of participants recruited to CRP and commercial studies. The highest level of annual research activity in CTUHB to date.

The R&D team has continued to work to meet the strategic objective to increase the number of Chief Investigators aligned to CTUHB and to increase the number of "in house" Chief Investigators.

The department continues to review research priorities and provide support to researchers, academic and industry partners.

Further investment in the R&D infrastructure has resulted additional posts to set up, support and deliver CRP and commercial studies across Cwm Taf.

The R&D team are processing an increasing number of feasibility requests (expressions of interests, feasibility questionnaires) for both commercial and non-commercial companies.

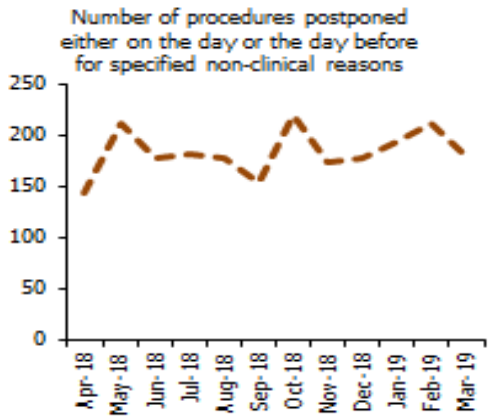
## Benchmarking: how do we compare?

| | Number of Clinical Research Portfolio Studies | Number of Commercially Sponsored Studies | Number of patients recruited Clinical Research Portfolio Studies | Number of patients recruited Commercially Sponsored Studies |
|---|---|---|---|---|
| | Quarter 1 to Quarter 2 2018/19 | | | |
| ABMU | 67 | 22 | 1116 | 59 |
| AB | 57 | 7 | 970 | 60 |
| BCU | 57 | 10 | 736 | 150 |
| C&V | 136 | 38 | 3116 | 167 |
| C Taf | **44** | **3** | **2156** | **7** |
| H Dda | 40 | 3 | 548 | 21 |
| Powys | 4 | 0 | 18 | 0 |
| | 2017/18 | | | |
| ABMU | 96 | 44 | 2207 | 401 |
| AB | 80 | 12 | 1282 | 161 |
| BCU | 81 | 10 | 1834 | 89 |
| C&V | 190 | 47 | 5031 | 305 |
| C Taf | **64** | **7** | **2324** | **36** |
| H Dda | 44 | 6 | 984 | 77 |
| Powys | 7 | 0 | 108 | 0 |

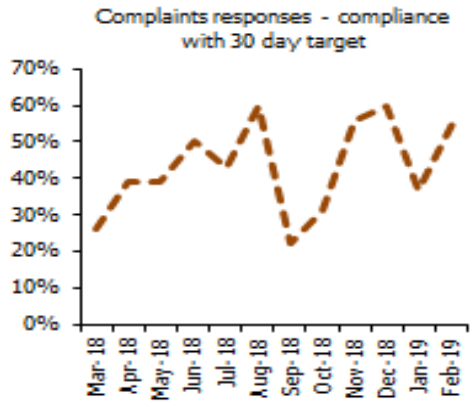
Source: Local / https://www.healthandcareresearch.gov.wales/performance-management/

## DIGNIFIED CARE – People in Wales are treated with dignity and respect and treat others the same

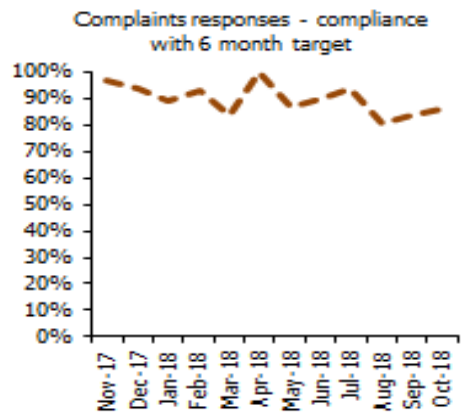
**Key: Cwm Taf Morgannwg** — **Cwm Taf** - - - **or** ■ **Morgannwg**



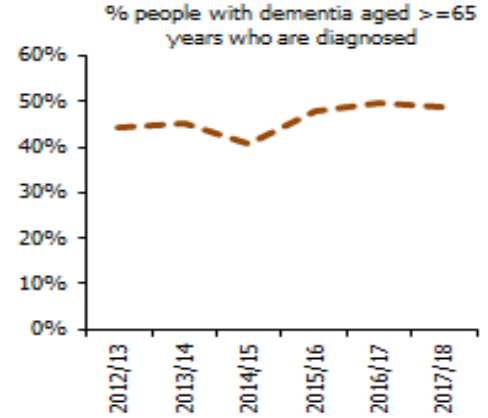

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 173 | N/A | N/A |



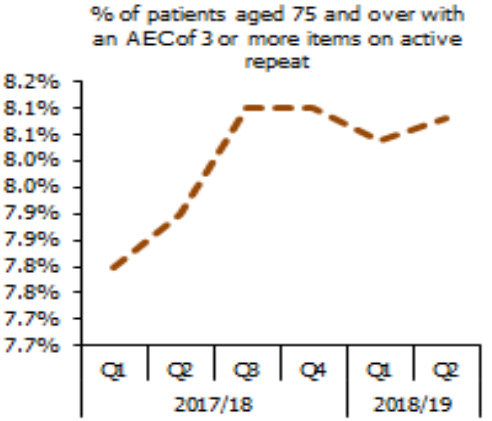

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 55.0% | N/A | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 86.0% | N/A | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 48.7% | N/A | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 8.08% | N/A | N/A |

## Indicator 43: Number of procedures postponed either on the day or the day before for specified non-clinical reasons

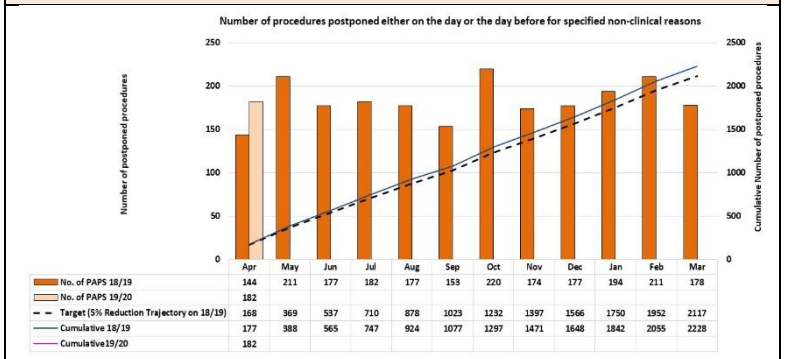
| Outcome: I receive a quality service in all care settings | Executive Lead: Chief Operating Officer |
|---|---|
| Period: Apr 2018 to Apr 2019 | Target: >5% reduction from 17/18 |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. of PAPS 18/19 | 144 | 211 | 177 | 182 | 177 | 153 | 220 | 174 | 177 | 194 | 211 | 178 |
| No. of PAPS 19/20 | 182 | | | | | | | | | | | |
| Target (5% Reduction Trajectory on 18/19) | 168 | 369 | 537 | 710 | 878 | 1023 | 1232 | 1397 | 1566 | 1750 | 1952 | 2117 |
| Cumulative 18/19 | 177 | 388 | 565 | 747 | 924 | 1077 | 1297 | 1471 | 1648 | 1842 | 2055 | 2228 |
| Cumulative19/20 | 182 | | | | | | | | | | | |

Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

The measure for postponed admitted procedures has changed with the 2018/19 Outcomes Framework from "Patients that should their operations be cancelled on more than one occasion, with less than 8 days' notice then they would receive treatment within 14 days of the second cancellation, or at the patient's earliest convenience" to "Number of procedures postponed either on the day or the day before for specified non-clinical reasons".

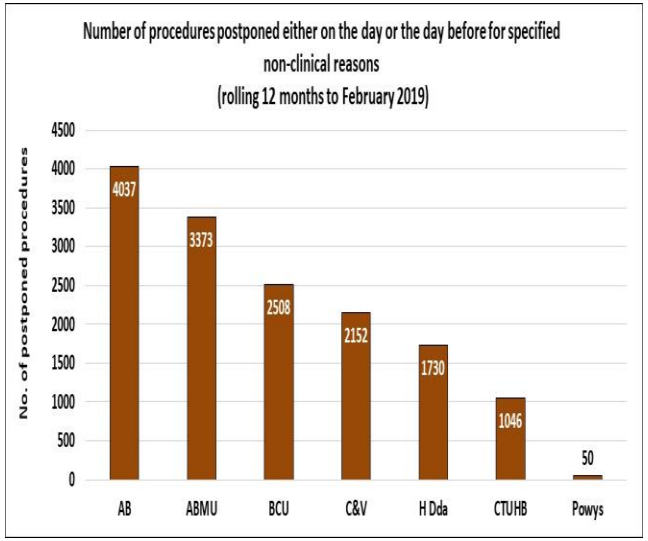
The data for this measure is extrapolated from the Health Board's Welsh PAS application at the end of each month.

The Health Board is raising awareness of this measure amongst patient booking staff and ensuring that data capture accurately reflects the discussions being undertaken with patients. This will ensure increased compliance with this measure.

One of the main issues relates to patients being booked prior to being declared fit by pre-assessment. Booking staff have been instructed to follow Health Board guidance in this area. Pre-assessment delays, which attribute to this issue are being addressed as part of the planned care work-streams.

Periods of patient unavailability need to be accurately recorded for this measure to be calculated precisely. Pre-assessment delays need to be minimised.

### Benchmarking: how do we compare?




**Cwm Taf is performing better than it's peers apart from Powys.**

**Source: Local Information Team**

**Indicator 44: Number of patients aged 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 years and over**

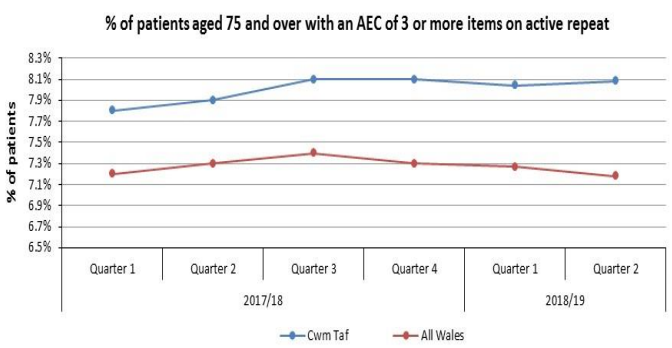
| | |
|---|---|
| Outcome: I receive a quality service in all care settings | Executive Lead: Director of Primary, Community and Mental Health |
| Period: 2017/18 to 2018/19 (Q2) | Target: 4 Quarter Reduction Trend |

## Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

## How are we doing, what actions are we taking?

Cwm Taf have the second highest number of patients aged 75 and over with an AEC of 3 or more. The % has increased slightly over the last few quarters.

The new care home service for community pharmacies in Wales has been designed to identify and review patients who have an ACE burden of 3 or more. This service is being commissioned within the HB from November 2018 onwards.

This work stream is being incorporated into the prescribing team work plan for 2019-20

It is good practice to use medicines with AEC scores of zero and to avoid those scored 1, 2 or 3. The clinician should discuss with the patient and carer the benefits and potential risks of continued use of these medicines with the aim of either stopping them or switching to an alternative drug with a lower AEC score (preferably zero).

There are a large number of medicines that fall into this category and reviewing all patients taking them is a time consuming process. There will be some patients where the risk / benefit ratio may favour the continuation of a higher scoring medicine.

## Benchmarking: how do we compare?

Number of patients aged 75 and over with an AEC (Anticholinergic Effect on Condition) of 3 or more for items on active repeat, as a % of all patients aged 75 years and over

| | | CTUHB | ABMU | AB | BCU | C&V | HDda | Powys |
|---|---|---|---|---|---|---|---|---|
| 2018/19 | Quarter 1 | 8.04% | 8.01% | 8.33% | 7.27% | 6.14% | 5.99% | 6.28% |
| | Quarter 2 | 8.08% | 8.04% | 8.13% | 7.09% | 6.19% | 5.77% | 6.11% |
| 2017/18 | Quarter 1 | 7.80% | 7.90% | 8.00% | 7.30% | 6.50% | 5.90% | 6.10% |
| | Quarter 2 | 7.90% | 7.90% | 8.00% | 7.30% | 6.50% | 5.90% | 6.40% |
| | Quarter 3 | 8.10% | 8.20% | 8.30% | 7.50% | 6.40% | 6.10% | 6.40% |
| | Quarter 4 | 8.10% | 8.00% | 8.30% | 7.40% | 6.20% | 6.00% | 6.40% |

**We are currently the 2nd highest prescriber in Wales, there has been an increase in Cwm Taf alongside six other HB's. Only one HB has demonstrated a decrease.**

Source: Welsh Government Delivery and Performance Website

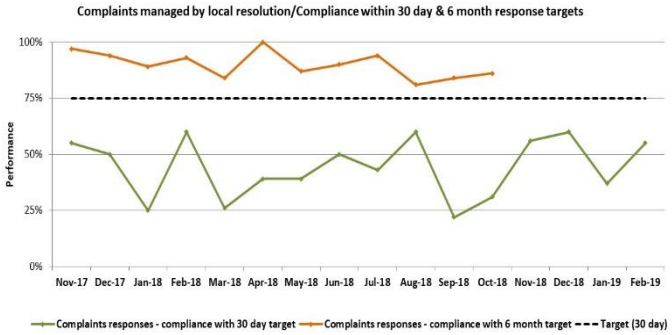
**Indicator 46: The percentage of concerns that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the concern was first received by the organisation**

| Outcome: My voice is heard and listened to | Executive Lead: Director of Nursing |
|---|---|
| Period: Feb 2018 to Jan 2019 | Target: 75% |

## Current Performance:

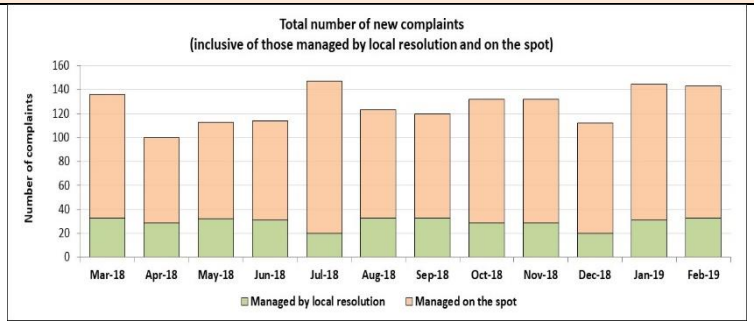
Cwm Taf Morgannwg

Cwm Taf




Morgannwg

## How are we doing, what actions are we taking?




**New complaints:** Many complaints which would have been managed through the more protracted formal process are now being managed 'on-the-spot' or are being prevented in the first place through a more proactive approach by the Directorates. 80% of complaints are now dealt with informally. As at 28 February 2019 the Health Board had open 98 formal complaints.

**Compliance with Timescales:** work continues to be undertaken to embed improvements to processes to ensure compliance with Putting Things Right response targets. This includes a clear process of escalation and monthly deep dives to address any barriers identified. The Clinical pressures being experienced within Directorates impact on the ability to investigate concerns in a timely manner. Triage system to direct concerns where appropriate via informal process. Weekly meetings identifying issues. Monthly deep dive of all open cases to address barriers. Clear process of escalation

**Risk resulting from delays:** patients, family/people already distressed becoming dissatisfied with a protracted complaints process. Increased workload for the team as they have to offer additional support to complainants waiting to have their complaint answered. Increased workload consists of additional support e.g. telephone calls, letters providing assurance the complaint is being managed, cause of delay and predicted date of a response.

Financial and reputational risks:

- Escalation to the press and local MP's / AM's.
- Increased referrals to the Ombudsman.
- Fines imposed for delays in managing complaints.
- Increased likelihood of escalation to claims.

## Benchmarking: how do we compare?

% of concerns that have received a final reply (Reg 24) or an interim reply (Reg 26) up to & including 30 working days from the date the concern was first received by the organisation - Target 75%

| 2018/19 | CTUHB | ABMU | AB | BCU | C&V | HDda | Powys |
|---|---|---|---|---|---|---|---|
| Quarter 1 | 50.0% | 80.7% | 51.4% | 42.1% | 65.6% | 62.9% | 60.4% |
| Quarter 2 | 22.9% | 77.2% | 47.3% | 35.2% | 75.2% | 66.4% | 50.0% |

**Cwm Taf was the worst performing for Quarter 2 2018/19. ABMU and C&V were the only health boards to achieve target.**

Source: Local Datix

## Indicator 47: Percentage of people in Wales registered at a GP practice (age 65 years or over) who are diagnosed with dementia

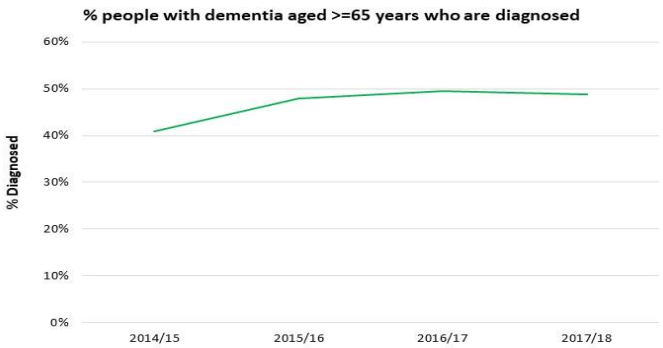
| Outcome: My voice is heard and listened to | Executive Lead: Director of Primary, Community and Mental Health |
|---|---|
| Period: 2014 to 2018 | Target: Annual Improvement |

### Current Performance:

Cwm Taf Morgannwg

Not currently available

Cwm Taf




Morgannwg

Not currently available

### How are we doing, what actions are we taking?

Health Boards are required to monitor numbers and percentages of patients recorded with Dementia.

Available data for people within dementia in Wales aged 65 years or over who are diagnosed (registered on a GP QOF register) is available up to the period 2017/18.

Discussions to be picked up with Primary Care.

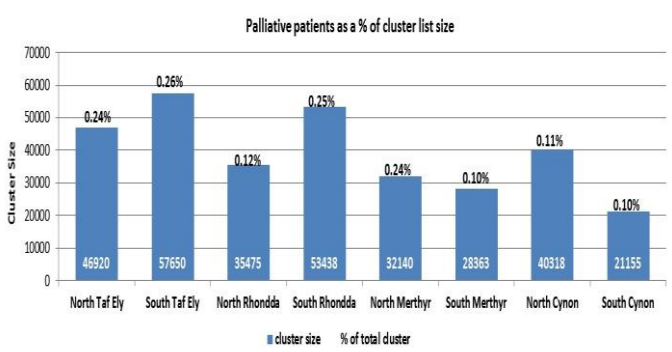
### Benchmarking: how do we compare?

| | Number of people on QoF dementia register (number with a diagnosis) | | | |
|---|---|---|---|---|
| **Health Board** | **2014/15** | **2015/16** | **2016/17** | **2017/18** |
| Abertawe Bro Morgannwg | 3305 | 3581 | 3925 | 3768 |
| Aneurin Bevan | 3608 | 3685 | 3873 | 3883 |
| Betsi Cadwaladr | 4614 | 4705 | 5191 | 5092 |
| Cardiff & Vale | 2799 | 2859 | 3266 | 3158 |
| **Cwm Taf** | **1531** | **1622** | **1693** | **1629** |
| Hywel Dda | 2369 | 2424 | 2671 | 2685 |
| Powys | 1013 | 979 | 1036 | 1023 |
| Wales | 19239 | 19806 | 21655 | 21238 |
| | **Estimated number of people with dementia (diagnosed and undiagnosed)** | | | |
| **Health Board** | **2014/15** | **2015/16** | **2016/17** | **2017/18** |
| Abertawe Bro Morgannwg | 7359 | 6412 | 6480 | 6545 |
| Aneurin Bevan | 7798 | 6841 | 6954 | 7090 |
| Betsi Cadwaladr | 10985 | 9600 | 9752 | 9922 |
| Cardiff & Vale | 5652 | 4947 | 4993 | 5045 |
| **Cwm Taf** | **3752** | **3287** | **3321** | **3345** |
| Hywel Dda | 6368 | 5588 | 5681 | 5807 |
| Powys | 2448 | 2160 | 2204 | 2239 |
| Wales | 44362 | 43478 | 39385 | 39995 |
| | **Percent of people with dementia with a diagnosis** | | | |
| **Health Board** | **2014/15** | **2015/16** | **2016/17** | **2017/18** |
| Abertawe Bro Morgannwg | 44.9% | 55.8% | 58.8% | 57.6% |
| Aneurin Bevan | 46.3% | 53.9% | 54.0% | 54.8% |
| Betsi Cadwaladr | 42.0% | 49.0% | 51.6% | 51.3% |
| Cardiff & Vale | 49.5% | 57.8% | 63.4% | 62.6% |
| **Cwm Taf** | **40.8%** | **47.9%** | **49.5%** | **48.7%** |
| Hywel Dda | 37.2% | 43.4% | 45.6% | 46.2% |
| Powys | 41.4% | 45.3% | 45.6% | 45.7% |
| Wales | 43.4% | 51.0% | 53.3% | 53.1% |

**Cwm Taf is comparable to its peers**

**Source:**[https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/PatientsOnQualityAndOutcomesFramework-by-LocalHealthBoard-DiseaseRegister](https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/PatientsOnQualityAndOutcomesFramework-by-LocalHealthBoard-DiseaseRegister)

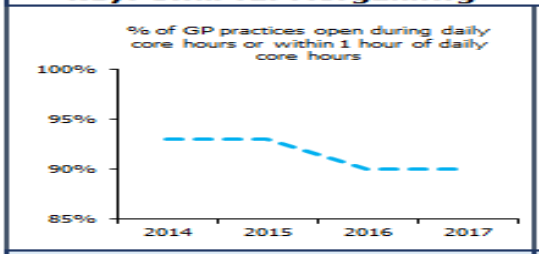
| Local Measure: Percentage of Patients registered as receiving palliative care with their GP practice | |
|---|---|
| Outcome: I am treated with dignity and respect and treat others the same | Executive Lead: Director of Primary, Community and Mental Health |
| Period: | Target: |

| Current Performance: | How are we doing, what actions are we taking? | Benchmarking: how do we compare? |
|---|---|---|
| Cwm Taf Morgannwg<br><br>Not currently available<br><br>Cwm Taf<br><br>  <br><br><br>Morgannwg<br><br>Not currently available | Health Boards are also requested to monitor those patients on a Palliative Care pathway.<br><br>The graphs shown are for 2016/17 for all patients on the Palliative Register. There is no further update this month.<br><br>Discussions to be picked up with Primary Care. | **Benchmark not available** |

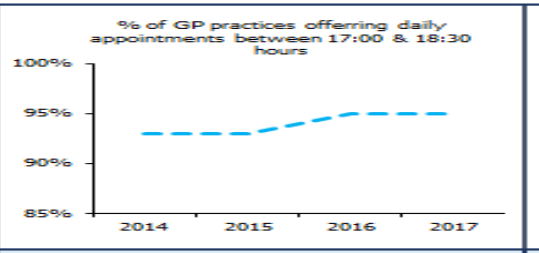
**Source:** https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Primary-and-Community-Activity/GMS-Contract/PatientsOnQualityAndOutcomesFramework-by-LocalHealthBoard-DiseaseRegister

## TIMELY CARE - People in Wales have timely access to services based on clinical need and are actively involved in decisions about their care

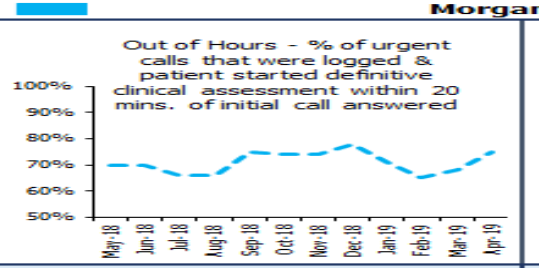
**Key: Cwm Taf Morgannwg** — **Cwm Taf** - - - **or** ▬ **Morgannwg**



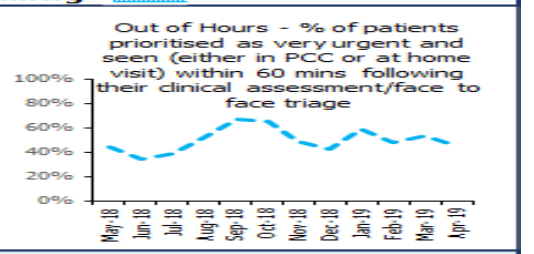

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 90% | N/A | N/A |



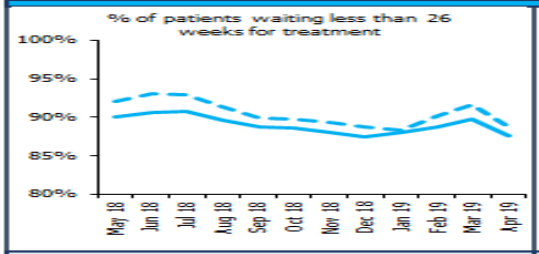

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 95% | N/A | N/A |



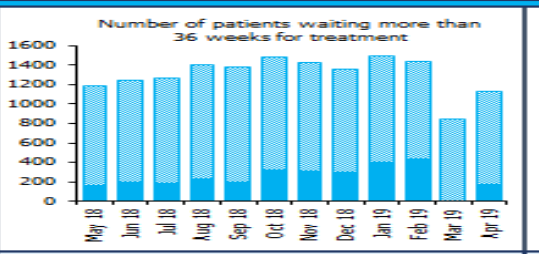

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 75.0% | N/A | N/A |



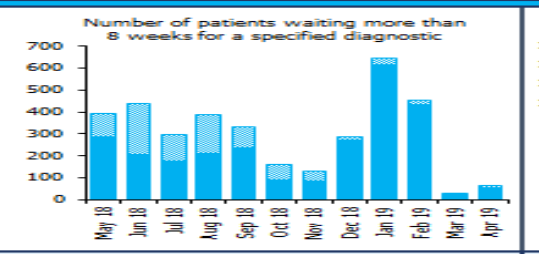

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 45.0% | N/A | N/A |



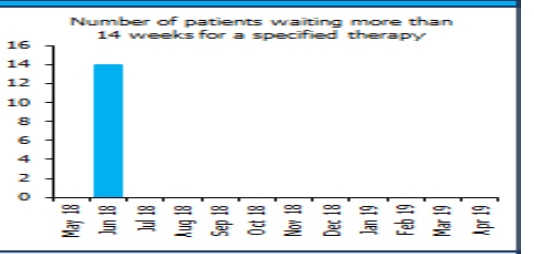

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 88.7% | 85.7% | 87.6% |



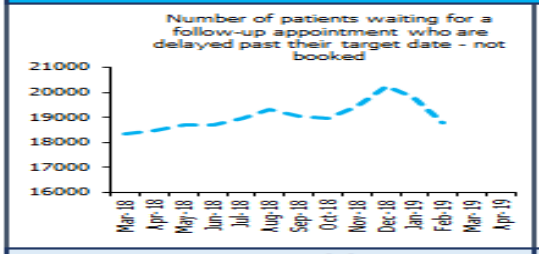

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 171 | 961 | 1132 |



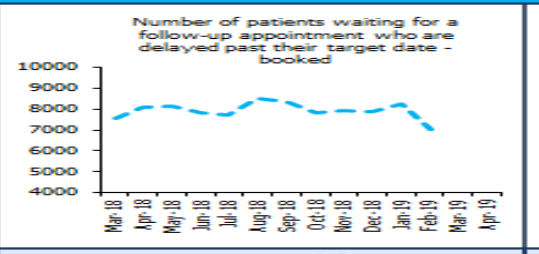

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 52 | 10 | 62 |



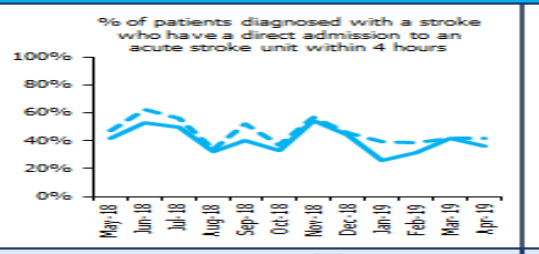

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 0 | 0 | 0 |



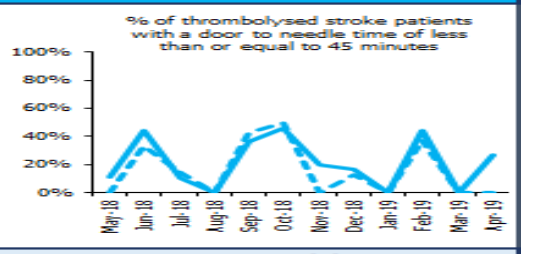

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 19119 | N/A | N/A |



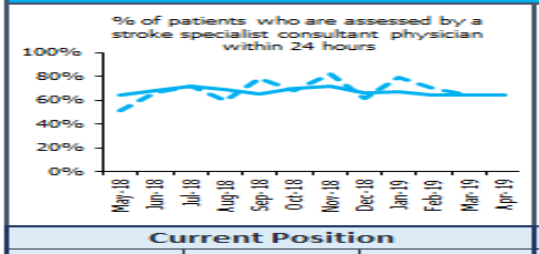

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 8188 | N/A | N/A |



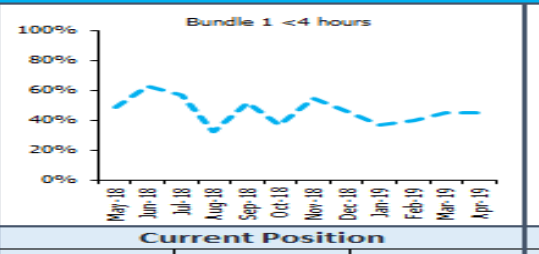

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 41.7% | 27.0% | 35.9% |



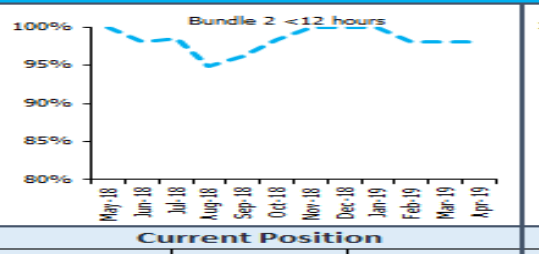

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 0.0% | 60.0% | 27.3% |



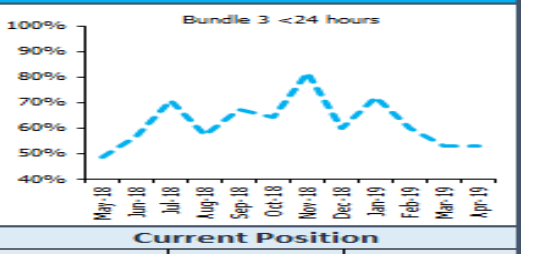

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 64.7% | 64.5% | 64.6% |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 451.0% | N/A | N/A |

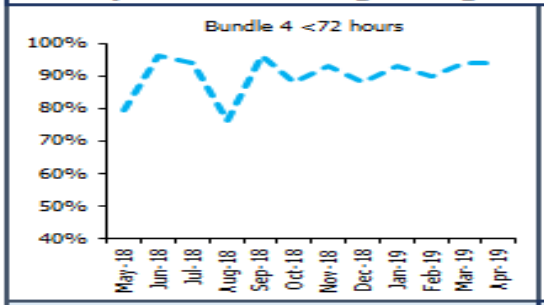



| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 98.0% | N/A | N/A |

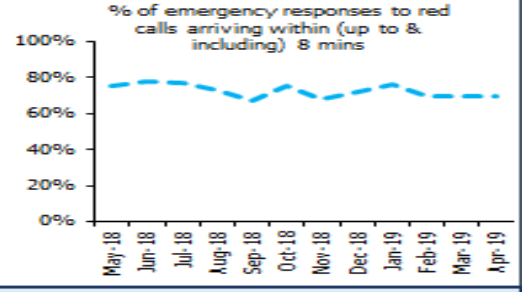



| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 52.9% | N/A | N/A |

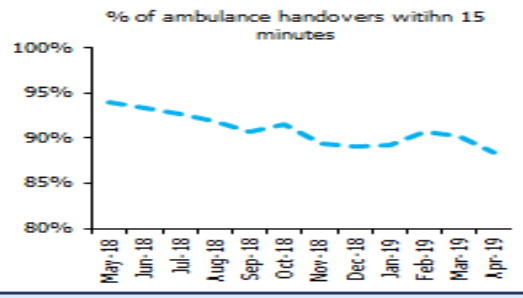
Key: Cwm Taf Morgannwg —— Cwm Taf - - - or ▬ Morgannwg ▬



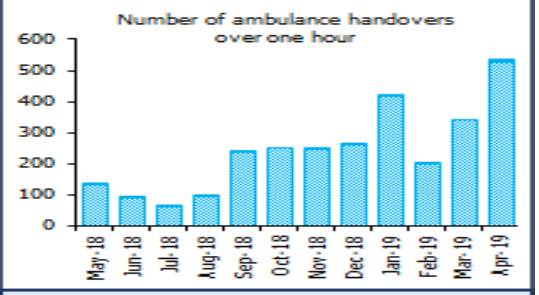

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 94.1% | N/A | N/A |



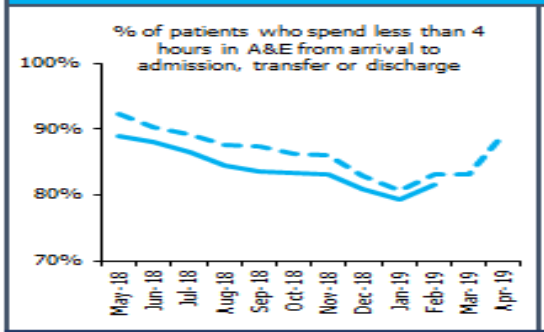

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 70.0% | N/A | N/A |



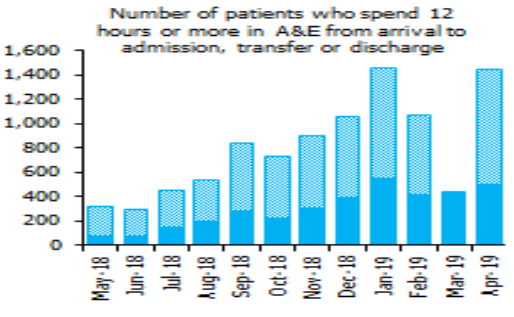

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 88.4% | 22.40% | N/A |



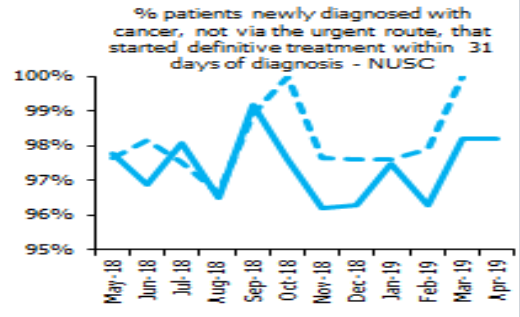

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 11 | 513 | 524 |



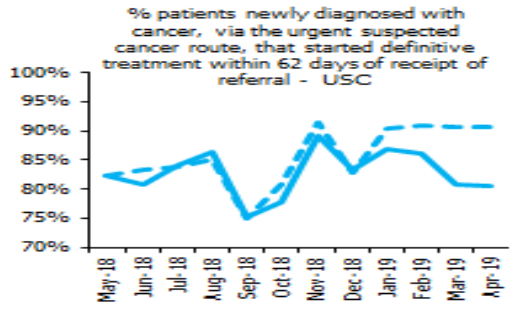

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 89.1% | 66.2% | 74.2% |



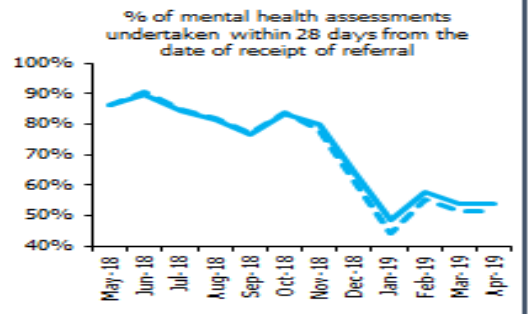

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 506 | 418 | 944 |



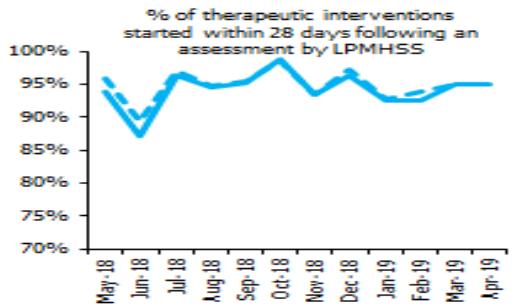

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 100.0% | 93.1% | 98.2% |



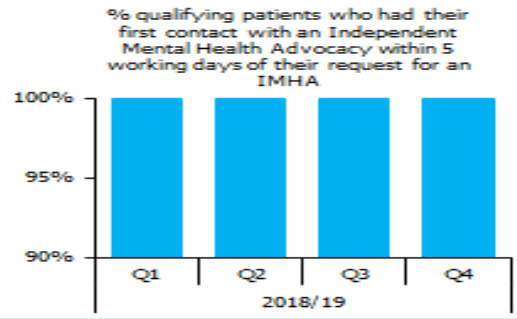

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 90.6% | 67.5% | 80.7% |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 51.2% | 81.0% | 53.6% |



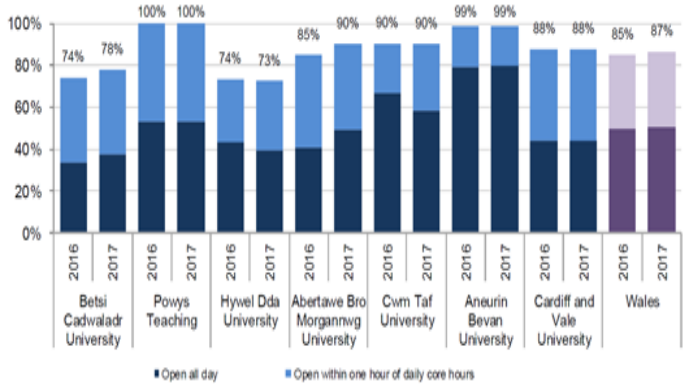
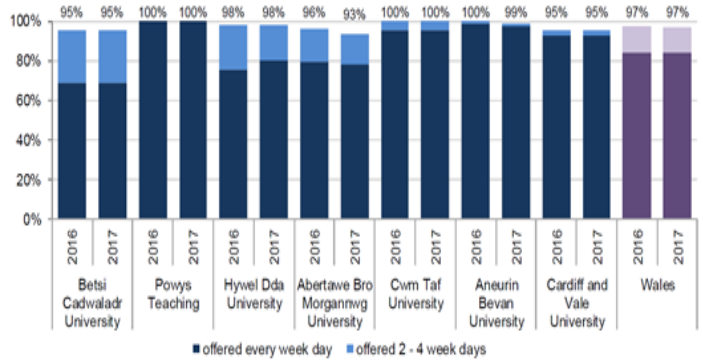

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 95.1% | 93.8% | 95.1% |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 100% | N/A | N/A |

**Indicator 53: Percentage of GP practices open during daily core hours or within 1 hour of daily core hours**
**Indicator 54: Percentage of GP practices offering daily appointments between 17:00 and 18:30 hours**

| Outcome: I have easy and timely access to primary care services | Executive Lead: Director of Primary, Community and Mental Health |
|---|---|
| Period: 2016-2017 | Target: Annual Improvement |

| Current Performance: | How are we doing, what actions are we taking? | Benchmarking: how do we compare? |
|---|---|---|
| Cwm Taf Morgannwg<br><br>Data is not currently available<br><br>Cwm Taf<br><br>Data post 2017 is not currently available<br><br>Morgannwg<br><br>Data post 2017 is not currently available | For practices not offering appointments specifically between 18:00 and 18:30 hours, it has been noted that, in the majority of practices, appointments run up to practice closing hours ie 18:30 hours. Depending on need, the last appointment would be scheduled to conclude by closing hours 18:30 hours.<br><br>**What actions are we taking?**<br>Regularly assessing if practices are meeting needs by:<br>• Cluster Programme – all practices assessing patient satisfaction by survey and or creation of patient participation group.<br>• Access Improvement Group (meet quarterly):<br>  ○ Membership: Representatives from all localities, LMC, CHC, Clinical Director, OOH and Primary Care Team.<br>  ○ Cwm Taf wide DNA policy.<br>  ○ Practices comply with opening and surgery times meeting the contract requirements.<br>  ○ Activity monitoring – seasonal planning.<br>  ○ OOH and A&E attendance.<br><br>**What are the areas of risk?**<br>• Single handers and small practices.<br>• Recruitment issues leading to pressure and difficulty in sustaining appointments.<br>• Demand fluctuations and seasonal pressures.<br>• High use of Locum GPs. | **Open during daily core hours or within 1 hour of daily core hours**<br>  <br><br><br>**Appointments between 17:00 and 18:30 hours**<br>  <br><br><br>**Cwm Taf Health Board (as was) compared favourably with other Welsh Health Boards.** |

**Source:** ***https://gov.wales/statistics-and-research/?topics=Health+and+social+care&subtopics=GPs&view=Search+results&lang=en***

**Indicator 55: For health boards with Out of Hours (OoH) services, the percentage of urgent calls that were logged and patients started their clinical definitive assessment within 20 minutes of their initial calls being answered; for health boards with 111 services, the percentage of P1 calls that were logged and patients started their definitive assessment within 20 minutes of the initial calls being answered**

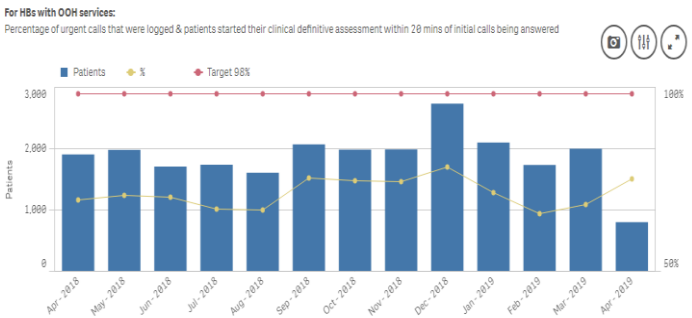
| Outcome: I have easy and timely access to primary care services | Executive Lead: Chief Operating Officer |
|---|---|
| Period: Apr 2018 to Apr 2019 | Target: 98%/12 Month Improvement |

## Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Following the boundary change on 1 April 2019 responsibility for Out of Hours for Bridgend remains with Swansea Bay University Hospital

## How are we doing, what actions are we taking?

**How are we doing?**
This chart shows the percentage of patients who received urgent calls and received clinical assessment within 20 minutes.

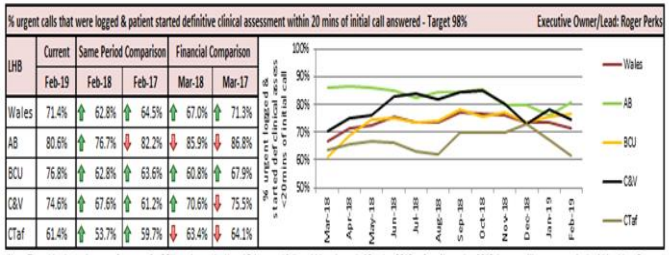
The current target for this measure is at 98% (with an improvement trend). Our current position is at 75%.

**What actions are we taking?**
Whilst noting that the targets were set without the benefit of a detailed demand and capacity analysis, it is clear at the moment that there is a gap, with available capacity insufficient to meet the current target.

The main risk would be the availability of medical staff to fill the existing shifts within the core capacity. Thereafter, it may be worth reviewing the nature of the demand to see if there is the potential to reduce the level or avoid certain types of demand altogether.

**What are the areas of risk?**
Availability of medical staff to fill existing shifts. There is continued commitment within the service to fill as many shifts as possible for every day in order to provide as much resilience as possible to this key unscheduled care service.

## Benchmarking: how do we compare?




**Cwm Taf's OOH performance compared to peers is poor.**

Source: Local OOH/Qlik

**Indicator 56: For health boards with Out of Hours (OoH) services, the percentage of patients prioritised as very urgent and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage for health boards with 111 services, the percentage of patients prioritised as P1 and seen (either in PCC or home visit) within 60 minutes following their clinical assessment/face to face triage**

Outcome: I have easy and timely access to primary care services

Executive Lead: Chief Operating Officer

Period: Apr 2018 to Apr 2019

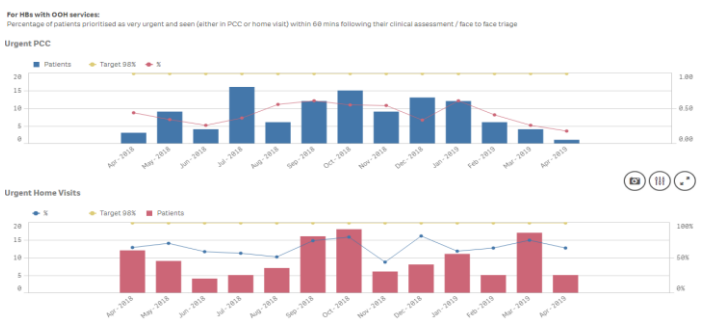
Target: 90%/12 Month Improvement

## Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Following the boundary change on 1 April 2019 responsibility for Out of Hours for Bridgend remains with Swansea Bay University Hospital

## How are we doing, what actions are we taking?

**How are we doing?**

The charts shown are a combination of urgent face to face consultation either in the home, or at a Primary Care Centre (PCC). The practical ability to be able to meet the very urgent face to face target needs to be reviewed in the context of, for example, the service having to manage overnight with a single GP, working with the team to provide all aspects of the service during that time. This together with the geography of the region and the location of the Primary Care Centres provide significant challenges to be able to provide this type of urgent access, let alone meet very challenging access target times.

| Urgent Face to Face | Apr |
|---|---|
| Home Visit | 63% |
| PCC | 17% |
| Total | 43% |
| **Number of Patients** | |
| Home Visit | 5 |
| PCC | 1 |
| Total | 6 |

% of patients that were prioritized as very urgent for health boards that only have GP Out of Hours (defined as P1 for health boards with the 111 service) and seen (either in the primary care centre or via a home visit) within 60 mins following their initial clnical assessment/face to face triage

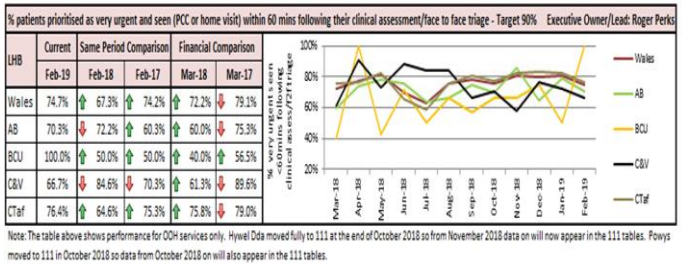
| Urgent Face to Face | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Home Visit | 63% | 69% | 57% | 56% | 50% | 73% | 78% | 43% | 80% | 58% | 63% | 74% |
| PCC | 43% | 33% | 25% | 36% | 55% | 60% | 54% | 53% | 33% | 60% | 40% | 25% |
| Total | 57.6% | 44.6% | 34.8% | 39.3% | 52.2% | 66.8% | 64.9% | 48.5% | 42.5% | 59.0% | 48.0% | 53.9% |
| Number of Patients | | | | | | | | | | | | |
| Home Visit | 12 | 9 | 4 | 5 | 7 | 16 | 18 | 6 | 8 | 11 | 5 | 17 |
| PCC | 3 | 9 | 4 | 16 | 6 | 12 | 15 | 9 | 13 | 12 | 6 | 4 |
| Total | 15 | 18 | 8 | 21 | 13 | 28 | 33 | 15 | 21 | 23 | 11 | 21 |

The relatively small number of patients in these two categories mean that the compliance is highly variable when combined with other variable aspects, such as the available capacity, geography of the patients' home addresses and the distance needing to be travelled by the patients.

**What actions are we taking?**

The service continues to fill as many shifts as possible for every day in order to provide as much resilience as possible to this key unscheduled care service.

## Benchmarking: how do we compare?




Cwm Taf's performance is comparable to other Welsh Health Boards.

Source:

## Indicator 58: The percentage of patients waiting less than 26 weeks for treatment

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Apr 2018 to Apr 2019

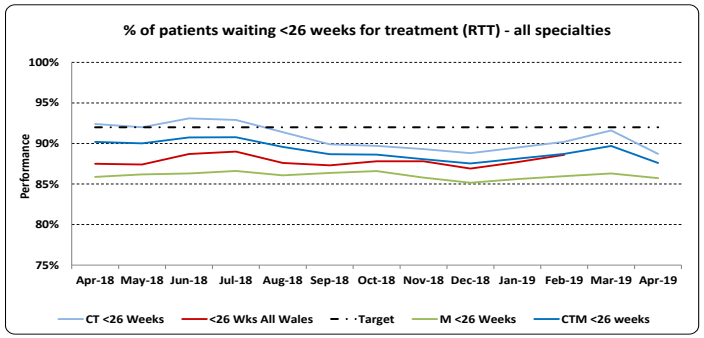
Target: 95%

### Current Performance:

Cwm Taf Morgannwg

See graph below

Cwm Taf




Morgannwg

| % of patients waiting less than 26 weeks for treatment (RTT) - POWH | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 |
| 86.2% | 86.3% | 86.6% | 86.1% | 86.4% | 86.6% | 85.8% | 85.2% | 85.6% | 86.0% | 86.3% | 85.7% |

### How are we doing, what actions are we taking?

**How are we doing?**

The provisional position for April is 85.7% for the Princess of Wales Hospital, 88.7% for Cwm Taf giving a Cwm Taf Morgannwg compliance of 87.6%. The reported 26 week position for the corresponding month last year ie April 2018 was 85.88% for Bridgend, Cwm Taf 92.40% giving a combined compliance of 90.19%.

**What actions are we taking?**

A 26 week trajectory is in development.

**What are the areas of risk?**

- The number of 53 week breaches post 1 April 2019 as a result of the boundary change;
- The number of open pathways 26 and 36 weeks. The April open pathway position is shown below.

36 Weeks

| | | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| | | | | CT | Morgannwg | CTM |
| Month | 2016/17 | 2017/18 | 2018/19 | Total | Total | Total |
| Apr | 1463 | 249 | 74 | 166 | 961 | 1127 |

26 Weeks

| | | | | 2019/20 | | |
|---|---|---|---|---|---|---|
| | | | | CT | Morgannwg | CTM |
| Month | 2016/17 | 2017/18 | 2018/19 | Total | Total | Total |
| Apr | 5221 | 3889 | 2852 | 3969 | 2933 | 6902 |

### Benchmarking: how do we compare?

| Period | Cwm Taf Compliance | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Wales | Morgannwg | CT Morgannwg |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan-18 | 87.9% | 86.2% | 90.4% | 80.5% | 84.8% | 85.5% | 99.5% | 85.6% | | |
| Feb-18 | 91.3% | 87.5% | 91.1% | 83.2% | 86.1% | 87.0% | 99.8% | 87.3% | | |
| Mar-18 | 92.8% | 87.8% | 90.3% | 84.4% | 86.5% | 86.3% | 100.0% | 87.6% | | |
| Apr-18 | 92.4% | 87.8% | 90.2% | 84.6% | 85.7% | 86.9% | 100.0% | 87.5% | 85.9% | |
| May-18 | 92.0% | 88.1% | 89.9% | 84.6% | 85.7% | 86.0% | 99.8% | 87.4% | 86.2% | |
| Jun-18 | 93.1% | 88.7% | 90.8% | 85.8% | 88.7% | 86.4% | 99.8% | 88.7% | 86.3% | |
| Jul-18 | 92.9% | 89.3% | 91.1% | 85.8% | 89.3% | 86.7% | 99.6% | 89.0% | 86.6% | |
| Aug-18 | 91.4% | 89.1% | 89.3% | 84.5% | 87.4% | 84.8% | 99.4% | 87.6% | 86.1% | |
| Sep-18 | 89.9% | 89.1% | 89.0% | 84.5% | 86.7% | 85.0% | 99.4% | 87.3% | 86.4% | |
| Oct-18 | 89.7% | 89.1% | 90.0% | 84.7% | 87.3% | 86.1% | 99.2% | 87.8% | 86.6% | |
| Nov-18 | 89.3% | 88.8% | 91.1% | 84.1% | 87.0% | 87.3% | 99.0% | 87.8% | 85.8% | |
| Dec-18 | 88.8% | 88.0% | 90.4% | 82.7% | 85.5% | 87.4% | 98.8% | 86.9% | 85.2% | |
| Jan-19 | 89.5% | 88.7% | 90.7% | 83.0% | 86.3% | 89.5% | 99.1% | 87.7% | 85.6% | |
| Feb-19 | 90.2% | 89.2% | 91.9% | 84.0% | 87.6% | 90.4% | 99.3% | 88.6% | 86.0% | |

**For the period 2018/19 Cwm Taf's performance was comparable with other Welsh Health Boards. It was expected that performance for Cwm Taf Morgannwg would be significantly lower as was the case for April 2019 at 87.6%.**

Source: Local / Welsh Government Delivery & Performance Website: http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Indicator 59: The number of patients waiting more than 36 weeks for treatment

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Apr 2018 to Apr 2019

Target: Zero

### Current Performance:

Cwm Taf Morgannwg

The provisional reporting position:
53 weeks – 335 patients  36 week – 1132 patients

Breakdown by speciality is not currently available for April

| Number of patients waiting more than 53 weeks for treatment (RTT) | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 |
| 487 | 467 | 470 | 536 | 541 | 536 | 542 | 532 | 489 | 434 | 367 | 335 |

| CT Morgannwg RTT Open Pathways 36+ Weeks | 2018/19 | | | | | | | | | | | | 2019/20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
| Total | 1076 | 1183 | 1246 | 1263 | 1404 | 1385 | 1479 | 1420 | 1354 | 1496 | 1436 | 844 | 1132 |

Cwm Taf

The provisional reporting position:
53 weeks – 0 patients
36 weeks – 171

Breakdown by speciality is not currently available for April

| CT RTT Open Pathways 36+ Weeks | 2018/19 | | | | | | | | | | | | 2019/20 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr |
| Total | 74 | 157 | 195 | 187 | 229 | 196 | 321 | 309 | 297 | 399 | 440 | 0 | 171 |

Morgannwg

| Number of patients waiting more than 36 weeks for treatment (RTT) - POWH | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 |
| 1026 | 1051 | 1076 | 1175 | 1189 | 1158 | 1111 | 1057 | 1097 | 996 | 844 | 961 |

| Number of patients waiting more than 53 weeks for treatment (RTT) - POWH | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 |
| 487 | 467 | 470 | 536 | 541 | 536 | 542 | 532 | 489 | 434 | 367 | 335 |

### How are we doing, what actions are we taking?

**How are we doing?**
The provisional reporting position for patients waiting over 52 weeks for April 2019 is 335. All 335 patients are patients with resident addresses within Bridgend (Morgannwg). The provisional reporting position for patients waiting over 36 weeks is 1132. Of these, 171 patients are patients with resident addresses within Cwm Taf and 961 within the Bridgend area (this figure of 961 includes the 335 patients waiting over 52 weeks).

**What actions are we taking?**
.Specific focus going into the new financial year will be to remove the volume of patients waiting at, and greater than, 53 week breaches and address waits at stages 1 and 2: the longest waits will be monitored monthly with improvement expected monthly against the agreed trajectory.

Following approval to secure outsourced capacity for the first quarter of 2019-20 to support delivery of the target discussions are now underway with providers and contracts are being put in place for commencement of outsourcing in June 2019.

**What are the areas of risk?**
This additional activity will focus on the management of patients within General Surgery, Orthopaedics, Urology, Gynaecology and Ophthalmology.

### Benchmarking: how do we compare?

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Wales | Morgannwg | CT Morgannwg |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan-18 | 927 | 4609 | 1496 | 9976 | 2933 | 3014 | 0 | 22955 | | |
| Feb-18 | 514 | 4111 | 1122 | 7933 | 2921 | 2430 | 0 | 19031 | | |
| Mar-18 | 4 | 3373 | 812 | 5663 | 783 | 1494 | 0 | 12119 | | |
| Apr-18 | 74 | 3398 | 986 | 6348 | 2266 | 1725 | 0 | 14797 | 1002 | 1076 |
| May-18 | 157 | 3349 | 1090 | 6381 | 2569 | 1798 | 0 | 15344 | 1026 | 1183 |
| Jun-18 | 195 | 3319 | 848 | 5767 | 686 | 1779 | 0 | 12594 | 1051 | 1246 |
| Jul-18 | 187 | 3383 | 910 | 6579 | 890 | 1869 | 0 | 13818 | 1076 | 1263 |
| Aug-18 | 229 | 3497 | 1159 | 7291 | 1366 | 2080 | 0 | 15622 | 1175 | 1404 |
| Sep-18 | 196 | 3381 | 1067 | 6291 | 944 | 1794 | 0 | 13673 | 1189 | 1385 |
| Oct-18 | 321 | 3370 | 1214 | 6574 | 984 | 1638 | 0 | 14101 | 1158 | 1479 |
| Nov-18 | 309 | 3193 | 769 | 6846 | 954 | 1439 | 0 | 13510 | 1111 | 1420 |
| Dec-18 | 297 | 3030 | 249 | 7064 | 948 | 1394 | 0 | 12982 | 1057 | 1354 |
| Jan-19 | 399 | 3174 | 336 | 7939 | 984 | 3014 | 0 | 14140 | 1097 | 1496 |
| Feb-19 | 440 | 2967 | 469 | 7717 | 1046 | 633 | 0 | 13272 | 996 | 1436 |

**For the period 2018/19 Cwm Taf's performance was the best in Wales. It was expected that Cwm Taf Morgannwg's position would be significantly worse as was the case in April 2019 with 335 53 week breaches and 1132 36 week breaches.**

Source: Local / Welsh Government Delivery & Performance Website: http://howis.wales.nhs.uk/sitesplus/407/page/64649 http://howis.wales.nhs.uk/sitesplus/407/page/55547

## Indicator 60: The number of patients waiting more than 8 weeks for a specified diagnostic

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Apr 2019

Target: Zero

### Current Performance:

Cwm Taf Morgannwg

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CTM Actual 2018/19 | 250 | 275 | 344 | 187 | 274 | 254 | 160 | 129 | 287 | 644 | 454 | 27 |
| CTM Actual 2019/20 | 62 | | | | | | | | | | | |

Cwm Taf

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CT Actual 2017/18 | 966 | 1079 | 1212 | 1181 | 1347 | 1483 | 1504 | 1522 | 1676 | 1500 | 1071 | 72 |
| CT Actual 2018/19 | 190 | 168 | 112 | 64 | 101 | 161 | 92 | 86 | 270 | 613 | 431 | 27 |
| CT Actual 2019/20 | 52 | | | | | | | | | | | |
| CT Trajectory 2018/19 | 232 | 189 | 156 | 134 | 56 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CT Trajectory 2017/18 | 0 | 0 | 0 | 0 | 0 | 1370 | 1076 | 948 | 1087 | 779 | 351 | 76 |
| CT Trajectory 2019/20 | 121 | 158 | 135 | 93 | 61 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Morgannwg

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| M Actual 2018/19 | 60 | 107 | 232 | 123 | 173 | 93 | 68 | 43 | 17 | 31 | 23 | 0 |
| M Actual 2019/20 | 10 | | | | | | | | | | | |

### How are we doing, what actions are we taking?

**How are we doing?**

The provisional position for April is 62 patients waiting over 8 weeks. There are 10 patients within Morgannwg and 52 within Cwm Taf. The majority of the 52 patients within the old Cwm Taf footprint are awaiting treatment in three areas ie Diagnostic Angiography, Endoscopy and Cardiac Heart Rhythm. All 10 patients within Morgannwg are awaiting Cystoscopy.

The reported diagnostic position for the corresponding month last year ie April 2018 was 75 for Morgannwg, Cwm Taf 190 giving a combined diagnostic figure of 265.

**What actions are we taking?**

Following the boundary change on 1 April 2019 an agreed trajectory is being discussed and put in place.

### Benchmarking: how do we compare?

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Wales | Morgannwg | CT Morgannwg |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan-18 | 1500 | 473 | 1261 | 1400 | 1822 | 0 | 1 | 6457 | | |
| Feb-18 | 1071 | 278 | 550 | 1052 | 1111 | 66 | 1 | 4129 | | |
| Mar-18 | 72 | 29 | 2 | 484 | 883 | 0 | 6 | 1466 | | |
| Apr-18 | 283 | 702 | 320 | 817 | 1336 | 19 | 11 | 3488 | | |
| May-18 | 285 | 790 | 279 | 1147 | 1379 | 113 | 0 | 3993 | | |
| Jun-18 | 207 | 915 | 502 | 1742 | 1527 | 122 | 3 | 5018 | | |
| Jul-18 | 175 | 740 | 417 | 2107 | 1371 | 84 | 22 | 4916 | | |
| Aug-18 | 213 | 811 | 663 | 2462 | 1186 | 78 | 38 | 5449 | | |
| Sep-18 | 237 | 762 | 407 | 2200 | 846 | 48 | 79 | 4579 | | |
| Oct-18 | 92 | 735 | 283 | 1504 | 448 | 27 | 83 | 3172 | | |
| Nov-18 | 86 | 658 | 71 | 1276 | 431 | 86 | 35 | 3117 | | |
| Dec-18 | 270 | 693 | 4 | 1486 | 450 | 82 | 150 | 3135 | | |
| Jan-19 | 613 | 603 | 60 | 2116 | 448 | 30 | 122 | 3992 | | |
| Feb-19 | 431 | 558 | 15 | 2123 | 270 | 1 | 60 | 3458 | 23 | 454 |

**For the period 2018/19 Cwm Taf was one of the better performing Health Boards. Post the 1 April 2019 boundary change, it is not anticipated that there will be any significant change to diagnostic waits over and above.**

Source: Local/Information Team QL and Welsh Government Delivery & Performance Website https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-

## Indicator 61: The number of patients waiting more than 14 weeks for a specified therapy

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Apr 2019

Target: Zero

### Current Performance:

Cwm Taf Morgannwg

| Number of patients waiting over 14 weeks for therapies | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
| 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Cwm Taf

| Number of patients waiting over 14 weeks for therapies | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
| 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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| Number of patients waiting over 14 weeks for therapies | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### How are we doing, what actions are we taking?

**How are we doing?**
There were no therapy breaches for April 2019.

**What actions are we taking?**
Maintaining the current position of zero breaches**.**

**Areas of risk?**
Currently Cwm Taf Morgannwg is in a sustained period with no immediate risk.

### Benchmarking: how do we compare?

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Wales | Morgannwg | CT Morgannwg |
|---|---|---|---|---|---|---|---|---|---|---|
| Jan-18 | 0 | 32 | 238 | 0 | 226 | 312 | 12 | 820 | | |
| Feb-18 | 0 | 3 | 68 | 0 | 163 | 215 | 12 | 461 | | |
| Mar-18 | 0 | 0 | 0 | 0 | 126 | 116 | 3 | 245 | | |
| Apr-18 | 0 | 0 | 13 | 0 | 200 | 101 | 1 | 315 | | |
| May-18 | 0 | 1 | 15 | 0 | 166 | 164 | 1 | 347 | | |
| Jun-18 | 14 | 0 | 3 | 0 | 163 | 226 | 1 | 407 | | |
| Jul-18 | 0 | 0 | 31 | 0 | 61 | 288 | 0 | 380 | | |
| Aug-18 | 0 | 0 | 9 | 0 | 42 | 307 | 2 | 360 | | |
| Sep-18 | 0 | 0 | 13 | 0 | 20 | 352 | 2 | 387 | | |
| Oct-18 | 0 | 0 | 5 | 0 | 120 | 332 | 8 | 465 | | |
| Nov-18 | 0 | 0 | 0 | 0 | 112 | 265 | 3 | 380 | | |
| Dec-18 | 0 | 0 | 0 | 3 | 12 | 287 | 3 | 305 | | |
| Jan-19 | 0 | 0 | 0 | 0 | 14 | 177 | 14 | 205 | | |
| Feb-19 | 0 | 0 | 5 | 0 | 5 | 51 | 16 | 77 | 0 | 0 |

**Cwm Taf Morgannwg is one of three Health Boards achieving a zero position for therapies.**

Source: Local /Information Team QL and Welsh Government Statistics Website
https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Diagnostic-and-Therapy-Services/waitingtimes-by-month

## Indicator 62: The number of patients waiting for an outpatient follow-up (NOT BOOKED) who are delayed past their agreed target date for planned care sub specialties

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: as at 12 May 2019

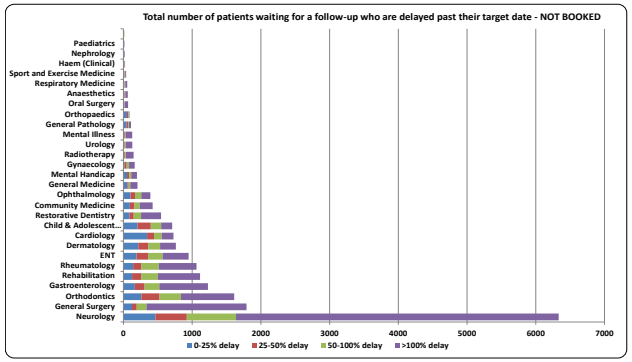
Target: 12 Month Reduction Trend

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

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### How are we doing, what actions are we taking?

**How are we doing?**

The number of patients waiting for an outpatient follow-up (not booked) who are currently delayed past their agreed target date as at 12 May is 19119.

| Census data 12/5/19 | 0-25% delay | 25-50% delay | 50-100% delay | >100% delay | Total |
|---|---|---|---|---|---|
| Neurology | 466 | 455 | 717 | 4696 | 6334 |
| General Surgery | 125 | 69 | 141 | 1456 | 1791 |
| Orthodontics | 261 | 265 | 310 | 776 | 1612 |
| Gastroenterology | 165 | 144 | 213 | 707 | 1229 |
| Rehabilitation | 126 | 136 | 238 | 615 | 1115 |
| Rheumatology | 142 | 120 | 252 | 549 | 1063 |
| ENT | 191 | 168 | 211 | 378 | 948 |
| Dermatology | 216 | 148 | 169 | 230 | 763 |
| Cardiology | 345 | 100 | 112 | 171 | 728 |
| Child & Adolescent Psych | 206 | 192 | 151 | 161 | 710 |
| Restorative Dentistry | 89 | 61 | 106 | 291 | 547 |
| Community Medicine | 93 | 67 | 78 | 186 | 424 |
| Ophthalmology | 103 | 66 | 91 | 132 | 392 |
| General Medicine | 57 | 18 | 24 | 106 | 205 |
| Mental Handicap | 52 | 32 | 29 | 84 | 197 |
| Gynaecology | 18 | 30 | 34 | 81 | 163 |
| Radiotherapy | 13 | 13 | 10 | 112 | 148 |
| Urology | 9 | 10 | 13 | 97 | 129 |
| Mental Illness | 9 | 11 | 12 | 95 | 127 |
| General Pathology | 47 | 20 | 13 | 30 | 110 |
| Orthopaedics | 50 | 18 | 11 | 10 | 89 |
| Oral Surgery | 7 | 6 | 4 | 50 | 67 |
| Anaesthetics | 5 | 12 | 10 | 36 | 63 |
| Respiratory Medicine | 12 | 5 | 10 | 28 | 55 |
| Sport and Exercise Medic | 6 | 10 | 9 | 15 | 40 |
| Haem (Clinical) | 10 | 5 | 3 | 5 | 23 |
| Nephrology | 2 | 2 | 4 | 10 | 18 |
| Paediatrics | | 1 | 1 | 13 | 15 |
| Palliative Medicine | 1 | 2 | 11 | | 14 |
| Total | 2826 | 2186 | 2987 | 11120 | 19119 |

**What actions are we taking?**

The FUNB Task and Finish group continues to meet on a fortnightly basis to review the FUNB dashboard and to review progress against individual specialty action plans. Work is also ongoing to validate the list of patients recorded as See on Symptom. Clinical review of Ophthalmology cases was outsourced at the end of March 2019 and there are 4,000 cases which will be discharged back to primary care.

**What are the areas of risk?**

An immediate concern is the potential increase in the number of FUNBs as a result of the boundary change. These numbers are not as yet available.

### Benchmarking: how do we compare?

**This data is not currently available**

Source: Local Information Team and WPAS Team

## Indicator 62 continued: The number of patients waiting for an outpatient follow-up (BOOKED) who are delayed past their agreed target date for planned care sub specialties

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: as at 12 May 2019

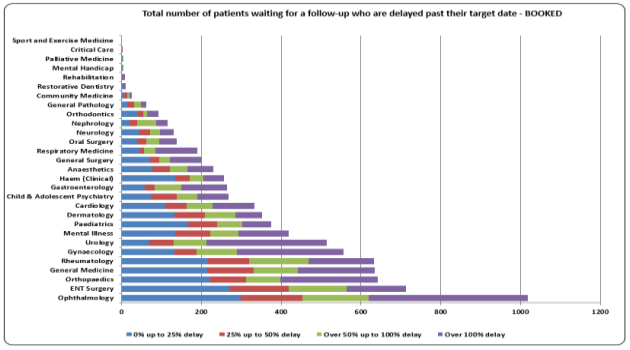
Target: 12 Month Reduction Trend

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

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Data not currently available

### How are we doing, what actions are we taking?

**How are we doing?**

The number of patients waiting for an outpatient follow-up (booked) who are currently delayed past their agreed target date as at 12 May 2019 has increased to 8,188.

| | 0% up to 25% delay | 25% up to 50% delay | Over 50% up to 100% delay | Over 100% delay | Total |
|---|---|---|---|---|---|
| Ophthalmology | 298 | 156 | 166 | 398 | 1,018 |
| ENT Surgery | 270 | 148 | 146 | 149 | 713 |
| Orthopaedics | 222 | 90 | 85 | 245 | 642 |
| General Medicine | 214 | 116 | 112 | 193 | 635 |
| Rheumatology | 217 | 102 | 149 | 164 | 632 |
| Gynaecology | 133 | 55 | 101 | 267 | 556 |
| Urology | 70 | 60 | 82 | 302 | 514 |
| Mental Illness | 134 | 89 | 70 | 125 | 418 |
| Paediatrics | 167 | 72 | 63 | 72 | 374 |
| Dermatology | 133 | 76 | 76 | 66 | 351 |
| Cardiology | 109 | 54 | 65 | 105 | 333 |
| Child & Adolescent Psychiatry | 73 | 66 | 51 | 77 | 267 |
| Gastroenterology | 58 | 25 | 66 | 115 | 264 |
| Haem (Clinical) | 134 | 37 | 34 | 52 | 257 |
| Anaesthetics | 77 | 44 | 43 | 65 | 229 |
| General Surgery | 72 | 23 | 26 | 81 | 202 |
| Respiratory Medicine | 44 | 13 | 28 | 105 | 190 |
| Oral Surgery | 38 | 24 | 32 | 44 | 138 |
| Neurology | 44 | 27 | 25 | 35 | 131 |
| Nephrology | 19 | 20 | 47 | 30 | 116 |
| Orthodontics | 41 | 13 | 10 | 29 | 93 |
| General Pathology | 15 | 16 | 18 | 12 | 61 |
| Community Medicine | 6 | 9 | 4 | 7 | 26 |
| Restorative Dentistry | 5 | 1 | 1 | 3 | 10 |
| Rehabilitation | 3 | 3 | | 2 | 8 |
| Mental Handicap | 2 | 1 | 2 | | 5 |
| Palliative Medicine | 2 | 1 | 1 | | 4 |
| Critical Care | | 1 | | | 1 |
| Sport and Exercise Medicine | | | | | 0 |
| | | | | | 8,188 |

**What actions are we taking?**

The FUNB Task and Finish group continues to meet on a fortnightly basis to review the FUNB dashboard and to review progress against individual specialty action plans. Work is also ongoing to validate the list of patients recorded as See on Symptom. Clinical review of Ophthalmology cases was outsourced at the end of March 2019 and there are 4,000 cases which will be discharged back to primary care.

**What are the areas of risk?**

An immediate concern is the potential increase in the number of FUNBs as a result of the boundary change. These numbers are not as yet available.

### Benchmarking: how do we compare?

**This data is not currently available**

Source: Local Information Team and WPAS Team

## Indicator 63-66: Percentage compliance with stroke quality improvement measures – QIM's

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Director of Planning and Performance

Period: Apr 2018 to Mar 2019

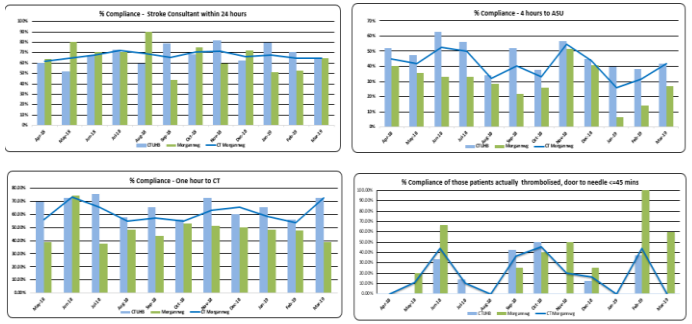
Target: SSNAP UK Quarterly Average

### Current Performance:

Cwm Taf Morgannwg

| Measure | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total admissions | 60 | 69 | 78 | 88 | 87 | 84 | 90 | 79 | 82 | 73 | 70 | 78 |
| No of patients within 4 hours | 27 | 29 | 41 | 44 | 28 | 34 | 30 | 43 | 36 | 19 | 22 | 28 |
| % Compliance | 45.0% | 42.0% | 52.6% | 50.0% | 32.2% | 40.5% | 33.3% | 54.4% | 43.9% | 26.0% | 31.4% | 35.9% |
| No of patients within 45 mins eligible | 6 | 9 | 18 | 10 | 13 | 11 | 11 | 5 | 12 | 9 | 9 | 11 |
| Total thrombolysed | 0 | 1 | 8 | 1 | 0 | 4 | 5 | 1 | 2 | 0 | 4 | 3 |
| % Compliance | 0.0% | 11.1% | 44.4% | 10.0% | 0.0% | 36.4% | 45.5% | 20.0% | 16.7% | 0.0% | 44.4% | 27.3% |
| Total admissions | 60 | 70 | 78 | 89 | 88 | 84 | 91 | 81 | 82 | 74 | 71 | 82 |
| No of patients within 1 hour | 16 | 39 | 57 | 58 | 48 | 48 | 50 | 51 | 46 | 43 | 38 | 49 |
| % Compliance | 26.7% | 55.7% | 73.1% | 65.2% | 54.5% | 57.1% | 54.9% | 63.0% | 56.1% | 58.1% | 53.5% | 59.8% |
| Total admissions | 60 | 70 | 78 | 89 | 88 | 84 | 91 | 81 | 82 | 74 | 71 | 82 |
| No of patients within 24 hours | 37 | 45 | 53 | 64 | 61 | 55 | 64 | 58 | 54 | 50 | 46 | 53 |
| % Compliance | 61.7% | 64.3% | 67.9% | 71.9% | 69.3% | 65.5% | 70.3% | 71.6% | 65.9% | 67.6% | 64.8% | 64.6% |

Cwm Taf

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| | Measure | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of patients who are diagnosed with a stroke who have a direct admission to an acute stroke unit (< 4hours) | Total admissions | 25 | 31 | 27 | 24 | 28 | 32 | 31 | 35 | 32 | 30 | 21 | 30 |
| | No of patients within 4 hours | 10 | 11 | 9 | 8 | 8 | 7 | 8 | 18 | 13 | 2 | 3 | 8 |
| | % Compliance | 40.0% | 35.5% | 33.3% | 33.3% | 28.6% | 21.9% | 25.8% | 51.4% | 40.6% | 6.7% | 14.3% | 26.7% |
| Percentage of thrombolysed stroke patients with a door to needle time of <= 45 mins | No of patients within 45 mins | 0 | 1 | 4 | 0 | 0 | 1 | 2 | 1 | 1 | 0 | 1 | 3 |
| | Total thrombolysed e | 4 | 5 | 6 | 3 | 6 | 4 | 5 | 2 | 4 | 1 | 1 | 5 |
| | % Compliance | 0.0% | 20.0% | 66.7% | 0.0% | 0.0% | 25.0% | 40.0% | 50.0% | 25.0% | 0.0% | 100.0% | 60.0% |
| Percentage of patients who are diagnosed with a stroke who receive a CT scan within 1 hour | Total admissions | 25 | 31 | 27 | 24 | 29 | 32 | 32 | 37 | 32 | 31 | 21 | 31 |
| | No of patients within 1 hour | 16 | 12 | 20 | 9 | 14 | 14 | 17 | 19 | 16 | 15 | 10 | 12 |
| | % Compliance | 64.0% | 38.7% | 74.1% | 37.5% | 48.3% | 43.8% | 53.1% | 51.4% | 50.0% | 48.4% | 47.6% | 38.7% |
| Percentage of patients who are assessed by a stroke specialist consultant physician within 24 hours | Total admissions | 25 | 31 | 27 | 24 | 29 | 32 | 32 | 37 | 32 | 31 | 21 | 31 |
| | No of patients within 24 hours | 16 | 25 | 19 | 17 | 26 | 14 | 24 | 22 | 23 | 16 | 11 | 20 |
| | % Compliance | 64.0% | 80.6% | 70.4% | 70.8% | 89.7% | 43.8% | 75.0% | 59.5% | 71.9% | 51.6% | 52.4% | 64.5% |

### How are we doing, what actions are we taking?

**How are we doing?**

Stroke data is for March 2019 and is therefore provided in detail for Prince Charles Hospital, Cwm Taf only. During March a total of 51 patients were recorded within the Sentinel Stroke National Audit Programme (SSNAP) database. All six eligible patients were thrombolysed.

*March 2019 Care Performance Indicators*
*Prince Charles Hospital*

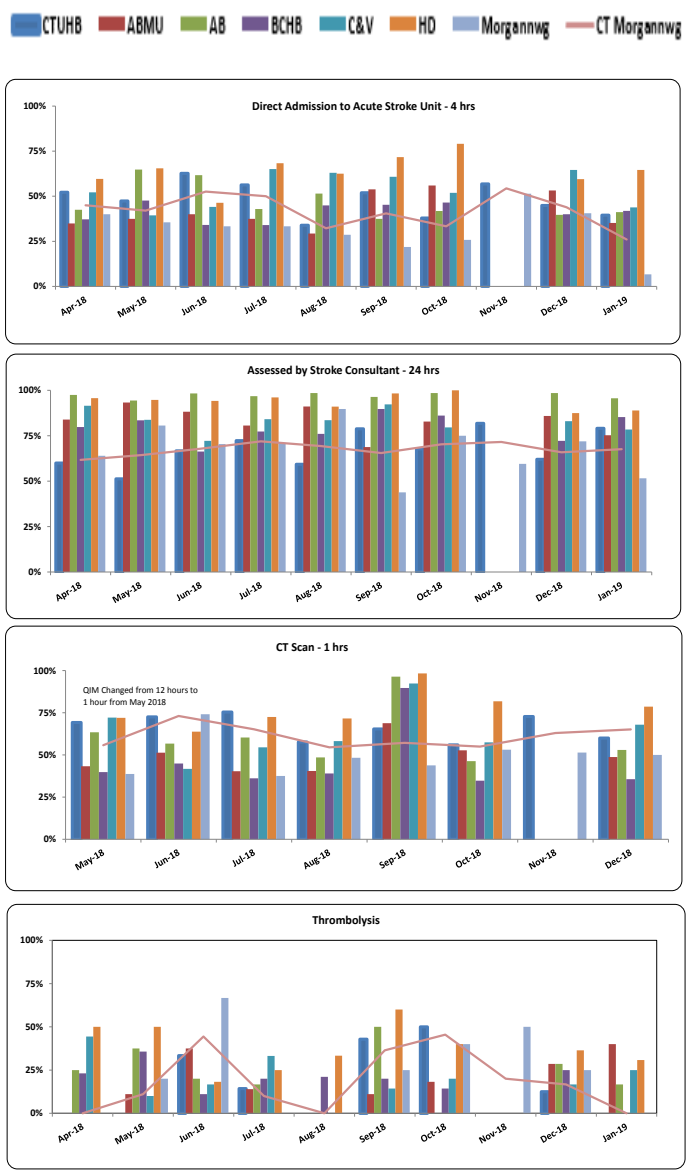
| *Thrombolysis Care Performance Indicators* | *Aspiration* | *Score* |
|---|---|---|
| **1. Access** | | |
| 1a - Percentage of All Stroke Patients Thrombolysed | *N/A* | 11.76% |
| 1b - Percentage of Eligible Stroke Patients Thrombolysed | *100%* | 100.0% |
| | | |
| **2. Time** | | |
| 2a - Thrombolysed Patients with Door-to-needle <=30 mins | *50%* | 0.0% |
| 2b - Thrombolysed Patients with Door-to-needle <=45 mins | *90%* | 0.0% |
| 2c - Thrombolsyed Patients with Onset-to-Needle <=90 mins | *N/A* | 0.0% |
| 2d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score | *100%* | 100.0% |
| ***72 Hour Pathway Care Performance Indicators*** | | |
| **1. Within 4 Hours Care Performance Indicator** | *95%* | 45.1% |
| 1a - Direct Admission to Acute Stroke Unit | *95%* | 41.7% |
| 1b - Swallow Screening | *95%* | 78.4% |
| | | |
| **2. Within 12 Hours Care Performance Indicator** | *95%* | 98.0% |
| 2a - CT Scan | *95%* | 98.0% |
| | | |
| **3. Within 24 Hours Care Performance Indicator** | *95%* | 52.9% |
| 3a - Assessed by a Stroke Consultant | *95%* | 64.7% |
| 3b - Assessed by a Stroke Nurse | *95%* | 88.2% |
| 3c - Assessed by One of OT, PT, SALT | *95%* | 62.7% |
| | | |
| **4. Within 72 Hours Care Performance Indicator** | *95%* | 94.1% |
| 4a - Formal Swallow Assessment | *95%* | 87.5% |
| 4b - OT Assessment | *95%* | 95.8% |
| 4c - Physiotherapy Assessment | *95%* | 95.8% |
| 4d - SALT Communications Assessment | *95%* | 93.8% |

**What actions are we taking?**

The March performance for the 4 hour bundle improved again this month to 45.1% from 40% in February. The one hour to CT time performance improved this month to 72.5% from 56% last month: there were 37 patients of the 51 compliant to one hour to CT.

The new Stroke QIMs were implemented from 1 April 2019. Performance will be monitored closely to ensure compliance for both Prince Charles and Princess of Wales Hospitals going forward.

### Benchmarking: how do we compare?




Source: SSNAP

## Local Measure: 72 hour stroke pathway care performance indicators (Stroke Bundles) and Thrombolysis

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Director of Planning and Performance

Period: Apr 2018 to Mar 2019

Target: 95%

### Current Bundle Performance:

Cwm Taf Morgannwg

Bundle information is not currently available

Cwm Taf

See column to right

Morgannwg

Bundle information is not currently available

### How are we doing, what actions are we taking?

**How are we doing?**

**Stroke data is for March 2019 and is therefore provided in detail for Prince Charles Hospital, Cwm Taf only.**

| | Bundle 1 - < 4 hours | | | Bundle 2 - <12 hours | | |
|---|---|---|---|---|---|---|
| | Target 95% | | | Target 95% | | |
| Period | Compliant | Non Compliant | Performance | Compliant | Non Compliant | Performance |
| Mar-18 | 23 | 28 | 45.1% | 49 | 2 | 96.1% |
| Apr-18 | 17 | 18 | 48.6% | 35 | 0 | 100.0% |
| May-18 | 19 | 20 | 48.7% | 39 | 0 | 100.0% |
| Jun-18 | 32 | 19 | 62.7% | 50 | 1 | 98.0% |
| Jul-18 | 37 | 28 | 56.9% | 64 | 1 | 98.5% |
| Aug-18 | 19 | 40 | 32.2% | 56 | 3 | 94.9% |
| Sep-18 | 27 | 25 | 51.9% | 50 | 2 | 96.2% |
| Oct-18 | 22 | 30 | 37.3% | 58 | 1 | 98.3% |
| Nov-18 | 24 | 20 | 54.5% | 44 | 0 | 100.0% |
| Dec-18 | 23 | 27 | 46.0% | 50 | 0 | 100.0% |
| Jan-19 | 16 | 27 | 37.2% | 43 | 0 | 100.0% |
| Feb-19 | 20 | 30 | 40.0% | 49 | 1 | 98.0% |
| Mar-19 | 23 | 28 | 45.1% | 50 | 1 | 98.0% |

| Bundle 3 - < 24 hours | | | Bundle 4 - < 72 hours | | |
|---|---|---|---|---|---|
| Target 95% | | | Target 95% | | |
| Compliant | Non Compliant | Performance | Compliant | Non Compliant | Performance |
| 23 | 28 | 45.1% | 44 | 7 | 86.3% |
| 20 | 15 | 57.1% | 33 | 2 | 94.3% |
| 19 | 20 | 48.7% | 31 | 8 | 79.5% |
| 29 | 22 | 56.9% | 49 | 2 | 96.1% |
| 46 | 19 | 70.8% | 61 | 4 | 93.8% |
| 34 | 25 | 57.6% | 45 | 14 | 76.3% |
| 35 | 17 | 67.3% | 50 | 2 | 96.2% |
| 38 | 14 | 64.4% | 52 | 7 | 88.1% |
| 36 | 8 | 81.8% | 41 | 3 | 93.2% |
| 30 | 20 | 60.0% | 44 | 6 | 88.0% |
| 31 | 12 | 72.1% | 40 | 3 | 93.0% |
| 30 | 20 | 60.0% | 45 | 5 | 90.0% |
| 27 | 24 | 52.9% | 48 | 3 | 94.1% |

**What actions are we taking?**

**Weekly performance meetings, Task and Finish Groups and Project Boards continue with good attendance from all disciplines.**

**What are the areas of risk?**

Work continues around time to ASU, door to needle times, swallow screen training and a review of out of area patients.

### Thrombolysis

| Percentage of all strokes thrombolysed | | | | | | |
|---|---|---|---|---|---|---|
| Period | Actual number of patients thrombolysed | Within door to needle <45 mins | Number of eligible patients (RCP) | % of all stroke patients thrombolysed | % of all eligible stroke patients thrombolysed (RCP) | Total |
| Mar-18 | 3 | 0 | 2 | 5.9% | 100.0% | 51 |
| Apr-18 | 2 | 0 | 2 | 5.7% | 100.0% | 35 |
| May-18 | 4 | 0 | 5 | 10.3% | 80.0% | 39 |
| Jun-18 | 12 | 4 | 12 | 23.5% | 100.0% | 51 |
| Jul-18 | 7 | 1 | 8 | 10.8% | 87.5% | 65 |
| Aug-18 | 7 | 0 | 8 | 11.9% | 87.5% | 59 |
| Sep-18 | 7 | 3 | 5 | 9.6% | 100.0% | 52 |
| Oct-18 | 6 | 3 | 5 | 8.5% | 100.0% | 59 |
| Nov-18 | 3 | 0 | 3 | 6.8% | 100.0% | 44 |
| Dec-18 | 8 | 1 | 8 | 16.0% | 100.0% | 50 |
| Jan-19 | 8 | 0 | 6 | 18.60% | 100.0% | 43 |
| Feb-19 | 8 | 3 | 8 | 16.00% | 100.0% | 50 |
| Mar-19 | 6 | 0 | 6 | 11.76% | 100.0% | 51 |

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| Percentage of all strokes thrombolysed | | | | | | |
|---|---|---|---|---|---|---|
| Period | Actual number of patients thrombolysed | Within door to needle <45 mins | Number of eligible patients (RCP) | % of all stroke patients thrombolysed | % of all eligible stroke patients thrombolysed (RCP) | Total |
| Apr-18 | 4 | 0 | 4 | 14.8% | 100.0% | 27 |
| May-18 | 6 | 1 | 6 | 18.2% | 100.0% | 33 |
| Jun-18 | 7 | 4 | 7 | 24.1% | 100.0% | 29 |
| Jul-18 | 3 | 0 | 3 | 12.0% | 100.0% | 25 |
| Aug-18 | 6 | 0 | 6 | 18.2% | 100.0% | 33 |
| Sep-18 | 4 | 1 | 4 | 12.5% | 100.0% | 32 |
| Oct-18 | 5 | 2 | 6 | 15.6% | 83.3% | 32 |
| Nov-18 | 2 | 1 | 1 | 5.4% | 100.0% | 37 |
| Dec-18 | 4 | 1 | 3 | 11.4% | 100.0% | 35 |
| Jan-19 | 1 | 0 | 1 | 3.2% | 100.0% | 31 |
| Feb-19 | 1 | 1 | 1 | 4.5% | 100.0% | 22 |
| Mar-19 | 5 | 3 | 5 | 16.1% | 100.0% | 31 |

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| Percentage of all strokes thrombolysed | | | | | | |
|---|---|---|---|---|---|---|
| Period | Actual number of patients thrombolysed | Within door to needle <45 mins | Number of eligible patients (RCP) | % of all stroke patients thrombolysed | % of all eligible stroke patients thrombolysed (RCP) | Total |
| Apr-18 | 6 | 0 | 6 | 9.7% | | 62 |
| May-18 | 10 | 1 | 11 | 13.9% | | 72 |
| Jun-18 | 19 | 8 | 19 | 23.8% | | 80 |
| Jul-18 | 10 | 1 | 11 | 11.1% | | 90 |
| Aug-18 | 13 | 0 | 14 | 14.1% | | 92 |
| Sep-18 | 11 | 4 | 9 | 13.1% | | 84 |
| Oct-18 | 11 | 5 | 11 | 12.1% | | 91 |
| Nov-18 | 5 | 1 | 4 | 6.2% | | 81 |
| Dec-18 | 12 | 2 | 11 | 14.1% | | 85 |
| Jan-19 | 9 | 0 | 7 | 12.2% | | 74 |
| Feb-19 | 9 | 4 | 9 | 12.5% | | 72 |
| Mar-19 | 11 | 3 | 11 | 13.4% | | 82 |

Source: SSNAP

## Indicator 67: The percentage of emergency responses to red calls arriving within (up to and including) 8 minutes

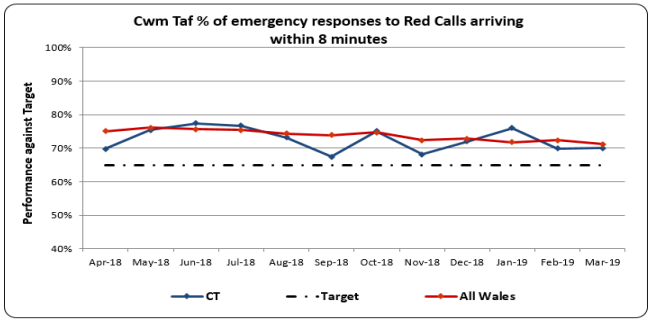
| Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need | Executive Lead: Chief Operating Officer |
|---|---|
| Period: Apr 2018 to Mar 2019 | Target: 65% |

### Current Performance:

Cwm Taf Morgannwg

Data is not currently available

Cwm Taf




Morgannwg

Data is not currently available

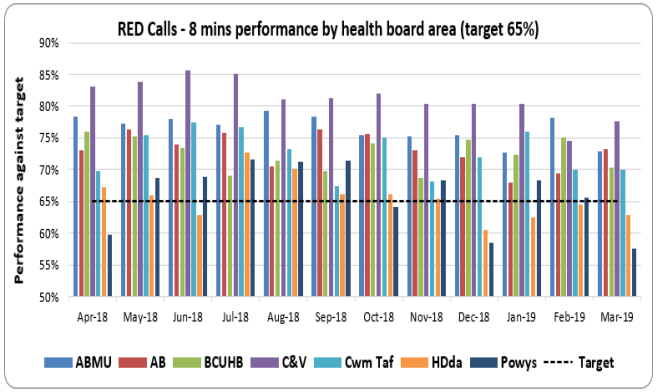
### How are we doing, what actions are we taking?

**How are we doing?**
The Cwm Taf March performance against the Red Ambulance target was 70%. The All Wales performance being 72.2%

**What actions are we taking?**
The Health Board continues to work closely with WAST colleagues to maintain this performance and develop further alternative pathways.

**What are the risk areas?**
The most significant risk is the boundary change and implications upon the service as a result.

### Benchmarking: how do we compare?

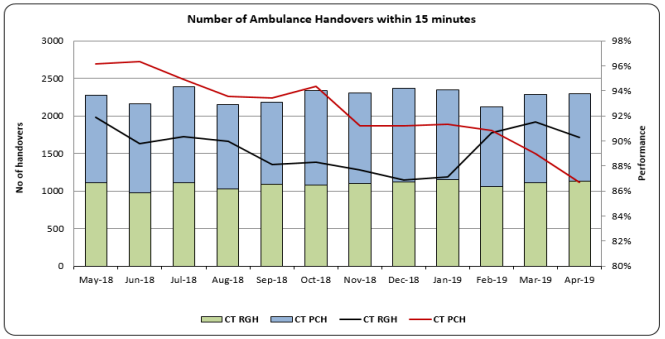



**The Health Board remains comparable with peers.**

Source: Local/Information Team
*https://statswales.wales.gov.uk/Catalogue/Health-and-Social-Care/NHS-Performance/Ambulance-Services/emergencyambulancecallsandresponsestoredcalls-by-lhb-month*

## Local Measure: Number of ambulance handovers within 15 minutes

| Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need | Executive Lead: Chief Operating Officer |
|---|---|
| Period: May 2018 to Apr 2019 | Target: Improvement |

| Current Performance: | How are we doing, what actions are we taking? | Benchmarking: how do we compare? |
|---|---|---|
| Cwm Taf Morgannwg<br><br>Data not currently available<br><br>Cwm Taf<br>  <br><br>Morgannwg<br><br>Compliance as per narrative | **How are we doing?**<br>The A&E departments are committed to ensuring ambulances are released back into the community as soon as clinically possible.<br><br>Current status for Cwm Taf for April is 88.43%. Compliance for Morgannwg was 22.4%.<br><br>**What actions are we taking?**<br>Monitoring of the handover performance continues and alerts are sent to senior managers when delays occur so that they can be reviewed.<br><br>Escalation within the departments is embedded to ensure support during times of high acuity.<br><br>**What are the risk areas?**<br>The most significant risk is the boundary change and implications upon the service as a result. | **This is a local measure and therefore no benchmarking data is available** |

Source: Local/Information Team

## Indicator 68: Number of ambulance handovers over one hour

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

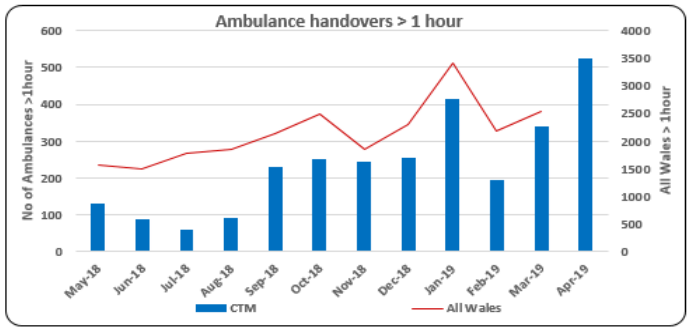
Executive Lead: Chief Operating Officer

Period: May 2018 to Apr 2019

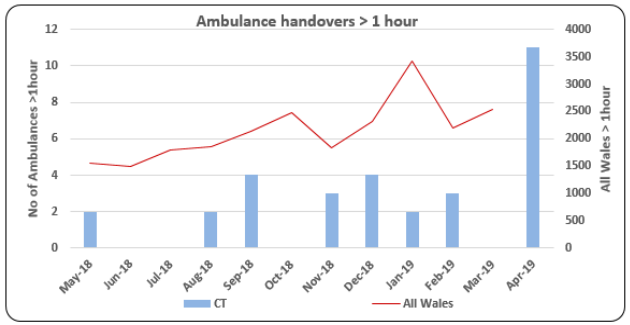
Target: Zero

### Current Performance:

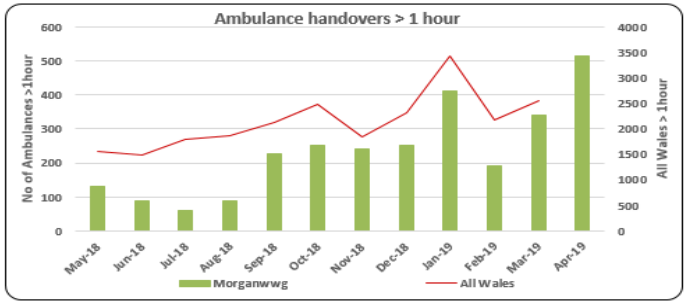
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

**How are we doing?**

Monitoring of the handover performance continues on a daily basis and the UHB remains the best performing HB. However, there were 11 delays in April 2019 for Cwm Taf alone  There were 513 delays for Morgannwg.

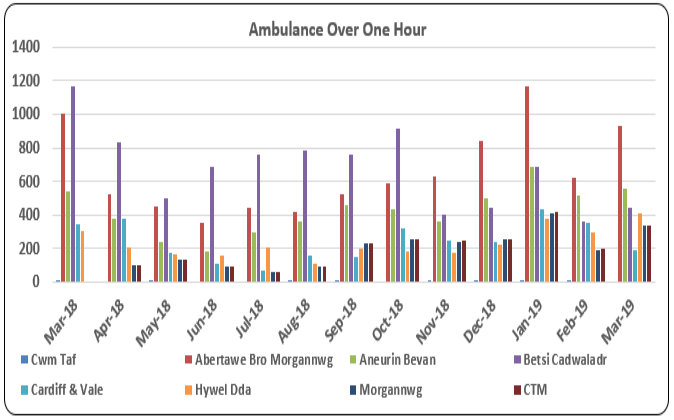
**What are the areas of risk?**

This area of performance is reasonably stable at the Royal Glamorgan and Prince Charles and we do not anticipate any problems, notwithstanding the additional delays at Princess of Wales as a result of the impact of the boundary change.

### Benchmarking: how do we compare?

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Wales | Morgannwg | CTM |
|---|---|---|---|---|---|---|---|---|---|
| Mar-18 | 11 | 1006 | 537 | 1170 | 344 | 303 | 3371 | | |
| Apr-18 | 0 | 526 | 373 | 835 | 374 | 202 | 2334 | 101 | 101 |
| May-18 | 2 | 452 | 239 | 498 | 171 | 165 | 1562 | 130 | 132 |
| Jun-18 | 0 | 351 | 178 | 686 | 109 | 158 | 1495 | 88 | 88 |
| Jul-18 | 0 | 443 | 293 | 761 | 68 | 209 | 1790 | 61 | 61 |
| Aug-18 | 2 | 420 | 357 | 785 | 161 | 112 | 1837 | 90 | 92 |
| Sep-18 | 4 | 526 | 461 | 757 | 145 | 200 | 2132 | 227 | 231 |
| Oct-18 | 0 | 590 | 432 | 914 | 323 | 183 | 2486 | 253 | 253 |
| Nov-18 | 3 | 628 | 363 | 403 | 244 | 171 | 1844 | 241 | 244 |
| Dec-18 | 4 | 842 | 495 | 446 | 241 | 226 | 2310 | 252 | 256 |
| Jan-19 | 2 | 1164 | 689 | 690 | 430 | 376 | 3418 | 412 | 414 |
| Feb-19 | 3 | 619 | 519 | 358 | 351 | 294 | 2188 | 191 | 194 |
| Mar-19 | 0 | 928 | 558 | 438 | 189 | 407 | 2544 | 340 | 340 |

**For the period 2018/19 Cwm Taf was the best performing Health Board in this area.**




Source: Local/Information Team and Welsh Government Performance and Delivery Site http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Indicator 69: The percentage of patients who spend less than 4 hours in all major and minor emergency care (i.e. A&E) facilities from arrival until admission, transfer or discharge

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

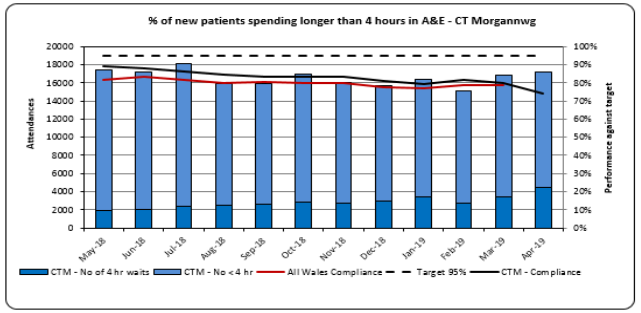
Executive Lead: Chief Operating Officer

Period: Apr 2018 to Mar 2019

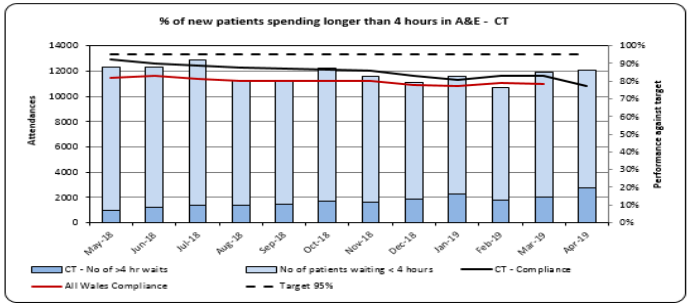
Target: 95%

### Current Performance:

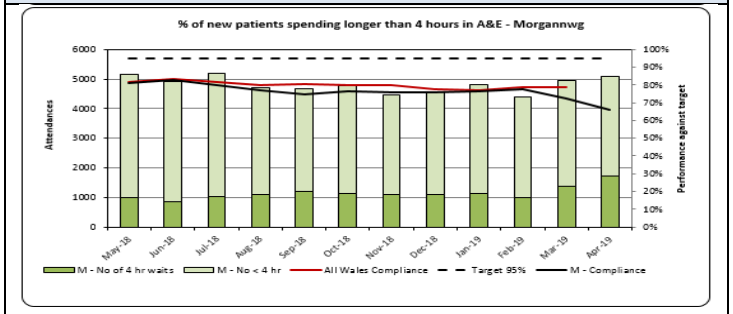
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

**How are we doing?**

The combined acute compliance for Cwm Taf Morgannwg University Health Board performance for the 4 hour target for April was a disappointing 74.2%. Individual acute department performance was 73.9% at Prince Charles Hospital (PCH) and 78.2% at Royal Glamorgan Hospital (RGH) and 66.2% at Princess of Wales (PoW). Compliance for Ysbyty Cwm Cynon (YCC) was 99.2% and Ysbyty Cwm Rhondda (YCR) at 100%. There were also 4 four hour breaches at YCC. Cwm Taf University Health Board compliance in April 2018 was 89.1%

**What actions are we taking?**

- Daily deep dive work on all acute and community wards continues.
- LA staff are fully engaged in all aspects of patient flow and attend weekly multiagency meetings.
- Twice daily bed meetings continue on each site.
- SW@H service is now in place on both DGH sites and early indications suggest that there is a reduction in LoS.

**What are the areas of risk?**

Staffing issues continue to be closely monitored.

### Benchmarking: how do we compare?

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Wales | Morgannwg | CTM |
|---|---|---|---|---|---|---|---|---|---|---|
| Feb-18 | 80.6% | 73.8% | 74.6% | 70.3% | 75.1% | 82.8% | 99.7% | 76.0% | | |
| Mar-18 | 81.6% | 71.4% | 75.3% | 67.8% | 80.2% | 81.6% | 99.2% | 75.7% | | |
| Apr-18 | 88.9% | 75.6% | 79.8% | 73.8% | 82.1% | 83.3% | 99.9% | 80.1% | 75.4% | 85.2% |
| May-18 | 91.8% | 78.9% | 79.6% | 77.5% | 83.4% | 83.3% | 100.0% | 82.0% | 81.1% | 88.9% |
| Jun-18 | 90.1% | 81.0% | 82.5% | 74.8% | 91.0% | 84.4% | 99.6% | 83.2% | 82.7% | 88.1% |
| Jul-18 | 88.7% | 79.9% | 78.8% | 71.5% | 92.5% | 82.9% | 99.6% | 81.4% | 80.1% | 86.5% |
| Aug-18 | 87.2% | 77.9% | 78.6% | 69.9% | 89.7% | 82.9% | 99.8% | 80.0% | 76.9% | 84.5% |
| Sep-18 | 87.1% | 77.5% | 78.6% | 69.7% | 90.3% | 83.4% | 99.8% | 80.3% | 74.5% | 83.6% |
| Oct-18 | 86.0% | 78.0% | 78.4% | 70.6% | 86.2% | 84.0% | 99.6% | 80.0% | 76.2% | 83.4% |
| Nov-18 | 85.5% | 76.7% | 78.3% | 71.7% | 85.7% | 85.6% | 99.6% | 80.1% | 75.8% | 83.2% |
| Dec-18 | 83.0% | 76.5% | 74.8% | 67.6% | 83.8% | 82.5% | 99.7% | 77.8% | 76.1% | 81.0% |
| Jan-19 | 80.0% | 76.9% | 76.2% | 66.9% | 84.0% | 81.9% | 99.7% | 77.2% | 76.3% | 79.3% |
| Feb-19 | 82.7% | 77.2% | 76.6% | 72.5% | 82.0% | 84.4% | 99.9% | 79.0% | 77.7% | 81.5% |
| Mar-19 | 82.8% | 75.7% | 78.5% | 71.1% | 84.3% | 81.7% | 100.0% | 78.7% | 72.2% | 80.0% |

The Health Board's performance remains comparable with peers. It was expected that performance would drop post 1 April and this has been the case: April performance 74.2%.

Source: EDDS [http://nww.infoandstats.wales.nhs.uk/page.cfm?orgid=527&pid=53004](http://nww.infoandstats.wales.nhs.uk/page.cfm?orgid=527&pid=53004)
https://statswales.gov.wales/Catalogue/Health-and-Social-Care/NHS-Hospital-Waiting-Times/Accident-and-Emergency/performanceagainst4hourwaitingtimestarget-by-hospital

## Indicator 70: 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

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

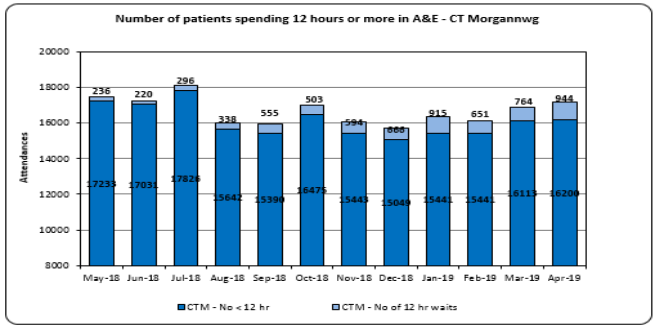
Executive Lead: Chief Operating Officer

Period: Apr 2018 to Mar 2019

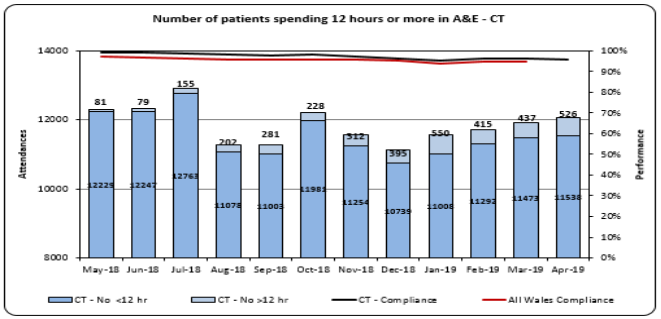
Target: Zero

### Current Performance:

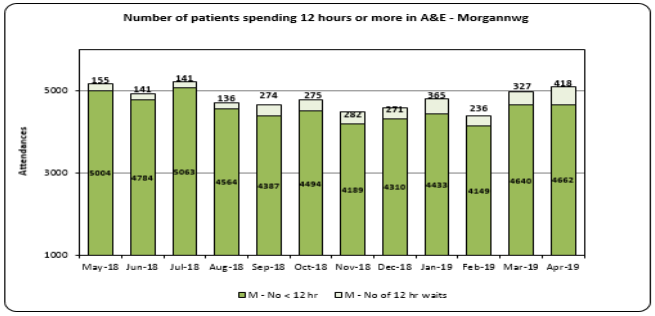
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

**How are we doing?**

The April performance for the twelve hour target was 944 patients. There were 355 breaches at PCH, 171 at RGH and 418 at PoW. The corresponding breach figure for Cwm Taf University Health Board in April 2018 was 219.

**What actions are we taking?**

- Daily deep dive work on all acute and community wards continues.
- LA staff are present on both community sites as routine and patients waiting to transfer to community sites have reduced dramatically.
- Concentrated effort is now being made to eradicate 12 hour waits.
- SW@H teams are now in place on both DGH sites and close monitoring of their impact is in place.

**What are the risk areas?**

Cwm Taf's performance has improved significantly and is currently the 3rd best in Wales for major care facilities.

### Benchmarking: how do we compare?

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Wales | Morgannwg | CTM |
|---|---|---|---|---|---|---|---|---|---|---|
| Feb-18 | 595 | 957 | 758 | 1808 | 291 | 682 | 0 | 5444 | 251 | 846 |
| Mar-18 | 516 | 1051 | 752 | 2059 | 207 | 858 | 0 | 5443 | 305 | 821 |
| Apr-18 | 208 | 737 | 545 | 1519 | 116 | 671 | 0 | 3796 | 163 | 371 |
| May-18 | 99 | 624 | 331 | 1040 | 26 | 707 | 0 | 2827 | 155 | 254 |
| Jun-18 | 71 | 476 | 246 | 1450 | 16 | 650 | 0 | 2909 | 141 | 212 |
| Jul-18 | 148 | 591 | 349 | 1854 | 17 | 813 | 0 | 3779 | 141 | 289 |
| Aug-18 | 214 | 511 | 389 | 1898 | 7 | 603 | 0 | 3622 | 136 | 350 |
| Sep-18 | 270 | 588 | 450 | 1816 | 17 | 663 | 0 | 3804 | 274 | 544 |
| Oct-18 | 230 | 681 | 374 | 1845 | 94 | 737 | 0 | 3961 | 275 | 505 |
| Nov-18 | 321 | 665 | 437 | 1404 | 56 | 675 | 0 | 3558 | 282 | 603 |
| Dec-18 | 395 | 758 | 470 | 1552 | 39 | 690 | 0 | 3904 | 271 | 666 |
| Jan-19 | 550 | 986 | 692 | 1989 | 137 | 943 | 0 | 5297 | 365 | 915 |
| Feb-19 | 415 | 685 | 615 | 1429 | 130 | 732 | 0 | 4006 | 236 | 651 |
| Mar-19 | 437 | 861 | 561 | 1633 | 34 | 948 | 0 | 4472 | 327 | 764 |

The Health Board's performance, prior to 1 April 2019, was amongst the best in Wales. It was expected that performance would decline post 1 April and this has been the case: April performance 944.

Source: http://nww.infoandstats.wales.nhs.uk/page.cfm?orgid=527&pid=53004

## Indicator 71: The percentage of patients newly diagnosed with cancer, not via the urgent route, that started definitive treatment within (up to & including) 31 days of diagnosis (regardless of referral route)

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Apr 2018 to Mar 2019

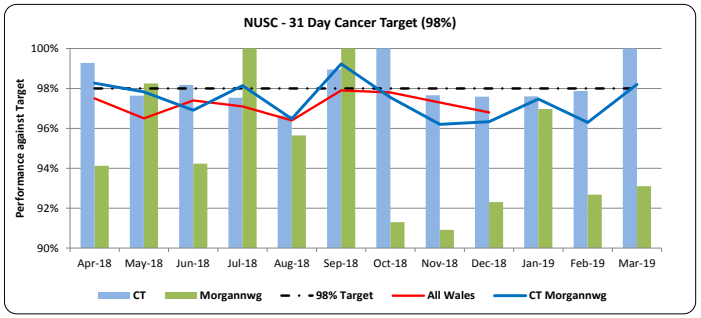
Target: 98%

### Current Performance:

Cwm Taf Morgannwg

| | CT Morgannwg | |
|---|---|---|
| Month | NUSC Treated <31 days | 98% Target |
| Apr-18 | 98.27% | 98.00% |
| May-18 | 97.83% | 98.00% |
| Jun-18 | 96.91% | 98.00% |
| Jul-18 | 98.14% | 98.00% |
| Aug-18 | 96.48% | 98.00% |
| Sep-18 | 99.23% | 98.00% |
| Oct-18 | 97.55% | 98.00% |
| Nov-18 | 96.20% | 98.00% |
| Dec-18 | 96.33% | 98.00% |
| Jan-19 | 97.47% | 98.00% |
| Feb-19 | 96.30% | 98.00% |
| Mar-19 | 98.20% | 98.00% |

Cwm Taf




Morgannwg

| | Morgannwg | |
|---|---|---|
| Month | NUSC Treated <31 days | 98% Target |
| Apr-18 | 94.12% | 98.00% |
| May-18 | 98.25% | 98.00% |
| Jun-18 | 94.23% | 98.00% |
| Jul-18 | 100.00% | 98.00% |
| Aug-18 | 95.65% | 98.00% |
| Sep-18 | 100.00% | 98.00% |
| Oct-18 | 91.30% | 98.00% |
| Nov-18 | 90.91% | 98.00% |
| Dec-18 | 92.31% | 98.00% |
| Jan-19 | 96.97% | 98.00% |
| Feb-19 | 92.68% | 98.00% |
| Mar-19 | 93.10% | 98.00% |

### How are we doing, what actions are we taking?

**How are we doing?**

The 31 day target (NUSC) of 98% was achieved this month.

| | CT | |
|---|---|---|
| Month | NUSC Treated <31 days | 98% Target |
| Apr-18 | 99.28% | 98.00% |
| May-18 | 97.64% | 98.00% |
| Jun-18 | 98.18% | 98.00% |
| Jul-18 | 97.54% | 98.00% |
| Aug-18 | 96.64% | 98.00% |
| Sep-18 | 98.95% | 98.00% |
| Oct-18 | 100.00% | 98.00% |
| Nov-18 | 97.66% | 98.00% |
| Dec-18 | 97.59% | 98.00% |
| Jan-19 | 97.60% | 98.00% |
| Feb-19 | 97.87% | 98.00% |
| Mar-19 | 100.00% | 98.00% |

**What actions are we taking?**

- The Cancer team have implemented enhanced scrutiny for the whole Urological pathway by putting in place a Urological cancer pathway coordinator, who has worked with the Urological CNS to manage the pathways and escalate these patients on a daily basis.
- They are continuing to monitor one stop diagnostic capacity and ensure delays are not reoccurring at the front end of the pathway.
- Capacity challenges remain however.
- A cancer pathway coordinator has commenced in radiology to improve the timeliness of appointments and reporting of patients on cancer pathways.
- Endoscopy capacity increase plans are being implemented, but will require time to embed and impact on pathway improvement.

**What are the areas of risk?**

There are concerns with regards to referral numbers and capacity within diagnostic services. There are currently issues in endoscopy capacity as a result of clinical staff shortages. There are also challenges with regards to throughput of colorectal patients as a result of capacity. The Directorate continues to scrutinise and escalate as appropriate all patients' pathways, in particular Urology pathways.

### Benchmarking: how do we compare?

| Non-Urgent suspected cancer - Target 98% | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Morgannwg | New CT |
| Mar-18 | 99.0% | 93.3% | 99.3% | 97.9% | 95.5% | 93.9% | | |
| Apr-18 | 99.3% | 92.4% | 99.3% | 98.0% | 98.6% | 98.1% | 94.12% | 98.27% |
| May-18 | 97.6% | 94.2% | 98.2% | 95.0% | 96.4% | 99.1% | 98.25% | 97.83% |
| Jun-18 | 98.2% | 96.2% | 98.1% | 97.8% | 96.4% | 97.5% | 94.23% | 96.91% |
| Jul-18 | 97.5% | 99.3% | 96.2% | 95.4% | 94.4% | 99.2% | 100.00% | 98.14% |
| Aug-18 | 96.6% | 97.4% | 96.8% | 98.9% | 88.6% | 96.0% | 95.65% | 96.48% |
| Sep-18 | 98.9% | 95.7% | 98.6% | 100.0% | 95.8% | 97.2% | 100.00% | 99.23% |
| Oct-18 | 100.0% | 95.9% | 96.4% | 98.4% | 98.8% | 99.1% | 91.30% | 97.55% |
| Nov-18 | 97.7% | 96.2% | 96.4% | 99.5% | 98.2% | 95.5% | 90.91% | 96.20% |
| Dec-18 | 97.6% | 85.7% | 97.8% | 98.1% | 93.9% | 95.9% | 92.31% | 96.33% |
| Jan-19 | 97.6% | 97.7% | 99.5% | 97.4% | 94.8% | 98.7% | 96.97% | 97.47% |
| Feb-19 | 97.9% | 94.7% | 97.5% | 98.9% | 95.5% | 100.0% | 92.68% | 96.30% |

**Cwm Taf's performance in this area is comparable with other Welsh Health Boards.**

Source: CANISC/Welsh Government Delivery & Performance Website [http://howis.wales.nhs.uk/sitesplus/407/page/64649](http://howis.wales.nhs.uk/sitesplus/407/page/64649)

## Indicator 72: The percentage of patients newly diagnosed with cancer, via the urgent suspected cancer route, that started definitive treatment within (up to & including) 62 days of receipt of referral

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Chief Operating Officer

Period: Apr 2018 to Mar 2019

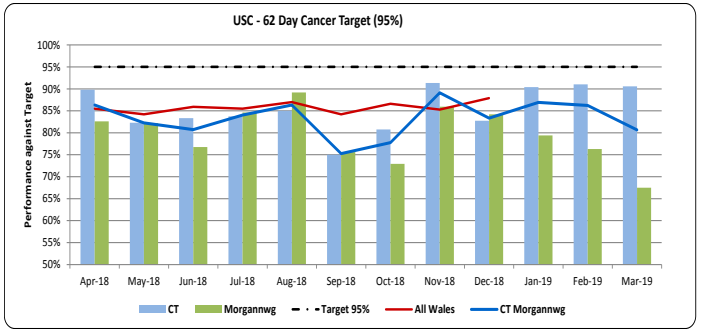
Target: 95%

### Current Performance:

Cwm Taf Morgannwg

| Month | USC Treated <62 days | 95% Target |
|---|---|---|
| Apr-18 | 86.32% | 95.00% |
| May-18 | 82.26% | 95.00% |
| Jun-18 | 80.73% | 95.00% |
| Jul-18 | 84.03% | 95.00% |
| Aug-18 | 86.32% | 95.00% |
| Sep-18 | 75.26% | 95.00% |
| Oct-18 | 77.78% | 95.00% |
| Nov-18 | 89.13% | 95.00% |
| Dec-18 | 83.33% | 95.00% |
| Jan-19 | 86.92% | 95.00% |
| Feb-19 | 86.21% | 95.00% |
| Mar-19 | 80.65% | 95.00% |

Cwm Taf




Morgannwg

| | Morgannwg | |
|---|---|---|
| Month | USCTreated <62 days | 95% Target |
| Apr-18 | 82.61% | 95.00% |
| May-18 | 82.22% | 95.00% |
| Jun-18 | 76.74% | 95.00% |
| Jul-18 | 84.62% | 95.00% |
| Aug-18 | 89.19% | 95.00% |
| Sep-18 | 75.61% | 95.00% |
| Oct-18 | 72.92% | 95.00% |
| Nov-18 | 85.96% | 95.00% |
| Dec-18 | 84.21% | 95.00% |
| Jan-19 | 79.41% | 95.00% |
| Feb-19 | 76.32% | 95.00% |
| Mar-19 | 67.50% | 95.00% |

### How are we doing, what actions are we taking?

**How are we doing?**

The 62 day target (USC) compliance was 90.57%, this is the third month in succession where a compliance greater than 90% has been attained. In total there were five breaches, with the reasons for non-achievement being delays awaiting diagnostic investigations and delays awaiting surgery, both local and tertiary.

| | CT | |
|---|---|---|
| Month | USC Treated < 62 days | Target 95% |
| Apr-18 | 89.80% | 95.00% |
| May-18 | 82.28% | 95.00% |
| Jun-18 | 83.33% | 95.00% |
| Jul-18 | 83.75% | 95.00% |
| Aug-18 | 85.00% | 95.00% |
| Sep-18 | 75.00% | 95.00% |
| Oct-18 | 80.77% | 95.00% |
| Nov-18 | 91.35% | 95.00% |
| Dec-18 | 82.76% | 95.00% |
| Jan-19 | 90.40% | 95.00% |
| Feb-19 | 91.03% | 95.00% |
| Mar-19 | 90.57% | 95.00% |

**What actions are we taking?**

- The Cancer team have implemented enhanced scrutiny for the whole Urological pathway by putting in place a Urological cancer pathway coordinator, who has worked with the Urological CNS to manage the pathways and escalate these patients on a daily basis.
- They are continuing to monitor one stop diagnostic capacity and ensure delays are not reoccurring at the front end of the pathway.
- Capacity challenges remain however.
- A cancer pathway coordinator has commenced in radiology to improve the timeliness of appointments and reporting of patients on cancer pathways.
- Endoscopy capacity increase plans are being implemented, but will require time to embed and impact on pathway improvement.

**What are the areas of risk?**

There are concerns with regards to referral numbers and capacity within diagnostic services. There are currently issues in endoscopy capacity as a result of clinical staff shortages. There are also challenges with regards to throughput of colorectal patients as a result of capacity. The Directorate continues to scrutinise and escalate as appropriate all patients' pathways, in particular Urology pathways.

### Benchmarking: how do we compare?

| Urgent suspected cancer - Target 95% | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Morgannwg | CTM |
| Mar-18 | 90.40% | 88.10% | 92.00% | 82.80% | 87.00% | 90.30% | | |
| Apr-18 | 89.80% | 77.40% | 91.20% | 82.80% | 88.90% | 90.00% | 82.61% | 86.32% |
| May-18 | 82.30% | 90.40% | 80.50% | 80.80% | 75.00% | 95.40% | 82.22% | 82.26% |
| Jun-18 | 83.33% | 84.10% | 87.90% | 83.30% | 87.00% | 91.00% | 76.74% | 80.73% |
| Jul-18 | 83.75% | 92.20% | 84.00% | 82.10% | 81.80% | 88.00% | 84.62% | 84.03% |
| Aug-18 | 85.00% | 94.10% | 83.60% | 85.30% | 79.80% | 90.90% | 89.19% | 86.32% |
| Sep-18 | 75.00% | 82.90% | 87.10% | 83.00% | 83.50% | 90.70% | 75.61% | 75.26% |
| Oct-18 | 80.77% | 84.30% | 89.90% | 85.80% | 84.50% | 93.50% | 72.92% | 77.78% |
| Nov-18 | 91.35% | 87.60% | 86.10% | 80.90% | 81.00% | 85.50% | 85.96% | 89.13% |
| Dec-18 | 82.80% | 88.10% | 91.30% | 87.20% | 85.70% | 88.30% | 84.21% | 83.33% |
| Jan-19 | 90.40% | 85.40% | 88.00% | 84.40% | 85.90% | 78.80% | 79.41% | 86.92% |
| Feb-19 | 91.00% | 80.60% | 91.40% | 80.80% | 87.00% | 80.70% | 76.32% | 86.21% |

**Cwm Taf's performance in this area is amongst the best in Wales.**

Source: CANISC/Welsh Government Delivery & Performance Website [http://howis.wales.nhs.uk/sitesplus/407/page/64649](http://howis.wales.nhs.uk/sitesplus/407/page/64649)

## Indicator 74: The percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

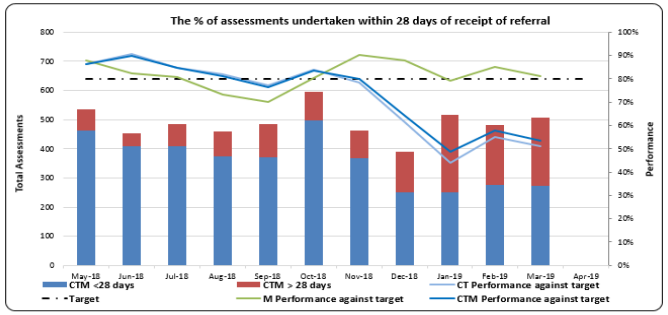
Executive Lead: Director of Primary, Community and Mental Health

Period: May 2018 to Mar 2019

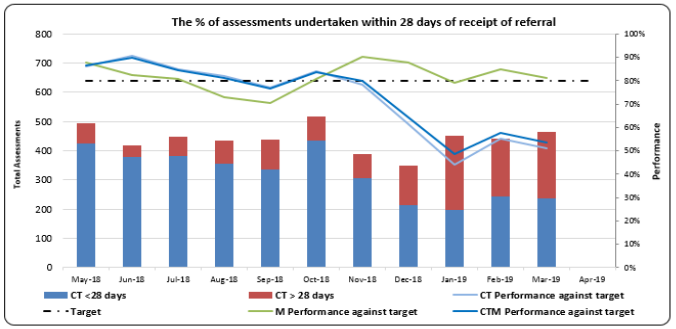
Target: 80%

### Current Performance:

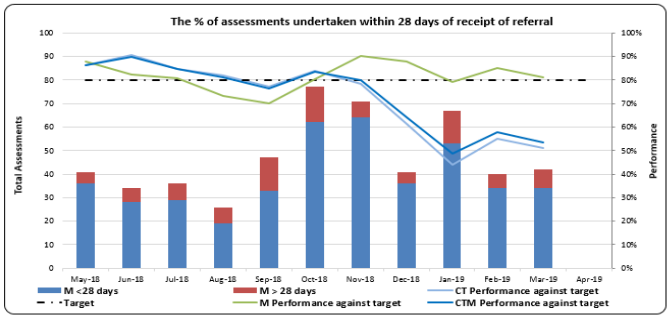
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

**How are we doing?**
Part One of the Mental Health Measure relates to primary care assessment and treatment and has a target for 80% of referrals to be assessed within 28 days.

As at the end of March:
Cwm Taf compliance 51.18%

Due to a backlog in referrals from December when there was less overtime clinics undertaken and a reduction in patients attending their appointments for assessment, the Primary Care Teams have increased capacity in order to deal with this backlog. This has involved evening and weekend clinics taking place.

**What actions are we taking?**
Continued liaison with GPs remains a priority for the Service to better manage referrals and ensure people receive a treatment at the earliest opportunity.

Recruitment to vacancies has been successful.

Continued support of Valley Steps is critical to address prevention and early intervention, opportunities to further integrate pathways for the management of depression are being explored with a view to seeing if this further reduces referrals to LPMHSS.

Further models of Primary Care mental health working are being explored with a view to closer more integrated working with clusters.

**What are the areas of risk?**
The resilience of a relatively small number of teams to maintain performance when there is annual leave and sick leave.

### Benchmarking: how do we compare?

| % of assessments by the LPMHSS undertaken within 28 days from the date of referral (target 80%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Morgannwg | CT Morgannwg |
| Jan-18 | 83.6% | 67.1% | 86.0% | 67.9% | 82.5% | 87.6% | 82.6% | | |
| Feb-18 | 88.5% | 73.8% | 95.9% | 77.6% | 94.9% | 94.2% | 86.8% | | |
| Mar-18 | 89.3% | 70.0% | 89.2% | 76.2% | 93.3% | 91.4% | 86.9% | | |
| Apr-18 | 82.4% | 84.1% | 84.6% | 71.0% | 87.4% | 82.4% | 94.9% | 80.36% | 82.14% |
| May-18 | 86.2% | 85.5% | 91.6% | 71.9% | 87.5% | 97.1% | 85.0% | 87.80% | 86.36% |
| Jun-18 | 90.5% | 82.5% | 86.8% | 73.4% | 90.5% | 96.6% | 93.1% | 82.35% | 83.87% |
| Jul-18 | 84.9% | 83.8% | 87.7% | 72.7% | 85.2% | 96.2% | 83.5% | 80.56% | 84.54% |
| Aug-18 | 81.8% | 80.5% | 83.2% | 70.9% | 83.1% | 93.4% | 80.1% | 73.08% | 81.30% |
| Sep-18 | 77.1% | 76.4% | 82.9% | 66.1% | 80.1% | 93.8% | 84.0% | 70.21% | 76.45% |
| Oct-18 | 84.0% | 83.8% | 91.1% | 68.2% | 88.6% | 96.4% | 87.6% | 80.52% | 83.53% |
| Nov-18 | 78.2% | 77.7% | 84.5% | 66.8% | 79.7% | 93.0% | 82.1% | 90.14% | 80.04% |
| Dec-18 | 61.5% | 83.8% | 84.0% | 75.1% | 68.7% | 93.5% | 87.1% | 87.80% | 64.27% |
| Jan-19 | 44.0% | 72.6% | 88.7% | 65.2% | 55.5% | 92.5% | 84.7% | 79.10% | 48.55% |
| Feb-19 | 55.2% | 79.8% | 86.0% | 19.3% | 90.4% | | 90.2% | 85.00% | 57.71% |

**The Health Board remains comparable with peers.**

Source: Local Mental Health

## Indicator 75: The percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

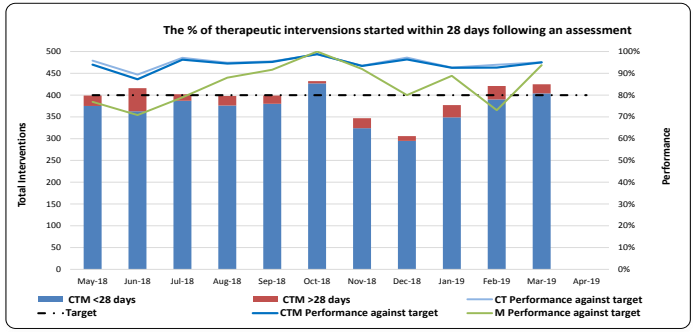
Executive Lead: Director of Primary, Community and Mental Health

Period: May 2018 to Mar 2019

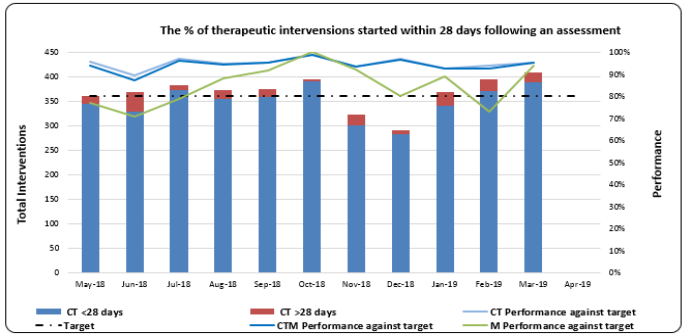
Target: 80%

### Current Performance:

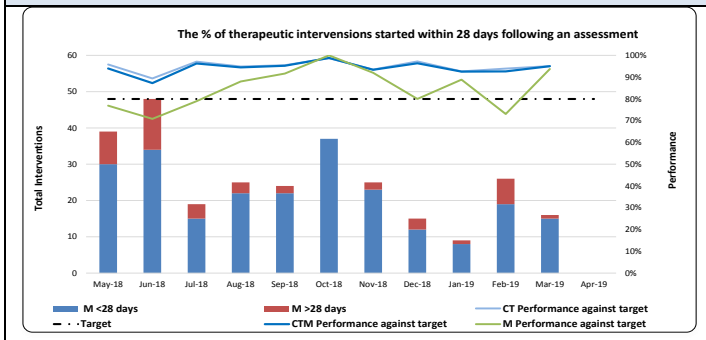
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

**How are we doing?**
Performance for Part 1 Treatment target (28 days) for March has improved further to 95.1% compared to the January position of 92.7% and February position of 93.9%.

**What actions are we taking?**
The Directorate Management Team will continue to monitor the waiting lists in all areas to ensure that compliance met.

Recruitment has been successful and needs to continue to be timely as any vacancies have significant effect on capacity to sustain over 80%.

Valley Steps are used as a first intervention for suitable people.

Addition intervention capacity has been bid for from new welsh Government funds for mental health services to further increase capacity and service resilience.

**What are the areas of risk?**
The resilience of a relatively small number of teams to maintain performance when there is annual leave and sick leave.

### Benchmarking: how do we compare?

% of therapeutic interventions started within 28 days following assessment by LPMHSS (target 80%)

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys | Morgannwg | CT Morgannwg |
|---|---|---|---|---|---|---|---|---|---|
| Jan-18 | 81.5% | 74.6% | 82.1% | 71.5% | 72.5% | 73.8% | 72.8% | | |
| Feb-18 | 95.2% | 88.8% | 92.6% | 78.5% | 75.4% | 84.0% | 87.7% | | |
| Mar-18 | 91.4% | 85.9% | 88.1% | 79.0% | 67.3% | 91.0% | 77.0% | | |
| Apr-18 | 89.8% | 79.3% | 83.9% | 73.4% | 76.5% | 88.0% | 73.1% | 75.00% | 88.54% |
| May-18 | 95.8% | 80.5% | 86.5% | 81.1% | 81.1% | 96.0% | 70.3% | 76.92% | 93.98% |
| Jun-18 | 89.4% | 79.5% | 85.0% | 71.5% | 71.4% | 88.9% | 82.1% | 70.83% | 87.26% |
| Jul-18 | 97.1% | 79.1% | 82.7% | 55.4% | 82.1% | 95.1% | 64.8% | 78.95% | 96.27% |
| Aug-18 | 94.9% | 90.3% | 91.2% | 59.9% | 74.3% | 90.7% | 70.7% | 88.00% | 94.47% |
| Sep-18 | 95.5% | 88.6% | 81.0% | 61.1% | 59.8% | 87.5% | 77.1% | 91.67% | 95.24% |
| Oct-18 | 98.7% | 91.5% | 82.4% | 65.9% | 64.9% | 92.5% | 80.3% | 100.00% | 98.84% |
| Nov-18 | 93.5% | 87.6% | 82.5% | 64.0% | 67.7% | 95.6% | 76.1% | 92.00% | 93.37% |
| Dec-18 | 97.3% | 85.2% | 80.4% | 73.8% | 73.3% | 93.8% | 77.8% | 80.00% | 96.41% |
| Jan-19 | 92.7% | 86.1% | 83.4% | 48.8% | 89.7% | 87.2% | 72.3% | 88.89% | 92.57% |
| Feb-19 | 93.9% | 87.5% | 82.0% | 67.1% | 85.2% | | 75.5% | 73.08% | 92.64% |

**The Health Board remains one of the best performing in this area.**

Source: Local Mental Health

**Indicator 76: The percentage of qualifying patients (compulsory and informal/voluntary) who had their first contact with an Independent Mental Health Advocacy (IMHA) within 5 working days of their request for an IMHA**

Outcome: To ensure the best possible outcome, my condition is diagnosed early and treated in accordance with clinical need

Executive Lead: Director of Primary, Community and Mental Health

Period: Nov 2017 to Sep 2018

Target: 80% (5 working days)

| Current Performance: | How are we doing, what actions are we taking? | Benchmarking: how do we compare? |
|---|---|---|
| Cwm Taf Morgannwg<br><br>Data is not currently available<br><br>Cwm Taf<br><br>Performance compliance is 100%<br><br>Morgannwg<br><br>Performance compliance is 100% | **There are no concerns in this area.**<br>**All Health Boards report 100% month on month.** | % qualifying patients who had their first contact with an IMHA within 5 working days of their request for an advocate<br>Target 100% |

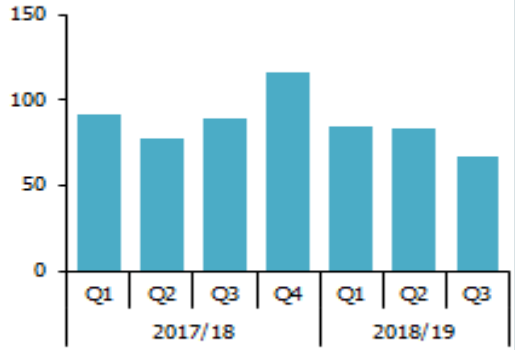
| LHB | 2018/19 | | 2017/18 | | | |
|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q1 | Q2 | Q3 | Q4 |
| ABM | 100% | 100% | 100% | 100% | 100% | 100% |
| AB | 100% | 100% | 99% | 100% | 100% | 100% |
| BCU | 100% | 100% | 100% | 100% | 100% | 100% |
| C&V | 100% | 100% | 100% | 100% | 100% | 100% |
| CTaf | 100% | 100% | 100% | 100% | 100% | 100% |
| HDda | 100% | 100% | 100% | 100% | 100% | 100% |
| Powys | 100% | 100% | 100% | 100% | 100% | 100% |
| Wales | 100% | 100% | 100% | 100% | 100% | 100% |

Source: Local Mental Health

## INDIVIDUAL CARE – People in Wales are treated as individuals with their own needs and responsibilities

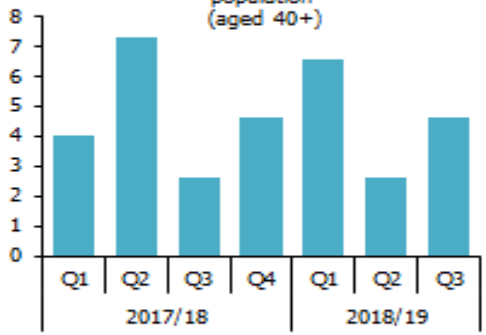
**Key: Cwm Taf Morgannwg** ——— **Cwm Taf** - - - **or** ▮ **Morgannwg** ▨

Number of calls to the mental health helpline CALL per 100,000 population



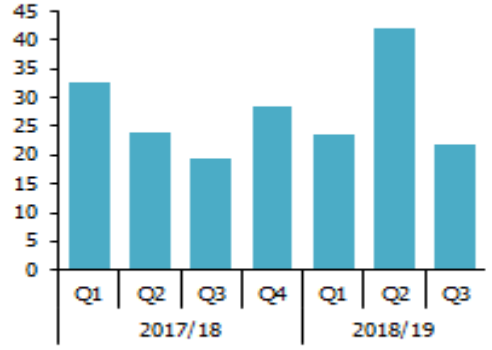

| Current Position | | |
|---|---|---|
| CT | POW | CTM |
| 67.2 | 7.9 | N/A |

Number of calls to the Wales dementia helpline per 100,000 population (aged 40+)



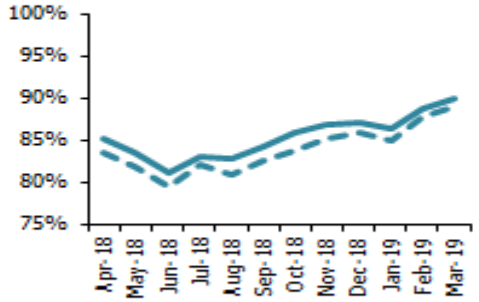

| Current Position | | |
|---|---|---|
| CT | POW | CTM |
| 4.6 | N/A | N/A |

Number of calls to the DAN 24/7 helpline per 100,000 population



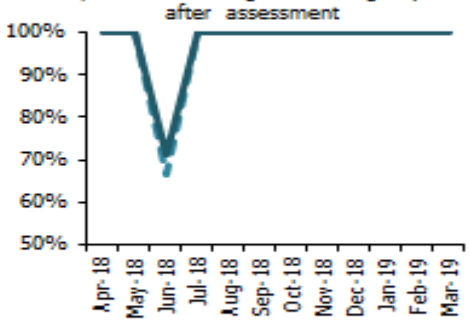

| Current Position | | |
|---|---|---|
| CT | POW | CTM |
| 21.7 | 5.5 | N/A |

The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)




| Current Position | | |
|---|---|---|
| CT | POW | CTM |
| 89.0% | 93.7% | 89.9% |

Residents assessed under part 3 mental health measure to be sent copy of outcome assessment report up to and including 10 working days after assessment




| Current Position | | |
|---|---|---|
| CT | POW | CTM |
| 100% | 100% | 100% |

## Indicator 82: Number of calls to the mental health helpline CALL (Community Advice and Listening Line) by Welsh residents per 100,000 of the population

Outcome: My individual circumstances are considered

Executive Lead: Director of Primary, Community and Mental Health

Period: Q1 to Q3 2018/19

Target: 4 Quarter Improvement Trend

### Current Performance:

Cwm Taf Morgannwg

**Data not currently available**

Cwm Taf

**Contacts to the CALL helpline – Cwm Taf University Health Board**

| | 2017-18 | 2018-2019 | | | |
|---|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 | Q4 |
| Rate per 100,000 of health board population* | 116.1 | 84.6 ↓ | 83.6 ↓ | 67.2 ↓ | |
| Number of contacts for health board | 346 | 253 ↓ | 250 ↓ | 201 ↓ | |
| Percentage of the Wales total | 6.4% | 4.7% ↓ | 4.4% ↓ | 4.0% ↓ | |

*2017-18 data is based on 2016 mid year population estimates, whilst 2018-19 data is based on 2017 mid year population estimates.

Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

The data shows that the subjects discussed by individuals contacting the CALL helpline is wide ranging. The top subject for Merthyr Tydfil it is alcohol, whilst for Rhondda Cynon Taf it is anxiety. The table outlining the top areas of focus for each local authority identifies other reported conditions – these include depression and mental health.

**Top subject areas discussed on the CALL helpline by local authority – Quarter 3, 2018-19**

| | Merthyr Tydfil | | Rhondda Cynon Taf | |
|---|---|---|---|---|
| | No. of enquiries | 38 | No. of enquiries | 358 |
| 1 | Anxiety | 10.5% | Anxiety | 15.9% |
| 2 | Mental health | 10.5% | Depression | 11.7% |
| 3 | Carers | 7.9% | Mental health | 8.4% |
| 4 | Depression | 7.9% | Bi-polar | 5.3% |
| 5 | Info on CALL | 7.9% | Suicide ideation | 5.0% |

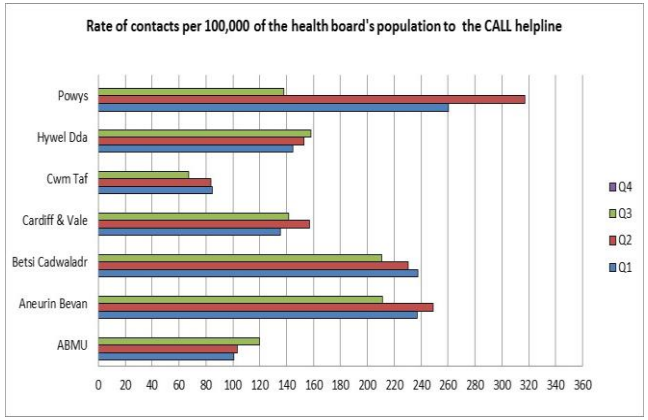
*Number of enquiries is the total number of issues that have been discussed by the local authority's residents. This figure differs to the number of contacts made to the help line.

Cwm Taf UHB to consider how the helpline services (CALL, DAN 24/7 and Dementia) are communicated to its service users. These are used by users as valuable helplines that provide information to promote self-help and where appropriate, support the delivery of wider local services. As a result, these helplines should be promoted by the health board.

Although not a performance management target, the health board should put in place actions (where necessary) to improve its communication about the helplines and increase the use of them.

The top 5 subject areas discussed by citizens in each of the local authority areas that fall within the health board's region may provide an indication of service user's perception of need and should be used to help inform service development. Further data on the other subject areas discussed is available on request.

### Benchmarking: how do we compare?




For quarter 3 2018-19, 201 contacts were made to the CALL helpline from the Cwm Taf University Health Board area (approximately 67 contacts per 100,000 of its population). This accounted 4.0% of the all Wales total. The local authority area with the highest number of callers is Rhondda Cynon Taf (183) – 91.0% of Cwm Taf's total.

Source: Welsh Government

## Indicator 83: Number of calls to the Wales dementia helpline by Welsh residents per 100,000 of the population (age 40+)

Outcome: My individual circumstances are considered

Executive Lead: Director of Primary, Community and Mental Health

Period: Q1 to Q3 2018/19

Target: 4 Quarter Improvement Trend

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

**Contacts to the Dementia helpline – Cwm Taf University Health Board**

| | 2017-18 | 2018-2019 | | | |
|---|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 | Q4 |
| Rate per 100,000 of health board population* | 4.6 | 6.6 ↑ | 2.6 ↓ | 4.6 ↑ | |
| Number of contacts for health board | 7 | 10 ↑ | 4 ↓ | 7 ↑ | |
| Percentage of the Wales total | 5.6% | 7.1% ↑ | 4.1% ↓ | 5.5% ↑ | |

*2017-18 data is based on 2016 mid year population estimates, whilst 2018-19 data is based on 2017 mid year population estimates.

Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

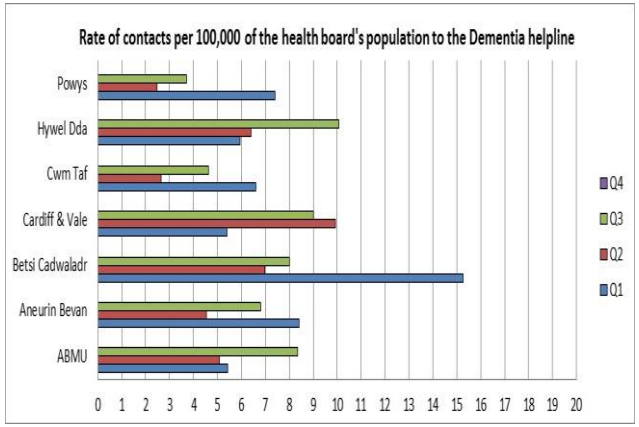
During quarter 3 2018-19, 7 contacts to the dementia helpline were made from the Cwm Taf area. This accounted for 5.5% of the all Wales total. Although the number of residents contacting the dementia helpline is low, the local authority area with the largest number of callers is Rhondda Cynon Taf (with 6 calls).

Cwm Taf UHB to consider how the helpline services (CALL, DAN 24/7 and Dementia) are communicated to its service users. These are viewed by users as valuable helplines that provide information to promote self-help and, where appropriate, support the delivery of wider local services. As a result, these helplines should be promoted by the health board.

Although not a performance management target, the health board should put in place actions (where necessary) to improve its communication about the helplines and increase the use of them.

The top 5 subject areas discussed by citizens in each of the local authority areas that fall within the health board's region may provide an indication of service user's perception of need and should be used to help inform service development. Further data on the other subject areas discussed is available on request.

### Benchmarking: how do we compare?




In comparison with the aforementioned helplines, the number of contacts to the dementia helpline is significantly lower. The total number of contacts to the dementia helpline for quarter 3 was 127, all of which were from Welsh citizens (approximately 8 calls per 100,000). The health board with the highest rate of contacts is Hywel Dda (10 calls per 100,000 of its population), whilst Powys has the lowest (3 calls per 100,000).

Source: Welsh Government

## Indicator 84: Number of calls to the DAN 24/7 helpline (drugs and alcohol) by Welsh residents per 100,000 of the population

Outcome: My individual circumstances are considered

Executive Lead: Director of Primary, Community and Mental Health

Period: Q1 to Q3 2018/19

Target: 4 Quarter Improvement Trend

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

**Contacts to the DAN 24/7 helpline – Cwm Taf University Health Board**

| | 2017-18 | 2018-2019 | | | |
|---|---|---|---|---|---|
| | Q4 | Q1 | Q2 | Q3 | Q4 |
| Rate per 100,000 of health board population* | 28.5 | 23.7 ↓ | 42.1 ↑ | 21.7 ↓ | |
| Number of contacts for health board | 85 | 71 ↓ | 126 ↑ | 65 ↓ | |
| Percentage of the Wales total | 7.9% | 6.7% ↓ | 10.0% ↑ | 7.0% ↓ | |

*20167-18 data is based on 2016 mid year population estimates, whilst 2018-19 data is based on 2017 mid year population estimates.

Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

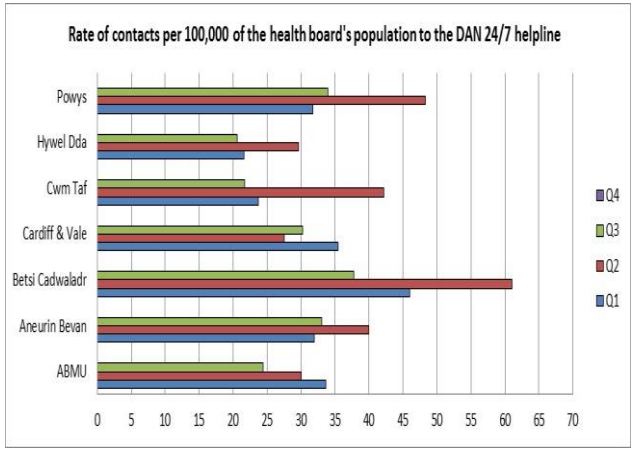
For quarter 3 2018-19, 65 contacts to the DAN 24/7 helpline came from Cwm Taf's area (approximately 22 calls per 100,000 of its population). This accounted for 7.0% of the all Wales total. The local authority area with the largest number of callers is Rhondda Cynon Taf (52) – 80% of Cwm Taf's total.

Cwm Taf UHB to consider how the helpline services (CALL, DAN 24/7 and Dementia) are communicated to its service users. These are viewed by users as valuable helplines that provide information to promote self-help and, where appropriate, support the delivery of wider local services. As a result, these helplines should be promoted by the health board.

Although not a performance management target, the health board should put in place actions (where necessary) to improve its communication about the helplines and increase the use of them.

The top 5 subject areas discussed by citizens in each of the local authority areas that fall within the health board's region may provide an indication of service user's perception of need and should be used to help inform service development. Further data on the other subject areas discussed is available on request.

### Benchmarking: how do we compare?




The total number of contacts to the DAN 24/7 helpline for quarter 3 was 959. The number of contacts associated with individuals residing in Wales was 925 (approximately 30 calls per 100,000 of its population). Betsi Cadwaladr UHB's catchment area had the highest rate of contacts (38 calls per 100,000 of its population), whilst Hywel Dda UHB's catchment area had the lowest rate (21 calls per 100,000).

Source: Welsh Government

## Indicator 85: The percentage of health board residents in receipt of secondary mental health services (all ages) who have a valid care and treatment plan (CTP)

Outcome: My individual circumstances are considered

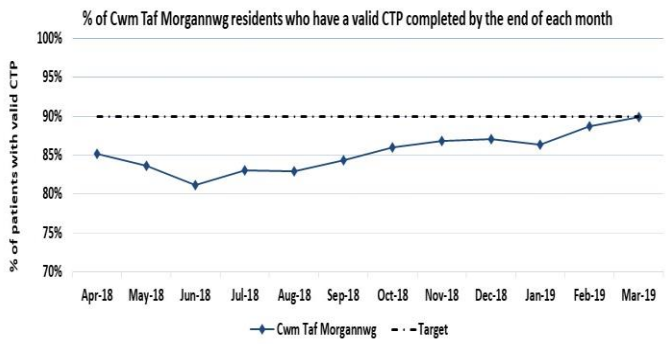
Executive Lead: Director of Primary, Community and Mental Health

Period: Apr 2018 to Mar 2019

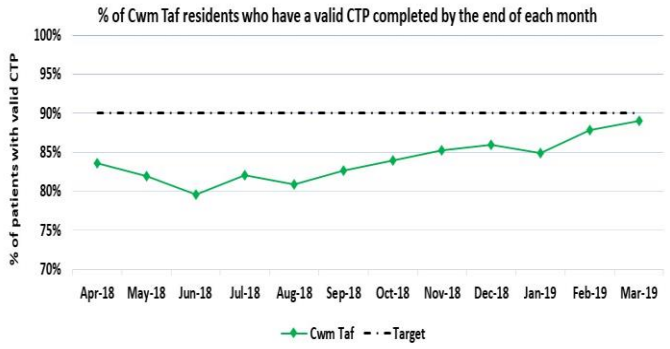
Target: 90%

### Current Performance:

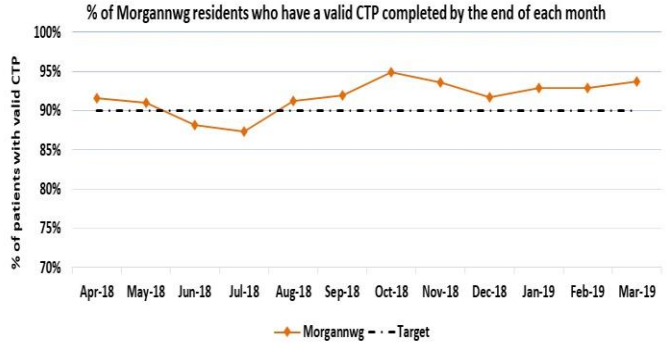
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




### How are we doing, what actions are we taking?

The Performance Target for Cwm Taf at the end of March was 89.0%, which is an increase from 87.8% in the previous month. This Performance Indicator Target remains at 90% and a steady progress towards achieving this can be seen over recent months. CAMHS compliance increased in March to 80.4% from 53.5% in February, with Learning Disabilities remaining the same as at the end of February at 93.1%. The adult mental health services although increasing their compliance to 88.3% in March are still not meeting the target however older persons reported compliance at 92.3% in March thereby meeting the 90% compliance target.

- Adult **88.3%**
- Older Persons Mental Health **92.3%**
- Learning Disabilities **93.1%**
- CAMHS **80.4%**

Experienced nursing staff had time redirected to support additional clinics with increased capacity for 16 patients weekly, the benefits have been seen from October onwards and as such these arrangements will remain in place and have been extended to a second locality.

Waiting list initiatives in CAMHS have continued up to March 2019 and an improvement in compliance can been seen. A recent Demand & Capacity exercise shows a gap in current capacity to meet demand. Engagement on the current model of adult community mental health services reinforcing the challenge in this area and that the volume of CTP's need completion by the medical team is not sustainable, the completion of this process will lead to a number of recommendations and a paper is being prepared and alternative models being explored.

The graph opposite shows the compliance for Morgannwg for March 2019 which indicates compliance against the 90% target for Part 2 of the Mental Health Measure. Work is progressing well to report for the new Cwm Taf Morgannwg footprint from April.

### Benchmarking: how do we compare?

% of LHB residents (all ages) to have a valid CTP completed at the end of each month (target 90%)

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
|---|---|---|---|---|---|---|---|
| Mar-18 | 86.1% | 88.8% | 90.9% | 85.4% | 90.6% | 92.0% | 94.9% |
| Apr-18 | 83.6% | 90.0% | 90.1% | 91.9% | 85.4% | 93.4% | 92.0% |
| May-18 | 81.9% | 89.6% | 90.9% | 91.7% | 84.1% | 92.8% | 92.2% |
| Jun-18 | 79.6% | 88.2% | 91.2% | 92.1% | 85.3% | 91.8% | 94.0% |
| Jul-18 | 82.1% | 87.6% | 87.4% | 88.0% | 85.1% | 91.1% | 95.3% |
| Aug-18 | 80.9% | 89.7% | 90.9% | 87.0% | 86.1% | 93.3% | 93.4% |
| Sep-18 | 82.6% | 91.3% | 90.3% | 88.0% | 85.3% | 91.2% | 93.9% |
| Oct-18 | 83.9% | 91.6% | 90.6% | 89.0% | 85.6% | 91.8% | 92.3% |
| Nov-18 | 85.2% | 90.6% | 90.6% | 89.2% | Not available | 92.1% | 95.4% |
| Dec-18 | 86.0% | 91.3% | 90.2% | 89.7% | 83.9% | 92.5% | 96.6% |
| Jan-19 | 84.9% | 90.9% | 91.1% | 89.9% | 84.2% | 91.3% | 95.4% |
| Feb-19 | 87.8% | 91.1% | 90.1% | 90.7% | 84.3% | 91.6% | 94.5% |

The Cwm Taf University Health Board performance remains below compliance in this area.

Source: Local Mental Health

**Indicator 86: 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**

Outcome: My individual circumstances are considered

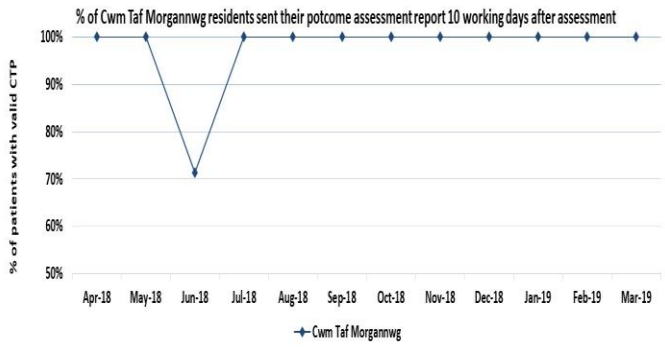
Executive Lead: Director of Primary, Community and Mental Health

Period: Apr 2018 to Mar 2019

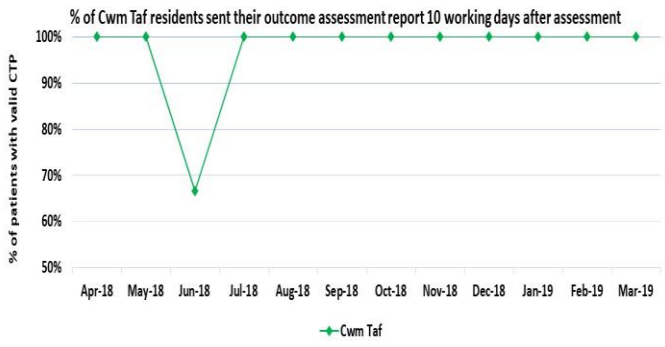
Target: 100%

## Current Performance:

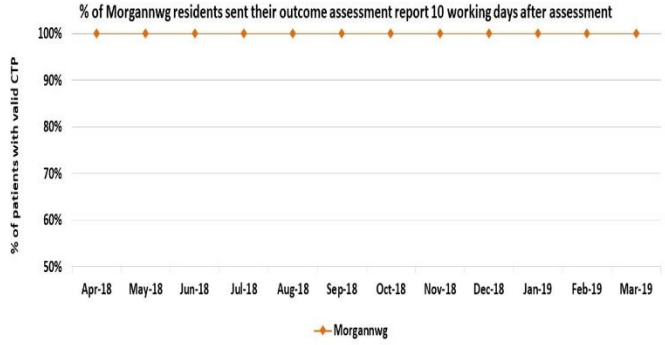
Cwm Taf Morgannwg




Cwm Taf




Morgannwg




## How are we doing, what actions are we taking?

The current compliance at the end of March has again reached 100% compliance.

We have had over a year's stability at 100% with the exception of one month (June 2018).

Risks are very low as clients have already been assessed and triaged.

## Benchmarking: how do we compare?

% of HB residents sent their outcome assessment report 10 working days after assessement (target 100%)

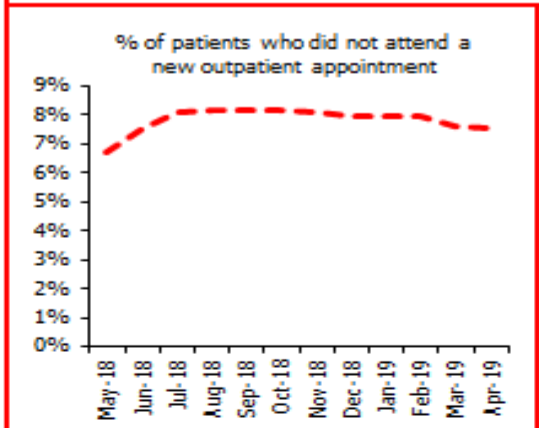
| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
|---|---|---|---|---|---|---|---|
| Mar-18 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Apr-18 | 100% | 100% | 100% | 93.3% | 100% | 100% | 100% |
| May-18 | 100% | 100% | 100% | 100.0% | 100% | 44.4% | 100% |
| Jun-18 | 66.7% | 100% | 100% | 88.9% | 100% | 100% | 100% |
| Jul-18 | 100% | 100% | 100% | 100% | 100% | 62.5% | 100% |
| Aug-18 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Sep-18 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Oct-18 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Nov-18 | 100% | 100% | 100% | 100% | Not available | 100% | 100% |
| Dec-18 | 100% | 100% | 100% | 100% | 100% | Not available | 100% |
| Jan-19 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Feb-19 | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

For data submitted, all of Wales achieved the target in this reporting period.

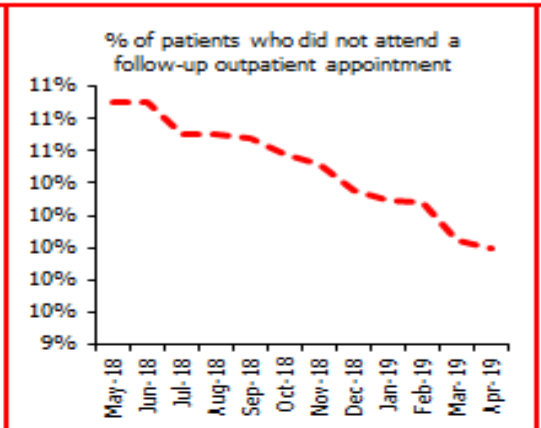
Source: Local Mental Health

## OUR STAFF AND RESOURCES – People in Wales can find information about how their NHS is resourced and make careful use of them

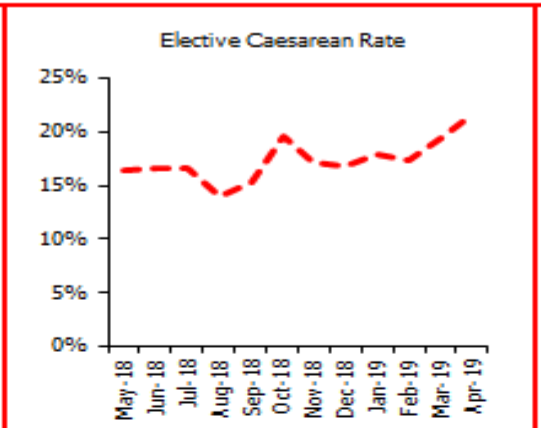
**Key: Cwm Taf Morgannwg** — **Cwm Taf** - - - **or** ▭ **Morgannwg**



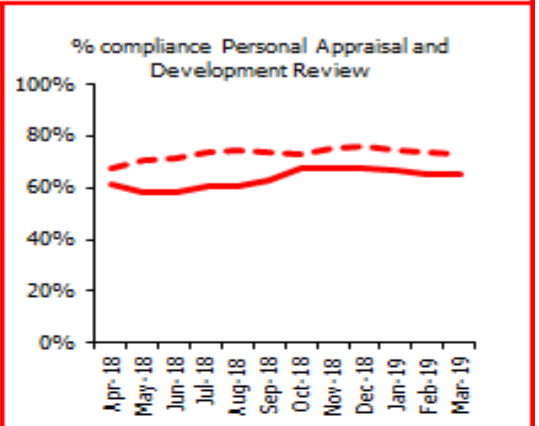

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 7.5% | N/A | N/A |



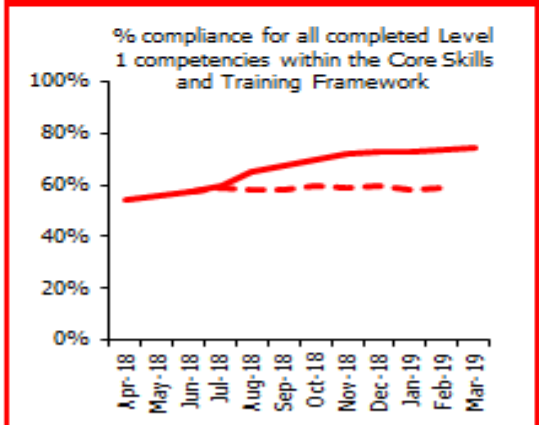

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 10.0% | N/A | N/A |



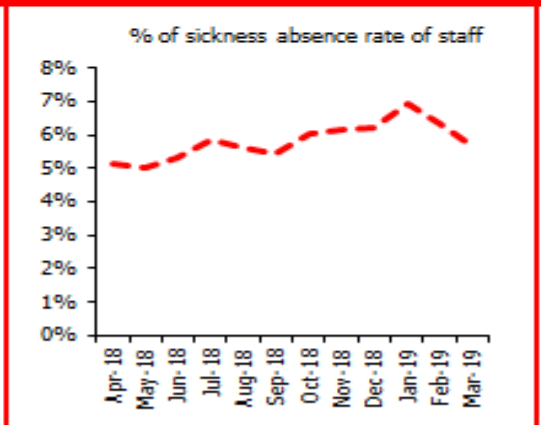

| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 17.4% | N/A | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 74% | N/A | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| N/A | 74.10% | N/A |




| Current Position | | |
|---|---|---|
| CT | M | CTM |
| 5.7% | N/A | N/A |

## Indicator 88: The percentage of patients who did not attend a new outpatient appointment (for selected specialties)

| Outcome: I work with the NHS to improve the use of resources | Executive Lead: Chief Operating Officer |
|---|---|
| Period: May 2018 to Apr 2019 | Target: 12 Month Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

New Outpatient DNA Rates for Specific Specialties (May 2018 to April 2019)

| Main Specialty | Number New Outpatients Attendances | Number of DNA's | DNA Rate (%) |
|---|---|---|---|
| Cardiology | 5164 | 281 | 5.16% |
| Dermatology | 5174 | 315 | 5.74% |
| ENT Surgery | 10430 | 738 | 6.61% |
| Gastroenterology | 2423 | 236 | 8.88% |
| General Medicine | 4242 | 478 | 10.13% |
| General Surgery | 10091 | 763 | 7.03% |
| Gynaecology | 8544 | 761 | 8.18% |
| Haem (Clinical) | 1502 | 91 | 5.71% |
| Nephrology | 280 | 17 | 5.72% |
| Neurology | 457 | 59 | 11.43% |
| Ophthalmology | 9312 | 936 | 9.13% |
| Oral Surgery | 5422 | 388 | 6.68% |
| Orthopaedics | 13812 | 1068 | 7.18% |
| Paediatrics | 3237 | 553 | 14.59% |
| Respiratory Medicine | 2687 | 176 | 6.15% |
| Rheumatology | 3501 | 258 | 6.86% |
| Urology | 5244 | 326 | 5.85% |
| **Total** | **91522** | **7444** | **7.52%** |

Morgannwg

Data not currently available

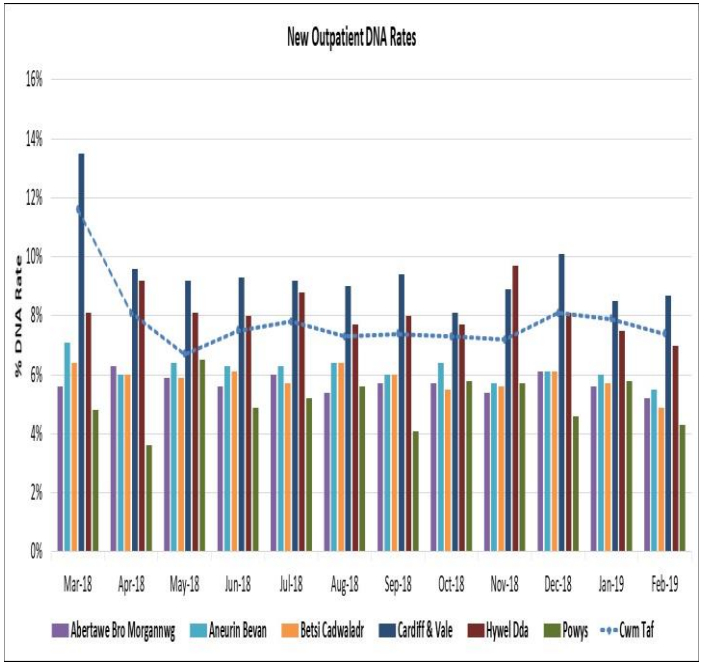
### How are we doing, what actions are we taking?

The percentage DNA rate of new outpatient appointments for the specialties identified in the adjacent table for the rolling 12 month period to April 2019 is 7.52%.

Work is in progress as part of the cross cutting themes in this regard within the planned care stream.

Short notice hospital cancellations are the main risk and needs to be reduced to a manageable number.

### Benchmarking: how do we compare?




Source: Local /Information Team and Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Indicator 89: The percentage of patients who did not attend a follow-up outpatient appointment (for selected specialties)

| | |
|---|---|
| Outcome: I work with the NHS to improve the use of resources | Executive Lead: Chief Operating Officer |
| Period: May 2018 to Apr 2019 | Target: 12 Month Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

Follow-up Outpatient DNA Rates for Specific Specialties (May 2018 to April 2019)

| Main Specialty | Number of Follow-up Outpatients Attendances | Number of DNA's | DNA Rate (%) |
|---|---|---|---|
| Cardiology | 4945 | 319 | 6.06% |
| Dermatology | 9294 | 749 | 7.46% |
| ENT Surgery | 15444 | 1788 | 10.38% |
| Gastroenterology | 3976 | 491 | 10.99% |
| General Medicine | 16263 | 2272 | 12.26% |
| General Surgery | 12468 | 1337 | 9.68% |
| Gynaecology | 10620 | 1298 | 10.89% |
| Haem (Clinical) | 29021 | 1426 | 4.68% |
| Nephrology | 1935 | 182 | 8.60% |
| Neurology | 859 | 204 | 19.19% |
| Ophthalmology | 29481 | 3328 | 10.14% |
| Oral Surgery | 5485 | 711 | 11.48% |
| Orthopaedics | 30379 | 3406 | 10.08% |
| Paediatrics | 8990 | 2461 | 21.49% |
| Respiratory Medicine | 4765 | 510 | 9.67% |
| Rheumatology | 8446 | 1131 | 11.81% |
| Urology | 8150 | 763 | 8.56% |
| **Total** | **200521** | **22376** | **10.04%** |

Morgannwg

Data not currently available

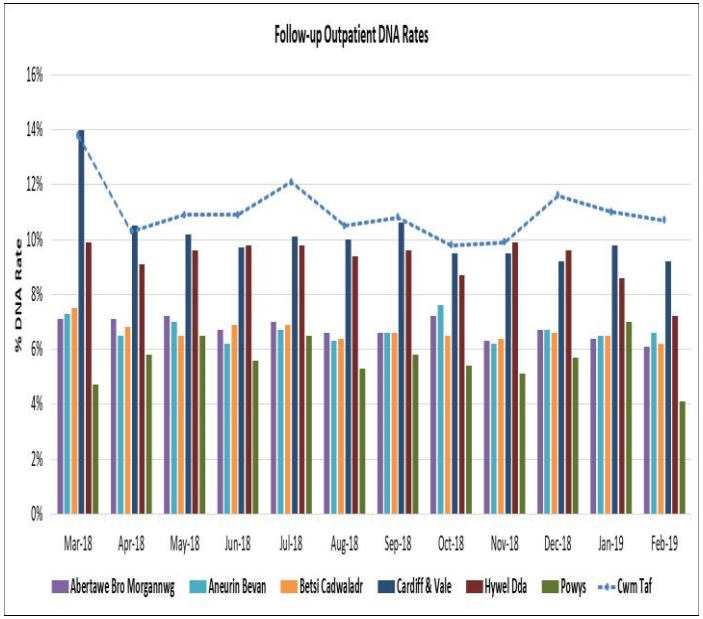
### How are we doing, what actions are we taking?

The percentage DNA rate of follow up outpatient appointments for the specialties identified in the adjacent table for the rolling 12 month period to April 2019 is 10.04%.

Work is in progress as part of the cross cutting themes in this regard within the planned care stream, running alongside validation, potentially through case note review via virtual clinics, within specialties.

Short notice hospital cancellations are the main risk and needs to be reduced to a manageable number.

### Benchmarking: how do we compare?




Source: Local /Information Team and Welsh Government Delivery & Performance Website http://howis.wales.nhs.uk/sitesplus/407/page/64649

## Indicator 90: Quantity of biosimilar medicines prescribed as a percentage of total `reference' product plus biosimilar

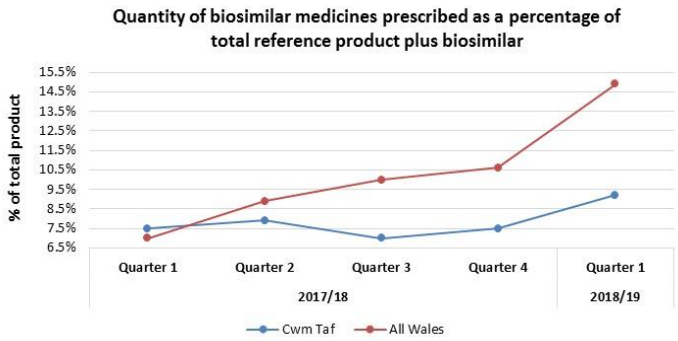
| Outcome: Resources are used efficiently and effectively to improve my health outcomes | Executive Lead: Director of Primary, Community and Mental Health |
|---|---|
| Period: 2017/18 to 2018/19 Qtr 1 | Target: Quarter on Quarter Improvement |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

The table does not reflect the actual status of biosimilar uptake in CTUHB, this could be due to the inclusion of insulin glargine in primary care which is skewing the results of the basket of medicines included. All Wales central data shows that CTUHB has the following percentage use of biosimilar medicines prescribed as a percentage of the reference product:
Etanercept- 86%
Inflximab - 100%
Rituximab - 100%
Filgrastim primary and secondary care - 100%

From up to date local data: All suitable patients have been switched to biosimilar product for these medicines. For insulin glargine there is very little difference in the cost of the biosimilar vs the originator product and so no incentive to switch diabetic patients. In addition CTUHB prescribes proportionately less insulin glargine than other HBs.
Insulin glargine secondary care 4%
Insulin glargine primary care 3%.

CTUHB have agreed a programme of maximising the use of biosimilar products where there is a cost effective benefit. A medicines management nurse is supporting this programme ensuring a safe and effective process for clinical staff and patients. The programme is monitored via the monthly CRES process.

Clinical staff have been engaged and supportive of the changes, although discussions are still ongoing with some clinicians over the use of a new biosimilar – Adalimumab.

Risks are: there are patients who cannot tolerate or do not consent to change to the biosimilar and so there will always be some prescribing of the originator product. Supply of the biosimilar products must be sustainable.

### Benchmarking: how do we compare?

Quantity of biosimilar medicines prescribed as a percentage of total reference product plus biosimilar

| | | CTUHB | ABMU | AB | BCU | C&V | HDda | Powys |
|---|---|---|---|---|---|---|---|---|
| 2018/19 | Quarter 1 | 9.2% | 20.9% | 14.0% | 14.0% | 12.5% | 19.7% | 5.9% |
| 2017/18 | Quarter 1 | 7.5% | 6.4% | 6.6% | 8.7% | 4.7% | 9.4% | 2.0% |
| | Quarter 2 | 7.9% | 10.4% | 7.4% | 10.1% | 7.4% | 11.3% | 3.2% |
| | Quarter 3 | 7.0% | 12.3% | 7.7% | 11.7% | 9.0% | 12.7% | 3.4% |
| | Quarter 4 | 7.5% | 12.2% | 8.7% | 12.9% | 9.0% | 13.3% | 5.3% |

With the medicines we use we are as good as our peers

Source: Welsh Government Delivery and Performance Website

## Indicator 92: Elective caesarean rate

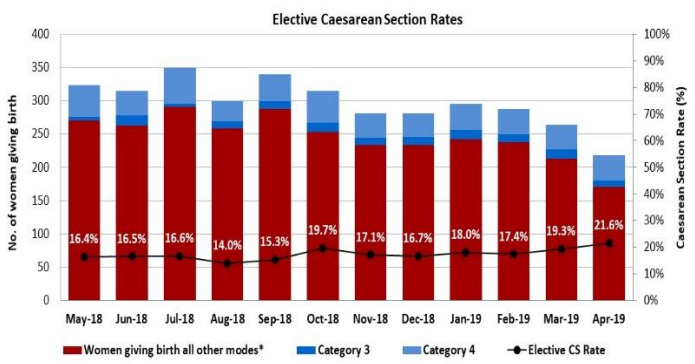
| Outcome: Resources are used efficiently and effectively to improve my health outcomes | Executive Lead: Director of Nursing |
|---|---|
| Period: May 2018 to Apr 2019 | Target: Annual Reduction |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf




Morgannwg

Data not currently available

### How are we doing, what actions are we taking?

Individual clinical practice and women's choice have been identified as the main contributors to high rate of C-Section births. This is being addressed by the multidisciplinary team aiming for a reduction by 1% each year until the combined target rate of 25% is achieved for elective and non-elective c-sections.

Continued drive towards an increase in Midwifery led Care and Normal Birth with all healthy pregnant women having the option of home birth, free standing birth Centre at RGH, Alongside Midwifery Unit at PCH. As the default position in an 'opt out' model rather than 'opt-in' in order to reduce medicalisation of childbirth with increased use of water for labour/birth.

Birth Choices Clinic established 2015 to support and counsel all women who have had a previous CS, traumatic vaginal birth or with a fear of childbirth in support of developing a birth plan in support of normal birth. Women invited to provide 'Patient Stories' to share learning/outcomes and highlight the impact on the Patient Experience
Continuous audit of all Inductions of Labour.

CS rate a standing agenda item on Monthly Audit Meeting, Monthly Labour Ward Forums, Quarterly Directorate Quality & Safety Meeting and Bi-monthly joint (cross sites) Consultant Obstetric.

Meetings with the Directorate Management Team and Senior Midwives.

Consultant Midwife for Normality appointed awaiting start date.
Education of Community Midwifery Teams ongoing in support of promoting choices for place of birth in line with WAG requirement for 45% of women to be offered birth in a midwifery led environment and to ensure appropriate Lead Professional throughout the pregnancy, with women returning to Midwifery Led care following Obstetric review if appropriate.

### Benchmarking: how do we compare?

**Elective Caesarean Rate - Annual Reduction Target**

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda |
|---|---|---|---|---|---|---|
| 2017/18 | 17.4% | 13.2% | 11.6% | 11.3% | 11.9% | 13.8% |
| 2016/17 | 16.7% | 14.0% | 11.1% | 12.8% | 11.1% | 12.6% |
| 2015/16 | 14.4% | 12.1% | 10.6% | 9.9% | 11.8% | 13.3% |

Source: Information Team/MITS Team

## Local Measure: Theatre efficiency

| | |
|---|---|
| Outcome: Resources are used efficiently and effectively to improve my health outcomes | Executive Lead: Chief Operating Officer |
| Period: May 2018 to Apr 2019 | Target: Annual Reduction |

### Current Performance:

Cwm Taf Morgannwg

| | May - 2018 | Jun - 2018 | Jul - 2018 | Aug - 2018 | Sep - 2018 | Oct - 2018 | Nov - 2018 | Dec - 2018 | Jan - 2019 | Feb - 2019 | Mar - 2019 | Apr - 2019 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Procedures | 4254 | 4247 | 3992 | 3593 | 3657 | 4267 | 3781 | 3337 | 3985 | 3591 | 3842 | 3440 | 45986 |
| Total No. of Cancellations | 975 | 991 | 955 | 737 | 868 | 1002 | 826 | 912 | 864 | 938 | 915 | 851 | 10834 |
| %age total cancellations | 22.92% | 23.33% | 23.92% | 20.51% | 23.74% | 23.48% | 21.85% | 27.33% | 21.68% | 26.12% | 23.82% | 24.74% | 23.56% |
| Patient - Clinical | 11.58% | 13.12% | 12.88% | 16.55% | 19.35% | 18.96% | 19.01% | 15.46% | 19.79% | 13.97% | 15.19% | 14.57% | 15.77% |
| Patient - Non-Clinical | 14.67% | 18.77% | 18.53% | 17.37% | 17.97% | 15.87% | 18.04% | 17.21% | 17.01% | 15.35% | 15.52% | 17.27% | 16.94% |
| Hospital - Clinical | 33.03% | 27.35% | 30.37% | 26.59% | 22.47% | 24.25% | 27.36% | 18.20% | 25.35% | 20.36% | 21.09% | 20.33% | 24.78% |
| Hospital - Non-Clinical | 25.54% | 28.36% | 28.48% | 37.04% | 36.64% | 35.93% | 32.93% | 36.40% | 33.56% | 42.64% | 35.63% | 40.78% | 34.34% |
| Other | 15.18% | 12.41% | 9.74% | 2.44% | 3.57% | 4.99% | 2.66% | 12.72% | 4.28% | 7.68% | 12.57% | 7.05% | 8.17% |

### How are we doing, what actions are we taking?

**Cwm Taf**

| | May - 2018 | Jun - 2018 | Jul - 2018 | Aug - 2018 | Sep - 2018 | Oct - 2018 | Nov - 2018 | Dec - 2018 | Jan - 2019 | Feb - 2019 | Mar - 2019 | Apr - 2019 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Procedures | 2412 | 2213 | 2117 | 2072 | 1912 | 2230 | 1994 | 1751 | 2024 | 1829 | 1998 | 1823 | 24375 |
| Total No. of Cancellations | 509 | 407 | 444 | 357 | 368 | 452 | 367 | 353 | 392 | 374 | 317 | 387 | 4727 |
| %age total cancellations | 21.10% | 18.39% | 20.97% | 17.23% | 19.25% | 20.27% | 18.41% | 20.16% | 19.37% | 20.45% | 15.87% | 21.23% | 19% |
| Patient - Clinical | 6.68% | 5.41% | 11.94% | 16.81% | 19.84% | 18.81% | 20.71% | 18.41% | 18.37% | 11.23% | 18.93% | 13.70% | 14.70% |
| Patient - Non-Clinical | 10.61% | 12.53% | 13.51% | 14.29% | 13.86% | 13.94% | 13.35% | 11.90% | 13.01% | 16.84% | 19.56% | 13.95% | 13.77% |
| Hospital - Clinical | 39.49% | 38.82% | 36.26% | 29.13% | 28.80% | 26.77% | 37.87% | 25.78% | 31.12% | 26.20% | 27.76% | 23.77% | 31.33% |
| Hospital - Non-Clinical | 14.34% | 13.51% | 18.24% | 35.01% | 33.70% | 34.51% | 25.89% | 36.54% | 31.63% | 40.37% | 29.34% | 43.15% | 29.05% |
| Other | 28.88% | 29.73% | 20.05% | 4.76% | 3.80% | 5.97% | 2.18% | 7.37% | 5.87% | 5.35% | 4.42% | 5.43% | 11.15% |

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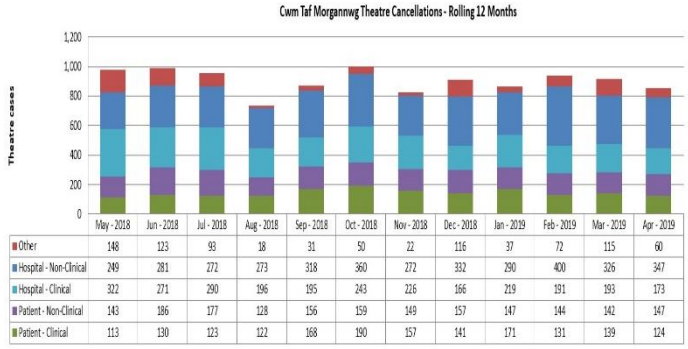
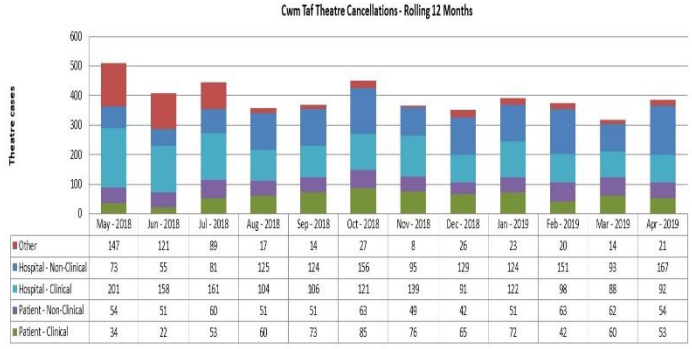
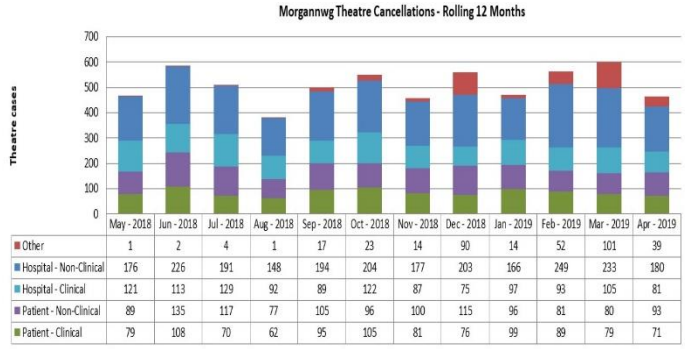
| | May - 2018 | Jun - 2018 | Jul - 2018 | Aug - 2018 | Sep - 2018 | Oct - 2018 | Nov - 2018 | Dec - 2018 | Jan - 2019 | Feb - 2019 | Mar - 2019 | Apr - 2019 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Planned Procedures | 1842 | 2034 | 1875 | 1521 | 1745 | 2037 | 1787 | 1586 | 1961 | 1762 | 1844 | 1617 | 21611 |
| Total No. of Cancellations | 466 | 584 | 511 | 380 | 500 | 550 | 459 | 559 | 472 | 564 | 598 | 464 | 6107 |
| %age total cancellations | 25.30% | 28.71% | 27.25% | 24.98% | 28.65% | 27.00% | 25.69% | 35.25% | 24.07% | 32.01% | 32.43% | 28.70% | 28% |
| Patient - Clinical | 16.95% | 18.49% | 13.70% | 16.32% | 19.00% | 19.09% | 17.65% | 13.60% | 20.97% | 15.78% | 13.21% | 15.30% | 16.60% |
| Patient - Non-Clinical | 19.10% | 23.12% | 22.90% | 20.26% | 21.00% | 17.45% | 21.79% | 20.57% | 20.34% | 14.36% | 13.38% | 20.04% | 19.39% |
| Hospital - Clinical | 25.97% | 19.35% | 25.24% | 24.21% | 17.80% | 22.18% | 18.95% | 13.42% | 20.55% | 16.49% | 17.56% | 17.46% | 19.72% |
| Hospital - Non-Clinical | 37.77% | 38.70% | 37.38% | 38.95% | 38.80% | 37.09% | 38.56% | 36.31% | 35.17% | 44.15% | 38.96% | 38.79% | 38.43% |
| Other | 0.21% | 0.34% | 0.78% | 0.26% | 3.40% | 4.18% | 3.05% | 16.10% | 2.97% | 9.22% | 16.88% | 8.41% | 5.86% |



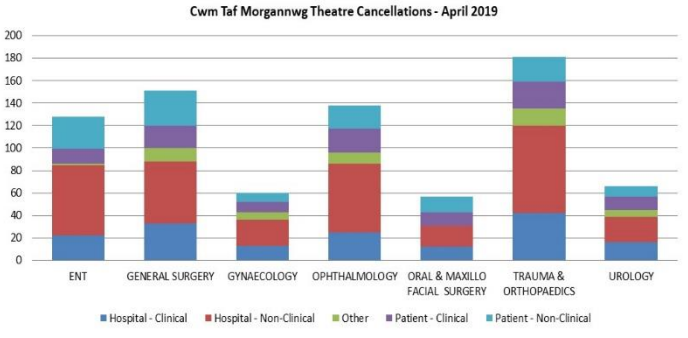

| | May - 2018 | Jun - 2018 | Jul - 2018 | Aug - 2018 | Sep - 2018 | Oct - 2018 | Nov - 2018 | Dec - 2018 | Jan - 2019 | Feb - 2019 | Mar - 2019 | Apr - 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other | 148 | 123 | 93 | 18 | 31 | 50 | 22 | 116 | 37 | 72 | 115 | 60 |
| Hospital - Non-Clinical | 249 | 281 | 272 | 273 | 318 | 360 | 272 | 332 | 290 | 400 | 326 | 347 |
| Hospital - Clinical | 322 | 271 | 290 | 196 | 195 | 243 | 226 | 166 | 219 | 191 | 193 | 173 |
| Patient - Non-Clinical | 143 | 186 | 177 | 128 | 156 | 159 | 149 | 157 | 147 | 144 | 142 | 147 |
| Patient - Clinical | 113 | 130 | 123 | 122 | 168 | 190 | 157 | 141 | 171 | 131 | 139 | 124 |

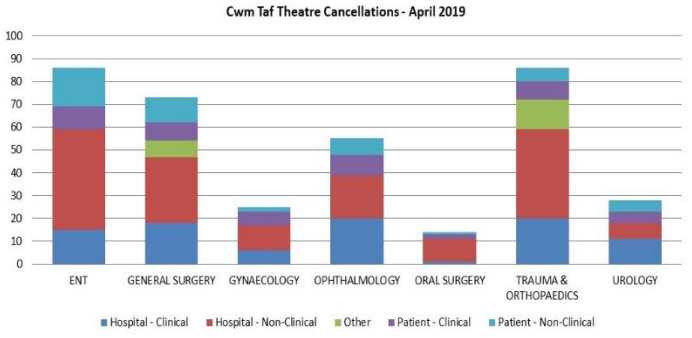


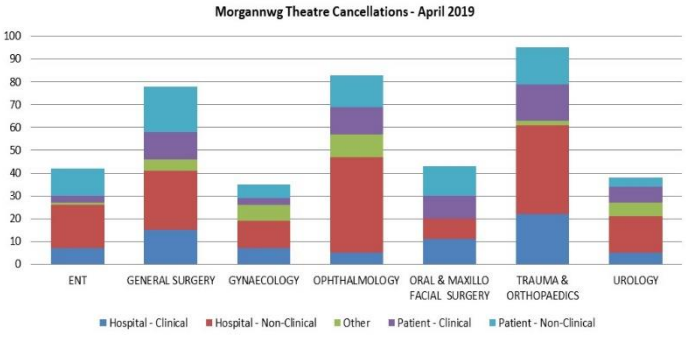

| | May - 2018 | Jun - 2018 | Jul - 2018 | Aug - 2018 | Sep - 2018 | Oct - 2018 | Nov - 2018 | Dec - 2018 | Jan - 2019 | Feb - 2019 | Mar - 2019 | Apr - 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other | 147 | 121 | 89 | 17 | 14 | 27 | 8 | 26 | 23 | 20 | 14 | 21 |
| Hospital - Non-Clinical | 73 | 55 | 81 | 125 | 124 | 156 | 95 | 129 | 124 | 151 | 93 | 167 |
| Hospital - Clinical | 201 | 158 | 161 | 104 | 106 | 121 | 139 | 91 | 122 | 98 | 88 | 92 |
| Patient - Non-Clinical | 54 | 51 | 60 | 51 | 51 | 63 | 49 | 42 | 51 | 63 | 62 | 54 |
| Patient - Clinical | 34 | 22 | 53 | 60 | 73 | 85 | 76 | 65 | 72 | 42 | 60 | 53 |




| | May - 2018 | Jun - 2018 | Jul - 2018 | Aug - 2018 | Sep - 2018 | Oct - 2018 | Nov - 2018 | Dec - 2018 | Jan - 2019 | Feb - 2019 | Mar - 2019 | Apr - 2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Other | 1 | 2 | 4 | 1 | 17 | 23 | 14 | 90 | 14 | 52 | 101 | 39 |
| Hospital - Non-Clinical | 176 | 226 | 191 | 148 | 194 | 204 | 177 | 203 | 166 | 249 | 233 | 180 |
| Hospital - Clinical | 121 | 113 | 129 | 92 | 89 | 122 | 87 | 75 | 97 | 93 | 105 | 81 |
| Patient - Non-Clinical | 89 | 135 | 117 | 77 | 105 | 96 | 100 | 115 | 96 | 81 | 80 | 93 |
| Patient - Clinical | 79 | 108 | 70 | 62 | 95 | 105 | 81 | 76 | 99 | 89 | 79 | 71 |



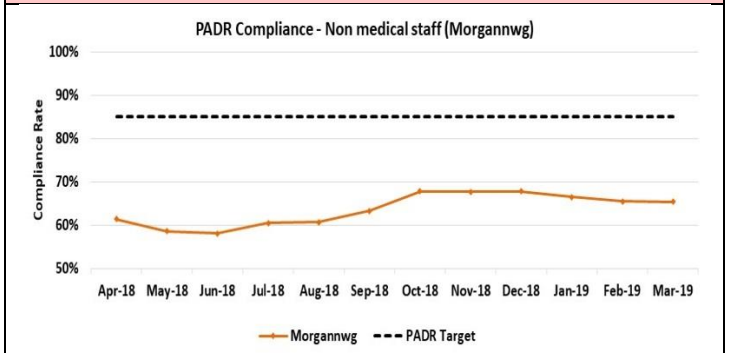

Source: Information Team

## Indicator 93: Percentage of headcount by organisation who have had a Personal Appraisal and Development Review (PADR)/medical appraisal in the previous 12 months (excluding doctors and dentists in training)

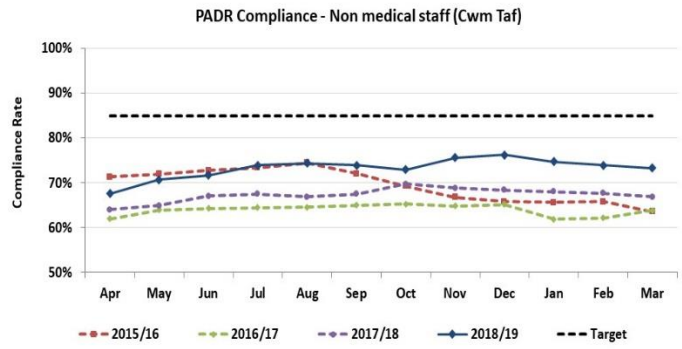
| Outcome: Quality trained staff who are fully engaged in delivering excellent care and support to me and my family | Executive Lead: Director of Workforce and Organisational Development |
|---|---|
| Period: as at 1st Apr 2019 | Target: 85% |

### Current Performance:

Cwm Taf Morgannwg




Cwm Taf

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**Data not currently available**

### How are we doing, what actions are we taking?

As at 1st April 2019 PDR compliance is **73.31%** a decrease of 0.66% since last month's reported position. Of the 30 Directorates, 3 are performing within the desired target range of 85-100%, 8 are in the 75% - 85% compliance range, and 19 are performing below 75%.
Of the 30 Directorates, 13 have either seen improvement or remained static in their compliance this month.

**Using ESR Business Intelligence to report PDR compliance**

ESR Business Intelligence (BI) continues to be used to report PDR compliance to Directorate Managers & Director of Nursing.
Managers are continually encouraged to access BI PDR Dashboards through their ESR Self-Serve Accounts allowing them to view a full set of compliance data for their area of responsibility, accessible at any time and always less than 24 hours old.
Guides on "How to Access/Use BI Dashboards" are available via the ESR Self-Serve SharePoint site

**The Learning & Development Department continue to support Directorates in the following ways to improve PDR compliance:-**

Providing a comprehensive suite of reports to DMs on a monthly basis providing the latest PDR compliance data, contextualising each Directorate's performance; what to do to improve compliance; where to seek further help and guidance
Supporting the PDR agenda at the Clinical & Corporate Business Meetings through preparation of summary reports via the PMO Office.

### Benchmarking: how do we compare?

% of headcount who have had a PADR/medical appraisal in the previous 12 months (target 95%)

| Period | Cwm Taf | Abertawe Bro Morgannwg | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Hywel Dda | Powys |
|---|---|---|---|---|---|---|---|
| Feb-18 | 67.7% | 59.5% | 77.5% | 63.1% | 62.3% | 64.5% | 73.1% |
| Mar-18 | 66.9% | 59.9% | 74.3% | 64.8% | 59.7% | 65.3% | 66.5% |
| Apr-18 | 67.6% | 60.4% | 75.7% | 64.1% | 60.4% | 66.8% | 76.8% |
| May-18 | 70.7% | 58.4% | 75.6% | 65.7% | 61.1% | 68.0% | 78.7% |
| Jun-18 | 71.7% | 58.1% | 75.4% | 65.1% | 61.7% | 70.2% | 77.6% |
| Jul-18 | 74.0% | 60.4% | 73.8% | 65.9% | 61.5% | 71.8% | 78.7% |
| Aug-18 | 74.4% | 60.4% | 73.8% | 64.5% | 61.4% | 71.8% | 79.2% |
| Sep-18 | 74.0% | Not available | | | | | |
| Oct-18 | 72.9% | 64.9% | 73.6% | 60.3% | 60.6% | 74.1% | 79.2% |
| Nov-18 | 75.7% | 66.3% | 74.0% | 61.5% | 60.5% | 74.3% | 80.6% |
| Dec-18 | 76.3% | Not available | | | | | |
| Jan-19 | 74.8% | 66.8% | 73.4% | 61.8% | 58.9% | 76.7% | 80.8% |

Source:ESR/MARS

## Indicator 96: Percentage compliance for all completed Level 1 competencies within the Core Skills and Training Framework by organisation

| Outcome: Quality trained staff who are fully engaged in delivering excellent care and support to me and my family | Executive Lead: Director of Workforce and Organisational Development |
|---|---|
| Period: as at 1st Mar 2019 | Target: 85% |

**Current Performance:**

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

See adjacent table

Morgannwg

Data not currently available

| Health Board | Equality, Diversity and Human Rights - 3 Years | Fire Safety - 2 Years | Health, Safety and Welfare - 3 Years | Infection Prevention and Control - Level 1 - 3 Years | Information Governance (Wales) - 2 Years | Moving and Handling - Level 1 - 3 Years | Resuscitation - Level 1 - 3 Years | Safeguarding Adults - Level 1 - 3 Years | Safeguarding Children - Level 1 - 3 Years | Violence and Aggression (Wales) - Module A - No Specified Renewal | Ward / Departmental Fire Safety Training - 2 Years |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 110 Cwm Taf University Health Board | 77.63% | 67.08% | 76.31% | 80.11% | 71.19% | 75.86% | 80.10% | 73.20% | 73.31% | 80.73% | 58.82% |
| Department/Ward Compliance | | | | | | | | | | | |
| 110 ACT Directorate | 73.61% | 60.82% | 71.75% | 77.32% | 58.76% | 69.28% | 75.67% | 65.98% | 68.87% | 72.58% | 52.78% |
| 110 Acute Medicine and A&E Directorate | 68.50% | 59.39% | 66.34% | 74.27% | 63.35% | 70.45% | 76.29% | 65.86% | 63.21% | 72.04% | 46.38% |
| 110 CAMHS Network Directorate | 76.58% | 62.08% | 72.12% | 74.35% | 68.77% | 71.00% | 71.38% | 67.66% | 72.86% | 81.78% | 40.89% |
| 110 Chief Executive Directorate | 30.00% | 65.00% | 35.00% | 45.00% | 35.00% | 30.00% | 40.00% | 40.00% | 40.00% | 45.00% | 25.00% |
| 110 Contract and Commissioning Directorate | 100.00% | 66.67% | 100.00% | 100.00% | 0.00% | 100.00% | 33.33% | 100.00% | 100.00% | 100.00% | 33.33% |
| 110 Corporate Development Directorate | 75.61% | 87.80% | 75.61% | 75.61% | 87.80% | 78.05% | 87.80% | 68.29% | 73.17% | 92.68% | 85.37% |
| 110 Emergency Ambulance Services Committee Directorate | 60.00% | 13.33% | 53.33% | 66.67% | 53.33% | 60.00% | 53.33% | 60.00% | 60.00% | 66.67% | 20.00% |
| 110 Estates Directorate | 90.29% | 87.38% | 92.23% | 90.29% | 55.34% | 90.29% | 90.29% | 89.32% | 89.32% | 98.06% | 63.11% |
| 110 Facilities Directorate | 77.73% | 70.52% | 79.00% | 87.06% | 75.08% | 77.52% | 84.31% | 73.28% | 72.64% | 86.32% | 78.26% |
| 110 Finance Directorate | 94.92% | 89.83% | 88.14% | 94.92% | 91.53% | 94.92% | 96.61% | 93.22% | 93.22% | 98.31% | 89.83% |
| 110 General Surgery, Trauma & Orthopaedics and Urology Directorate | 51.48% | 46.25% | 51.13% | 66.67% | 48.69% | 52.53% | 67.54% | 48.34% | 46.77% | 55.67% | 27.57% |
| 110 Head & Neck Directorate | 56.76% | 48.65% | 52.43% | 50.81% | 47.03% | 44.86% | 58.38% | 51.35% | 52.97% | 51.89% | 20.54% |
| 110 ICT Directorate | 89.47% | 85.96% | 89.47% | 87.72% | 80.70% | 87.72% | 84.21% | 85.96% | 85.96% | 89.47% | 84.21% |
| 110 Innovation and Transformation Directorate | 50.00% | 66.67% | 50.00% | 50.00% | 83.33% | 50.00% | 66.67% | 66.67% | 50.00% | 66.67% | 50.00% |
| 110 Localities Directorate | 85.26% | 72.99% | 85.26% | 82.77% | 77.08% | 83.80% | 91.39% | 81.17% | 81.46% | 87.45% | 54.60% |
| 110 Medical Director Directorate | 50.00% | 50.00% | 50.00% | 50.00% | 50.00% | 50.00% | 50.00% | 50.00% | 50.00% | 50.00% | 50.00% |
| 110 Medicines Management Directorate | 82.33% | 67.44% | 78.14% | 80.47% | 76.28% | 65.58% | 67.44% | 77.21% | 75.81% | 93.95% | 68.37% |
| 110 Mental Health Directorate | 90.72% | 73.76% | 89.44% | 83.84% | 80.32% | 86.56% | 86.56% | 85.44% | 85.44% | 88.16% | 68.64% |
| 110 National Imaging Academy Directorate | 75.00% | 75.00% | 50.00% | 50.00% | 75.00% | 75.00% | 75.00% | 75.00% | 50.00% | 50.00% | 50.00% |
| 110 Obstetrics & Gynaecology and Sexual Health Directorate | 82.56% | 58.21% | 81.54% | 82.31% | 77.69% | 77.18% | 73.85% | 71.03% | 77.95% | 83.08% | 42.05% |
| 110 Operations Management Directorate | 66.67% | 60.42% | 56.25% | 62.50% | 54.17% | 58.33% | 54.17% | 54.17% | 56.25% | 64.58% | 27.08% |
| 110 Paediatrics Acute & Community Directorate | 88.17% | 73.24% | 87.55% | 87.34% | 81.74% | 87.55% | 86.10% | 82.99% | 84.44% | 89.42% | 77.80% |
| 110 Pathology Directorate | 88.38% | 72.61% | 82.57% | 87.55% | 71.78% | 74.69% | 78.84% | 79.25% | 80.50% | 84.65% | 77.18% |
| 110 Patient Care & Safety Directorate | 87.14% | 72.86% | 77.14% | 85.71% | 77.14% | 80.00% | 82.86% | 85.71% | 82.86% | 88.57% | 74.29% |
| 110 Performance & Information Directorate | 97.73% | 81.82% | 100.00% | 100.00% | 93.18% | 97.73% | 95.45% | 97.73% | 100.00% | 100.00% | 84.09% |
| 110 Planning and Partnership Directorate | 93.75% | 81.25% | 87.50% | 87.50% | 56.25% | 93.75% | 87.50% | 87.50% | 93.75% | 93.75% | 50.00% |
| 110 Primary Care Directorate | 86.96% | 78.26% | 88.04% | 85.14% | 80.07% | 86.23% | 83.33% | 82.25% | 82.25% | 88.41% | 68.84% |
| 110 Radiology Directorate | 75.37% | 60.10% | 73.40% | 76.35% | 64.04% | 80.30% | 75.37% | 70.44% | 71.43% | 74.38% | 52.22% |
| 110 Therapies Directorate | 87.96% | 88.62% | 87.75% | 93.22% | 93.22% | 91.47% | 95.19% | 90.59% | 88.62% | 97.16% | 86.87% |
| 110 Welsh Health Specialist Services Committee Directorate | 82.81% | 79.69% | 79.69% | 78.13% | 82.81% | 75.00% | 81.25% | 76.56% | 78.13% | 82.81% | 59.38% |
| 110 Workforce & Organisational Development Directorate | 78.41% | 70.45% | 77.84% | 77.27% | 78.41% | 78.41% | 81.82% | 76.70% | 76.70% | 83.52% | 68.75% |

Source: ESR, L&D W&OD

## Indicator 97: Percentage of sickness absence rate of staff

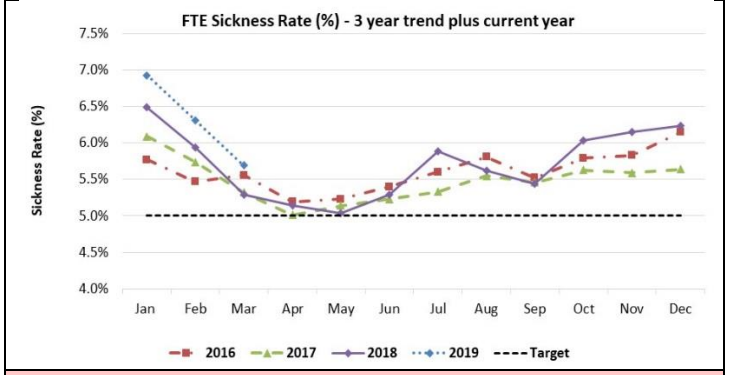
| Outcome: Quality trained staff who are fully engaged in delivering excellent care and support to me and my family | Executive Lead: Director of Workforce and Organisational Development |
|---|---|
| Period: Jan 2016 to Mar 2019 | Target: 12 Month Reduction Trend |

### Current Performance:

Cwm Taf Morgannwg

Data not currently available

Cwm Taf

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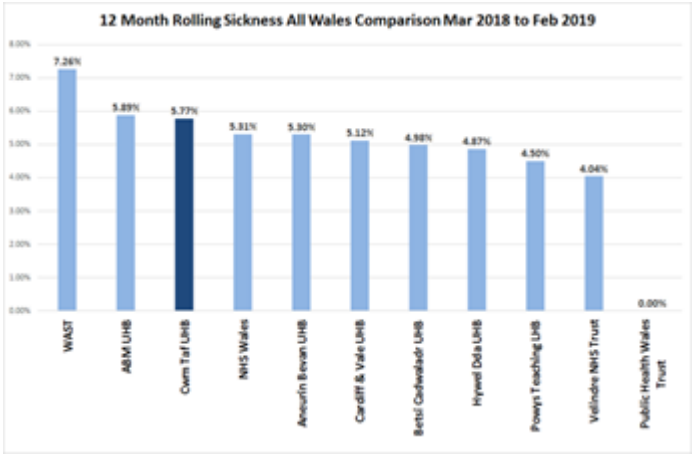
Data not currently available

### How are we doing, what actions are we taking?

Sickness absence decreased to 5.69% in March which is above the Health Board's target of 5.30%. Short term occurrences have reduced since January (917 occurrences Jan 2019, compared with 666 occurrences Mar 2019). Sickness data is scrutinised at monthly CBMs, then followed up with work tailored to each directorate's needs. Where Directorates are experiencing particularly high levels of sickness absence a Deep Dive will take place by the Workforce Team.

**Managing** attendance at Work Policy training programme in partnership with staff side is continuing. 35% of managers have undertaken the training.
**Toolkit** to support new policy is live and has been promoted throughout the Health Board.
**H&WB** calendar with monthly well-being events has been communicated throughout the Health Board.
**Sickness absence** data continues to be scrutinised at monthly CBMs and at monthly nurse staffing meetings.
**Scrutiny** of average length of sickness absence taken to ensure that supportive interventions are timely and sufficient and in particular that stress risk assessment are being carried out promptly when stress identified as the cause of the sickness absence to ensure appropriate support is quickly put in place whenever possible.
**An 8 week** mindfulness course to reduce sickness absence as a consequence of stress and anxiety in the workplace has been completed with many positive outcomes. Most participants who were on long term sickness have returned to work. A new cohort will commence during May 2019
**OHWB** continues to have self-referral options for both counselling and physiotherapy**.** The Health Board are currently looking at Rapid Access in line with NHS Employers recommendations to ensure employees can receive treatment in a timely manner and allow them to return to workplace as soon as possible.
**Reviewing** organisation's support process around dealing with stress & anxiety. This will also include an overhaul of the current stress risk assessment and action plan.

### Benchmarking: how do we compare?




For the 12 month period to Feb 2019 (All Wales Dashboard Statistics) we know that comparatively we remain in the upper quartile of sickness absence across Wales. Though we have seen in recent decrease in our sickness absence we would not expect to significantly improve our position immediately but hope to see some betterment given the many initiatives that we are promoting. In comparison with NHS Wales's organisations we experience high rates for most staff groups and are third highest for Nursing and Midwifery (average 5.89%).

Source: ESR, W&OD/ Welsh Government for Benchmark

## Commissioning: Cwm Taf Residents waiting at other health boards for treatment – Referral to Treatment (RTT)

Period: as at 31st March 2019

### waiting at Swansea Bay UHB

| Specialty | <=26 Weeks | >26 <=36 Weeks | >36 <=52 Weeks | >52 Weeks | Grand Total |
|---|---|---|---|---|---|
| Allied Health | 9 | | | | 9 |
| Cardiology | 9 | 2 | | | 11 |
| Dermatology | 48 | 1 | | | 49 |
| Diagnostic | 2 | | | | 2 |
| Endocrinology | 6 | | | | 6 |
| ENT | 43 | 1 | | | 44 |
| Gastroenterology | 4 | 1 | | | 5 |
| General Medicine | 2 | | | | 2 |
| General Surgery | 37 | | 1 | 3 | 41 |
| Gynaecology | 15 | 2 | | | 17 |
| Neurology | 8 | | | | 8 |
| Ophthalmology | 34 | 1 | | | 35 |
| Oral Surgery | 21 | 3 | 1 | 3 | 28 |
| Paediatrics | 5 | | | | 5 |
| Plastic Surgery | 177 | 21 | 11 | 5 | 214 |
| Respiratory Medicine | 4 | | | | 4 |
| Restorative Dentistry | 2 | | | | 2 |
| Rheumatology | 1 | | | | 1 |
| Trauma & Orthopaedics | 37 | 8 | 3 | 4 | 52 |
| Urology | 11 | | | | 11 |
| **Grand Total** | **475** | **40** | **16** | **15** | **546** |

**Of those waiting over 52 weeks:-**

| Specialty | 53 - 56 | 57 - 60 | 61 - 64 | 65 - 68 | 105 | 73 - 76 | 69 - 72 | Grand Total |
|---|---|---|---|---|---|---|---|---|
| General Surgery | 2 | 1 | | | | | | 3 |
| Oral Surgery | | | | | 3 | | | 3 |
| Plastic Surgery | | 2 | 2 | | | | 1 | 5 |
| Trauma & Orthopaedics | | 1 | 1 | 1 | | 1 | | 4 |
| **Grand Total** | **2** | **4** | **3** | **1** | **3** | **1** | **1** | **15** |

### waiting at Aneurin Bevan UHB

| Specialty | <=26 Weeks | >26 <=36 Weeks | Grand Total |
|---|---|---|---|
| Allied Health | 4 | | 4 |
| Cardiology | 3 | 1 | 4 |
| Clinical Haematology | 1 | | 1 |
| Dermatology | 13 | | 13 |
| Diagnostic | 2 | | 2 |
| Endocrinology | 2 | | 2 |
| ENT | 9 | 1 | 10 |
| Gastroenterology | 12 | 1 | 13 |
| General Surgery | 12 | 2 | 14 |
| Geriatric Medicine | 1 | | 1 |
| Gynaecology | 10 | | 10 |
| Interventional Radiology | 2 | | 2 |
| Neurology | 3 | | 3 |
| Ophthalmology | 11 | 4 | 15 |
| Oral Surgery | 9 | 3 | 12 |
| Orthodontics | 3 | | 3 |
| Paediatrics | | 1 | 1 |
| Pain Management | 3 | | 3 |
| Respiratory Medicine | 8 | | 8 |
| Rheumatology | 1 | 1 | 2 |
| Trauma & Orthopaedics | 34 | 3 | 37 |
| Urology | 41 | 3 | 44 |
| Chemical Pathology | 2 | | 2 |
| **Grand Total** | **186** | **20** | **206** |

There were no patients waiting over 52 weeks.

### waiting at Betsi Cadwaladr UHB

| Specialty | <=26 Weeks | Grand Total |
|---|---|---|
| Ophthalmology | 1 | 1 |
| **Grand Total** | **1** | **1** |

There were no patients waiting over 52 weeks at Betsi Cadwaladr University Local Health Board

Source: Information Team/ WG D&P

## Commissioning continued: Cwm Taf Residents waiting at other health boards for treatment – Referral to Treatment (RTT)

Period: as at 31st March 2019

### waiting at Cardiff and Vale UHB

| Specialty | <=26 Weeks | >26 <=36 Weeks | >36 <=52 Weeks | >52 Weeks | Grand Total |
|---|---|---|---|---|---|
| Allied Health | 10 | | | | 10 |
| Anaesthetics | 2 | | | | 2 |
| Cardiology | 147 | 16 | | | 163 |
| Cardiothoracic Surgery | 54 | 10 | 2 | 1 | 67 |
| Clinical Haematology | 34 | 3 | | | 37 |
| Clinical Immunology And Allergy | 97 | 9 | | | 106 |
| Clinical Pharmacology | 3 | | | | 3 |
| Dental Medicine Specialties | 18 | | | | 18 |
| Dermatology | 70 | 10 | | | 80 |
| ENT | 64 | 6 | | | 70 |
| Gastroenterology | 23 | 1 | | | 24 |
| General Medicine | 69 | 2 | | | 71 |
| General Surgery | 93 | 7 | | | 100 |
| Geriatric Medicine | 6 | | | | 6 |
| Gynaecology | 57 | 6 | | | 63 |
| Nephrology | 10 | | | | 10 |
| Neurology | 694 | 99 | | | 793 |
| Neurosurgery | 154 | 5 | 1 | | 160 |
| Ophthalmology | 228 | 50 | | | 278 |
| Oral Surgery | 45 | 8 | | | 53 |
| Orthodontics | 12 | | | | 12 |
| Paediatric Dentistry | 54 | 6 | | | 60 |
| Paediatric Neurology | 22 | 2 | | | 24 |
| Paediatric Surgery | 97 | 27 | | | 124 |
| Paediatrics | 91 | 4 | | | 95 |
| Pain Management | 23 | | | | 23 |
| Rehabilitation Service | 1 | | | | 1 |
| Respiratory Medicine | 27 | | | | 27 |
| Restorative Dentistry | 23 | 1 | | | 24 |
| Rheumatology | 11 | 2 | | | 13 |
| Trauma & Orthopaedics | 686 | 145 | 33 | 19 | 883 |
| Urology | 74 | 5 | | | 79 |
| **Grand Total** | **2999** | **424** | **36** | **20** | **3479** |

**Of those waiting over 52 weeks:**

| Specialty | 53 - 56 | 57 - 60 | 61 - 64 | 65 - 68 | 73 - 76 | 69 - 72 | 77 - 80 | 85 - 88 | 97 - 100 | Grand Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Cardiothoracic Surgery | | | 1 | | | | | | | 1 |
| Trauma & Orthopaedics | 2 | 3 | 3 | 4 | 2 | 1 | 2 | 1 | 1 | 19 |
| **Grand Total** | **2** | **3** | **4** | **4** | **2** | **1** | **2** | **1** | **1** | **20** |

### waiting at Hywel Dda LHB

| Specialty | <=26 Weeks | >26 <=36 Weeks | Grand Total |
|---|---|---|---|
| General Surgery | | 1 | 1 |
| Neurology | 2 | | 2 |
| Ophthalmology | 1 | | 1 |
| Trauma & Orthopaedics | | 1 | 1 |
| Urology | 3 | | 3 |
| **Grand Total** | **6** | **2** | **8** |

There were no patients waiting over 52 weeks at Hywel Dda Local Health Board

### waiting at Powys TLHB

| Specialty | <=26 Weeks | Grand Total |
|---|---|---|
| General Surgery | 3 | 3 |
| **Grand Total** | **3** | **3** |

There were no patients waiting over 52 weeks at Powys Teaching Local Health Board

Source: Information Team/ WG D&P

| Acronym | Detail | Explanation |
|---|---|---|
| AvLos | Average Length of Stay | A mean calculated by dividing the sum of inpatient days by the number of patients admissions |
| CALL | Community Advice & Listening Line | Offers emotional support and information/literature on Mental Health and related matters to the people of Wales |
| C.difficle | Clostridium difficile | A bacterium that can infect the bowel and cause diarrhoea. |
| CHKS | Part of Capita PLC | Leading provider of healthcare intelligence |
| CTP | Care and Treatment Planning | New measure within Mental Health Services |
| DAN 24/7 | Wales Drug and Alcohol Helpline | A free and bilingual helpline providing a single point of contact for anyone in Wales wanting further information or help relating to drugs or alcohol. |
| DNA | Did not attend outpatient clinic | A count of patients that failed to attend an outpatient appointment and did not notify the hospital in advance. |
| DSU | Delivery and Support Unit | The Welsh Government established the Delivery and Support Unit (DSU) to assist National Health Service (NHS) Wales in delivering the key targets and levels of service expected by both the Welsh Government and the public of Wales. |
| DTOC | Delayed transfers of care | A patient who continues to occupy a hospital bed after his/her ready-for transfer of care date during the same inpatient episode. |
| E.Coli | Escherichia coli | A bacteria found in the environment, foods and intestines of people and animals. |
| EDDS | Emergency Department Data Set | A data set which is made up of both injury data and illness data received from each of the Major Emergency Departments across Wales. |
| FCE | Finished Consultant Episode | A period of care under one consultant within one hospital |
| FTE | Full Time Equivalent | Number of employed persons as a whole unit |
| GP Cluster | GP Practice Cluster | Grouping of GP's & Practices locally determined by individual Local Health Boards |
| HAI | Hospital Acquired Infection | Any infection that occurs during a patient's stay in hospital |
| HPV | Human Papilloma Virus vaccination | A vaccination to reduce the incidence of communicable diseases |
| HONS | Heads of Nursing | |
| KSF | Knowledge & Skills Framework | KSF defines & describes the knowledge & skills NHS staff need to apply in their work to deliver quality services |
| LPMHSS | Local Primary Mental Health Support Services | Under provisions of section 2 of the Mental Health (Wales) Measure 2010, all local mental health partners must work jointly to agree a scheme for the provision of mental health services within the area. |
| MAMSS | Models for Access to Maternal Smoking Cessation Support | Supporting pregnant women to stop smoking |
| MMR | Mumps, Measles, Rubella vaccination | A vaccination to reduce the incidence of communicable diseases |
| MRSA | Methicillin Resistant *Staphylococcus aureus* | A type of bacteria resistant to several widely used antibiotics. |
| MSSA | Methicillin Sensitive *Staphylococcus aureus* | A type of bacteria not resistant to certain antibiotics. |
| Mortality | Measured as Crude Death Rate | The simplest death rate is the crude death rate & is usually calculated for periods of one year |

| Acronym | Detail | Explanation |
|---|---|---|
| NEWS | National Early Warning Score | Wales became the first country to adopt NEWS, with the life-saving intervention now an integral part of ward care in hospitals across the nation. It is providing frontline clinical teams with a standardised approach to deteriorating patients, meaning life-threatening conditions like sepsis are spotted earlier and stopped more quickly |
| NIHSS | National Institute of Health Stroke Scale | The NIH Stroke Scale/Score (NIHSS) quantifies stroke severity based on weighted evaluation findings. |
| NISCHR | National Institute for Social Care & Health Research | Welsh Government body that develops, in consultation with partners, strategy and policy for research in the NHS and social care in Wales. |
| NUSC | Non Urgent Suspected Cancer | Patients referred as non-urgent patients but subsequently diagnosed with cancer should start definitive treatment within 31 days of diagnosis, regardless of the referral route |
| NWIS | NHS Wales Informatics Service | Have a national role to support NHS Wales to make better use of IT skills & resources |
| PDR | Personal Development Review | Process whereby an employee meets at least annually with their manager or nominated deputy to discuss their performance for the last year, appraise objectives set for the previous year and agree a Personal Development Plan (PDP) for the coming year |
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| QOF | Quality Outcomes Framework | The Quality and Outcomes Framework (QOF) is a voluntary system of financial incentives. It is about rewarding GP's for good practice through participation in an annual quality improvement cycle. |
| RRAILS | Rapid Response to Acute Illness | Patients who become acutely ill whilst on wards benefit from early recognition and intervention with rapid treatment and escalation if needed. The aim is to avoid further deterioration and possibly death. |
| RTT | Referral to treatment | 95% of patients referred to Secondary Care planned care services to receive their treatment within 26 weeks. All patients referred to RTT included services are to receive treatment within 36 weeks of referral. |
| TOMS | Theatre Operating Management System | Cwm Taf's local electronic system for managing theatre activity |
| UMR | Universal Mortality Review | Process of reviewing In-Hospital Deaths |
| USC | Urgent Suspected Cancer | Patients referred as urgent suspected cancer and subsequently diagnosed with malignant cancer to start definitive treatment within 62 days of receipt of referral |
| WISDM | Welsh Information Solution for Diabetes Management | ICT solution for the management of diabetes patients across Wales. This will provide a clinical, multidisciplinary record, outpatient workflow and it will share and integrate information across primary, secondary and community healthcare settings |
| YTD | Year to Date | Period commencing 1st April |