GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Ysbyty Gwynedd, Penrhosgarnedd
Bangor, LL57 2PW

Claire Griffiths
Deputy Clerk
Public Accounts Committee
Chamber & Committee Service
National Assembly for Wales
Cardiff

Ein cyf / Our ref: GLP/LJ
☎**:** 01248 384290
Gofynnwch am / Ask for: Chairman's Office
Ebost / email peter.higson@wales.nhs.uk
Dyddiad / Date: 13th April 2015

Dear Ms Griffiths

During our session giving evidence to the Public Accounts Committee on 24th March 2015 we agreed to submit a series of updates to the Committee and I am pleased to be able to provide these as follows:

- **The trail of discussions by the health board relating to Ysbyty Glan Clwyd Obstetrics & Gynaecology, including issues around recruitment:**

The context for these comments was concern from members of the Public Accounts Committee that the serious concerns regarding this service had emerged rapidly and had not been visible at the Board level.

During the Committee session we referred to the fact that there had been a long standing trail of discussions within the Board and its sub- committees regarding the challenges facing Obstetric and Gynaecology services in Ysbyty Glan Clwyd. This included referencing this matter on the Board's Corporate Risk register which is reviewed in our public Board sessions and is published routinely as part of our Board papers.

Reporting of concerns and the management responses to these concerns was taking place regularly throughout 2013 within our Workforce and Organisational Development Committee and our Quality and Safety Committee. Due to the nature of the concerns and links to a small number of staff these discussions were held in confidence initially. In October 2013 the risk associated with the provision of maternity services in Glan Clwyd was added to the Board's Corporate Risk Register along with mitigating actions which were in place to address these risks. This entry has remained in the risk register since that date, reflecting the ongoing concern at Board level and the oversight of management response that was in place.

In February 2014 the Board's Quality and Safety Committee received a paper in its public session detailing the background to the concerns within this service and setting out what actions were ongoing to secure better engagement from the Consultant staff. The Committee continued to monitor progress in relation to these concerns, receiving updates from the Clinical Programme Group and considering indicators of quality and safety for services across North Wales.

The Board received reports from the Quality and Safety Committee on these concerns and received the minutes of this Committee's meetings in public session throughout 2014. During the autumn of 2014, in addition to reviewing this risk in public session the Board had discussions "in Committee" regarding the need to address the risks in the service if they could not be reduced by other means. In February 2015 the Board received the paper which proposed the urgent service change.

The Board established an Implementation Group, with an independent Chair to oversee this work and determined that a series of "gateway" checks should be made prior to the service being changed. In the intervening period an alternative proposition has been received from some of the Consultants in Glan Clwyd and this is being assessed for viability, safety and sustainability alongside the Board's original proposition. The Board will meet on 20th April to make a formal decision regarding the outcome of this assessment and the "gateway" reviews.

- **Well North**

During our evidence session we made reference to the work we are initiating in areas of North Wales to reduce health inequalities**.** The Health Board is planning a systematic approach to improving the health of the poorest fastest, through a place- based health inequalities program. This is outlined in our Annual Operating Plan for 2015/16 in the Prevention and Health Improvement and Primary and Community Services sections. We are currently identifying the communities to focus on, and will be working with Public Health Wales to develop a plan for multi agency engagement, multi-faceted interventions and evaluation of impact. We are taking learning from the Inverse Care Law programs in two Welsh Health Boards and the Well North and Well London approaches, among others to define our approach.

- **Communications in relation to Ysbyty Glan Clwyd, in particular the brochure:**

During our evidence session there was considerable discussion regarding the communication which had taken place with staff and stakeholders regarding the proposed change and the leaflet which was produced for expectant mothers. Given the concern over this aspect of the Board's actions I thought it helpful to set out in some detail the communications which did take place around the time of the Board discussion, and importantly those which have continued since.

Members of the Health Board's executive leadership team briefed senior colleagues across the service in the days ahead of the Board meeting on February 10th. These briefings were carried out on a confidential basis and it was made clear that no action would be taken, and no decision was made until the Board had had the opportunity to discuss and agree on a course of action at its meeting held in public. Issues relating to the obstetric service had been well known to staff in the Clinical Programme Group (CPG) and it was clinicians from within the CPG that recommended the interim suspension of Consultant led obstetric services at Ysbyty Glan Clwyd, which was endorsed by the Board's Clinical Executive Directors.

Significant communications activity has taken place since the decision was taken by the Board, including:

- A range of staff communications including messages from the Chief Executive on a weekly basis to keep colleagues updated with facts and developments. Regular drop-in sessions have been held for staff across all three district general hospital sites, with all questions raised and responses provided published on a dedicated intranet hub.

- A range of materials have also been developed as part of an information campaign for the public. These include a Birthplace Choices leaflet for mothers-to-be which is provided to women during midwife appointments. This is also available in an easy read version. The approach taken in producing this leaflet has been endorsed by the Royal College of Midwives in Wales as an excellent publication. The Health Board has been approached by midwives in Northern Ireland seeking to produce their own version based on this approach.

- The Health Board is producing a comprehensive information toolkit which includes factsheets on Neonatal Care in North Wales, support for transport costs and a maternity services information sheet; the completed toolkit will be provided to all mums-to-be during their initial booking meeting with their midwife;

- A dedicated external bilingual web hub has been established, with comprehensive Frequently Asked Questions, supporting information and evidence http://www.wales.nhs.uk/sitesplus/861/page/77408. This is being developed on an ongoing basis;

- A North Wales Midwives Facebook page has been developed to showcase the work of midwives. This is supported by multimedia content such as photos and videos of Midwifery-Led Units and interviews with midwives, including the Executive Director of Nursing and Midwifery;

- A series of online web chats have been hosted by clinicians from the Health Board, encouraging members of the public to ask questions;

- Questions from users of social media – namely Facebook and Twitter – are also being responded to as appropriate

- A series of public drop-in sessions spread across numerous locations in North Wales have also been arranged, supported by information stands and the materials described above. These have been widely advertised, in the media and through posters across hospital sites and in communities;

- Members of the Health Board's executive team attended the public meeting at St Asaph Cathedral on Thursday 12th March to answer questions and address concerns

- Stakeholders including AMs, MPs, GPs, the Community Health Council, Local Authorities and Community Voluntary Services receive a weekly newsletter update from the Chief Executive on the preparations for the interim changes;

As will be seen from the above there is a significant amount of communication work ongoing regarding the proposed changes. This is seen as a key priority for the Health Board to ensure that mothers-to-be are given up to date information, and our staff and stakeholders are aware of the changes which are proposed and the way services will be delivered.

This emphasis upon communication will continue during the coming months and will focus upon service delivery as well as the plans which will be progressed to re-instate services in Glan Clwyd should changes be made.

With specific regard to the brochure which was issued shortly after the Board made its decision, this was considered to be a very important document to inform mothers-to-be regarding the implication of the Board's decision for their birth choices. The booklet was prepared in order to clearly outline birthplace options and to provide reassurance to mothers-to-be. It was designed to be handed to expectant mothers by community midwives during appointments.

The timing of the booklet's production was designed in order to be ready for a decision from the Board and initiate public communications accordingly. Draft text based on the contents of the Board paper of 10th February was sent to the printing company on Monday 9th February in anticipation of a decision by the Board, however there was no commitment to produce the document at this stage. Had the Board agreed not to act, the work with the printer to design and typeset the leaflet would have ceased. The final proof of the booklet was agreed and signed off on the afternoon of the 12th February, in line with the Board's decision and copies of the booklet were delivered to the Health Board on 16th February for distribution to Community Midwife Teams.

We believe that this proactive preparatory work to be able to communicate quickly to mothers-to-be and allow our staff to engage in positive discussions with them regarding choices was an essential communication activity around the Board's decision.

An updated version of the leaflet is currently being drafted to include additional information for mothers-to-be and will be available in April.

- **The Training of Board Members:** An externally facilitated Board Development programme has been in place for more than 12 months and is ongoing. This is focused on improving the effectiveness and performance of the Board as a whole as well as the individual contribution from Board Members. I have attached a summary note of the dates, topics covered and attendance of Board members as requested by the Committee.

- **Performance Indicators:** In my introductory comments I made reference to the improvements we have been making to our reporting of performance within the Board. This work started during 2014-15, and a new performance framework was put in place for the Board. This has been revised and updated further following the appointment of our new Chief Operating Officer and its refinement continues. Importantly this performance framework draws together a number of local indicators as well as those which reflect performance against national targets. It covers matters of safety and quality in addition to traditional organisational performance targets. This gives the Board a broader view of the performance of the organisation and allows focus upon areas where improvement is expected.

  The design of the performance report has been influenced by standards adopted elsewhere including the Good Governance Institute and board reports from other organisations in Wales and NHS England. A Board Development session took place on 30th October 2014, to enable Board Members to debate the future design and content of Board Reports to allow a preferred style and content determined. A copy of the current report is attached with this response for information.

- **Management of Capital Schemes:** Following our attendance the Chairman of the Committee asked that I provide an update regarding the Board's arrangements for managing its capital programme and resource. The Committee will be aware that capital is one of the areas where the Board has been subject to intervention from Welsh Government.

  A number of changes were made to the way capital expenditure was managed and reported during 2014/15 to ensure that systems were robust and reliable. This was supported by reviews from NHS Wales Specialist Services Internal Audit. These audit studies continue and have reported improvements in the governance and management of capital programmes.

  In addition, the Board commissioned Capita to undertake a review of its arrangements for managing capital. Capita have now reported and the Board is amending its governance and management processes to reflect the recommendations made. Capita are also working with the Board to produce a new guidance manual for "managing capital" within the Board. This will cover areas of business case preparation, scheme management and benefits realization. This will be implemented along with the changes to governance arrangements during quarter 1 of 2015/16.

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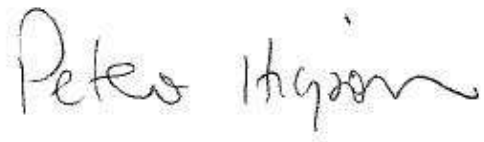
I trust that the further information above, and the attachments with this letter will provide sufficient additional information for the Committee on the issues raised. If there is anything further that would be helpful please do not hesitate to contact me.

Yours sincerely



Dr Peter Higson
CHAIRMAN

Attachments:

- Attendance at Board Development 2014
- Attendance at Board Development 2015
- Integrated Quality and Performance Report – Board Meeting April 2015

		P Higson	M Hanson	K McDonou	C Tillson	H Owen Jones	H Stevens	HM Davies	J Dean	M W Jones	E Roberts	J R Malone	T Purt	N Bradsha	B Evans	A Hopkins	A Jones	J M Jones	G Lang	G Lewis Pa	T Lynch	M Olsen	M Makin	C Wright	S Baxter	R Favager	I Mitchell	A Thomas	V Babu	N Stubbins
Date	**Topic**	**Chair**	**ViceChair**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**CEO**	**Exec**	**Exec**	**Exec**	**Exec**	**Exec**	**Exec**	**Director**	**Exec**	**Exec**	**Exec**	**Exec**	**Exec**	**Exec**	**HPF**	**Ass Dir**	**SRG**	**Assoc Mbr**
7.2.14	Quality Improvement Strategy 3 Year Plan - Sustainable Clinical Services	Y	Y	Y	Y	Y	apols	apols	Y	Y	Y			apols	apols	Y	Y	Y	**Y**	apols	Y							Y	Y	
17.4.14	Risk Appetite (John Bullivant) Culture and Change (Paul Walker)	Y	apols	apols	apols	Y	apols	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	y		apols		Y			apols	Y	
22.5.14	Follow on, feedback and diagnosis Root cause analysis of key areas of concern Behaviours to improve board effectiveness (Paul Walker)	apols	Y	Y	Y	apols	Y	apols	Y	Y	Y	apols			apols	apols	Y	Y	Y	apols	apols		Y		Y			N	N	
19.6.14	Board realignment, renewal and change (Paul Walker)	Y	Y	Y	Y	Y	apols	apols	Y	Y	Y	Y	Y (part)		Y	Y	Y	Y	Y	apols	Y	apols		Y		Y		Y	apols	Y	
17.7.14`	Board realignment, renewal and change (Paul Walker)	Y	Y	Y	Y	Y	apols	Y	Y	Y	Y	Y	Y		apols	Y	Y	Y	Y	Y	apols			Y		Y		Y	apols	Y	
21.8.14	Paul Walker session (Board Vision work, RCA work, Board styles/behaviours - Effective challenge, giving and receiving feedback between Board members, lean and innovative working techniques)	Y	Y	apols	Y	Y	apols	Y	apols	Y	Y	apols	apols			y (part)	apols	apols	Y	Y	apols		y		apols	Y	y	apols		
15.9.14	John Bullivant Good Governance Session	Y	Y	Y	apols	Y	apols	Y	Y	Y	Y	apols	Y			apols	Y	Y	Y	Y	apols		Y		Y	Y	Y	Y		
18.9.14	Paul Walker session (Session with the Chief Executive - first 100 days, Leading Change and a practical tool for the Board - Kotter Model, Board Vision, Board styles/behaviours - Constructive challenge)	Y	Y	Y	apols	apols	apols	Y	Y	A	Y (part)	apols	Y			Y	Y	Y	Y	Y	apols		Y		Y	Y	Y	Y	Apols	
23.10.14	Paul Walker session (Session with the Chairman - first year in post, Board leadership and culture, Board vision (Charter) work, Board styles/behaviours - constructive challenge, Giving and receiving feedback between Board members	Y	apols	Y	Y	apols	Y	Y	Y	apols	apols	apols	Y			Y	Y	Y	Y	Y		Y	Y		Y	Y	apols	Y	Y	Y
30.10.14	3 Year Plan Performance Management	Y	Y	Y	apols	apols	Y	N	Y	Y	apols	N	Y			Y	Y	Y	Y	Y		Y	Y		Y	Y	Y	apols	N	PART
27.11.14	Paul Walker Session (Board operating model, Board leadership and culture, Giving and receiving feedback between Board members	Y	Y	Y	Y	Y	apols	apols	Y	Y	apols	apols	Part			Part	Y	Y	Apols	Y		Part	Part			Part	apols			Y
18.12.14	Paul Walker Session (Board leadership and culture; Board operating model; Giving and receiving feedback between Board members)	Y	Y	Y	Y	Apols	N	Y	Y	Y	Y	N	Y			Apols	Y	Y	Y	Y		Y	Y	Y		Y	Y	Y		Y

		P Higso	M Hanson	K McDono	C Tillson	H Owen Jo	H Stevens	H M Davie	J Dean	M W Jones	E Roberts	J R Malone	B Feeley	T Purt	A Hopkins	A Jones	J M Jones	G Lang	B Cuthel	G Lewis-Pa	M Olsen	M Makin	R Favager	C Wright	I Mitchell	Vacant	A Thomas	N Stubbins
Date	**Topic**	**Chair**	**ViceChair**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**IM**	**CEO**	**Exec**	**Exec**	**Exec**	**Exec**	**Director**	**Director**	**Director**	**Exec**	**Exec**	**Director**	**HPF**	**SRG**	**Ass Dir**	**Assoc Mbr**
8.1.15	Paul Walker Session (board leadership & culture, operating model, behavioural styles, personal takeouts)	Y	Y	Y	Y	Apols	Apols	Y	Y	Apols	Y	Y	Apols	Apols	Y	Y	Y	**Y**		Apols	Y	Y	Apols	Y	Y		Y	Apols
26.2.15	Paul Walker Session (vision, leadership, board role, new committee structure)	Y	Y	Y	Y	Apols	Apols	Y	Y	Y		Apols	Apols	Y	Y	Y	Y	Y		Y	Y	Apols	Y	Y	Y		Y	Apols
26.2.15	Board Briefing (shared services presentation; governance & accountability module)	Y	Y	Y	Y	Apols	Apols	Y	Y	Y		Apols	Apols	Y	Y	Apols	Y	Y		Y	Y	Apols	Y	Y	Y		Y	Apols
31.3.15	Paul Walker Session (team health check, vision, leadership, behavioural styles, board role, problem based learning)	Y	Y	Y	Y	Y	Apols	Y	Y	Y		Apols	Y	Y	Apols	Y	Y	Y	Y	Y	Y	Apols	Y	Y	Y		Apols	Apols

Board Paper

Item 15/87

Date of meeting
14 April 2015

Date of Paper
20 March 2015

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

To improve health and provide excellent care

Title:	**Integrated Quality and Performance Report**	
Author:	**Jill Newman, Assistant Director of Improvement & Business Support** **Richard Gillett, Head of Performance Assurance & Business Intelligence**	
Responsible Director:	**Morag Olsen, Chief Operating Officer**	
Summary of Key Issues:	This paper outlines the key performance and quality issues. They cover all seven domains of the national framework. The report notes achievement. This report includes a number of local indicators which will be monitores and developed upon in the coming months. In relation to Timely Care, the report contains a description of the actions being taken to reduce long waiting times for treatment to achieve the March 2015 target. It also notes the unscheduled care agenda in depth. The report notes the staff sickness rates and the actions being taken by the Workforce and Organisational Development departments to improve attendance. The report also briefly describes the financial position, however this is described in more depth in the Finance Report.	
Action Required By Board:	**To:**	
	Note	X
	Endorse	
	Ratify	
	Approve	
Key Impacts:	*(Please provide a short summary against all that apply)*	
	Corporate Objective	Provides the Board with an overview of delivery against key performance metrics
	Finance	Integrates finance and service deliver
	Quality Impact Assessment	Integrates quality and performance metrics
	Standards for Health Services	Includes aspects from Health Care Standards

	in Wales	
	Equalities, Diversity & Human Rights	Applies equally to all patients covered by the metrics
	Risk & Assurance	The report is prepared with the latest validated performance data available. The exception report include actions being taken to improve performance and mitigate against risk to delivery.

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Integrated Quality & Performance Report 2014/15

Performance to the end of February 2015

Health Board

Contents

Foreword

This report reflects our Health Board's performance against key government and local targets. We will further enhance this report over the coming months to provide a richer picture of our performance. The report contains actions to address any performance failings and so provides greater assurance of achievement going forward.

We are presenting performance using the framework against which NHS Wales is measured. It outlines what people can expect from the NHS within the seven domains of; Staying Healthy, Safe Care, Effective Care, Dignified Care, Timely Care, Individual Care and NHS Staff and Resources. We are receiving early indication of changes proposed to the measures for 2015-2016, a number of which are running in shadow form at present. Once confirmed these will be included within the report.

In addition to the national standards, we have included other measures which either the Board have requested visibility of or the executive team wish to inform the Board about. These are local indicators and are integrated into the most relevant domain of the report, however the allocation is preliminary and may change in the future. We benchmark our performance against the rest of Wales using the most recent data available. However, this is not always the same month as displayed. A benchmark report is available from the Office of the Chief Operating Officer.

Introductory Reports

Each local indicator will have an Introductory report that gives the context of the indicator.

Exception Reports

Exception reports are included where performance is either below the required standard or the Board and/or committee require sight of the actions being taken to maintain or improve performance. After we have achieved an indicator for three consecutive months, it will be stood down from exception reporting.

Sub-Committees

Two sub-committees of the Board, Quality, Safety and Experience and Finance & Performance, also receive sections of this report.

Status Guide and Legend

Status

On the following page, we report the overall escalation status of the Health Board. This uses the Welsh Government's status levels. The status level of each indicator is graded from zero to four, with four being of most concern.

0	Level 0 –	local delivery of all targets and /or within trajectory
1	Level 1 –	failure to deliver achieve or deliver one target or deliverable
2	Level 2 –	continued failure to achieve or maintain one or more key deliverables
3	Level 3 –	continued failure to maintain an agreed improvement trajectory
4	Level 4 –	continued failure to improve performance or failure to engage with the national process
80.0%	Cross-hatch	Cross-hatch background. Where the background is cross-hatched this figure is the **provisional**, unvalidated position.
-	No Target	No target level or the trajectory has not been set. The relevant executive director has been asked to set the target level.

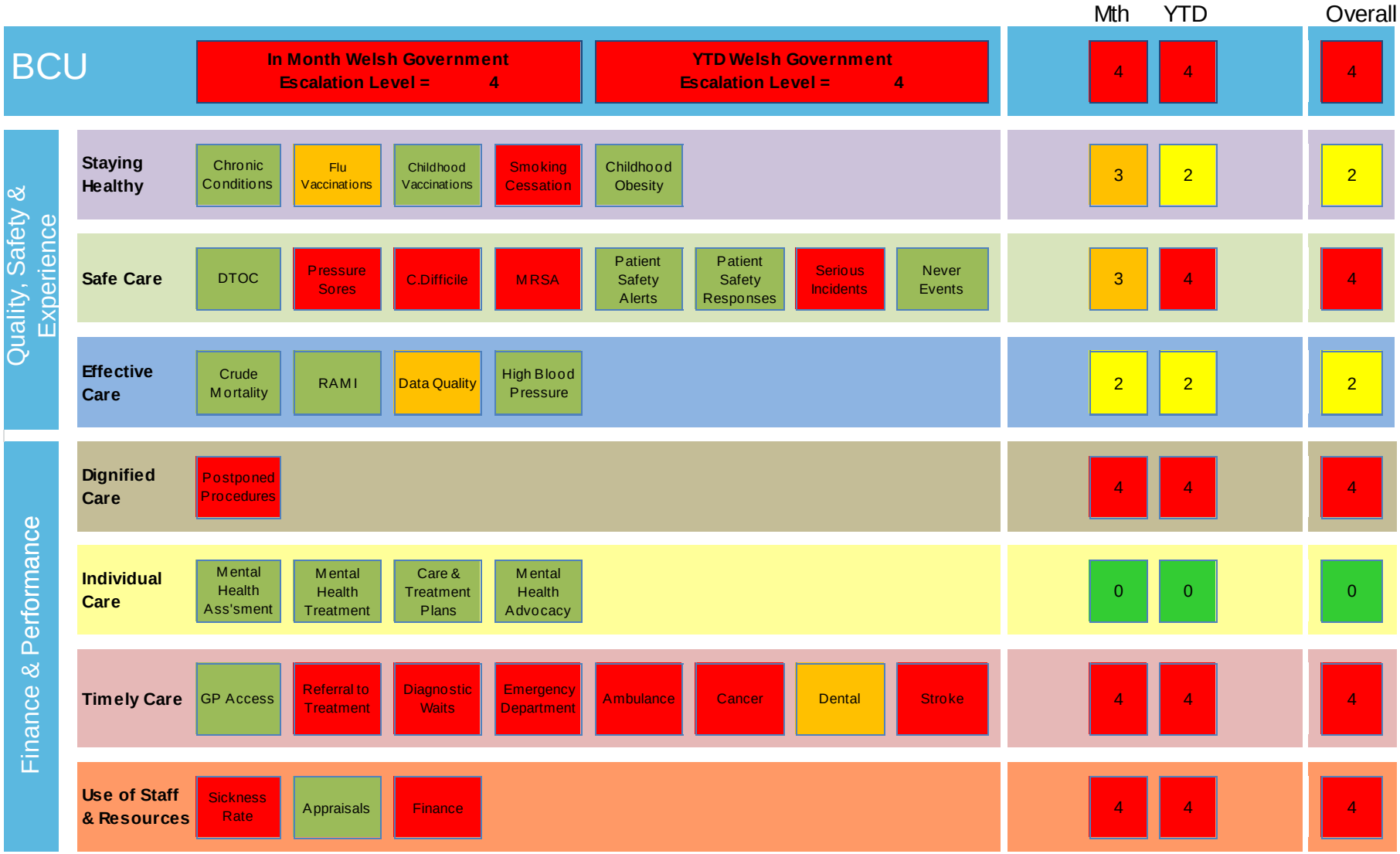
Legend

This report uses trend arrows. They show if the position has become **better** or **worse** than the previous month. Readers are asked to note that this is different compared to the first version of the report.

↑	The value is better than the previous month
→	The value is the same as the previous month
↓	The value is worse than the previous month

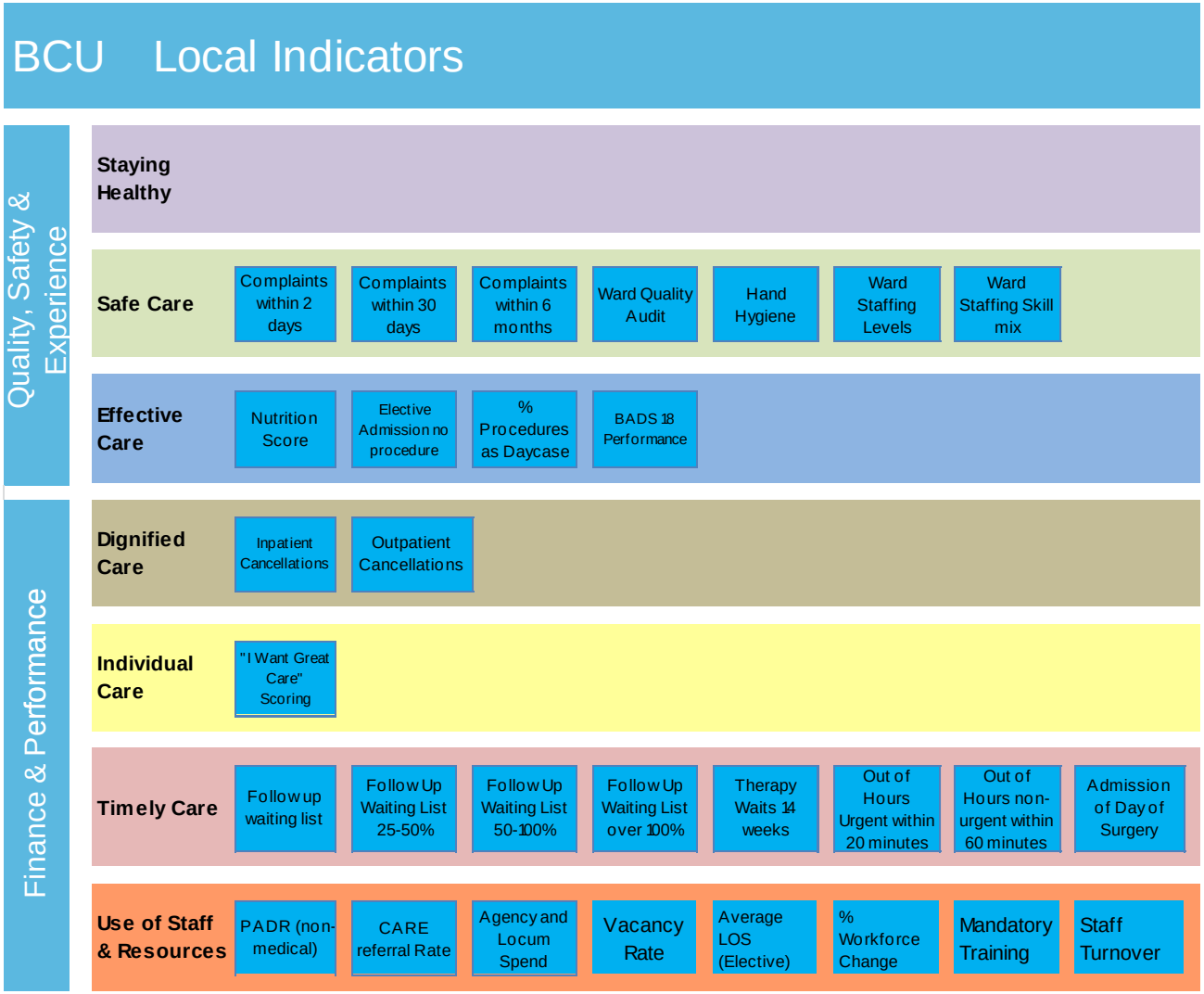
1 Executive Summary: Key Priority Areas

Below is a summary of the Health Board's performance in key areas for the current month, the movement from the previous month and the year to date (YTD) position using the national scoring methodology. Exception reports are included in section 2 in all areas where performance has dipped below standard or provision of assurance to maintain the standard is required.



1 Executive Summary: Local Indicators

Below is a summary of the Health Board's local indicators grouped into the national domains.
In future months, as performances are measured against local targets, this summary will develop to summarise the performance.



2 Staying Healthy Overview – National Measures

Staying Healthy

Chronic Conditions	Flu Vaccinations	Childhood Vaccinations	Smoking Cessation	Childhood Obesity
3	2			2

Staying Healthy		Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of emergency admissions for basket of 8 chronic conditions per 100,000 population		No	Sep-14	Reduce	-	-	1,103	1,062		↑	2nd
Number of emergency readmissions for basket of 8 chronic conditions per 100,000		No	Sep-14	Reduce	-	-	176	169		↑	3rd
% uptake of the influenza vaccine in the following groups:	Over 65s	No	Feb-15	75%	71%	70.1%	69.6%	70.1%	72%	↑	1st
	Under 65s in at risk groups	Yes	Feb-15	75%	54%	51.4%	50.7%	51.4%	54%	↑	2nd
% uptake of the influenza vaccine in the following groups:	Pregnant women	Yes	Feb-15	75%	50%	46.2%	46.3%	46.2%	51%	↓	1st
	Healthcare workers	Yes	Feb-15	50%	41%	50.1%	50.1%	50.1%	50.1%	→	5th
% uptake of the childhood vaccines up to the age of 4:	5 in 1 age 1	No	Sep-14	95%	97%	-	96.9%	95.3%		↓	3rd
	Men C age 2	No	Sep-14	95%	98%	-	97.6%	96.6%		↓	4th
	MMR1 age 2	No	Sep-14	95%	97%	-	96.3%	95.1%		↓	4th
	PCV age 2	No	Sep-14	95%	97%	-	96.3%	95.3%		↓	2nd
	Hib MenC Booster age 2	Yes	Sep-14	95%	97%	-	95.6%	94.8%		↓	3rd
% estimated LHB smoking population treated by NHS smoking cessation services		Yes	Dec-14	5.0%	3.9%	2.4%	2.2%	2.4%	3.40%	↑	1st
% smokers treated by NHS smoking cessation CO-validated as successful		Yes	Dec-14	40%	37%	32%	32.3%	31.5%	<40%	↓	6th
% of reception class children (aged 4/5) classified as overweight or obese		No	Mar-13	Reduce	-	-	.	26.4%		-	4th
New	% of GP Practices that are set up to use My Health On-Line (MHOL)	Yes	Jan-15	100%	-	-	.	96.5%	98%	-	7th
New	Of those practices set up to use MHOL, % who are offering appointment bookings	No	Jan-15	Improve	-	-	.	20.0%		-	4th
New	Of those practices set up to use MHOL, % who are offering repeat prescriptions	No	Jan-15	Improve	-	-	.	34.5%		-	4th

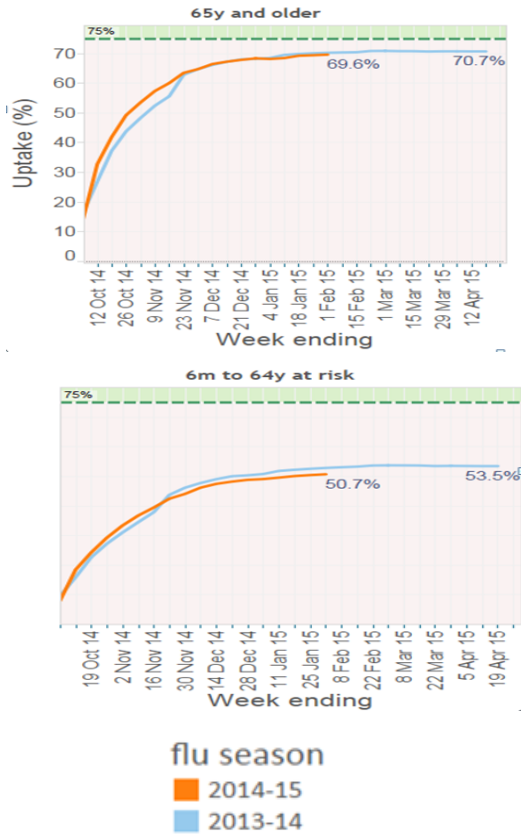
2.1 Staying Healthy: Exception Report

Staying Healthy		Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% uptake of the influenza vaccine in the following groups:	Over 65s	No	Feb-15	75%	71%	70.1%	69.6%	70.1%	72%	↑	1st
	Under 65s in at risk groups	Yes	Feb-15	75%	54%	51.4%	50.7%	51.4%	54%	↑	2nd
% uptake of the influenza vaccine in Under 65s in pregnant women		Yes	Feb-15	75%	50%	46.2%	46.3%	46.2%	51.0%	↓	1st

Over 65s and At Risk Under 65s:
Every year, more people become eligible, so GPs have to work even harder just to reach the same %. This year, **136,273** people over 65 or in one of the at risk groups have been vaccinated so far.

Plans are being developed for next year including visits to low uptake GP practices and information is being sent to cluster leads about low uptake practices in their area.
Engagement and supportive visits have commenced with 'new' practice managers.
Practices have been made aware of the Chief Medical Officer letter about flu vaccine ordering for next year.
Year 7 flu vaccine data has now been sent to GP practices for inputting onto the child record so that the vaccination data will be captured in national reports.
A Flu report is in development for the current campaign and will include identified actions for next year that target the unvaccinated.

Pregnant women Since the last report, some local data quality issues about the coding for pregnant women have emerged which are being investigated. The Health Board has recently completed the Point of Delivery audit which measures the Flu vaccination coverage of women giving birth, audit to be published before the end of April 2015.



2.1 Staying Healthy: Exception Report

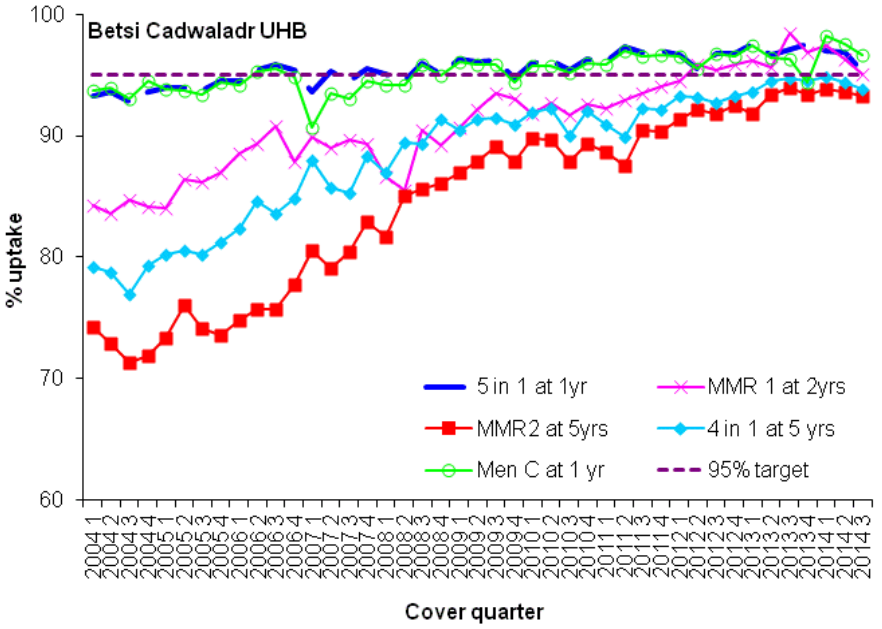
Staying Healthy	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% uptake of the childhood vaccines up to the age of 4: Hib MenC Booster age 2	Yes	Sep-14	95%	97%	-	95.6%	94.8%		↓	3rd

Investigations are ongoing into data quality issues with which the Health Board are assisting.
The implementation of procedures to follow up unvaccinated children continue.

Public Health Wales are currently working with Health Boards to audit the data quality of the immunisation uptake reported in the COVER 112 report.

Hib Men C Booster Age 2

Children that have missed their vaccines at 1 year, 2 years and 4 years and including the HIB/Men C vaccine by 2 years are identified and followed up and supported or reminded to attend their GP practice for their child's appointment. Where indicated home immunisation is offered.



2.1 Staying Healthy: Exception Report

Staying Healthy	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% estimated LHB smoking population treated by NHS smoking cessation services	Yes	Dec-14	5.0%	3.9%	2.4%	2.2%	2.4%	3.40%	↑	1st

Performance Context:
Decreased performance in December; this is in line with seasonal trends and an increase is expected in January

Key Actions for Improvement (update for March 2015):

Increase service provision

- Work ongoing on both Maternal and Secondary Care Cessation Service Business Cases, in line with 3 yr plan commitments
- Smoking Cessation Local Enhanced Service with General Practices sign up now at 65 GP practices

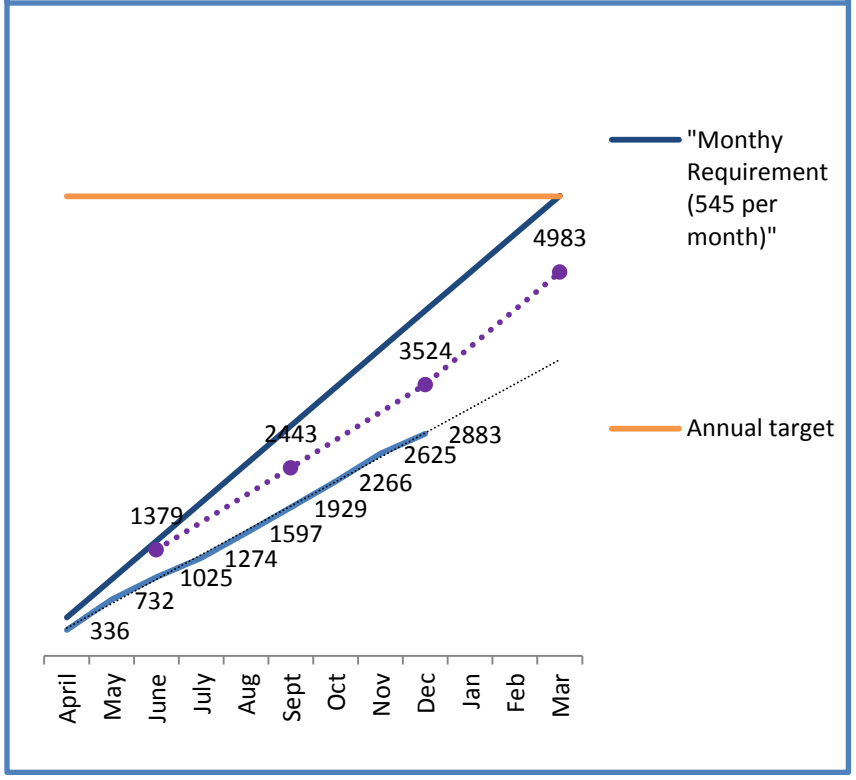
Marketing & Increase recruitment

- Secondary Care: Payslip messages sent to all BCU staff in February promoting smoking cessation services (led by YGC Tobacco Group)
- Use of insight from social marketing produce innovative 'Girls with Dreams' and 'Quit for Them, Quit for You' campaigns in Wrexham with roll-out to other N Wales counties – early success noted in first 7 days with 183 smokers requesting support to quit via Facebook

Leadership

- Hosting ASH Wales conference in St Asaph, focussing on broader tobacco control: preventing young people from starting to smoke (link to poverty of aspiration), smoke free public spaces (#sharetheair), and tackling illicit tobacco

Monthly trajectory figures for number of smokers needing to be treated to meet the Tier 1 target of 5% of treated smokers, 2014/15



Service quality

- Initiation of joint service evaluation project for Pharmacy and Stop Smoking Wales, including collating feedback from 150 former service users, staff delivering the services, and a Mental Wellbeing Impact Assessment. Project due to be completed end April with final report & recommendations for improvement

2.1 Staying Healthy: Exception Report

Staying Healthy	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% smokers treated by NHS smoking cessation CO-validated as successful	Yes	Dec-14	40%	37%	32%	32.3%	31.5%	<40%	↓	6th

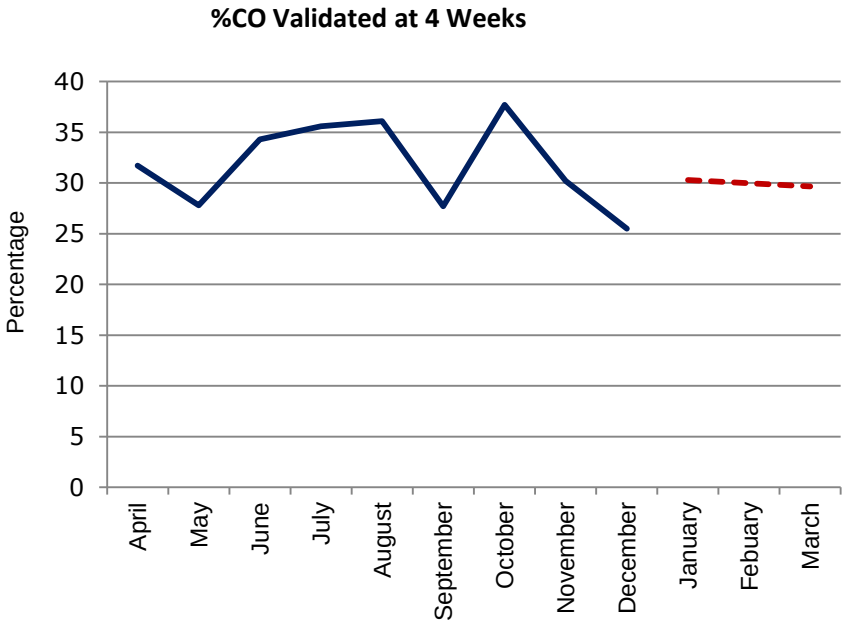
Key Actions for Improvement:

Review service quality: Initiation of joint service evaluation project for Pharmacy and Stop Smoking Wales, including collating feedback from 150 former service users, staff delivering the services, and a Mental Wellbeing Impact Assessment. Project due to be completed end April (draft report end March)

Continue delivery of training in Brief Intervention to frontline staff in BCU and partner organisations to ensure that clients are referred when they are motivated to quit, and that referral pathways are clear and relevant to specific settings

Provision of Carbon Monoxide Monitors to frontline healthcare staff delivering smoking cessation services, including the Local Enhanced Service - improving % quit via GP in house services is a priority due to the low performance achieved to date since the launch of the LES (see data on the right)

Please note: This target is a simple measure of the quality of the service provided, and there is wide variation across service providers and across areas. It is affected by case mix, as some people (particularly those living in more deprived areas, facing challenging circumstances) experience greater difficulty in giving up.



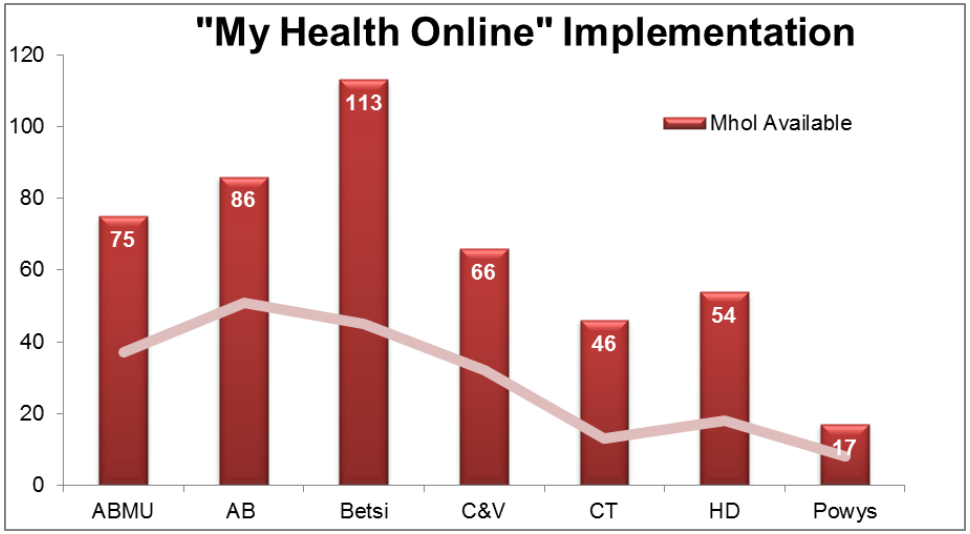
Performance Context:

SSW clinics are going to be re-scheduled for December 2015 in order to reduce disruption (and subsequent impact on performance) to quit attempts during the Christmas holidays. The respective %CO validated quit rates at 4 weeks of the individual services in December 2014 were:
- SSW at 28.9%
- PL3 at 31.4%
- Primary Care LES at 10.7%

2.1 Staying Healthy: Introductory Report

	Staying Healthy	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	% of GP Practices that are set up to use My Health On-Line (MHOL)	Yes	Jan-15	100%	-	-	.	96.5%	98%	-	7th
New	Of those practices set up to use MHOL, % who are offering appointment bookings	No	Jan-15	Improve	-	-	.	20.0%		-	4th
New	Of those practices set up to use MHOL, % who are offering repeat prescriptions	No	Jan-15	Improve	-	-	.	34.5%		-	4th

This is the first month these new indicators are presented in the Integrated Quality & Performance report. There are no national targets for this indicator. Local standards will be set by the Director of Primary Care, and reported by exception in future reports. The three indicators are to (i) rollout the software "My Health Online" which will enable patients to (ii) book appointments online and (iii) take up repeat prescriptions online. The rollout of software is progressing well, with 96.5% of practices switched on. 100% of practices will be switched on by July 2015.



Booking Appointments online

There are currently 20% of practices in North Wales offering appointments online. The use and benefits of online bookings are discussed with practices as part of the migration to their new clinical system and will be raised during the quality assurance visit cycle. Where training and support is required, the National Wales Informatics Service will provide further training to support practices in transition.

Offering repeat prescriptions online

Those practices which have implemented online prescriptions are reporting positive feedback and better patient experience. As with online appointments, discussions with practices will be taking place during the quality assurance visit cycle.

2.2 Safe Care Overview – National Measures

Safe Care	DTOC	Pressure Sores	C.Difficile	MRSA	Patient Safety Alerts	Patient Safety Responses	Serious Incidents	Never Events				
									3	4		4

Safe Care		Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Delayed transfers of Care per 10,000 LHB population, Rolling 12 months (all providers)	Mental Health	No	Feb-15	Reduce	2.7	2.59	2.6	2.59		↑	3rd
	Non Mental Health aged >65	Yes	Feb-15	Reduce	129.5	142.4	142.1	142.4		↓	1st
Number of healthcare acquired pressure sores in a hospital setting		Yes	Feb-15	Reduce	42	424	47	38	26	↑	7th
Number of cases of C.difficile per 100,000 of the population		Yes	Feb-15	31.00	-	-	58.61	57.96		↑	6th
Number of cases of MRSA bacteremias per 100,000 of the population		Yes	Feb-15	2.6	-	-	4.83	4.74		↑	4th
% compliance with patient safety solutions - alerts		No	Dec-14	Improve	-	87.50%	93.8%	93.8%		→	3rd
% compliance with patient safety alerts - rapid response notices		No	Dec-14	Improve	-	78.90%	92.1%	92.1%		→	6th
Number of new serious incidents		Yes	Feb-15	Reduce	240	-	43	39	30	↑	7th
Number of new never events		No	Feb-15	Reduce	-	-	0	0	0	→	1st

The domains above are monitored at the Quality, Safety & Experience committee.

An exception report is included for indicators which are not achieving the standard.

The exception reports are contained in the following sections.

2.2 Safe Care Overview – Local Measures

	Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	% of complaints acknowledged within 2 working days	No	Feb-15	Improve	-		86.7%	83.6%	-	-	-
New	% of complaints closed within 30 working days	No	Jan-15	Improve	-		19.6%	21.3%	-	-	-
New	% of complaints closed within 6 months	No	Oct-14	Improve	-		46.3%	47.0%	-	-	-
New	Ward Quality Audit	Yes	Feb-15	Improve	-		90.0%	91.0%	-	-	-
New	Hand Hygiene Rates	No	Feb-15	Improve	-		96.6%	94.2%	-	-	-
New	Ward Staffing Levels Fill Rate (Med & Surg Acute)	No	Feb-15	Improve	-		88.0%	88.0%	-	-	-
New	Ward Staffing Skill Mix Ratio (Registered : Unregistered, Med & Surg Acute)	No	Feb-15	Improve	-		68 : 32	67 : 33	-	-	-

This summary slide provides new indicators which have been agreed by the executive directors within this report. Where new indicators are introduced, and a lead for the indicator has been identified, an **introductory report** is included.

2.2 Safe Care: Exception Report

Safe Care		Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Delayed transfers of Care per 10,000 LHB population, Rolling 12 months (all providers)	Mental Health	No	Feb-15	Reduce	2.7	2.59	2.6	2.59		↑	3rd
	Non Mental Health aged >65	Yes	Feb-15	Reduce	129.5	142.4	142.1	142.4		↓	1st

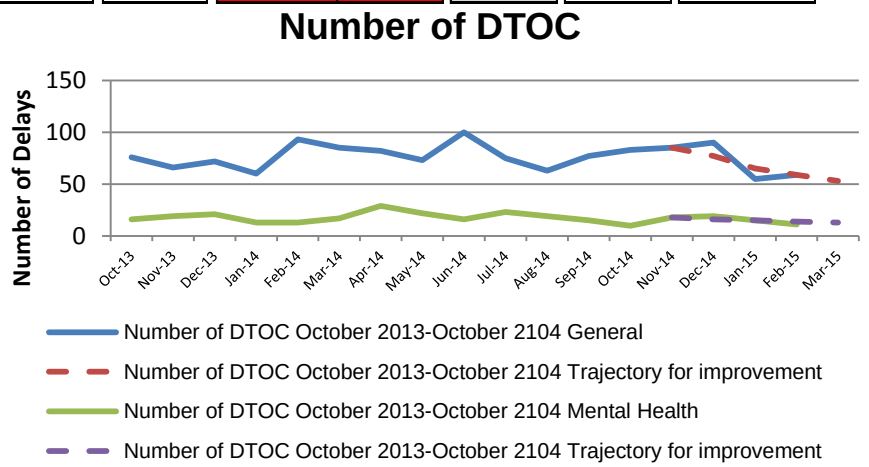
Delays are for all BCUHB residents at all welsh providers, however the information provided below only applies to tBCU provided beds.

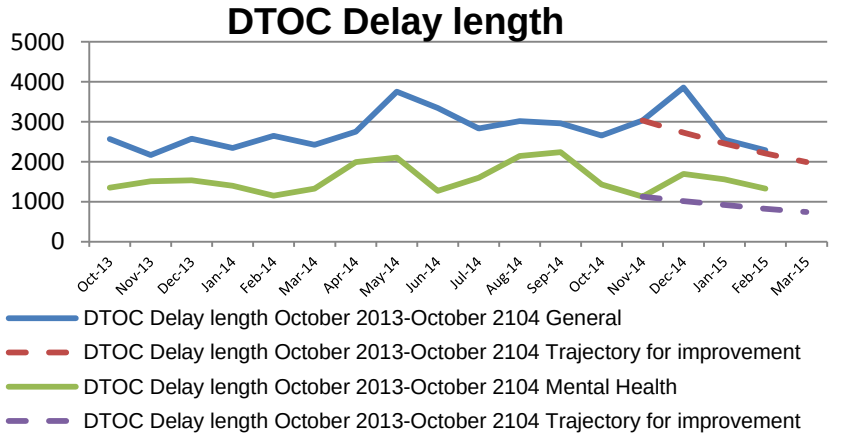
Position

There were 59 non mental health and 11 mental health Delayed Transfers of Care during February. The number of Bed days were 2286 for non mental health and 1323 for mental health delays.

Improvement actions:

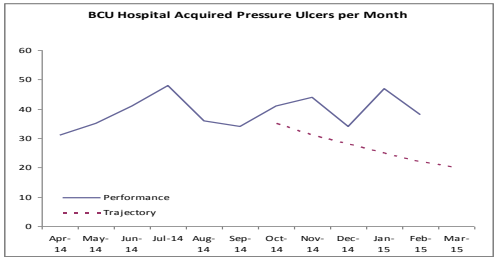
- Predicted Date of Discharge is being refreshed and will be rolled out across the Health Board during the next six months.
- The non elective average length of stay Project Management Office is developing a ''what good discharge planning looks like'' training package which will be delivered to all wards across the Health Board.
- The recently approved updated discharge policy is being implemented across the Health Board which includes clearer information for patients and there families about discharge planning and patient choice in relation to care home placement.

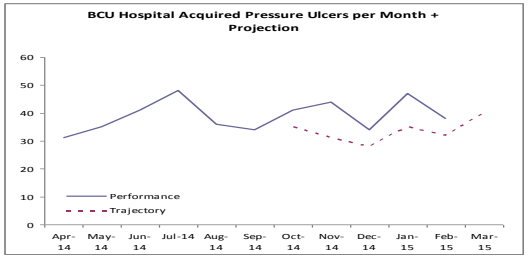




2.2 Safe Care: Exception Report

Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of healthcare acquired pressure sores in a hospital setting	Yes	Feb-15	Reduce	42	424	47	38	26	↑	7th





Position

Total number of Hospital Acquired Pressure Ulcers (HAPU) recorded Feb 2015 = 38, a decrease from previous month.

Grading

Of the 38 recorded: 1 was classified as grade 3 for which root cause analysis is undertaken to determine factors contributing to HAPU development, actions and learning required locally. The remaining 37 HAPU occurring in February were grade 1 or 2.

Actions being taken

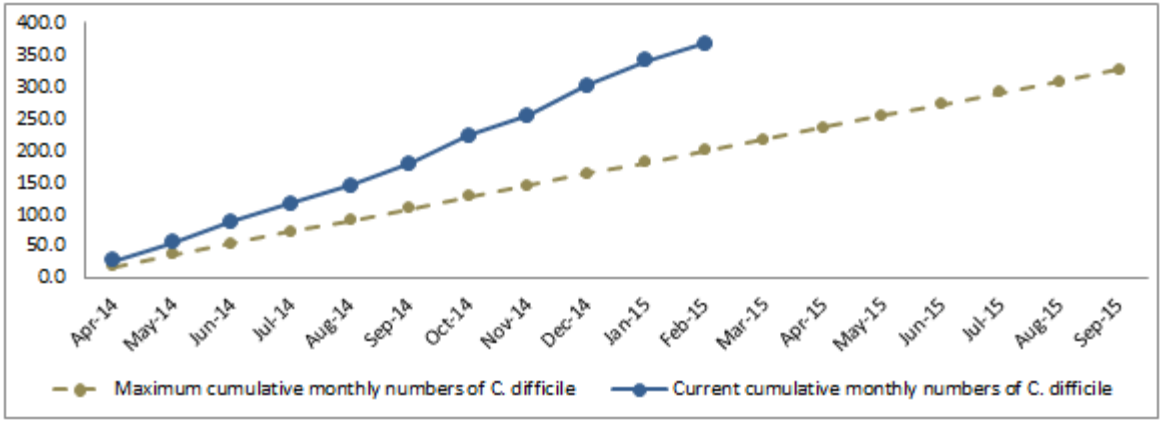
The ward to board audits score for tissue viability demonstrates sustained improvement with the overall score having increased from 83% in August 2014 to 90% in December 2014. Trends by area continue to be determined weekly by the Tissue Viability team which is circulated for discussion at local Patient Safety Groups and Matrons meetings. Time lines to complete RCA's have been implemented and actions agreed. Overall scrutiny continues to be in place via Area Associate Chief of Staff Nursing supported by locality Governance Teams .

An audit of foam mattresses across the acute hospitals is underway, with Wrexham and Glan Clwyd having been completed and Bangor scheduled for the 18th March. A capital bid has been submitted for replacement foam mattresses.
Tissue Viability teams continue to offer educational programmes and Link Nurse study days which include emphasis on documentation and report writing.

2.2 Safe Care: Exception Report

Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of cases of C.difficile per 100,000 of the population	Yes	Feb-15	31.00	-	-	58.61	57.96		↑	6th

Chart 1. Betsi Cadwaladr University Health Board maximum cumulative monthly numbers of C. difficile to achieve the 18 month (Apr 14 to Sep 15) target and current cumulative monthly numbers for Apr 14 to Feb 15

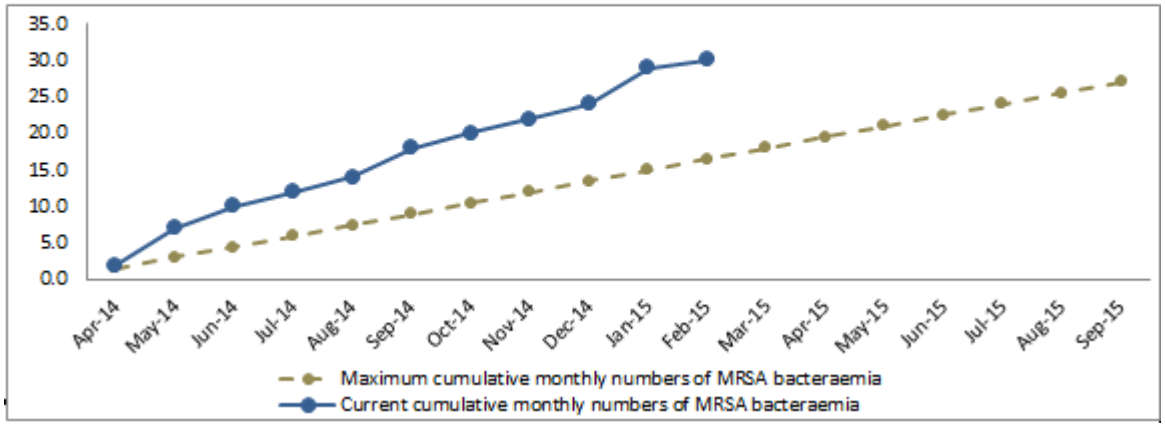


- Total number of new cases in February 2015 has reduced; 27 cases across BCUHB demonstrating improved performance compared with the past 4 months. Of these only 6 are recorded on the Ysbyty Glan Clwyd site, confirming that the rise seen in December 2014 has ceased.
- The Board has in place an approved Strategic Framework and Infection Prevention Improvement Programme. These set out the projects and work programmes that together will bring about the step-change improvements in performance needed to achieve very low rates of infection.
- Focus remains on hand hygiene, isolation, antimicrobial prescribing and cleanliness standards.

2.2 Safe Care: Exception Report

Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of cases of MRSA bacteremias per 100,000 of the population	Yes	Feb-15	2.6	-	-	4.83	4.74		↑	4th

Chart 1. Betsi Cadwaladr University Health Board maximum cumulative monthly numbers of MRSA bacteraemia to achieve the 18 month (Apr 14 to Sep 15) target and current cumulative monthly numbers for Apr 14 to Feb 15

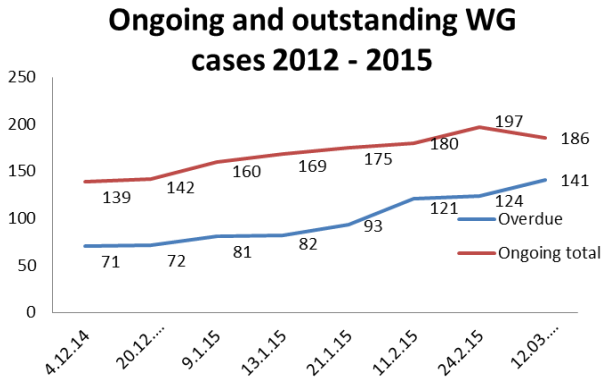


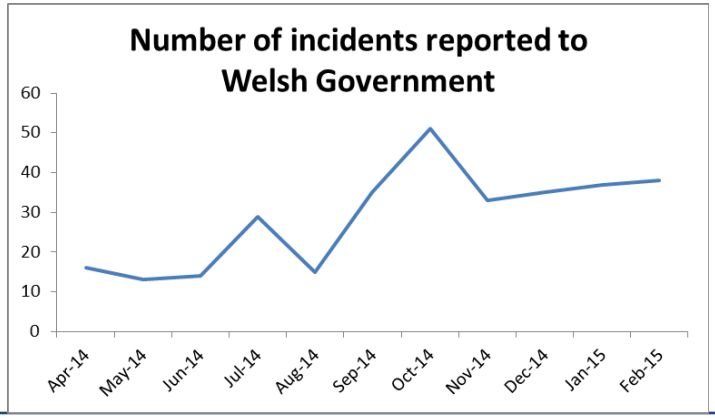
BCUHB recorded a single case of MRSA bacteraemia in February 2015.
The detailed improvement plan (described in detail at the December 2014 meeting) is being progressed. This will require support for increased laboratory screening from Public Health Wales.
Current focus remains on:

- Improving compliance with the care bundles for IV devices, with monthly monitoring and feedback in place down to individual ward level.
- Reviewing the aseptic non-touch technique programme, ready for a major re-launch to improve practice.
- Developing effective protocols for initiation of decolonisation when patients are found to be positive with MRSA.

2.2 Safe Care: Exception Report

Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of new serious incidents	Yes	Feb-15	Reduce	240	-	43	39	30	↑	7th





Position

Serious incidents are investigated by the Clinical Programme Group, supported by the Corporate Investigation team to reflect on the learning and emerging trends and themes for Quality Improvement.

Actions being taken

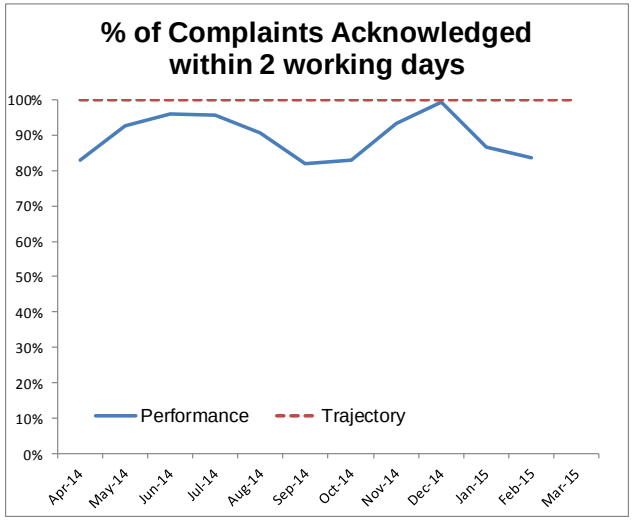
Work is on-going within the Health Board to continually strengthen the investigation and management of all incidents, and to ensure that lessons learnt are identified, acted upon and shared. Serious incidents are investigated by the Clinical Programme Group, supported by the Corporate Investigation team to reflect on the learning and emerging trends and themes for Quality Improvement. The Health Board encourages the reporting of incidents to improve quality and safety.

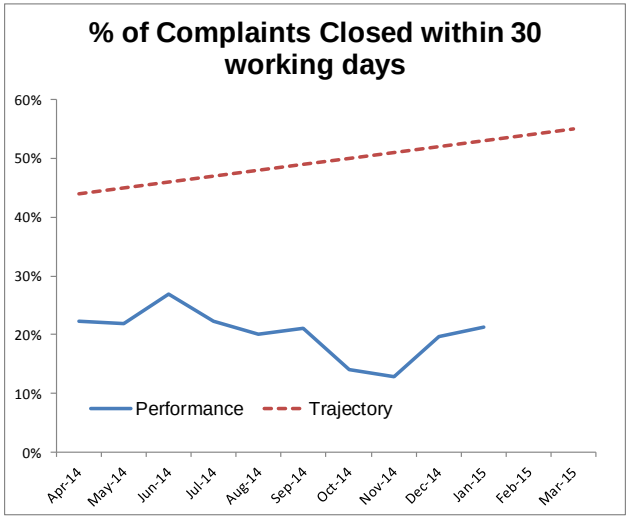
Lessons Learned

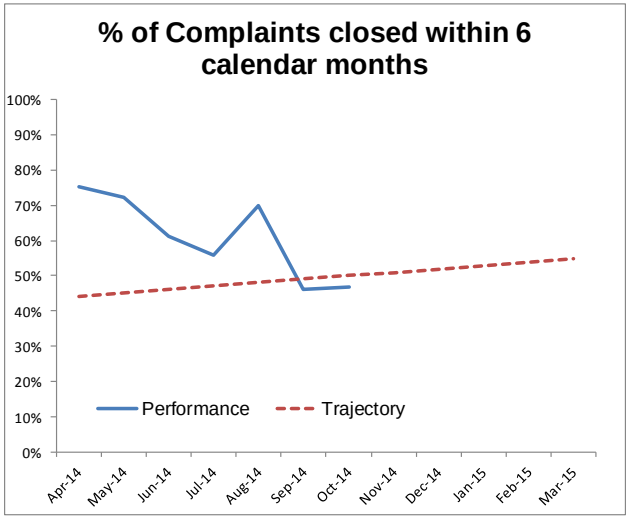
Monitoring focus on the themes and trends identified through incident reporting and ensuring lessons are learnt and improvements implemented to prevent the reoccurrence of incidents. The performance monitoring for all Concerns is now done through the CPG performance meetings. CPGs are expected to provide assurance regarding the good management of incidents and provide improvement plans to address poor performance.

2.2 Safe Care: Introductory Report - Complaints

	Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	% of complaints acknowledged within 2 working days	No	Feb-15	Improve	-		86.7%	83.6%	-	-	-
New	% of complaints closed within 30 working days	No	Jan-15	Improve	-		19.6%	21.3%	-	-	-
New	% of complaints closed within 6 months	No	Oct-14	Improve	-		46.3%	47.0%	-	-	-







- The number of concerns being received by the Health Board continues to rise
- There are interim plans being put in place to resolve cases open beyond the agreed time scales whilst revising processes to manage all new concerns received.
- The Senior Investigation Managers continue to drive the pace of closures with CPG/site teams, by both the performance management meetings and individual CPG/site sessions
- The regulations state all concerns should aim to be resolved with 30 working days. However if this is not possible (for more complex cases) a response must be sent within 6 months – those cases assessed as falling within the 'more complex' category are measured against a 6 month target.

2.2 Safe Care: Introductory Report Ward Staffing

	Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	Ward Staffing Levels Fill Rate (Med & Surg Acute)	No	Feb-15	Improve	-		88.0%	88.0%	-	-	-
New	Ward Staffing Skill Mix Ratio (Registered : Unregistered, Med & Surg Acute)	No	Feb-15	Improve	-		68 : 32	67 : 33	-	-	-

This report provides the position for nurse staffing within wards and acute departments for Acute and Community Hospitals (roster period 25th January – 21st February 2015)

The percentage of filled versus unfilled includes substantive and bank nurses but excludes agency nurses. The 12% average unfilled roster is therefore not a true reflection of nurse staffing levels.

For February 2015 the nursing agencies filled 74% of shifts requested, therefore this would increase the overall staffing levels to meet clinical need. Future reports aim to include agency nurses once systems are aligned to enable this.

The ratio of registered nurses to unregistered nurses across the three areas meets the Royal College of Nursing guidance of a 65% to 35% skill mix. In community hospitals skill mix is generally 50 : 50 registered to unregistered skill mix.

Nurse staffing is assessed daily at clinical site meetings with staff redeployed according to staffing gaps and clinical priority. Other mitigation includes bed reduction which is not captured in this report. Recruitment to substantive and bank posts continues.

25th Jan - 21st Feb roster	Filled Roster %	Unfilled Roster %	Registered Skill Mix %	Un-Registered Skill Mix %
Total Central Average	89%	11%	68%	32%
Total East Average	89%	11%	68%	32%
Total West Average	85%	15%	67%	33%
Total BCU Average	88%	12%	67%	33%

28th Dec - 24th Jan roster	Filled Roster %	Unfilled Roster %	Registered Skill Mix %	Un-Registered Skill Mix %
Total Central Average	90%	10%	68%	32%
Total East Average	89%	11%	68%	32%
Total West Average	84%	16%	67%	33%
Total BCU Average	88%	12%	68%	32%

2.2 Safe Care: Introductory Report

Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New Hand Hygeine Rates	No	Feb-15	Improve	-		96.6%	94.2%	-	-	-

This indicator demonstrates the percentage compliance with hand hygiene using the World Health Organisation (WHO) 5 moments: before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings.

Definition of the measure – by using the Lewisham Tool to audit if all staff disciplines working in patient areas have adequately decontaminated their hands, in accordance with the requirements of the WHO 5 moments. This is undertaken for a minimum period of 20 minutes (or until at least 10 opportunities are observed) across all clinical areas at least once a month.

Relevance of measure - to improve quality of patient care and to prevent harm and infection.

Baseline – the baseline reported enable the LHB to be aware of the scale of the opportunity for improvement and to monitor the benefit realisation from actions being taken to improve performance

Establishment of extent of improvement expected – commentary on how a trajectory for improvement will be developed and reported against in future months with exception reports created for periods in which the trajectory for improvement are not delivered.

2.2 Safe Care: Introductory Report

	Safe Care	Exception Report?	Month	Achieve	Mar 2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	Ward Quality Audit	Yes	Feb-15	Improve	-		90.0%	91.0%	-	↑	-

Description of the measure
Monthly Quality audits of a pre-agreed number of care delivery standards commenced in April 2014. The Quality audit utilises 11 themes using 66 questions overall which provide a level of detail on clinical assessments and care planning against national standards.

Definition of the measure – To provide an indication of the quality and safety of inpatient care (excluding emergency departments, paediatrics, critical care and maternity). This should not be confused with the Fundamentals of Care annual audit, which uses similar themes but does not extract as much detail . The methodology utilises a review of 10 sets of case notes on every ward, every month and includes the 3 acute hospital wards and all the Community Hospitals.

The information is analysed and fed back to the ward managers and Matrons to pick up on key areas for improvement, if and when those are required. It provides Board members an opportunity to review the overall percentage score for each of the 11 measures/ themes and then drill down to site specific information and then ward specific information to see where and if specific wards have a range of Indicators which indicates concerns about care provision.

The standard response to the monthly information is that ward managers will discuss the outcome and areas for improvement and agree the actions to improve the standard of care within any of the 11 clinical themes. Matrons and senior nurses can then provide the supervisory overview of improvements and support the improvements required and provide the positive feedback when improvements are made.

For Board members the Quality Dashboard provides an opportunity to review the overall dashboard within the body of this report and to identify if progress is being made on specific clinical outcome scores. It would also enable Board members to scrutinise specific areas of concern if those improvements are not being seen. The methodology for compliance is currently set at a consistent % standard (currently under review) and would not expect to vary. The Board would expect to review the key themes which are not meeting the standard and variance reporting would be provided on those clinical themes which are below 85%

2.3 Overview & Areas of Escalation: Effective Care

Effective Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Crude Mortality - rolling 12 months	No	Jan-15	Reduce	1.90%	1.9%	1.8%	1.9%		↓	3rd
Risk Adjusted Mortality Index 2013 - RAMI rolling 12 months	No	Sep-14	Reduce	107	106	106	106		→	5th
% valid principle diagnosis code 3 months after episode end date - monthly	Yes	Oct-14	95%	98.8%	85.9%	60.6%	64.1%	95%	↑	6th
% valid principle diagnosis code 3 months after episode end date - rolling 12 months	Yes	12 mths to Oct-14	98%	98.7%	85.9%	88.1%	85.9%	98%	↓	5th
New % people aged 45+ who have a GP record of blood pressure measurement in the last 5yrs	No	2013/14	Improve	88.2%	-	-	88.2%	88.3%	-	3rd

The indicators above are monitored at the Quality, Safety & Experience committee.

An exception report is included for indicators which are not achieving the standard.

2.3 Effective Care Overview – Local Measures

	Effective Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	% of Nutrition Score Completed and Action Taken within 24 hrs of admission	No	Feb-15	Improve		-	-	-	-	-	-
New	Efficiencies:Patient admitted but procedures not carried out	No	Dec-14	Improve		-	3.3%	3.1%	-	-	-
New	Efficiencies: % Procedures as Daycase	No	Dec-14	Improve		-	77.3%	78.8%	-	-	-
New	British Association of Day Surgery (BADS) basket of 18 procedures performed within the guideline length of stay	No	Dec-14	Improve		-	88.9%	91.4%	-	-	-

The indicators above are monitored at the Quality, Safety & Experience committee.

An exception report is included for indicators which are not achieving the standard.

2.3 Effective Care: Exception Report

Effective Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% valid principle diagnosis code 3 months after episode end date - monthly	Yes	Oct-14	95%	98.8%	85.9%	60.6%	64.1%	-	↑	6th
% valid principle diagnosis code 3 months after episode end date - rolling 12 months	Yes	12 mths to Oct-14	98%	98.7%	85.9%	88.1%	85.9%	98%	↓	5th

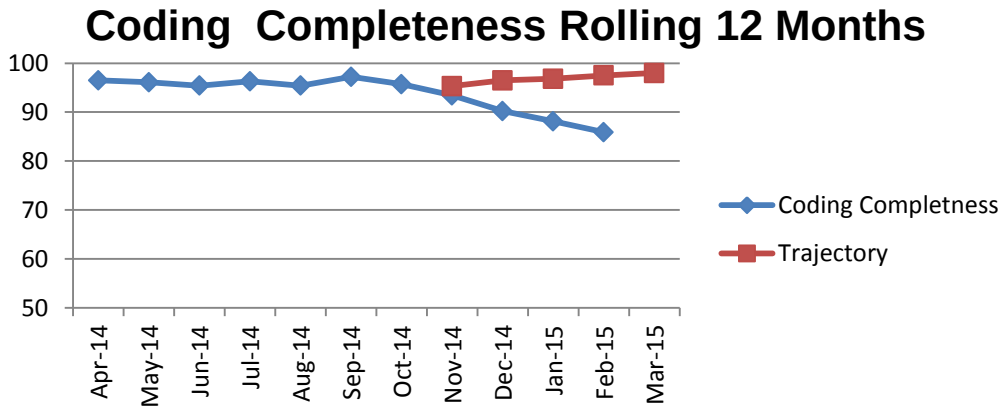
Coding completeness 3 months after episode end date for the month of October 14 was 64.1% against a target of 95% showing early signs of improvement.

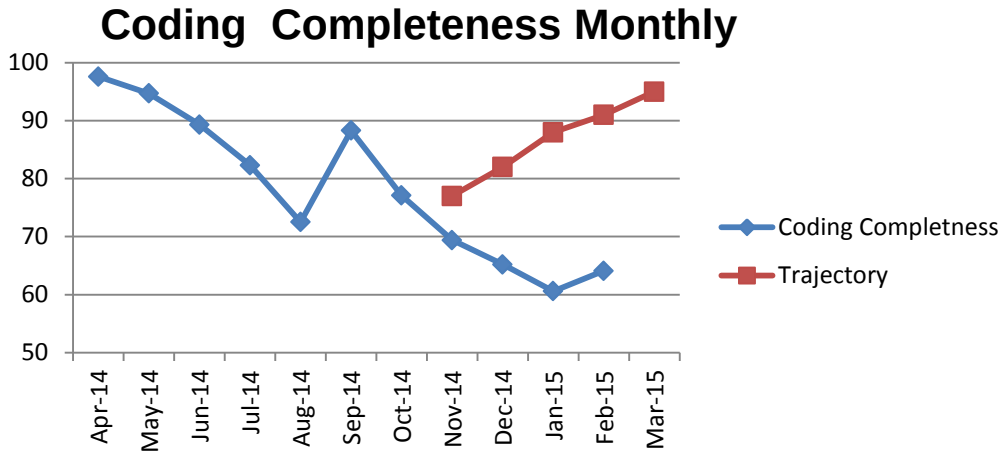
The Rolling 12 month completeness for the month of October 14 was 85.9% against a target of 98%.

Agency coders are scheduled to begin work at the end of March to assist in the recovery of coding completion.

The department is also in the process of recruiting to fill further vacancies following the retirement of experienced staff in the East.

The return of staff members from long term sickness absence and maternity leave will also assist the department in again reaching both targets.





2.3 Effective Care: Introductory Report

Effective Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New % of Nutrition Score Completed and Action Taken within 24 hrs of admission	No	Feb-15	Improve		-	-	-	-	-	-

Proposed Description of measure – A nationally defined standard of record keeping and assessment has been agreed nationally and is currently reviewed within the ward Quality audits. The percentage compliance of the nutritional score is established within the Quality Improvement Strategy and will remain a constant standard.

Definition - The current methodology to ascertain whether the agreed Nutritional Risk Assessment tool is completed within 24 hours of admission to the clinical area, and that any action required has been carried out; is defined through the monthly ward quality audits

Relevance - every patient admitted into hospital must have a nutritional risk assessment undertaken within 24 hours of admission, to improve the nutritional care and support they receive, and reduce harm caused by poor nutrition.

Considerations :
Any actions required with regard to poor compliance with completing the nutritional assessment and score will be picked up within the ward Quality audits and any ward incident investigations and the variances to that will be recorded within the Integrated Quality performance report under the ward quality audits template.

It is therefore suggested that this is a duplication of reporting and suggest that we do not utilise this to demonstrate effective care and instead utilise the wider Quality ward audits and identify the key areas of concern arising from those dashboards which relate to effective care.

2.3 Effective Care: Introductory Report

Effective Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New Efficiencies:Patient admitted but procedures not carried out	No	Dec-14	Improve		-	3.3%	3.1%	-	↑	-

This indicator applies to all elective inpatients and day cases and gives the rate at which the elective admission does not result in a procedure

Definition:
The measure uses a specific diagnosis code in the spell to identify qualifying admissions.

Rationale:
A number of patients are admitted as an elective inpatient or day case but do not undergo an operative procedure; e.g. patients who are unfit for surgery. There is a need for improved commitment to pre-operative assessment, planned bed management and better access to diagnostics.

2.3 Effective Care: Introductory Report

	Effective Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	Efficiencies: % Procedures as Daycase	No	Dec-14	Improve		-	77.3%	78.8%	-	↑	-

Rationale: This measure underpins commitment to improved performance against the Short Stay Surgery Basket of Procedures and is supported by the Wales Audi Office report '*Making better use of Day Surgery in Wales ' (2006)* which advocates the use of short stay surgery resources across a wide range of procedures

Description: This indicator looks at the rate of procedures that are carried out as a Daycase
Definition: Day surgery patients are those that require full operating theatre facilities and /or a general anaesthetic. Day case surgery promotes speedier recovery for patients, reduced risk of cancellation, and reduced risk of hospital acquired infection.

Improved service delivery through increased theatre utilisation (reduced cancelled ops due to no beds), lower waiting times.

2.3 Effective Care: Introductory Report

Effective Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New British Association of Day Surgery (BADS) basket of 18 procedures performed within the guideline length of stay	No	Dec-14	Improve		-	88.9%	91.4%	-	↑	-

This indicator follows a basket of 18 procedures defined by the British Association of Day Surgery and the rate of those procedures carried out within a given time frame

Rationale: The 18 procedures have been selected on the basis that relatively high volumes can reasonably be expected to be carried out against the required short stay delivery areas. It is further supported by the Wales Audit Office report '*Making better use of Day Surgery in Wales' (2006)* which advocates the use of short stay surgery resources across a wider range of procedures and provide an incentive / challenge to practitioners to expand their scope.

Day case surgery promotes speedier recovery for patients, reduced risk of cancellation, and reduced risk of hospital acquired infection.

Improved service delivery through increased theatre utilisation (reduced cancelled ops due to no beds), lower waiting times.

2.4 Overview & Areas of Escalation: Dignified Care

Dignified Care	Postponed Procedures			4	4	4

Dignified Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% procedures postponed on more than one occasion, had procedure <=14 days/earliest	Yes	Jan-15	Improve	-	-	9.1%	42.9%		↑	3rd

The scrutiny for this domain occurs with the Finance & Performance subcommittee.

An exception report is included for indicators which are not achieving the standard.

2.4 Dignified Care – Local Measures

	Dignified Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	Total Cancellations Inpatient (Clinical and Non-Clinical)	No	Jan-15	Improve	-	-	524	674	-	↓	-
New	Total Cancellations for Consultant and Nurse Led Outpatient appointments	No	Feb-15	Improve	-	-	7,107	6,457	-	↑	-

This summary slide provides new indicators which have been agreed by the executive directors within this report. Where new indicators are introduced, and a lead for the indicator has been identified, an **introductory report** is included.

2.4 Dignified Care: Exception Report

Dignified Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% procedures postponed on more than one occasion, had procedure <=14 days/earliest	Yes	Jan-15	Improve	-	-	9.1%	42.9%		↑	3rd

Despite there being a higher number of patients cancelled in January 2015, a greater number patients who had been cancelled twice, were rebooked within 14 days of their second cancellation, an increase from 9% to 43%. However, the target is that all patients should be booked within 14 days. The escalation process to ensure that cancelled patients are booked in a timely way has been further heightened.

The table below shows the site and specialty where patients were not booked in line with the Welsh Government requirements.

Patients not booked within 14 days of 2nd Postponement - by specialty	West	Centre	East	BCUHB Total
Gynaecology	2	1	2	5
Urology	1	1		2
Trauma & Orthopaedics			3	3
Ophthalmology				
Maxillo-Facial Surgery				
ENT			2	2
General Surgery	1			1
Gastroenterology	3			3
Radiology				

2.4 Dignified Care: Introductory Report

Dignified Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New Total Cancellations Inpatient (Clinical and Non-Clinical)	No	Jan-15	Improve	-	-	524	674	-	↓	-

This measure demonstrates the volume of hospital cancellations occurring monthly which includes both clinical and non-clinical.

Examples include:
Clinical – Pre-existing medical condition
Non-Clinical – List over booked

The measure demonstrates the opportunity to make better use of resources through reduction in avoidable cancellations which in turn improves patient experience by avoiding short notice cancellation of TCI/procedure

2.4 Dignified Care: Introductory Report

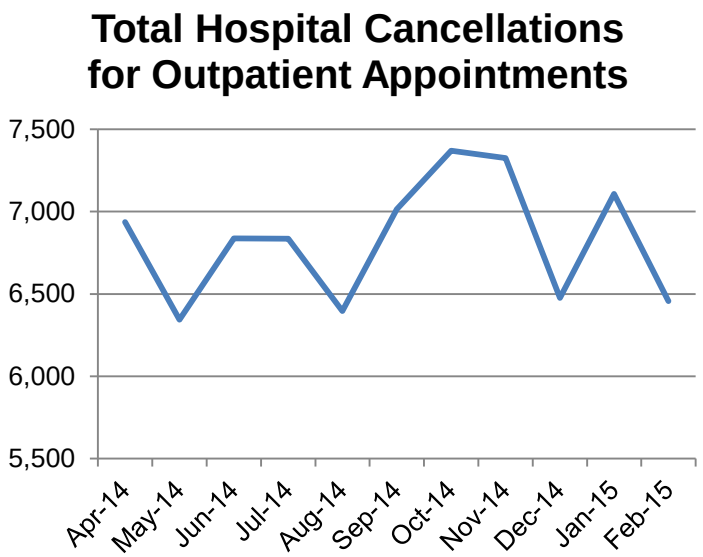
Dignified Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New Total Cancellations for Consultant and Nurse Led Outpatient appointments	No	Feb-15	Improve	-	-	7,107	6,457	-	↑	-

This measure reflects the monthly volume of cancelled outpatient appointments

Definition
This measure includes appointments cancelled by the hospital excluding therapy and diagnostic appointment. The health board has 3 different PAS each of which records cancellations slightly differently making comparisons between the sites difficult and leading to an over-recording of cancellations, due to re-scheduling of appointments being counted as cancellation on some systems. The relevance of the indicator will be to look at a downward trend over time rather than an absolute value.

Relevance:
Cancellations are seen as representing poor patient experience and inefficient use of hospital resources.

Expectation
The outpatient program is a key deliverable for the PMO and a trajectory will be developed through their officers.



2.5 Individual Care – National Measures

Individual Care	Mental Health Ass'sment	Mental Health Treatment	Care & Treatment Plans	Mental Health Advocacy			
					0	0	0

Individual Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% of assessment by the LPMHSS undertaken within 28 days of the date of referral	No	Feb-15	80%	75%	-	86.2%	81.6%	85%	↓	4th
% of therapeutic interventions started within 56 days following assessment by LPMHSS	No	Feb-15	90%	71%	-	94.7%	97.2%	90%	↑	3rd
% of LHB residents (all ages) to have a valid CTP completed at the end of each month	No	Jan-15	90%	93%	-	90.9%	92.4%	92%	↑	4th
% of hospitals with arrangements to ensure advocacy available to qualifying patients	No	Dec-14	100%	100%	100%	100.0%	100.0%	100%	→	1st

The scrutiny of this domain occurs though the Finance & Performance sub-committee.

This month, as all of the indicators have been achieved no exception reports are included.

2.5 Individual Care – Local Measures

	Individual Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	"I Want Great Care" initiative	No	Feb-15			-	4.73	4.78	-	-	-

This summary slide provides new indicators which have been agreed by the executive directors within this report. Where new indicators are introduced, and a lead for the indicator has been identified, an **introductory report** is included.

2.6 Timely Care: Introductory Report

	Individual Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	"I Want Great Care" initiative	No	Feb-15			-	473.0%	4.78	-	-	-

iWantGreatCare is a real-time patient feedback system that covers five areas: dignity / respect, patient involvement, information available to the patient, ward cleanliness and staff.

Patients are given a form and asked to complete it during their hospital stay.
They are then given 6 areas covering the five domains mentioned. The sixth asks how likely they would be to recommend the hospital ward to others.
The score is out of 5.

There is also a free text area where the patient can give verbal feedback which provides a rich source of information.

At present the system has only been rolled out on acute wards, maternity wards and the Emergency Department at Wrexham Maelor Hospital.

It is intended that a target be set of at least 4-stars for each clinical area involved.

2.6 Timely Care Overview – National Measures

Timely Care	GP Access	Referral to Treatment	Diagnostic Waits	Emergency Department	Ambulance	Cancer	Dental	Stroke	4	4	4

Timely Care		Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% GP practices	offering appts between 17:00 and 18:30 at least two days a week	No	Dec-14	Improve	94%	94%	94%	94%	98%	→	5th
	open during daily core hours or within1 hour of daily core hours	No	Dec-14	Improve	71%	71%	70%	73%	89%	↑	6th
% of patients waiting less than 26 weeks for treatment - all specialties		Yes	Feb-15	95%	88%	-	86%	87%	87%	↑	6th
Number of 36 week breaches- all specialties		Yes	Feb-15	0	2,911	-	4,261	3,943	5,000	↑	6th
% of patient waiting less than 8 weeks for diagnostics		Yes	Feb-15	100%	80.4%	-	71.0%	79.6%	100%	↑	4th
% of new patients spend no longer than 4 hours in A&E (inc Minor Injury Units)		Yes	Feb-15	95%	-	-	77.1%	77.7%	95%	↑	7th
Number of patients spending 12 hours or more in A&E		Yes	Feb-15	0	2,677	-	1,103	871	0	↑	7th
% of Cat A Ambulance responses within 8 minutes		Yes	Feb-15	65%	-	-	54.9%	56.2%	65%	↑	1st
Number of over 1 hour handovers		Yes	Feb-15	Reduce	479	-	814	766	32.8	↑	6th
% of patients referred as non-urgent suspected cancer seen within 31 days		No	Feb-15	98%	-	-	98.1%	98.0%	98%	↓	4th
% of patients referred as urgent suspected cancer seen within 62 days		Yes	Feb-15	95%	-	-	84.3%	82.5%	95%	↓	5th
Patients treated by an NHS dentist in the last 24 months as a % of the population		Yes	Feb-15	Improve	50.7%	-	50.35%	50.37%	50%	↑	6th
Stroke	1 - First hours bundle	No	Feb-15	95%	-	-	96.0%	98.6%	95%	↑	3rd
Stroke	2 - First days bundle	Yes	Feb-15	95%	-	-	86.7%	89.0%	95%	↑	4th
Stroke	3 - First 3 days bundle	No	Feb-15	95%	-	-	98.7%	97.3%	95%	↓	2nd
Stroke	4 - First 7 days bundle	Yes	Dec-14	95%	-	-	90.7%	93.8%	95%	↑	3rd

The indicators above are monitored at the Finance & Performance committee. Exception reports are included.

2.6 Timely Care Overview – Local Measures

	Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	All patients overdue on the Follow Up Waiting List	Yes	Feb-15	Reduce	-	-	45,756	44,299	-	↑	-
	Follow Up Waiting List (25-50% overdue)	Yes	Feb-15	Reduce	-	-	4,858	4,978	-	↓	-
	Follow Up Waiting List (50-100% overdue)	Yes	Feb-15	Reduce	-	-	6,810	6,395	-	↑	-
	Follow Up Waiting List (Over 100% overdue)	Yes	Feb-15	Reduce	-	-	27,326	26,572	-	↑	-
New	Therapies Waits Over 14 weeks	Yes	Feb-15	Reduce	-	-	4	5	-	-	-
New	Out of Hours : Urgents seen within 20 mins	No	Feb-15	Improve	-	-	70.2%	67.2%	-	-	-
New	Out of Hours : Non-Urgents seen in 60 mins	No	Feb-15	Improve	-	-	75.1%	72.1%	-	-	-
New	Admission on day of surgery	No	Dec-14	Improve	-	-	80.5%	81.0%	-	-	-

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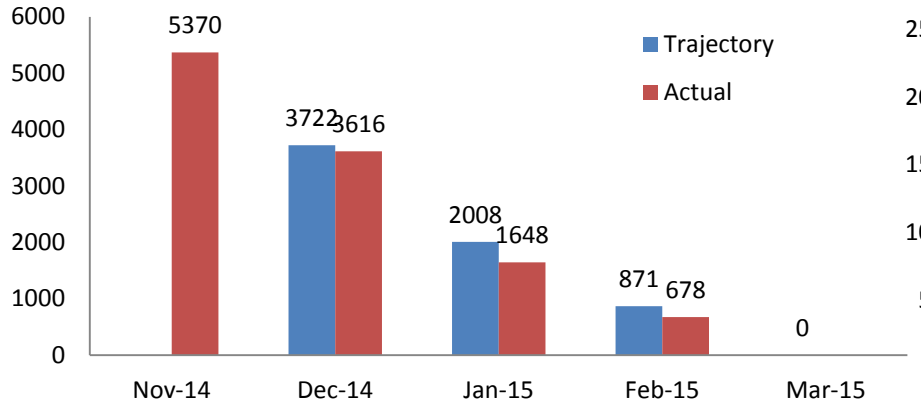
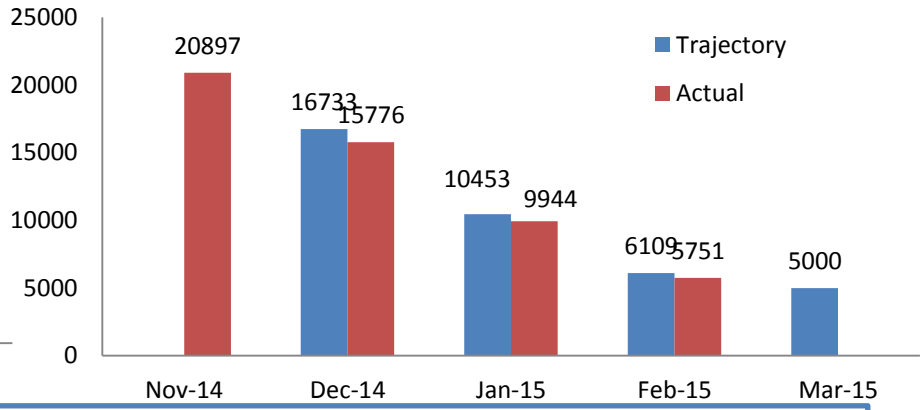
2.6 Timely Care: Exception Report

Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of 36 week breaches- all specialties	Yes	Feb-15	0	2,911	-	4,261	3,943	5,000	↑	6th
% of patients waiting less than 26 weeks for treatment - all specialties	Yes	Feb-15	95%	88%	-	86%	87%	87%	↑	6th

Open Pathways
Potential over 52 week patients



Open Pathways
Potential over 36 week patients



- The Referral to Treatment target for March 2015 is that no patient will be waiting over 52 weeks and there will be no more than 5,000 patients waiting over 36 weeks at the end of the financial year.
- The un-validated data as at 1/3/2015 reports a year end position better than trajectory and on target to deliver by 31 March 2015
- There is an individual action plan for every patient currently showing as over 52 weeks at year end and extensive validation is underway to ensure 36 week delivery.
- Trauma and orthopaedics remains the specialty at greatest risk, being challenged again with bed pressures in Wrexham

2.6 Timely Care: Exception Report

Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% of patient waiting less than 8 weeks for diagnostics	Yes	Feb-15	100%	80.4%	-	71.0%	79.6%	100%	↑	4th

Actions Being Taken

Endoscopy

Endoscopy is now reported as a medium risk for delivery. Urgent escalation has been taken with the Countess of Chester (COCH) who have been commissioned to deliver 495 endoscopies by 31 March 2015. A review of all patients booked dates is being completed at COCH. There is on-going work in Bangor to close the final gap of approximately 50 patients through the utilisation of capacity in YGC.

Radiology

The risk to delivery has decreased within radiology for all modalities. Additional capacity is coming on line in the remaining two weeks of March for MR. All patients are being carefully managed through to year end.

Cystoscopy

Cystoscopy and urodynamics is considered high risk despite the successful outsourcing of 160 patients. Additional plans/capacity are still being sought to mitigate the risk, urodynamic capacity is highly constrained due to the service being provided by a single clinician.

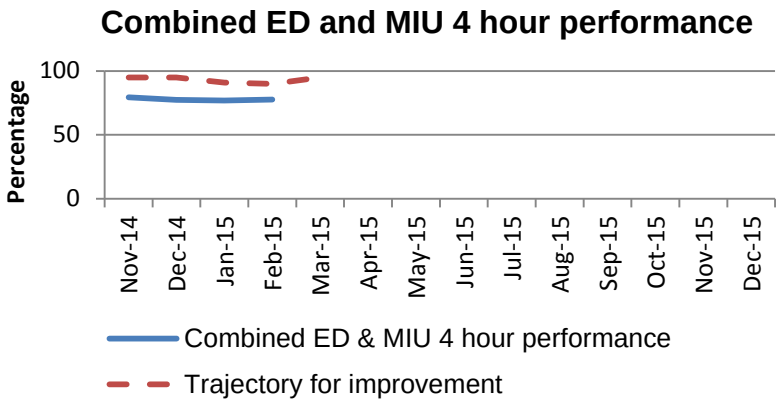
2.6 Timely Care: Exception Report

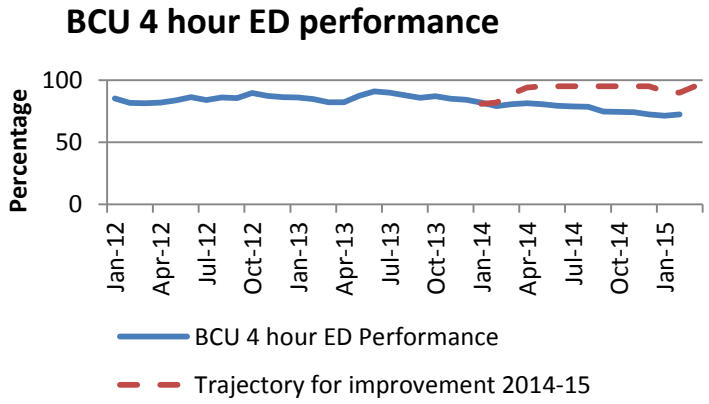
Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% of new patients spend no longer than 4 hours in A&E (inc Minor Injury Units)	Yes	Feb-15	95%	-	-	77.1%	77.7%	95%	↑	7th

Combined Emergency Department and Minor Injuries Unit 4 hour performance in February was 77.7%. Emergency Department 4 hour performance in February was 72.3%.

Improvement actions:

- External review of GP Out of Hours service complete. Final report received and actions to address recommendations are underway.
- Escalation and plus one beds open and sustained during February.
- Implementation of Board Rounds on going. Data collection identifying delays and actions escalated to Matrons and Hospital Management Teams.
- Step down beds utilised in three areas
- Work to reduce frequent attenders at Emergency Department ongoing in three areas
- National Patient Flow Collaborative working well in YG and YGC but further engagement work ongoing in YMW.





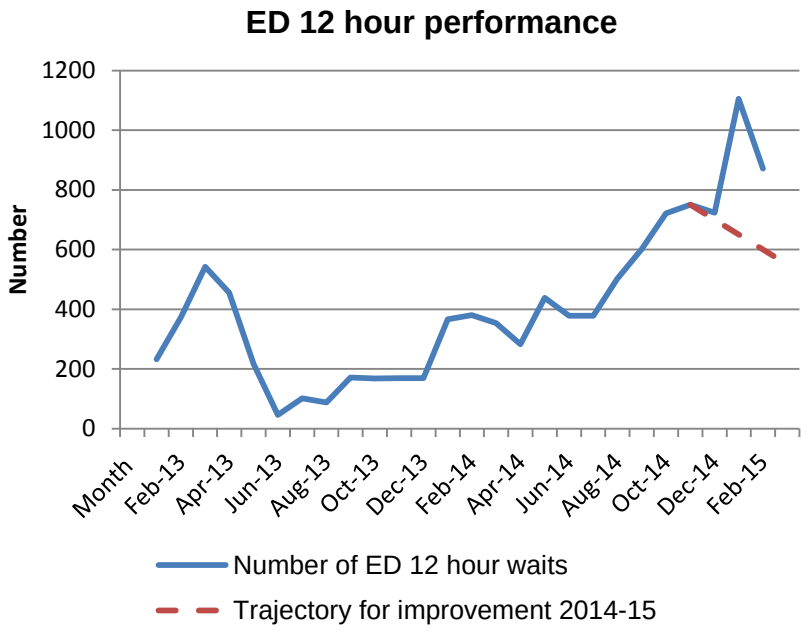
2.6 Timely Care: Exception Report

Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of patients spending 12 hours or more in A&E	Yes	Feb-15	0	2,677	-	1,103	871	0	↑	7th

871 Patients waited over 12 hours in an Emergency Department during February.

Improvement actions:

- Review of 10% of case notes of patients who have waited over 12 hours in ED continued with actions for improvement addressed locally.
- External review of GP Out of Hours service complete. Final report received and actions to address recommendations are underway.
- Escalation and plus one beds open and sustained during February.
- Implementation of Board Rounds on going. Data collection identifying delays and actions escalated to Matrons and Hospital Management Teams.
- Step down beds utilised in three areas.
- Work to reduce frequent attenders at Emergency Department ongoing in three areas
- National Patient Flow Collaborative working well in YG and YGC but further engagement work ongoing in YMW.

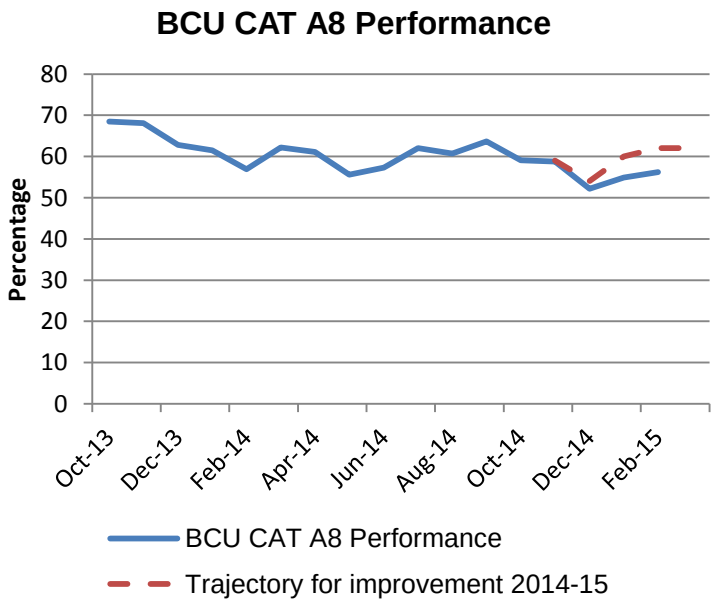


2.6 Timely Care: Exception Report

Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% of Cat A Ambulance responses within 8 minutes	Yes	Feb-15	65%	-	-	54.9%	56.2%	65%	↑	1st

Category A ambulance response time in February was 56.2%

- Paramedic Pathfinder being rolled out across North Wales.
- Revised monthly audit of Ambulance handover implemented during February.
- All Wales Handover Guidance received and implemented. Local ambulance handover and escalation protocols updated.
- Alternatives to conveyance and taxi transport for appropriate patients ongoing.
- Ambulance commissioning monthly meetings monitoring monthly performance.
- Joint BCU/WAST monthly operational meeting ongoing and monitoring all admission avoidance initiatives related to WAST.



2.6 Timely Care: Exception Report

Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Number of over 1 hour handovers	Yes	Feb-15	Reduce	479	-	814	766	32.8	↑	6th

During February the number of ambulance handovers greater than 1 hour was 766 and greater than 15 minutes was 2167.

•Paramedic Pathfinder being rolled out across North Wales.

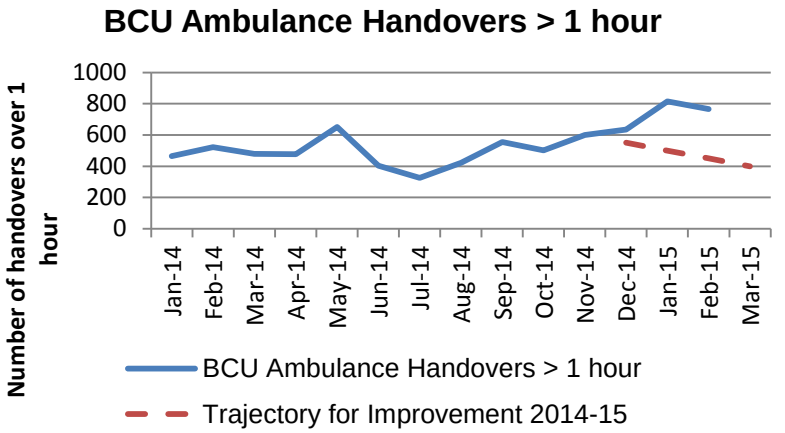
•Revised monthly audit of Ambulance handover implemented during February.

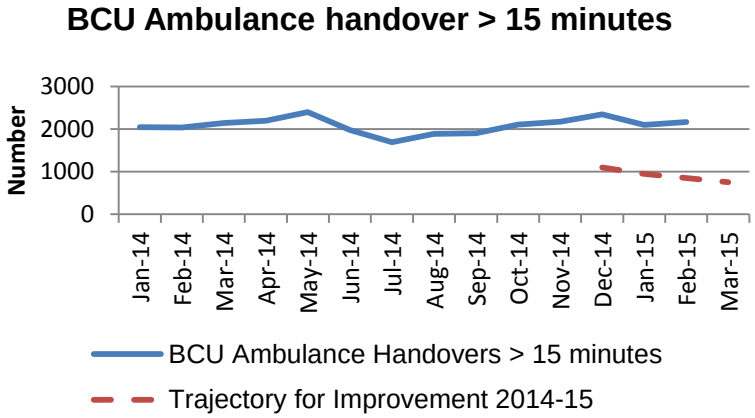
• All Wales Handover Guidance received and implemented. Local ambulance handover and escalation protocols updated.

•Alternatives to conveyance and taxi transport for appropriate patients ongoing.

•Ambulance commissioning monthly meetings monitoring monthly performance.

•Joint BCU/WAST monthly operational meeting ongoing and monitoring all admission avoidance initiatives related to WAST





2.6 Timely Care: Exception Report

Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% of patients referred as urgent suspected cancer seen within 62 days	Yes	Feb-15	95%	-	-	84.3%	82.5%	95%	↓	5th

February – un-validated position 80%; forecast position 82.5%

Actions taken:

Booking and escalation policies amended to ensure all new referrals seen within 10 or 14 days dependent upon tumour site; performance reached 80% during February. Performance dipped in gastro following increased referrals after a Public Health campaign; extra capacity will be in place by March-2015

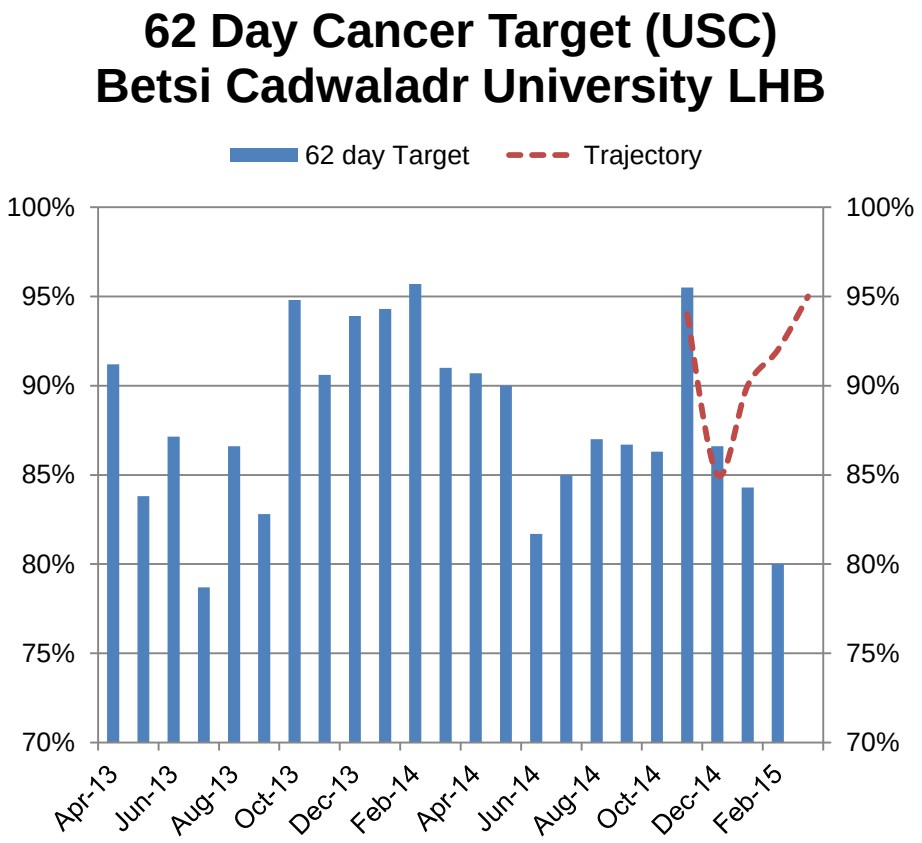
Additional radiology and endoscopy capacity introduced from December 2014

Additional laparoscopic urology surgery contracted from Arrowe Park Hospital (effective immediately) and a locum surgeon commenced January 2015

Weekly multi-CPG meeting led by corporate performance lead established to monitor March compliance and instigate remedial actions; additional capacity currently being sought to increase total numbers of cancers treated in month

Revised trajectory:

We expect to improve performance against the urgent suspected cancer (USC) target from March but delivery cannot be guaranteed; current forecast is 88-96%



2.6 Timely Care: Exception Report

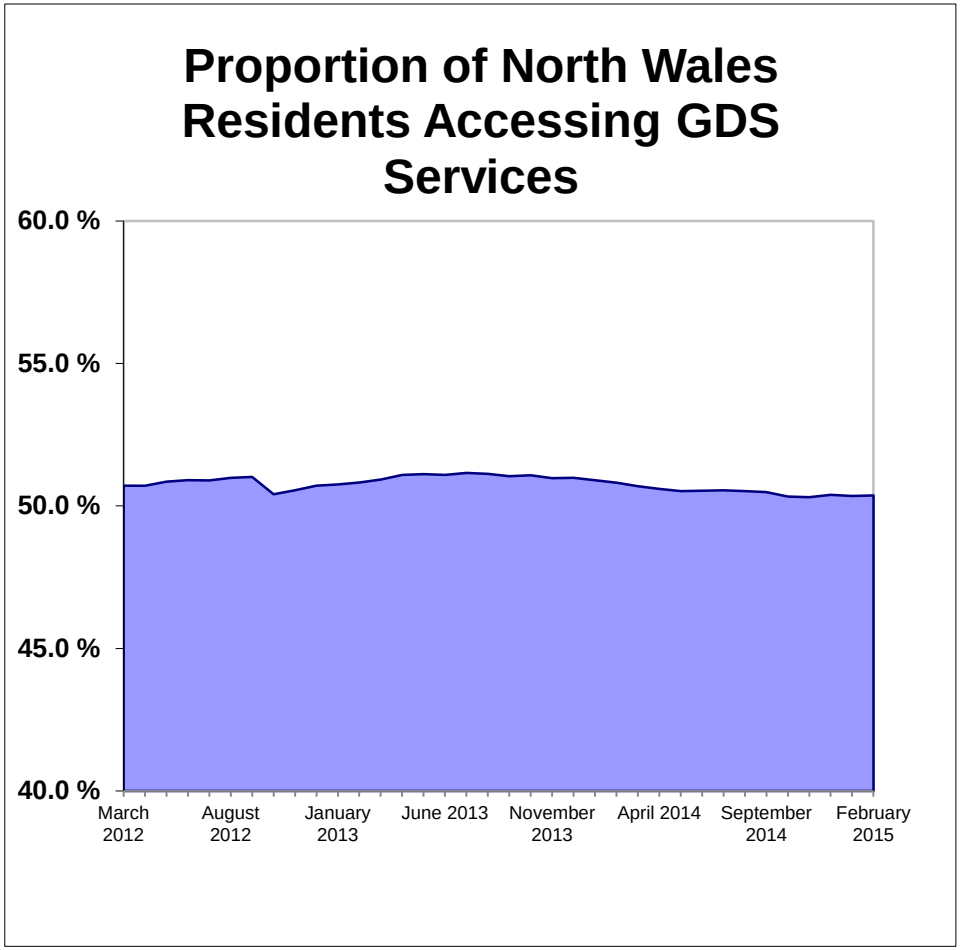
Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Patients treated by an NHS dentist in the last 24 months as a % of the population	Yes	Feb-15	Improve	50.7%	-	50.35%	50.37%	50%	↑	6th

Last 3 months performance:
December – 50.39%
January – 50.35%
February – 50.37%

Actions taken:
The Primary Care Support Unit routinely works with contractors to towards ensuring contracted services are delivered as efficiently as possible and patient access to GDS services is optimised within the available budget.

Current funding constraints mean that additional non-recurring activity cannot be commissioned within this financial year. It is therefore unlikely that there will be an improvement in the current trajectory before the year end

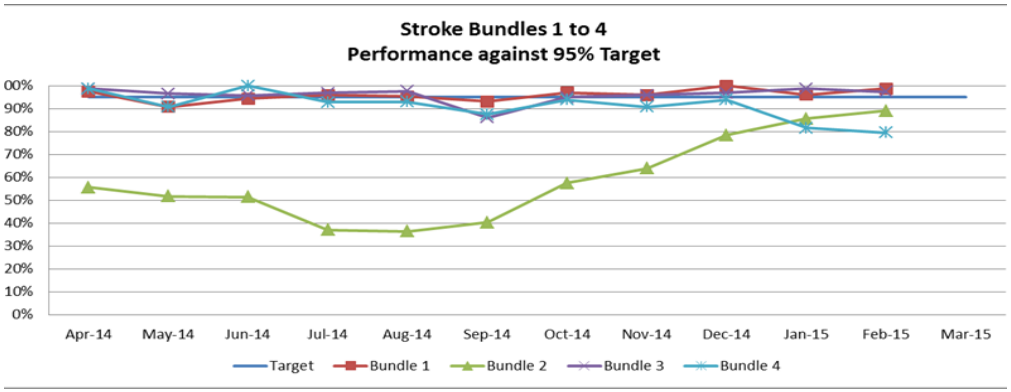
Revised trajectory:
We do not expect the current trajectory to improve prior to the end March 2015



2.6 Timely Care: Exception Report

Timely Care		Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Stroke	2 - First days bundle	Yes	Feb-15	95%	-	-	86.7%	89.0%	95%	↑	4th
Stroke	4 - First 7 days bundle	Yes	Dec-14	95%	-	-	90.7%	93.8%	95%	↑	3rd

Bundle 2 The chart shows the increase in performance against the Stroke 2 bundle since August 2014.
Bundle 4 is reported 2 months in arrears. The chart shows the currently incomplete position for January and February 2015.



Exception

Bundle 2 contains 5 elements of care which are clinically accepted as contributing to improved patients outcomes if delivered within the first 24 hours of arrival at hospital. The health board has significantly improved its performance against this bundle, with month on month improvement demonstrated since August and is now the best performer within Wales. In February 65 out of the 73 stroke patients received all 5 elements of the bundle within 24 hours. The reasons for the breach of the standard related to access to a dedicated stroke bed directly from ED admission. These patients received all other elements of the bundle within the 24 hours. During February Wrexham site delivered the 95% target. **Bundle 4** data is currently incomplete, with 90 out of 97 records complete. Of those records which are complete, the LHB is meeting over 95% compliance for Bundle 4.

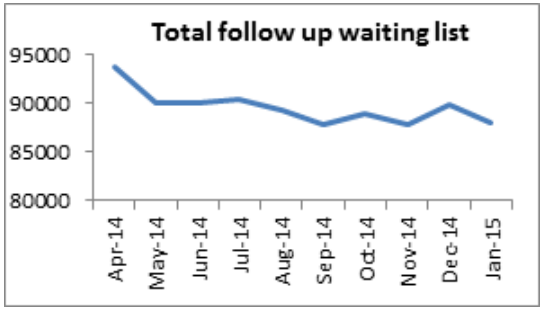
Actions

Relevant staff in and out of hours have been reminded of the importance of; (i) the ring-fenced stroke bed, (ii) the escalation process and (iii) the need for recovery plan to re-establish the bed at times of escalation.

2.6 Timely Care: Introductory Report

Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Follow Up Waiting List (25-50% overdue)	Yes	Feb-15	Reduce	-	-	4,858	4,978	-	↓	-
Follow Up Waiting List (50-100% overdue)	Yes	Feb-15	Reduce	-	-	6,810	6,395	-	↑	-
Follow Up Waiting List (Over 100% overdue)	Yes	Feb-15	Reduce	-	-	27,326	26,572	-	↑	-

Total number of patients waiting for follow-up where there is NO documented target date	Total number of patients waiting for follow-up where there IS a documented target date	Total number of patients waiting for a follow-up who are delayed past their target date				
		0% up to 25% delay	Over 26 up to 50% delay	Over 50% to 100% delay	Over 100% delay	Total
0	44,253	3,048	2,239	3,594	17,401	26,282



The number of patients overdue a follow up outpatient appointment remains a significant challenge to the Health Board. Whilst the numbers of patients overdue has fallen since April 2014 as can be shown in Tables 2 and 3,the pace and volume of reduction is not at the rate that was expected by the Health Board.

- The elimination of the Follow Up Backlog features in the organisations Three Year Plan due to be submitted to the Welsh Government in March 2015. Account of the backlog and the sustainable impact of the additional elective activity requiring follow up activity has been quantified and now features within the demand and capacity planning process of the Health Board. CPGs are developing plans to increase capacity to tackle the backlog in 2015-2016.
- A Hothouse project has been initiated in Urology as a key priority of the Programme Management Office to provide intense support and review of the root causes of the follow up backlog in terms of process, clinical practice and capacity. Additional management support to deliver this programme of work is being identified though the PMO.
- The follow up backlog will be subject to a Welsh Audit Office study during the summer to assess across Wales, Health Board's understanding, quantification of the backlog and the actions being take to eliminate it and manage clinical risk.

2.6 Timely Care: Introductory Report

	Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	Therapies Waits Over 14 weeks	Yes	Feb-15	Reduce	-	-	4	5	-	-	-

This indicator reflects compliance with the Welsh Government expected standard of waiting times for therapy services.

Description:
The present operating standard is 14 weeks from referral to first attendance this measure is recorded in accordance with Welsh Government definitions

Relevance:
Timely access to therapy care is desirable to support patients rehabilitation and reduce risk of conditions becoming chronic.

Expectation
The expectation is that all patients have access to therapy services within 14 weeks, where this is not the case an exception report will be included in future

2.6 Timely Care: Introductory Report

	Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	Out of Hours : Urgents seen within 20 mins	No	Feb-15	Improve	-	-	70.2%	67.2%	-	-	-
New	Out of Hours : Non-Urgents seen in 60 mins	No	Feb-15	Improve	-	-	75.1%	72.1%	-	-	-

1. Description of measure – this measure demonstrates the volume of patients triaged within the specified Welsh Government target times – split by urgency – Urgent to be triaged within 20 minutes and Routine to be triaged within 60 minutes.

2. Definition of measure – includes all calls made to the north Wales GP Out Of Hours Service.

3. Relevant of measure – demonstrates the number of calls that fail the target, demonstrating an opportunity to review the staffing levels to ensure that they are sufficient in order to meet the required targets.

4. Baseline – the baseline reported enable the LHB to be aware of the scale of the opportunity for improvement and to monitor the benefit realisation from actions being taken to improve performance through identified actions.

5. Establishment of extent of improvement expected – reviews of staffing levels and performance for improvement will be reported against in future months with exception reports created for periods in which the trajectory for improvement are delivered.

2.6 Timely Care: Introductory Report

	Timely Care	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	Admission on day of surgery	No	Dec-14	Improve	-	-	80.5%	81.0%	-	-	-

This indicator gives the rate at which procedures are carried out on the same day as the admission for the elective procedure.

The indicator measures all elective admissions with a procedure, excluding day cases.

Should be the norm, unless clinically or socially determined. Admitting a patient to a bed a days in advance of their operation for non-clinical or social reasons wastes valuable hospital bed capacity and increases costs. This measure promotes the use of more effective pre-operative assessment, bed management and admission initiatives and processes.

2.7 Staff and Resources Overview – National Measures

Use of Staff & Resources	Sickness Rate	Appraisals	Finance			4	4		4

Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% staff absence due to sickness (rolling 12mths)	Yes	Jan-15	4.55%	5.48%	5.22%	5.47%	5.50%	5.49%	↓	2nd
% of total medical staff undertaking appraisals	No	Q3 2014/15	Improve	68%	84%	86%	76%		↓	4th
Finance - % variance against budget	Yes	Feb-15	Improve	0.20%	2.8%	1.1%	-0.9%		↑	-

The indicators above are monitored at the Finance & Performance committee.

An exception report is included for indicators which are not achieving the standard.

The **statutory duty compliance** including breakeven has been included in addition to the national template.

Other workforce indicators are included in the local indicators.

2.7 Staff & Resources Overview – Local Measures

	Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	PADR (Appraisal for non-medical staff)	No	Jan-15			-	36.00%	35.00%	-	-	-
New	CARE referral rate	No	Jan-15			-	47.71%	48.58%	-	-	-
New	Agency & Locum Spend in **£000's**	No	Jan-15			-	3,120	2,875	-	-	-
New	Vacancy Rate - This measure is under development	No	Jan-15			-	4.12%	4.31%	-	-	-
New	Average Length of Stay (Elective Admissions)	No	Feb-15			-	2.72	2.91	-	-	-
New	Average Length of Stay (Emergency Admissions)	No	Feb-15			-	10.24	10.74	-	-	-
New	Percentage Workforce Change - This measure is under development	No	Jan-15			-	0.07%	0.00%	-	-	-
New	Mandatory Training Overall - This measure is under development	No	Feb-15			-	-	-	-	-	-
New	Staff Turnover - This measure is under development	No	Feb-15			-	-	-	-	-	-

This summary slide provides new indicators which have been agreed by the executive directors within this report. Where new indicators are introduced, and a lead for the indicator has been identified, an **introductory report** is included.

2.7 Staff and Resources: Exception Report

Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
% staff absence due to sickness (rolling 12mths)	Yes	Jan-15	4.55%	5.48%	5.22%	5.47%	5.50%	5.49%	↓	2nd

Disappointingly absence levels across the organisation continue to be significantly worse than the target. The year to date rate January 2015 was 5.22% as compared with 5.02% for the same period in 2014. The absence rate for January was 5.50% a slight improvement from the 5.58 % recorded in December.

Areas across the organisation with sickness above 6% included Mental Health 6.66%, Women's 6.14%, Improvement and Business Support 7.13% and Planning including facilities at 6.90%.

Revised sick pay arrangements came into force for staff for staff on salaries above the top of pay band 2 with effect from 1st January 2015. Sick pay for these staff is now based on basic pay only and will exclude unsocial hours premiums. Sickness levels for staff in bands 1 to 6 inclusive are all above the organisations average, however staff in pay band 1 registered absence levels of 8.28% and staff in band 2 experienced absence levels of 7.44%. The occupation groups with the highest level of absence are estates and ancillary staff at 7.30%, additional clinical services (including HCSW) AT 7.37% and nursing and midwifery at 5.98%. As the staff with the highest levels of absence HCSW and ancillary staff on bands 1 and 2 are not affected by these changes it is important that the relevant departments have robust sickness management processes in place.

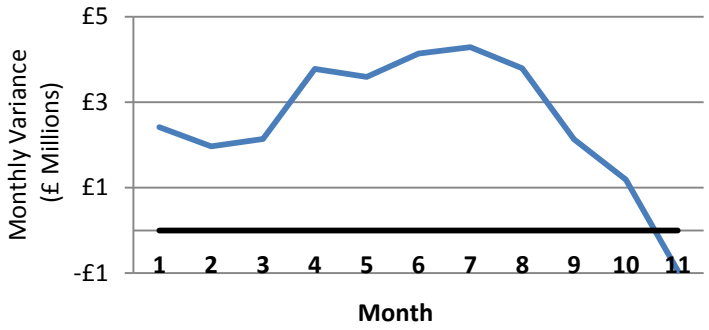
The number of staff absent each day throughout the month of January varied between 842 and 976, although high the figure is less than the 1019 and 1017 who were off due to sickness on Tuesday 16th and Wednesday 17th December 2014.

The CARE early intervention service for the management of sickness absence continues to experience low levels of referrals. The overall referral rate was 48.58%,however the referrals for surgical CPG were 30.49%, PCSM 32.43%, and Anaesthetics at 31.08%. These levels are considerably worse than the 80% required to make a real difference.

Sickness training continues to be delivered across the organisation. WOD continues to provide targeted support to management teams through coaching, attendance at sickness management meetings and highlighting particular areas of concern and absence trends. Drop in sessions held for matrons have been held in YG for the medicine directorate and have been very well received.

2.7 Staff and Resources: Exception Report

Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
Finance - % variance against budget	Yes	Feb-15	Improve	0.20%	2.8%	1.1%	-0.9%		↑	-

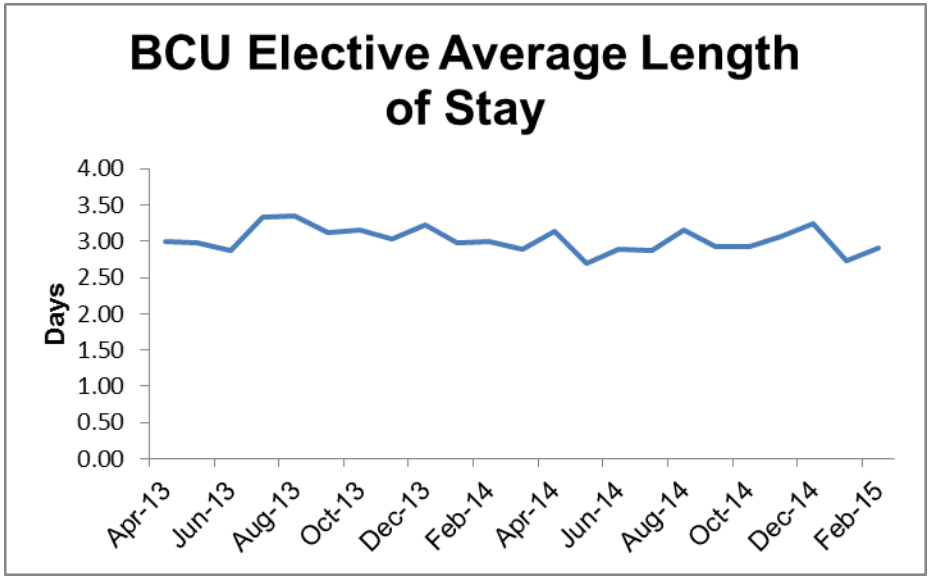
Key Target	Target (£'000)	Year to date performance (£'000)	Risk	
Achievement against Revenue Resource Limit (RRL)	0	28,470	Red	Following the Month 11 financial review, the Health Board's financial position at the end of February 2015 is a cumulative over spend position of £28.5 million compared to £29.4m at the end of January. This is a month on month improvement of £0.9 million. The underlying run-rate, after adjusting for the additional resource allocation of £35M equally across each month, has consistently reduced over each of the last 4 months and is shown in the graph below. The year end forecast positions is £27.5 million overspend (2.2 % variance). 
Performance against savings (internal target)	91,715	23,599	Red	• The current annual saving target is £91.7m (7.5%). • £34.65m of cash releasing savings schemes have been identified to date across CPGs and Corporate Departments and £6.35m cost avoidance measures. • As at the end of December, £19.5m cash releasing savings have been delivered against planned savings of £23.6m (82.6%) and £4.1m cost avoidance savings against planned savings of £4.6m (89.1%).

2.7 Staff and Resources: Introductory Report

Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New Average Length of Stay (Elective Admissions)	No	Feb-15			-	2.72	2.91	-	↓	-

This measure uses the average length of stay methodology outlined in the document "Improving Efficiency & Productivity Within Wales". It looks at electively admitted patients discharged in the month and the complete length of stay that the patient experiences, both acute and community stays, across any hospital in the health board.

General Surgery, Orthopaedics, Urology Ear Nose and Throat and Gynaecology admissions are included. Day cases are excluded as are patients discharged with a length of stay greater than 50 days.



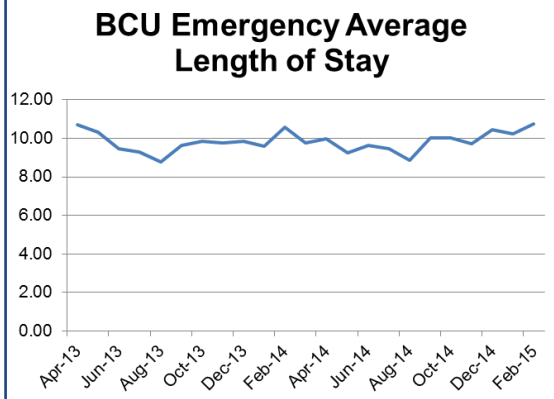
2.7 Staff and Resources: Introductory Report

Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New Average Length of Stay (Emergency Admissions)	No	Feb-15			-	10.24	10.74	-	↓	-

This measure uses the average length of stay (LOS) methodology outlined in the by the Welsh Government document "Improving Efficiency & Productivity Within Wales". It looks at patients admitted as an emergency (unplanned) who are discharged in the reporting month. The length of stay includes acute episodes of care as well as any community hospital length of stay related to the emergency admission.

All specialties are included with the exception of paediatric, obstetric and mental health also excluded are patients with a length of stay greater than 100 days.

The LOS measure is an indicator of how efficiently patients are managed, for example: treatment / decision making is carried out efficiently and effectively
without any avoidable delays such as diagnostic tests or other assessment delays.
Monitoring the LOS performance encourages good and safe discharge planning processes to ensure patients are not delayed unnecessarily within hospital environment.
Longer lengths of stay increases patient risk of hospital acquired infection as well as reducing the ability of the organisation to respond in a timely manner to new emergency admissions on an on-going daily basis (adversely impacting ED waiting time targets and ambulance handover times).



2.7 Staff and Resources: Introductory Report

	Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New	PADR (Appraisal for non-medical staff)	No	Jan-15			-	36.00%	35.00%	-	-	-

Description of measure - Percentage of appraisals that have been completed for non - medical staff

Definition of measure – The total number of non-medical staff who have received a PADR from their manager of the total number of non-medical staff who were due to receive a PADR

Relevance of measure –Staff are required to undertake an annual appraisal (referred to as PADR) to ensure any training needs can be met and objectives agreed to ensure the best possible service can be provided to patients and customers . PADR is informed by the values of the Organisation. By continually developing BCUHB staff to a high standard the standard of service to patients and customers is enhanced.

2.7 Staff and Resources: Introductory Report

Staff and Resources	Exception Report?	Month	Achieve	2013/14	YTD	Previous	Current	FYF	Trend	Welsh Benchmark
New CARE referral rate	No	Jan-15			-	47.71%	48.58%	-	↑	-

Description of measure - Percentage of referrals to CARE and episodes of absence per month.

Definition of measure - This measure demonstrates the number of CARE referrals made by managers in the CPG's in relation to the number of episodes of absence reported into the ESR database per month.

Relevance of measure - Demonstrates the opportunity to provide early support and advice for staff from first day of sickness absence.

Baseline – the baseline reported enable the Health Board to be aware of the scale of the opportunity for improvement and to monitor the benefit realisation from actions taken to improve health through and early intervention system for support and advice when off sick.

Establishment of improvement expected – the Staff Health & Wellbeing group will consider further measures on how engagement of managers can improve referral rates. At a service level each CPG will be required to provide an exception report in which the trajectory for improvement are not delivered.

3.0 Activity

April 2014 to January 2015

	Internal				External			
Activity Type	**Plan**	**Actual**	**Diff**	**% Diff**	**Plan**	**Actual**	**Diff**	**% Diff**
Elective Inpatients	14,542	17,120	**2,578**	**17.7%**	2,957	3,059	**102**	**3.4%**
Elective Daycases	24,834	22,120	**-2,714**	**-10.9%**	5,845	5,920	**75**	**1.3%**
Emergency Inpatients	71,418	74,567	**3,149**	**4.4%**				
Endoscopies	13,489	16,444	**2,955**	**21.9%**	4,026	4,079	**53**	**1.3%**
MOPS (Cleansed DC)	1,899	1,614	**-285**	**-15.0%**	2,380	4,273	**1,893**	**79.5%**
Regular Day Attenders	35,920	35,264	**-656**	**-1.8%**				
New Outpatients	168,323	168,254	**-69**	**0.0%**	13,786	14,438	**652**	**4.7%**
Review Outpatients	304,967	371,217	**66,250**	**21.7%**	46,864	43,732	**-3,132**	**-6.7%**
New ED Attendances	179,261	179,105	**-156**	**-0.1%**	6,522	6,824	**302**	**4.6%**
Follow up ED Attendances	9,539	9,235	**-304**	**-3.2%**				
Unknown								
Grand Total	**824,192**	**894,940**	**70,748**	**8.6%**	**82,380**	**82,325**	**55**	**0.1%**

This report was previously presented at the last Board meeting in February.

The table reports activity versus plan and includes internally provided within North Wales and externally provided outside North Wales. Some contracts for North Wales residents are managed by Welsh Health Specialised Services Committee are not shown.

4.0 Appendix A – Further Information

Further detailed information is available :

- Further information is available from the office of the Chief Operating Officer which includes;
  - performance reference tables
  - tolerances for red, amber and green
  - the Welsh benchmark information which we have presented

- Further information on our performance can be found online at:
  - Our website www.pbc.cymru.nhs.uk
    www.bcu.wales.nhs.uk
  - StatsWales www.statswales.wales.gov.uk

- We also post regular updates on what we are doing to improve healthcare services for patients on
  twitter follow @bcuhb
  http://www.facebook.com/bcuhealthboard