AGENDA ITEM
6.1

CTM BOARD

INTEGRATED PERFORMANCE DASHBOARD

Date of meeting	27/05/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Rowland Agidee, Head of Performance and Clinical Information
Presented by	Clare Williams, Director of Planning & Performance (Interim)
Approving Executive Sponsor	Executive Director of Planning & Performance
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	
ILG	Integrated Locality Group
RTT	Referral to Treatment
FUNB	Follow Ups Not Booked
SOS	See on Symptom
PIFU	Patient Initiated Follow Up
DTOC	Delayed Transfers of Care
PMO	Programme Management Office
PCH	Prince Charles Hospital
RGH	Royal Glamorgan Hospital
CT	Cwm Taf

POW	Princess of Wales
YCC	Ysbyty Cwm Cynon
YCR	Ysbyty Cwm Rhondda
CTM	Cwm Taf Morgannwg
RCT	Rhondda Cynon Taff
SB	Swansea Bay
NPT	Neath Port Talbot
IMTP	Integrated Medium Term Plan
HMRC	HM Revenue & Customs
ED	Emergency Department
IPC	Infection Prevention and Control
SIs	Serious Incidents
NUSC	Non Urgent Suspected Cancer
USC	Urgent Suspected Cancer
SCP	Single Cancer Pathway
NOUS	Non Obstetric Ultra-Sound
SSNAP	Sentinel Stroke National Audit Programme
QIM	Quality Improvement Measures
SALT	Speech and Language Therapy
CAMHS	Child and Adolescent Mental Health Services
p-CAMHS	Primary Child and Adolescent Mental Health Services
s-CAMHS	Specialist Child and Adolescent Mental Health Services
SIOF	Single Integrated Outcomes Framework
ONS	Office for National Statistics
WAST	Welsh Ambulance Service NHS Trust
WPAS	Welsh Patient Administration System
MPI	Master Patient Index
RCS	Royal College of Surgeons
WCP	Welsh Clinical Portal
WHSSC	Welsh Health Specialised Services Committee
TAVI	Transcatheter Aortic Valve Implantation
QIA	Quality Impact Assessment

1. SITUATION/BACKGROUND

1.1 This report provides the Board with a summary of performance against a number of key quality and performance indicators. This will include areas where the organisation has made significant improvements or has particular challenges including the impact of COVID-19, together with areas where the Health Board is under formal escalation measures from the Welsh Government and/or where local progress is being monitored.

1.2 The Integrated Performance Dashboard (**Appendix 1**), provides the detail of the performance position, where in addition to the detail on key indicators, there is also the *At a Glance* summary of the indicators within the Quadruple Aims.

1.3 On the 6 April 2020, the Welsh Government issued the Delivery Framework 2020-21. The framework is an interim document whilst further work is undertaken to identify outcome focused measures that deliver the priorities of the Single Integrated Outcomes Framework for Health and Social Care (SIOF), a recommendation of A Healthier Wales.

1.4 This month sees a revised Quality quadrant in the Balanced Scorecard, the result of collaborative work between the Quality & Safety and Performance & Information teams, with further iterative enhancements expected in two months' time.

1.5 The associated narrative within this report is taken from the Quality Dashboard Report presented to the Quality & Safety Committee in May, resulting from the Patient Care and Safety team working in partnership with the ILGs. It is intended that this narrative will be detailed in the Dashboard itself in future months, consistent with the approach taken for the Performance quadrant.

1.6 This collaborative relationship is key to establishing an organisation wide systematic approach to maintaining consistently high quality services through target and outcomes setting, ongoing comparative measurement and reporting on safety, effectiveness and experience, identifying areas for improvement and enabling the sharing of good practice and lessons learned.

1.7 The health board is making good headway in respect of its Targeted Intervention status and DU recommendations for quality governance and incident management. The sustained effort to systematically improve and evidence the health boards position against the recommendations, provide meaningful assurance, leadership and delivery of measurable outcomes for those who use our services, and those who work within the health board, demonstrates continued commitment to progress the quality agenda.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

FINANCE

Month 11 *(Month 12 not available at the time of writing this report)*

	Variance from Plan			
	Current Month	Year to Date	Forecast Full Year	Forecast Recurrent
	£m	£m	£m	£m
Pay	-1.0	-3.6		
Non-Pay	0.3	-1.6		5.0
Income	-0.6	-1.0		
Efficiency Savings	-0.8	1.8		14.1
Non-delegated (including WG allocations)	2.0	4.2		£15.0m (including £13.4m planned deficit)
Total	**-0.1**	**-0.2**	**0**	**34.1**

	Current Month	Year to Date	Forecast Full Year	
PSPP	96.7%	93.5%	93.5%	Target 95%
Capital Expenditure	£5.1m	£38m	£52.6m	Includes £3.9m of anticipated funding
Agency as % of total pay costs	6.5%	7.0%	6.8%	

QUALITY

Indicators	Qtr 3 20/21	Qtr 2 20/21	Target	RAG
% complaints final/interim reply within 30 working days	62.2%	61.7%	75%	
	Mar-21	**Feb-21**	**Target**	**RAG**
Single Cancer Pathway	56.9%	51.9%	75%	
Number of Never Events in Month	0	1	0	
Thrombolysis for Eligible Stroke Patients within 45 Minutes	28.6%	87.5%	100%	
	Apr 20 to Mar 21	**Apr 20 to Feb 21**	**Target**	**RAG**
Cumulative rate of bacteraemia cases per 100,000 population - E.coli	70.53	68.98	N/A	
Cumulative rate of bacteraemia cases per 100,000 population - S.aureus	26.06	25.53		
Cumulative rate of bacteraemia cases per 100,000 population - C.difficle	25.16	24.55		
	Mar-21	**Feb-21**	**Target**	**RAG**
Number of Serious Incidents	8	6	TBC	
Number of Formal Complaints Managed through Putting Things Right	126	114		
Falls Causing Harm (Moderate/Severe/Death) - Rolling 12 Month Position	18	13		
Total number of instances of hospital acquired pressure ulcers (all hospital sites)	72	102		
Hospital Acquired Pressure Ulcers (Grade 3/4) - Rolling 12 Month Position	3	3		
Number of Potential Hospital Acquired Thrombosis (HATs)	8	11		
Cardiac Arrest Calls	43	34		

PERFORMANCE

Indicators	Apr-21	Mar-21	Target	RAG
A&E 12 hour Waiting Times	718	533	Zero	
Ambulance Handover Times >1 Hour	296	142	Zero	
RTT 52 Weeks	31,314	31,725	Zero	
Diagnostics >8 Weeks Waits	13,098	12,890	Zero	
% of Stage 4 Urgent Patients Clinically Prioritised	27.0%	30.5%	100%	
	Mar-21	**Feb-21**	**Target**	**RAG**
Mental Health Part 1a - CAMHS	56.4%	16.7%	80%	
Mental Health Part 1b - CAMHS	77.8%	66.7%	80%	
FUNB - Patients Delayed over 100% for Follow-up Appointment	28,009	27,974	14,815	
Admission to Stroke Unit within 4 hrs	12.0%	10.6%	SSNAP Average 54%	
Out of Hours (OOH)/111	In development - data not yet available			
	Apr-21	**Mar-21**	**All Wales Average**	**RAG**
Delayed Discharges rate per 100,000 population	7.68	7.78	2.93	

PEOPLE

Indicators	Apr-21	Mar-21	Target	RAG
Turnover	9.7%	9.4%	11%	
Exit Interview by Leaver	4.7%	4.0%	60%	
Sickness Absence Rate (in month)	N/A	5.20%	4.5%	
Sickness Absence Rate (rolling 12 month)	N/A	6.99%		
Return to Work Compliance	N/A	39.84%	85%	
Fill Rate Bank	27.0%	36.0%	90%	
Fill Rate On-contract Agency (RNs)	53.0%	62.0%		
PADR	51.7%	50.5%	85%	
Statutory and Mandatory Training - All Levels	57.8%	58.0%	85%	
Statutory and Mandatory Training - Level 1	65.5%	66.3%		
Job Planning Compliance (Consultant)	18.0%	17.0%	90%	
Job Planning Compliance (SAS)	17.0%	15.0%		
Direct Engagement Compliance (M&D)	97%	97%	100%	
Direct Engagement Compliance (ADP)	67%	69%	100%	
RN Shift Fill by Off-contract	370.3	2130.0	0 Hours	

2.1 This is the emerging Balanced Scorecard, with indicators that bring together Quality & Safety, Finance, Workforce and Performance for the Health Board.

2.2 This particular report will concentrate on the Performance and Quality quadrants, with other reports on the agenda covering the remaining quadrants.

- **Planned Care – Executive Lead, Director of Operations**

2.3 Pages 2 and 3 of the Dashboard detail elective activity undertaken in both internal and independent hospital capacity. Whilst treatment continues to be undertaken in independent hospital capacity, the granularity of data has not been maintained.

2.4 The increasing trend in elective waiting times largely continues, albeit that the total Stage 4 waiting list has reduced, aided by the waiting list validation exercise.

2.5 The Planned Care Recovery Programme has commenced with demand and capacity work having been completed for both RTT and Cancer waiting times.

- **Unscheduled Care – Executive Lead, Director of Operations**

2.6 Unscheduled care indicators, are highlighted on pages 7 and 9, they show a reduction in the volume of unscheduled presentations at PCH from Aneurin Bevan UHB. The volume from Powys UHB remains fairly static.

- **Cancer Waiting Times – Executive Lead, Medical Director**

2.7 As at 7th May 2020 the total number of active patients waiting at first outpatient stage of their pathway has increased markedly to almost 74% (2,372 patients), while patients waiting at the diagnostic stage accounts for just over 18% (582 patients) of the total increase.

- **Quality Improvement Measures - Executive Lead, Director of Therapies & Health Sciences**

2.8 Current performance levels are detailed on page 8 of the Dashboard.

2.9 Stroke Performance has been referred to the Health Board Quality and Safety Committee for monitoring and oversight. A report will go to the May meeting of the committee, outlining the performance against the Stroke QIMs in comparison to other Health Boards across Wales. The CTM Stroke Delivery Group anticipates publication of the Quality Statement for Stroke, which will replace the Stroke Delivery Plan for Wales as a key driver for the improvement in stroke services across Wales.

- **Mental Health Measure – Executive Lead, Director of Operations**

2.10 Compliance against Part One of the Mental Health Measure fell below the 80% target for the first time since May 2020 during March to 75% (89.6% in February).

2.11 Further compliance figures across the range of services are shown on page 11 of the Dashboard, where compliance in Neurodevelopment and Specialist CAMHS services continue to be low. Part 1a of the Mental Health Measure for CAMHS continues to remain under target. However, there has been significant improvement this month to 56.4% from 16.7% in the previous month.

2.12 Psychological Therapy compliance continued to improve during March to 79.8%, with the vast majority of patients waiting in excess of 26 weeks within three specific teams. When Psychological Therapy reporting first began, the Bridgend LPMHSS had 63 out of 182 patients waiting over 26 weeks. Bridgend have improved from 65.4% to 96.2% and are now one of the top performing teams. RTE CMHT have also improved from 56.3% to 72%.

Psychological Therapy Waiting Times					
	M&C	RTE	Bridgend	CTM	CTM
Reporting Period March 2021	CMHT	CMHT	LPMHSS	All other PT services	Total
0 - 26 weeks	36	59	125	135	355
27 - 35 weeks	13	9	4	8	34
36 - 51 weeks	5	12	1	8	26
52+ weeks	15	2	0	13	30
Total Waits	**69**	**82**	**130**	**164**	**445**
% <26 weeks	**52.2%**	**72.0%**	**96.2%**	**82.3%**	**79.8%**
% >36 weeks	**29.0%**	**17.1%**	**0.8%**	**12.8%**	**12.6%**
% >52 weeks	**21.7%**	**2.4%**	**0.0%**	**7.9%**	**6.7%**

- **WHSSC Commissioned Services – Executive Lead, Director of Planning & Performance**

2.13 Using data collected and reported by Digital Health and Care Wales (DHCW) page 12 of the dashboard shows waiting times for CTM residents at other Welsh providers, though the actual Commissioner is not WHSSC in all instances.

- **Never Events**

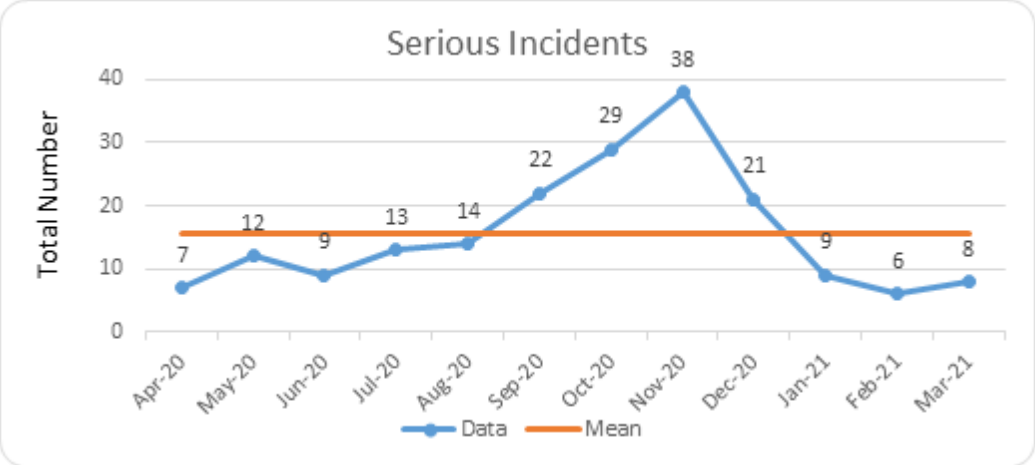
2.14 There was 1 never event reported in February 2021. This event related to a CTM patient receiving treatment at an English hospital where a swab was retained. Although the Never Event was not as a result of actions taken by CTMHB clinicians there has been organisational post-surgery involvement and joint investigation.

- **Serious Incidents**

2.15 During February to March 2021 a total of 3,478 Patient Safety incidents were reported. Of these, 188 were categorised as a serious incident i.e. resulting in avoidable severe harm or death. This is 0.40% of the total incidents reported.

2.16 Unexpected deaths of individuals known to our services as a result of apparent completed suicide remain a feature of SI reporting - 3 cases reported for February and March 2021. A desktop review of suspected suicides in contact with mental health services is in progress and early learning has been shared. There is a regional multi-agency approach to understanding, reviewing and preventing suicide within CTM, hosted by the Safeguarding Board.

2.17 HCAI-Covid 19 outbreak related deaths continue to be reported daily to the DU since December 2020 and account for the reduction in SI reporting after this date seen in the following chart.



2.18 As part of ensuring robust, continuous quality governance during the Covid-19 period, quality impact assessments (QIAs) are being undertaken for the key service changes underway to ensure any potential consequences on quality are considered and any necessary mitigating actions are outlined in a consistent way.

2.19 It is anticipated for the future that a QIA will be consistently considered as part of all development and proposal stage of new services, and when planning changes to existing services. This will ensure quality remains the driving component in CTM's provision of its services.

- **Complaints**

2.20 During February and March 2021, there were 240 complaints managed through Putting Things Right regulations. The main themes from complaints relate to Communication (104), Delays (56), Treatment Error (50), and Admission/discharge/transfer (ADT) concerns (15).

2.21 The complaints relating to communication are in the main concerned with attitude and behaviour of staff, perceived lack of communication and general communication issues regarding treatment.

2.22 The complaints regarding delays are in relation to treatment for surgery, follow-ups and investigations in the radiology service. The ADT complaints relate to potential inappropriate or unsafe discharge and poor discharge planning.

2.23 Treatment Errors relate to reported missed diagnoses, inappropriate treatment, and a perceived lack of duty of care. All complaints are responded to within the corresponding or host ILG, coordinated by the governance team and approved by group/nurse directors. Learning from complaints can be shared with the wider organisation.

2.24 Timely response rates have varied in this reporting period as a direct consequence of clinical teams not having the capacity to respond, despite relaxed requirements. Compliance varies across ILGs, reflecting not only resource allocation but also logistical management of the complaints process and differing hosting responsibilities. This variation offers an opportunity to establish a preferred and therefore consistent model across the UHB.

2.25 Learning from complaints will be strengthened by the appointment of a centrally based dedicated practitioner and within the locality and organisational governance structure, providing a more streamlined framework for cross pollination of learning and improvement.

- **Compliments**

2.26 During February and March 2021 there were 125 compliments reported to the PALS team, well down from December 2020 and January 2021 (196). The total number of compliments received for the year so far is 823.

2.27 Visiting has once again been restricted during this period and there is consequently less footfall on all of our sites. This is a difficult time for anything other than core business for colleagues however, reminders have been sent to colleagues to share any compliments with the PALS team for reporting on Datix.

- **Hospital Falls**

2.28 There was a marked reduction in falls reported for February and March 2021 (470) compared to the previous 2 months (576). The highest number of inpatient falls occurred within the Medicine specialty and Emergency Units at the Princess of Wales Hospital and Prince Charles Hospital.

2.29 Although severe harm from falls is very low in number there is an increasing incidence of moderate harm from falls reported. There is a Datix review underway of all falls within the past 24 months being carried out by the central patient care and safety team, in order to establish any themes, trends and opportunities for learning/practice development.

2.30 Over the past 12 months, a total of 3,245 falls were reported of which, 138 caused harm. This fell short of the planned improvement trajectory of a 20% reduction by 23 falls. It is anticipated that an ILG Nurse Director will lead on developing a CTM falls management strategy and progress improvement work on behalf of the Executive Director of Nursing.

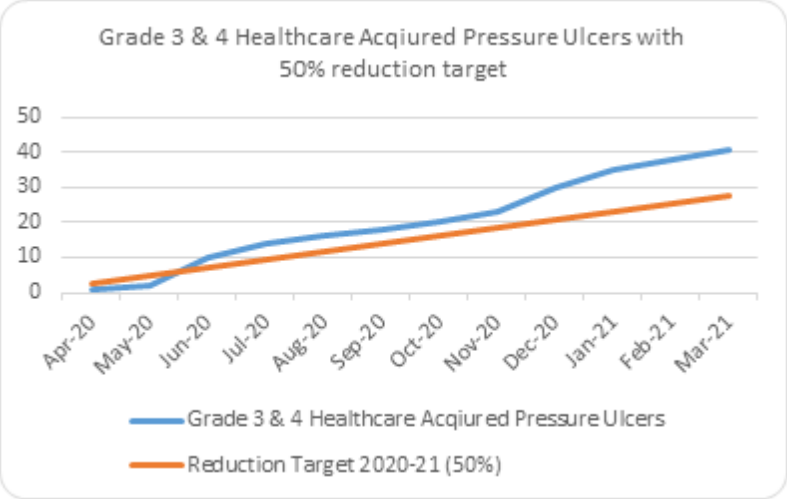
- **Hospital Acquired Pressure Damage**

2.31 The number of reported pressure damage has decreased for February and March 2021 (174) compared to 253 for the previous 2 months. The highest number of pressure damage incidents reported occurred within the patient's home with District Nursing input.

2.32 There were double the number of pressure damage incidents reported for the Princess of Wales and Prince Charles hospitals compared to the Royal Glamorgan hospital, predominantly within Medicine, Care of the Elderly and Orthopaedics.

2.33 Over the past 12 months, a total of 1,148 hospital acquired pressure ulcers were reported across the Health Board, of which 42 were graded either as 3 or 4. All avoidable pressure damage must be reported to the Multi-Agency Safeguarding Hub (MASH), with varying compliance with this requirement across ILGs.

2.34 An improvement trajectory of a 50% reduction in grade 3 and 4 pressure ulcers was set for 2020-21. Whilst the actual figure has been above this run-rate since June, the variance is much greater from December onwards as shown in the following chart:



2.35 Given the financial and humanitarian cost of pressure ulcers, this potentially avoidable injury is increasingly becoming a key policy and professional target within the UHB.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

3.1 The key risks for the **Performance** quadrant are covered in the summary and main body of the report.

3.2 The following issues/risks have been identified in relation to the **Quality** quadrant:

3.3 As in all public institutions the impact of the Covid-19 pandemic from both the first and second waves has had considerable and ongoing consequences on the ability of the UHB to provide continuity around its core business.

3.4 Gaining health board wide assurance of the breadth of UHB services and consideration of the four harms, with the changes in this month's report reflective of a greater ambition for assurance and measurement of quality.

3.5 An integral quality strategy and identification of priorities for the Health Board will be introduced at the next Quality and Safety Committee.

3.6 Progress has been sustained against recommendations and improvement action plans relating to the targeted intervention areas. Beyond this, ambitious pursuit of quality and safety in all aspects of the Health Board's work is imperative in order to provide excellence in service delivery to the population of CTM.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	A number of indicators monitor progress in relation to Quality, Safety and Patient Experience, such as Healthcare Acquired Infection Rates and Access rates.
Related Health and Care standard(s)	Choose an item.
	The 22 Health & Care Standards for NHS Wales are mapped into the 7 Quality Themes. The work reported in this summary and related annexes take into account many of the related quality themes.
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below)
	Not yet assessed
Legal implications / impact	Yes (Include further detail below)

	A number of indicators monitor progress in relation to legislation, such as the Mental Health Measure.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
	There are no directly related resource implications as a result of this report, although a number of improvement areas have underpinning financial plans.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 **NOTE** the Integrated Performance Dashboard together with this report.