AGENDA ITEM
7.1

CTM BOARD

INTEGRATED PERFORMANCE DASHBOARD

Date of meeting	(29/07/2021)

FOI Status	Open/Public

If closed please indicate reason	Not Applicable - Public Report

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Presented by	Prof. Kelechi Nnoaham, Executive Director of Public Health
Approving Executive Sponsor	Executive Director of Public Health

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 sets out the UHB's performance in a number of areas, considered highest risk and includes performance against targets for the year to date, as set out in the Welsh Government (WG) Delivery Framework and other priority areas for the UHB.

1.2 This report aims to ensure the performance report highlights the key areas that the UHB is concentrating on, to improve service delivery and those posing the greatest risk. The summary assessment therefore highlights critical areas of performance which are below target for attention, and the actions being taken to drive improvement.

1.3 Appendix 1, the Performance Dashboard, sets out the UHB's performance against the unscheduled and planned care elements of the Welsh Government (WG) Delivery Framework as at the end of June 2021.

1.4 Executive Management and Strategic Scorecards are provided in sections 2.1 and 2.2 of this paper. The Executive Management scorecards indicates that the UHB is presently compliant with two of its twenty-nine performance measures and is making satisfactory progress towards delivering a further three (October = 12). There remains twenty-four measures where either performance is below the expected standard or progress has not been made sufficiently quickly to ensure delivery by the requisite timescale.

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

2.1 The UHB's emerging Executive Management Scorecard is shown below. The measures selected are operational and output based in nature, allowing for earlier change detection in metrics that will ultimately affect our impact and outcomes.

FINANCE

Month 2	Variance from Plan			
	Current Month	Year to Date	Forecast Full Year	Forecast Recurrent
	£m	£m	£m	£m
Pay	0.8	3.4		
Non-Pay	1	-1		TBC
Income	0.2	0.3		
Efficiency Savings	0	0.0		TBC
Non-delegated (including WG allocations)	-1.7	-2.4		
Total	**0.24**	**0.25**	**0**	**TBC**

	Current Month	Year to Date	Forecast Full Year	
PSPP	93.7%	91.3%	94.0%	Target 95%
Capital Expenditure	£14.5m	£52.3m	£52.3m	
Agency as % of total pay costs	6.4	6.8	6.8%	

QUALITY

Indicators	Qtr 4 20/21	Qtr 3 20/21	Target	RAG
% complaints final/interim reply within 30 working days	52.7%	62.2%	75%	
	May-21	**Apr-21**	**Target**	**RAG**
Single Cancer Pathway	61.0%	61.9%	75%	
Thrombolysis for Eligible Stroke Patients within 45 Minutes	30.0%	45.5%	100%	
	Apr-Jun 21	**Apr-May 21**	**Target**	**RAG**
Cumulative rate of bacteraemia cases per 100,000 population - E.coli	95.66	94.69	N/A	
Cumulative rate of bacteraemia cases per 100,000 population - S.aureus	32.19	33.34		
Cumulative rate of bacteraemia cases per 100,000 population - C.difficile	30.40	28.01		
	May-21	**Apr-21**	**Target**	**RAG**
Number of Serious Incidents	2	6	TBC	
Number of Formal Complaints Managed through Putting Things Right	126	124		
Falls Causing Harm (Moderate/Severe/Death) - Rolling 12 Month Position	13	10		
Hospital Acquired Pressure Ulcers (Grade 3/4) - Rolling 12 Month Position	4	2		
Total number of instances of hospital acquired pressure ulcers	98	80		
Number of Potential Hospital Acquired Thrombosis (HATs)	4	12		
Cardiac Arrest Calls	39	38		
Number of Never Events in Month	0	0	0	

PERFORMANCE

Indicators	Jun-21	May-21	Target	RAG
A&E 12 hour Waiting Times	857	950	Zero	
Ambulance Handover Times >1 Hour	208	302	Zero	
RTT 52 Weeks	30,174	30,420	Zero	
Diagnostics >8 Weeks Waits	13,365	13,113	Zero	
% of Stage 4 Urgent Patients Clinically Prioritised	21.3%	23.9%	100%	
	May-21	**Apr-21**	**Target**	**RAG**
Mental Health Part 1a - CAMHS	40.0%	62.5%	80%	
Mental Health Part 1b - CAMHS	53.8%	65.0%	80%	
FUNB - Patients Delayed over 100% for Follow-up Appointment	28,365	27,876	14,815	
Admission to Stroke Unit within 4 hrs	16.0%	14.6%	SSNAP Average 54%	
Out of Hours (OOH)/111	In development - data not yet available			
	Jun-21	**May-21**	**All Wales Average**	**RAG**
Delayed Discharges rate per 100,000 population	7.24	8.87	4.5	

PEOPLE

Indicators	Jun-21	May-21	Target	RAG
Turnover	9.5%	9.5%	11%	
Exit Interview by Leaver	2.0%	3.1%	60%	
	May-21	**Apr-21**	**Target**	**RAG**
Sickness Absence Rate (in month)	6.3%	5.6%	4.5%	
Sickness Absence Rate (rolling 12 month)	6.6%	6.7%		
Return to Work Compliance	48.9%	43.8%	85%	
	Jun-21	**May-21**	**Target**	**RAG**
Fill Rate Bank	28.5%	25.8%	90%	
Fill Rate On-contract Agency (RNs)	55.2%	57.7%		
PADR	54.6%	53.6%	85%	
Statutory and Mandatory Training - All Levels	57.3%	58.2%	85%	
Statutory and Mandatory Training - Level 1	66.0%	65.8%		
Job Planning Compliance (Consultant)	17.0%	17.0%	90%	
Job Planning Compliance (SAS)	15.0%	18.0%		
Direct Engagement Compliance (M&D)	97%	98%	100%	
Direct Engagement Compliance (AHPs)	66%	68%	100%	
RN Shift Fill by Off-contract	31.0	36.0	0 Hours	

2.1 Quadruple Aims *"At a Glance"* are summarised below providing the detail on key performance indicators.

Quadruple Aim 1: People in Wales have improved health and well-being with better prevention and self-management

Measure		Target	Current Period		Last Period	
% of babies who are exclusively breastfed at 10 days old		Annual Improvement	2019/20	27.8%	not available	
% of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1		95%	Q4 20/21	97.3%	Q3 20/21	96.4%
% of children who received 2 doses of the MMR vaccine by age 5		95%		92.8%		93.3%
% of adult smokers who make a quit attempt via smoking cessation services		5% Annual Target	Q1 to Q3	2.9%	2019/20	3.6%
% of those smokers who are CO-validated as quit at 4 weeks		40% Annual Target	20/21	not available		38.4%
European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales (episode based)		4 Qtr Reduction Trend	Q3 20/21	311.6	Q3 19/20	419.7
% of people who have been referred to health board services who have completed treatment for alcohol misuse		4 Qtr Improvement Trend	Q4 20/21	70.8%	Q3 19/20	66.6%
Uptake of influenza vaccination among:	65 year old and over	75%	not available		2019/20	68.9%
	under 65's in risk groups	55%				40.3%
	pregnant women	75%				81.7%
	health care workers	60%				63.2%
Uptake of cancer screening for:	bowel	60%	2018/19	56.8%	2017/18	54.8%
	breast	70%		74.1%		73.9%
	cervical	80%		72.8%		not available
% of health board residents in receipt of secondary mental health services who have a valid care and treatment plan (for those age under 18 years and 18 years and over)	under 18 years	90%	May-21	95.9%	Apr-21	73.6%
	over 18 years			86.9%		86.3%
% of people in Wales at a GP practice (age 65 years and over) who are estimated to have dementia that are diagnosed		Annual Improvement	2019/20	51.9%	2018/19	50.0%

Quadruple Aim 2: People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

Measure		Target	Current Period		Last Period	
% of GP practices that have achieved all standards set out in the National Access Standards for In-hours GMS		100%	2019/20	65.4%	not available	
% of children regularly accessing NHS primary dental care within 24 months		4 Qtr Improvement Trend	Q2 20/21	62.3%	Q1 20/21	64.2%
% of Out of Hours (OoH)/111 patients prioritised as P1CHC that started their definitive clinical assessment within 1 hour of their initial call being answered		90%	Jan-20	97.0%	Dec-19	91.2%
% of emergency responses to red calls arriving within (up to and including) 8 minutes		65%	Jun-21	59.0%	May-21	58.2%
Number of ambulance patient handovers over 1 hour		Zero		208		301
% 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		95%		69.5%		69.7%
Number of patients who spend 12 hours or more in all hospital major and minor emergency care facilities from arrival until admission, transfer or discharge		Zero		857		940
% of survival within 30 days of emergency admission for a hip fracture		12 Month Improvement Trend	Mar-21	71.7%	Mar-20	75.5%
% of patients who are diagnosed with a stroke who have a direct admission to a stroke unit within 4 hours of the patient's clock start time		SSNAP Average 59.3%	May-21	16.0%	Apr-21	14.6%
% of patients who are assessed by a stroke specialist consultant physician within 24 hours of the patient's clock start time		SSNAP Average 85.2%		75.6%		78.8%
% of patients starting first definitive cancer treatment within 62 days from point of suspicion (regardless of the referral route)		75%		61.0%		61.9%
Number of patients waiting more than 8 weeks for a specified diagnostic		Zero	Jun-21	13,365	May-21	13,113
Number of patients waiting more than 14 weeks for a specified therapy				272		336
% of patients waiting less than 26 weeks for treatment		95%		48.2%		46.8%
Number of patients waiting more than 36 weeks for treatment		Zero		42,533		41,793
Number of patients waiting for a follow-up outpatient appointment		74,734	May-21	106,040	Apr-21	105,796
Number of patients waiting for a follow-up outpatient appointment who are delayed over 100%		14,815		28,365		27,876
% of ophthalmology R1 patients who are waiting within their clinical target date or within 25% in excess of their clinical target date for their care or treatments		95%		35.4%		34.7%
Rate of hospital admissions with any mention of intentional self-harm for children and young people (age 10-24 years) per 1,000 population		Annual Reduction	2019/20	2.5	not available	
% of patients waiting less than 28 days for a first outpatient appointment for Child and Adolescent Mental Health Services (tCAMHS)		80%	May-21	54.8%	Apr-21	57.9%
% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age under 18 years)				41.9%		58.8%
% of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral (for those age 18 years and over)				61.7%		46.3%
% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age under 18 years)				62.5%		66.7%
% of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS (for those age 18 years and over)				84.0%		84.6%
% of children and young people waiting less than 26 weeks to start a neurodevelopment assessment				46.0%		42.0%
% of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health				81.2%		78.6%
Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: Ecoli; S.aureus bacteraemias (MRSA and MSSA) and; C.difficile	E-coli	To be confirmed	Apr-21 to Jun-21	95.66	Apr-21 to May-21	94.69
	S.aureus bacteraemia			32.19		33.34
	C.difficile			30.40		28.01
Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp and; Aeruginosa	Klebsiella sp			17.88		18.67
	P. aeruginosa			5.36		5.33
Number of potentially preventable hospital acquired thromboses		4 Qtr Reduction Trend	Q1 - Q3 20/21	4	Q4 19/20	2

Quadruple Aim 3: The health and social care workforce in Wales is motivated and sustainable

Measure	Target	Current Period		Last Period	
Average rating given by the public (age 16+) for the overall satisfaction with health services in Wales	Improvement	2018/19	6.33	2016/17	6.03
% of adults (age 16+) who reported that they were very satisfied or fairly satisfied about the care provided by their GP/family doctor	Annual Improvement	2019/20	90.8%	not available	
Overall staff engagement score	Annual Improvement	2020	71%	not available	
% 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)	85%	Jun-21	54.6%	May-21	53.6%
% of staff who have had a performance appraisal who agree it helps them improve how they do their job	Annual Improvement	2018	53.0%	2016	54%
% compliance for all completed level 1 competencies of the Core Skills and Training Framework by organisation	85%	Jun-21	65.5%	May-21	65.5%
% of sickness absence rate of staff	12 Month Reduction Trend	Apr-21	5.7%	Apr-20	8.4%
% of staff who would be happy with the standard of care provided by their organisation if a friend or relative needed treatment	Annual Improvement	2020	61.4%	2018	75.0%
% of complaints 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 complaint was first received by the organisation	75%	Q4 20/21	52.7%	Q3 20/21	62.2%

Quadruple Aim 4: Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes

Measure	Target	Current Period		Last Period	
Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	1,848	Q1-Q3 20/21	1626	2019/20	1680
Number of patients recruited in Health and Care Research Wales commercially sponsored studies	29		24		28
Crude hospital mortality rate (74 years of age or less)	12 Month Reduction Trend	Mar-21	2.09%	Feb-21	2.15%
% of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within 1 hour of positive screening	12 Month Improvement Trend	May-21	85.7%	Apr-21	42.5%
% 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 1 hour of positive screening			71.4%		56.3%
% of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours	12 Month Improvement Trend	Mar-21	0.5%	Mar-20	2.2%
All new medicines recommended by AWMSG and NICE, including interim recommendations from cancer medicines, must be made available where clinically appropriate, no later than 2 months from the publication of the NICE Final Appraisal Determination and the AWMSG appraisal recommendation	100%	Q3 20/21	98.9%	Q2 20/21	98.8%
Total antibacterial items per 1,000 STAR-PUs (specific therapeutic age related prescribing unit)	To be confirmed		279.2		262.5
Number of patients age 65 years or over prescribed an antipsychotic	Qtr on Qtr Reduction		1437		1474
Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age			0.17%		0.18%
Opioid average daily quantities per 1,000 patients	4 Qtr Reduction Trend	Q3 20/21	5240.6	Q2 20/21	5017.9
Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product including biosimilar (for a selected basket of biosimilar medicines)	Qtr on Qtr Improvement	Q2 20/21	72.3%	Q1 20/21	66.7%
% of adult dental patients in the health board population re-attending NHS primary dental care between 6 and 9 months	4 Qtr Reduction Trend	Q4 20/21	25.6%	Q3 20/21	21.6%
% of critical care bed days lost to delayed transfer of care (ICNARC definition)	Qtr on Qtr Reduction towards Target of no more than 5%	Q4 20/21	6.8%	Q3 20/21	6.7%
Number of procedures postponed either on day or the day before for specified non-clinical reasons	2,713	Mar-21	571	Feb-21	1,014
Agency spend as a percentage of the total pay bill	12 Month Reduction Trend	Jan-21	6.7%	Dec-20	6.1%
% of clinical coding accuracy attained in the NWIS national clinical coding accuracy audit programme	Annual Improvement	2019/20	94%	2018/19	not available

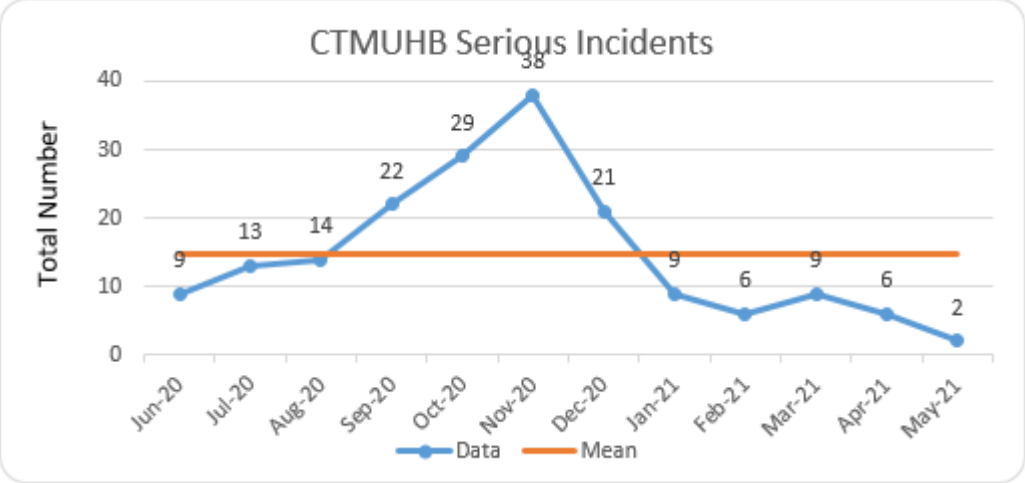
2.2 Quality

2.2.1 Never Events

There have been no never events reported in the present financial year.

2.2.2 Serious Incidents

8 Serious Incidents were reported in April and May. This decrease in is due to a reduced reporting criteria having been put in place during the pandemic and Covid Health Care Acquired Infections being reported separately to the NHS Delivery Unit.



Whilst numbers are therefore relatively low, the UHB's guidance does seek to ensure that all new and previously reportable *serious patient safety incidents* must continue to be reported to the appropriate ILG governance team for initial approval. These are then submitted to the Central Patient Safety team to provide pan-organisational oversight and assurance for executives and Board members. It is anticipated that future reporting to Quality and Safety Committee will feature Nationally Reported Incidents and Locally Reportable Incidents.

Unexpected deaths as a result of completed suicide and self-harm incidents of those engaged with our mental health or drug and alcohol (MH/D&A) services remain a feature, with two cases reported for April and May 2021. The UHB are undertaking a review of all suspected suicides who have received a MH/D&A service within the preceding twelve months of the incident to establish the robustness of investigation and to support learning and preventative practice. Multi-agency strategic work in respect of suicide and self-harm prevention is well led and attended by health board colleagues.

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 to ensure any potential consequences on quality are considered and any necessary mitigating actions are outlined in a consistent way.

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.

2.2.3 **Complaints**

During April and May 2021, there were two hundred and fifty complaints managed through Putting Things Right regulations. The main themes from complaints relate to:

- Communication: these are predominantly failures in communication between health board staff and patients
- Treatment Errors: these relate to failure to treat, inappropriate treatment, and missed diagnoses.
- Delays in access to care, such as treatment waiting time and onward referral
- Potentially inappropriate or unsafe discharge and discharge planning

The Covid response has had an impact on the UHB's ability to investigate and respond to concerns within thirty days, with considerable differences in compliance across the ILG's being observed. The factors influencing these differences include levels of resource allocation towards the management of concerns; differences in complexity of concerns and the logistical management of the complaints process. Work is ongoing to identify the resource/process used within each ILG in order to identify a preferred and therefore consistent model to managing and learning from concerns across the UHB.

Complainants have received acknowledgement and explanation where there are have been any delays in providing a response to them.

Improvements and learning from concerns will be strengthened by the appointment of a centrally based Head of Complaints and Legal Services, providing a supportive steer for complaints management and response and a more streamlined framework for cross pollination of learning and improvement.

2.2.4 **Compliments**

During April and May 2021, there were one hundred and forty four compliments reported to the PALS team; an increase on the one hundred and sixteen received in the previous two month period.

This coincides with an increase in the numbers of patients attending departments and receiving hospital based treatments, whilst there have been minimal changes in the restrictions to visiting and there continues to be less footfall on sites as a whole.

The people's experience module within the new risk management system is anticipated as a method of facilitating standardised meaningful data, allowing for improved triangulation of intelligence on how services are experienced by those who use them.

In addition, the Health Board are implementing the new national 'Civica' patient experience feedback monitoring system. Nationally and within CTM, there is a commitment to ensuring patient feedback is captured and used to inform learning and drive quality, and the impact of this should be seen in the near future with a Civica lead recently appointed.

2.2.5 **Hospital Falls**

There was a slight increase in falls reported for April and May 2021 (480) compared to the previous 2 months (470). The highest number of inpatient falls occurred within medicine and emergency care departments at Prince Charles Hospital. Although severe harm/death from falls is very low in number there is an increasing incidence of moderate harm from falls reported.

Over the past 12 months, three thousand one hundred and ninety two falls have been reported, of which one hundred and thirty nine caused harm. Initiatives to reduce falls across our sites are underway, with the ambition of achieving a 20% reduction by year-end. These include deep dive analyses of clinical areas where there are high incidence, and informed interventions and environmental improvements to reduce the likelihood of falls and improve patient safety in these areas. Most notably Bridgend ILG have acted to reduce the probability of falls within Angleton Ward 2 specialising in elderly dementia care through analysis of patient demographic, the effects of 'sundowning', staffing numbers and use of medication. Whilst Merthyr/Cynon ILG have created a falls dashboard to improve intelligence including falls per 1000 bed days and repeated falls data. These endeavours improve understanding and therefore potential to prevent harm from falls occurring.

Progress against the UHB's ambition will be monitored and supported through the falls prevention group which will be re-established when the current demands on staff are less acute.

2.2.6 Hospital Acquired Pressure Damage

The number of patients reported as having suffered pressure damage has increased for April and May 2021 to one hundred and seventy eight, which compares to one hundred and sixty six for the previous two months. The highest number of pressure damage incidents reported occurred within the patient's home with District Nursing input.

The highest number of pressure damage incidents reported for secondary care was for the Princess of Wales, followed by Prince Charles hospital and the Royal Glamorgan hospital, predominantly within general medicine, care of the elderly and orthopaedics.

Over the past twelve months, a total of one thousand one hundred and sixty one hospital acquired pressure ulcers were reported across the health board, of which, forty six were Grade 3 and 4s. All avoidable pressure damage must be reported to the Multi-Agency Safeguarding Hub (MASH), however the consistency and timing of this requirement within the three ILG's is not yet uniform.

An improvement trajectory of a 50% reduction in Grade 3 and 4s has been set for 2021-22. Pressure ulcer scrutiny panels are held in each district general hospital and within community settings. Scrutiny panels drive accountability and quality improvement relating to pressure ulcer prevention and management, providing feedback and learning locally and potentially across the organisation.

Progress will be monitored and supported through the pressure ulcer improvement group, which will also be re-established shortly under the direction of the RTE Nurse Director.

A new policy for the prevention and management of pressure damage has been drafted for comments. Given the financial and humanitarian cost of pressure ulcers, this potentially avoidable injury is increasingly becoming a key policy and professional target within our organisation.

2.3 People

In summary the main themes of the People Scorecard (below) are:

- Overall PDR (non-medical staff) compliance for May 2021 is 51.73% and is a slight improvement on April (50.48%).

- M&D medical appraisals are at 98.7% with other staff groups ranging from the highest 63.16% (E&A) to the lowest 16.28% (ST)
- Combined core mandatory training compliance for May 2021 averages 57.84%
- The overall Cwm Taf rolling twelve month sickness rate to May 2021 is 6.65%. Occurrences of long term sickness absence continues to fall but since February this year short term occurrences have begun to rise.

2.4 **Performance**

2.4.2 **Elective Services**

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.

The provisional June position for Referral to Treatment Times (RTT) is:

- 30,174 patients waiting over 52 weeks
- 42,533 patients waiting over 36 weeks (includes the numbers waiting over 52 weeks)
- 48.2% of patients waiting <26 weeks

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. Provisionally, at the end of June the treatment waiting list was 15,368 patients, of which 4,189 were urgent patients.

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

The ambition remains to return to no patients waiting over 36 weeks for elective treatment by the end of March 2023 and to do so in a sustainable way. The milestone for March 2022 is to have no patients waiting over 52 weeks.

2.4.3 **Unscheduled Care**

As at the end of June the overall compliance for waiting times at all CTM's Emergency Units is:

- The total number of attendances were 17,153

- 69.5% of patients were admitted, discharged or transferred from our minor injuries and emergency units within 4 hours of arrival
- 857 patients were required to wait more than 12 hours in our Emergency Departments for reasons other than clinical necessity.

Further detail in regards to unscheduled care indicators is provided in appendix 1.

2.4.3 Cancer Waiting Times

The end of May position for Single Cancer Pathway (SCP) is 61.0% of patients started first definitive treatment within 62 days from point of suspicion. The total number of patients starting treatment was 213 with 83 patient breaches.

As at 7th July 2021, the total number of active patients waiting at first outpatient stage of their pathway currently stands at 1,760 patients, while patients waiting at the diagnostic stage accounts stands at around 987 patients.

2.4.4 Stroke services

Current performance levels for the two stroke units are detailed on page 8 of the Dashboard. The overall CTM compliance during May for the four Quality Improvement Measures (QIMs) is:

- Admission to stroke unit within 4 hours – 16.0%
- 45 minute door to needle time – 30.0%
- CT scan within 1 hour – 62.8%
- Stroke Consultant within 24 hours – 75.6%

The Health Board Quality and Safety Committee received a report on stroke performance in their May meeting and will now include it in its monitoring and oversight. Monthly meetings of a Stroke Planning Group have been established to develop both a short and long term plan for Stroke Services in CTM, linking in with the CTM Stroke Delivery Group.

2.4.5 Mental Health Measure

Compliance against Part One of the Mental Health Measure saw an improvement during June at 59.6% (47.5% in May) but continues to be below the 80% target.

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 with a fall in compliance to 40.0% from 62.5% in the previous month.

Compliance for Psychological Therapy improved to 81.2% during May (78.6% in April). When Psychological Therapy reporting first began, the Bridgend LPMHSS had 63 out of 182 patients waiting over 26 weeks and the table below shows the good progress made within the service, as May's position reveals that no patients are waiting over 26 weeks.

Psychological Therapy Waiting Times					
	M&C	RTE	Bridgend	CTM	CTM
Reporting Period May 2021	CMHT	CMHT	LPMHSS	All other PT services	Total
0 - 26 weeks	28	46	176	169	419
27 - 35 weeks	10	8	0	15	33
36 - 51 weeks	6	7	0	13	26
52+ weeks	14	3	0	21	38
Total Waits	**58**	**64**	**176**	**218**	**516**
% <26 weeks	**48.3%**	**71.9%**	**100.0%**	**77.5%**	**81.2%**
% >36 weeks	**34.5%**	**15.6%**	**0.0%**	**15.6%**	**12.4%**
% >52 weeks	**24.1%**	**4.7%**	**0.0%**	**9.6%**	**7.4%**

2.5 **Finance**

The draft financial plan submitted at the end of March 2021 has been updated to reflect the guidance on 'Final Annual Plans – Financial Principles & Expectations' issued by the Finance delivery Unit on 20 May 2021. The updated draft financial plan was submitted to WG on 30 June 2021 and can be broken down into three separate elements:

- The core plan
- Covid response
- Planned care recovery

The three key elements of the financial plan are summarised below:

Summary of Core Plan, Covid, & Planned Care Recovery	Q1	Q2	Q3	Q4	Total
	£m	£m	£m	£m	£m
Core plan	5.1	5.1	5.1	5.1	20.5
Covid plan	-5.1	-5.1	-5.1	-5.1	-20.5
Planned care recovery plan	0.0	0.0	0.0	0.0	0.0
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Cumulative total	**0.0**	**0.0**	**0.0**	**0.0**	

This shows a breakeven position through Q1 to Q4, with the deficit in the Core plan being offset by a corresponding surplus against Covid funding, giving an overall breakeven position for 2021/22.

The key aspects of the updated financial plan are as follows:

- Anticipated additional non-recurring Covid funding of £20.5m for the Covid overspends from 2020/21. This includes a £16.2m shortfall against the 2020/21 savings plan resulting from Covid and £4.3m of additional cost pressures. This reflects the recent funding principles issued by the Welsh Government, but will be subject to WG review, and may not be fully agreed.
- Requested additional non-recurring Covid funding of £5.5m over the confirmed Welsh Government allocation of £26.1m, to reflect a revised assessment of demand relating to Covid, Winter and paediatric respiratory virus.
- Anticipated non-recurring allocations from Welsh Government of £7.0m in 2021/22 for investment in Think 111 First, Urgent primary care and Same Day Emergency Care (SDEC).
- The plan assumes that around £9m of existing cost pressures projected by ILGs & Directorates are avoided or managed out. There is a £5m transitional budget to support this and Covid funding for Q1 may also provide some temporary headroom if actual costs are lower.
- The plan assumes recurrent savings delivered will be £16.1m and in year savings £14.5m. In comparison with this, bottom up savings plans at the end of Q1 are so far falling short of this by £0.9m, and we do not yet have adequate assurance on their delivery.
- The provision for new investment in the plan is relatively low (£1m enabling) and a small amount of non-recurring funding.
- The plan is bolstered on a one off basis in 21/22 by release from the balance sheet of over £6m and by £4.7m non-recurring release of budgets committed to out of hospital transformation from 2022/23. Therefore the underlying recurrent position is worse, and is a £31.4 deficit at the end of 2021/22 provided that the assumptions above are delivered.

There is significant risk in the plan, and provided it is delivered in 2021/22, there will still remain a large recurrent deficit to be addressed from 2022/23 onwards.

The overall funding position across Welsh Government is such that there is likely to be further funding potentially becoming available, particularly around planned care recovery. This may be at a level that exceeds what the NHS in Wales could practically spend in 21/22, and so an element may be made available for other initiatives on a one-off basis. However, this is predicated on the CTM plan being delivered internally.

We will identify priorities for any non-recurring investment but the focus needs to be on delivering the plan above, which we need to do from a

sustainability perspective anyway. This will put us in the best position to be able to utilise any non-recurring WG funding which does become available.

Full details are provided in the Finance report.

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 The Board is asked to **NOTE** the Integrated Performance Dashboard together with this report.