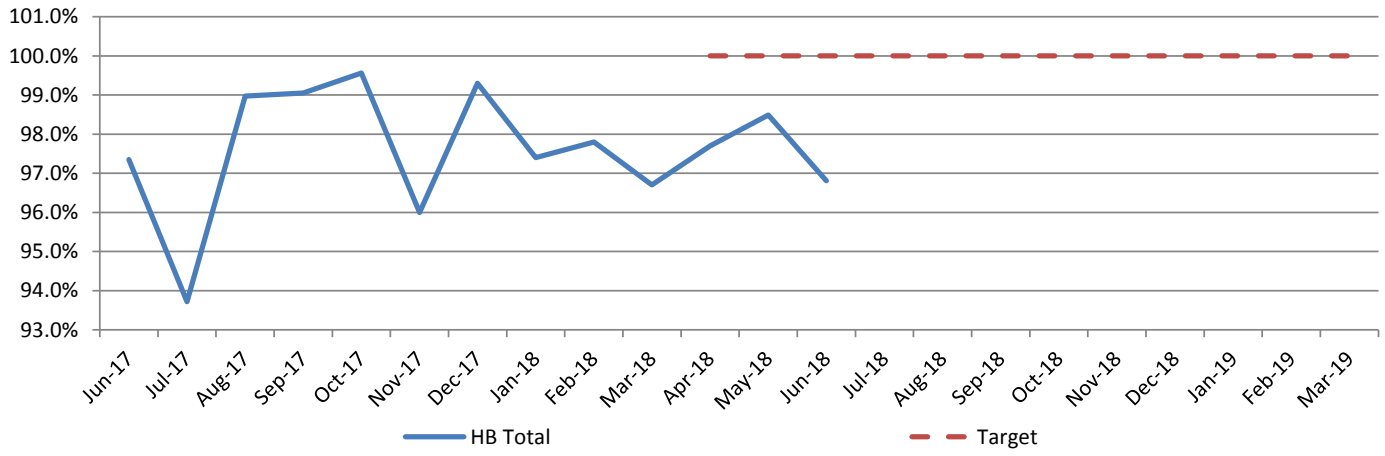
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: % patients with completed NEWS score and appropriate responses actioned

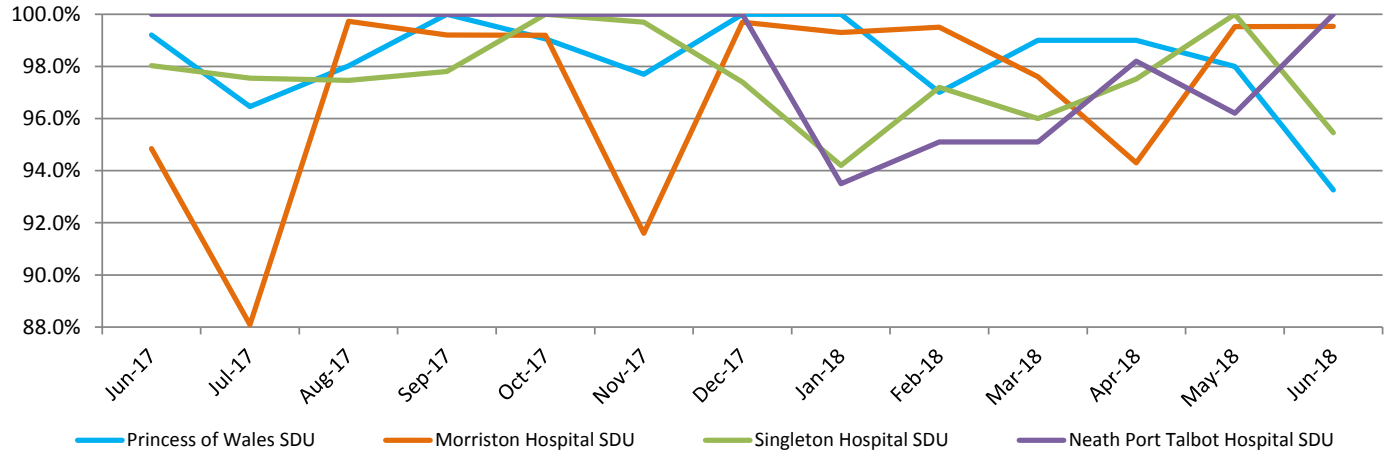
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : June 2018	IMTP Profile Target : N/A	Local Target : 100%	Current Status :	Movement : Improving

Current Trend: Jun 17 - Jun 18

(1) % patients with completed NEWS score and appropriate responses actioned.



(1) % patients with completed NEWS score and appropriate responses actioned (by Service Delivery Unit).



Benchmarking

No Benchmarking Data Available.

Source : ABMU Care Matrix

Measure 1: % patients with completed NEWS score and appropriate responses actioned

How are we doing ?

- The overall Health Board percentage of patients with a completed NEWS Score in June 2018 was 96.8% compared with 98.5% in May
- In month performance improved in 1/4 Delivery Unit's (DU), remained static in 1/4 and declined in the remaining two.
- Neath Port Talbot (NPT) achieved 100% in June
- Morriston achieved 99.5%, the same as in May
- Singleton achieved 95.5% having reached 100% in May
- Princess of Wales Hospital's (POWH) compliance was 93.3% , a fall from 98% in May

What actions are we taking?

- The percentage of patients with a completed NEWS score is kept under regular review by Delivery Unit Quality & Safety Groups
- The Spot the Sick Patient (StSP) work is focussing on training staff to use NEWS scores appropriately to recognise deterioration in a patient's condition early so that prompt intervention can take place and also on the recognition and treatment of sepsis
- Morriston- The StSP Sepsis Programme has been rolled out to all relevant wards and champions identified. Paediatrics, Burns and Cardiac specialties are currently excluded. Education & training has been expanded. HCSWs are responding well to training being delivered by HCSW Sepsis Champions. Since May 2017, 1300 staff have received sepsis training.
- NPTH- New alerts stickers to prompt investigations into Acute Kidney Injury, sepsis and general deterioration have been introduced. Since 1st December 2017, every resuscitation trolley in NPTH will has a "Sepsis Bucket", containing what staff need for sepsis screening. As part of 'Spot the Sick Patient campaign NPTH is undertaking NEWS education at ward level again alongside response/action. Sepsis is included.
- POWH - over the past 20 months, 237 nursing staff and 44 medical staff have received training. The Action for NEWS sticker is working well as a prompt for staff to review patients
- Singleton - Staff training has almost reached 100%. Junior medical staff are strongly engaged with the StSP programme.
- The findings of the recent RRAILS Peer Review will be used to build upon the improvements achieved to date

What are the main areas of risk?

- Timeliness of rollout given the operational pressures.

How do we compare with our peers?

- No comparable data available.

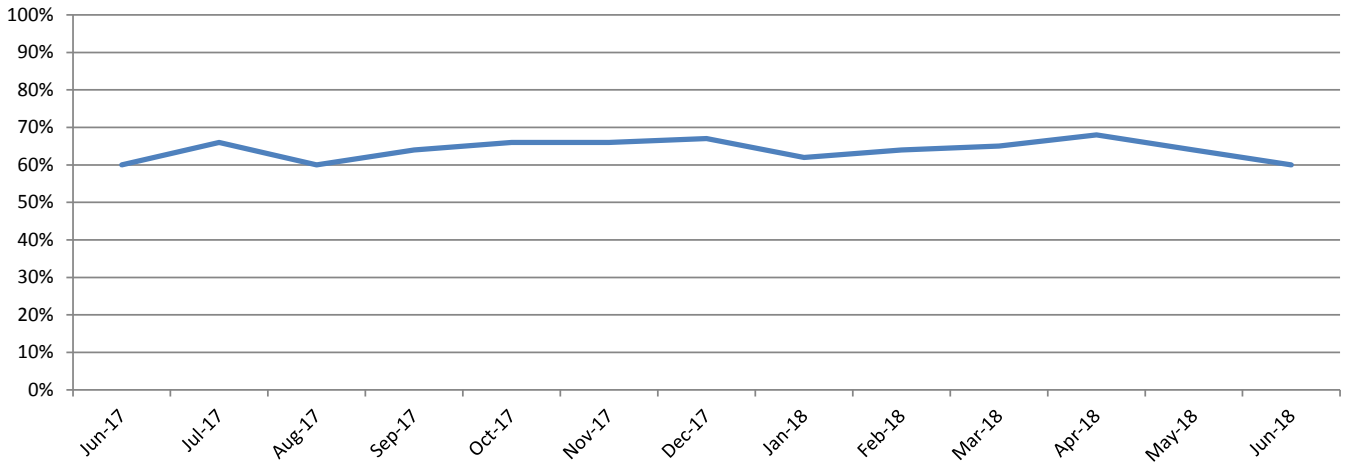
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % of completed discharge summaries

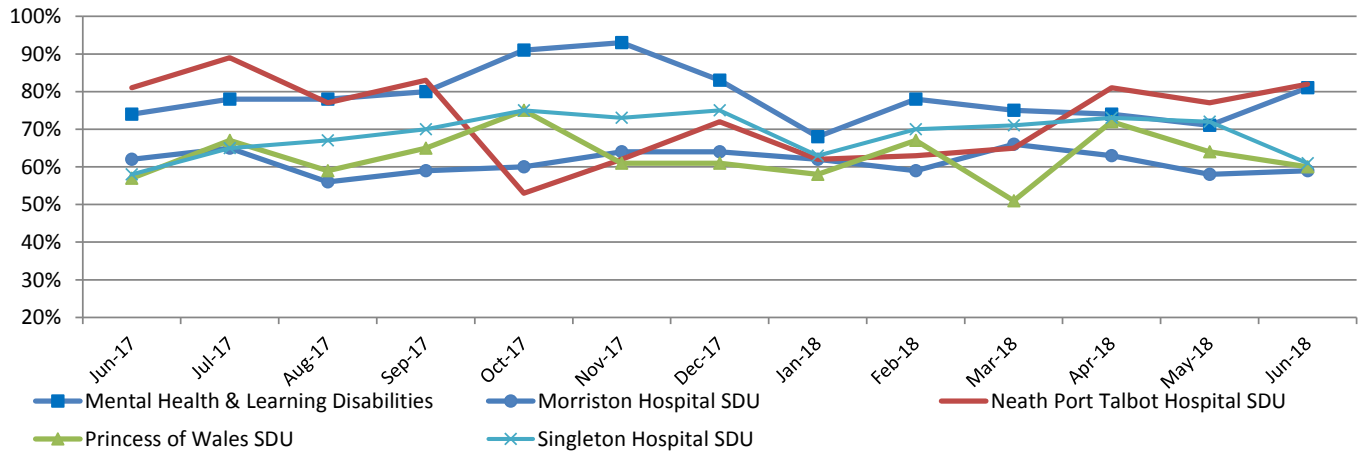
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : June 2018	IMTP Profile Target : Improve	Local Target 100%	Current Status : ✖	Movement : ↓ Improving

Current Trend: Jun 17 - Jun 18

(1) % of completed discharge summaries ABMU



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



Benchmarking

No Benchmarking data available

Source : ETOC Dashboard

Measure 1: % of completed discharge summaries

How are we doing ?

• Performance in this quality priority has declined on a Health Board-wide basis in June (60%) compared with May (64%)
• Overall Health Board performance is now at the same level as June 2017 despite reaching 68% in April 2018
• There continues to be performance variance between Service Delivery Units (59%-82%)
• This month the performance has improved in 3/5 Delivery Units, and declined in the remaining two
• In June Neath Port Talbot was again the best performer, achieving 82%
• The most significant improvement in performance from May to June was in Mental Health & Learning Disabilites (81% in June compared with 71% in May)

What actions are we taking?

• The Executive Medical Director (MD) has asked Unit Medical Directors (UMDs) to consider how, and by whom, discharge summaries are completed and to invite members of the clinical teams other than doctors to contribute to them to ensure the highest quality and timely summary gets to the patient's GP.
• The Executive MD and the relevant UMDs has met with T&O Leads at Morriston and POWH to emphasise the need to prioritise discharge summaries.
• Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician' Associate role could improve communication
• The primary measure being used in Princess Of Wales Hospital is % discharge summaries completed within 24hrs of discharge. There have been notable improvements on individual wards

• Risk to patient care and the need for readmission.

How do we compare with our peers?

ABMU is the only health board to publish its performance

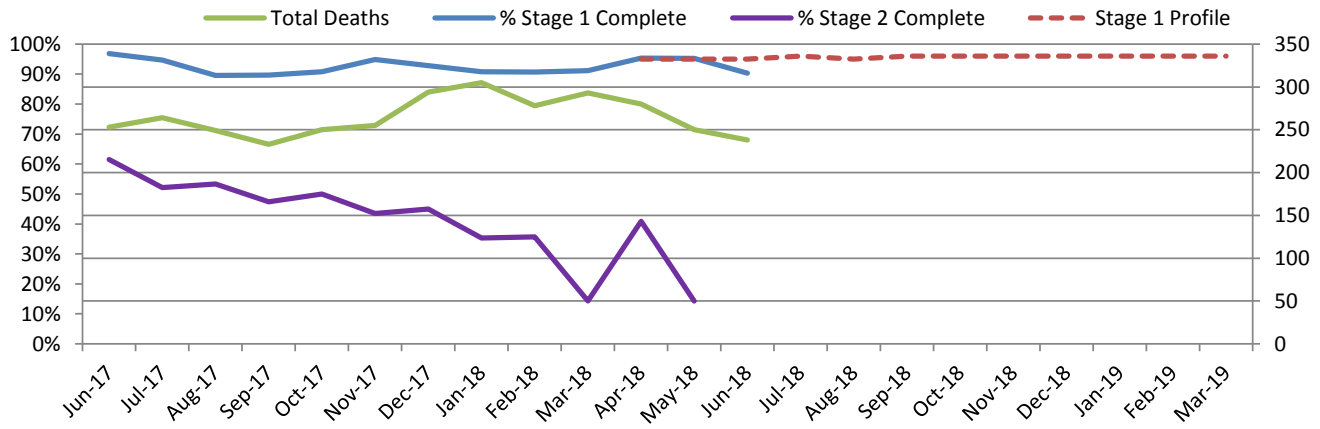
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

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

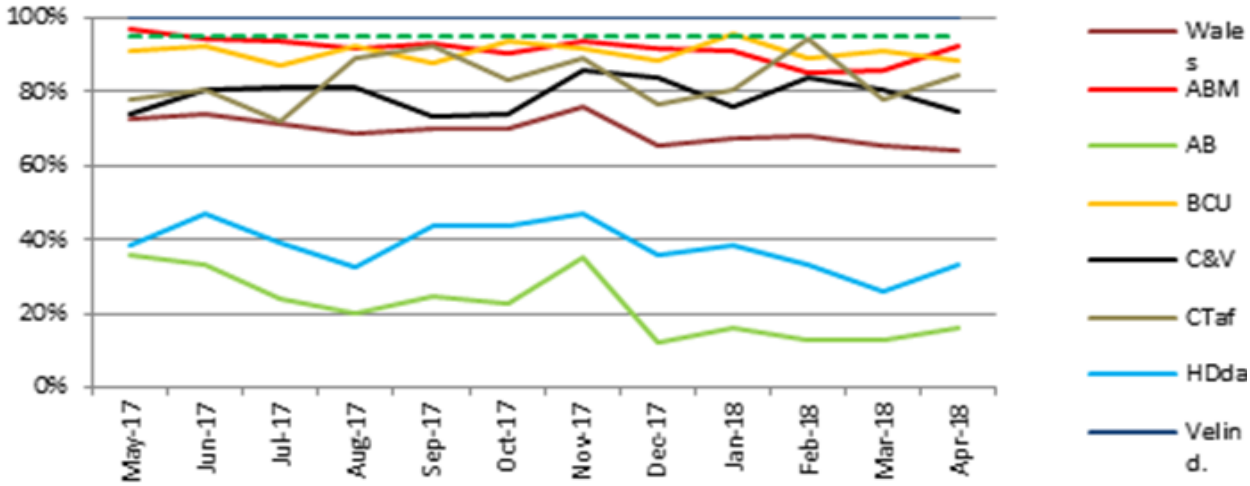
Current Trend: Jun 17 - Jun 18

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



Benchmarking

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



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

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

How are we doing ?

• Welsh Government Mortality Review Performance - ABMU achieved 92.5% completion of UMRs within 28 days of death in April. The overall Wales compliance was 64.4%
• The Health Board UMR rate in June was 90%, 5% lower than April & May
• Singleton and Neath Port Talbot Hospital (NPTH) achieved 100%, Princess of Wales Hospital (POWH) 94.5% and Morriston 84%.
• There were 23 missing UMR forms, 19 in Morriston and 4 in POWH. 9/19 in Morriston were in General Medicine. 5/23 of the missing forms were from Palliative Medicine
• 15 deaths triggered a Stage 2 review in June
• Completion of Stage 2 reviews within 8 weeks (April deaths) was 41%. There are 80 outstanding Stage 2 reviews from April 2017 - March 2018. 40/80 (50%) from Morriston & 28/80 (35%) from POWH.
• Mental Health and Community data are unavailable via the eMRA application at present. This is being addressed by Informatics.
• Thematic (Stage 3) reviews - Nothing untoward was found in the majority of thematic reviews. Where a theme is identified, infection remains the most common, often pneumonia in elderly patients

What actions are we taking?

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

What are the main areas of risk?

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

How do we compare with our peers?

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

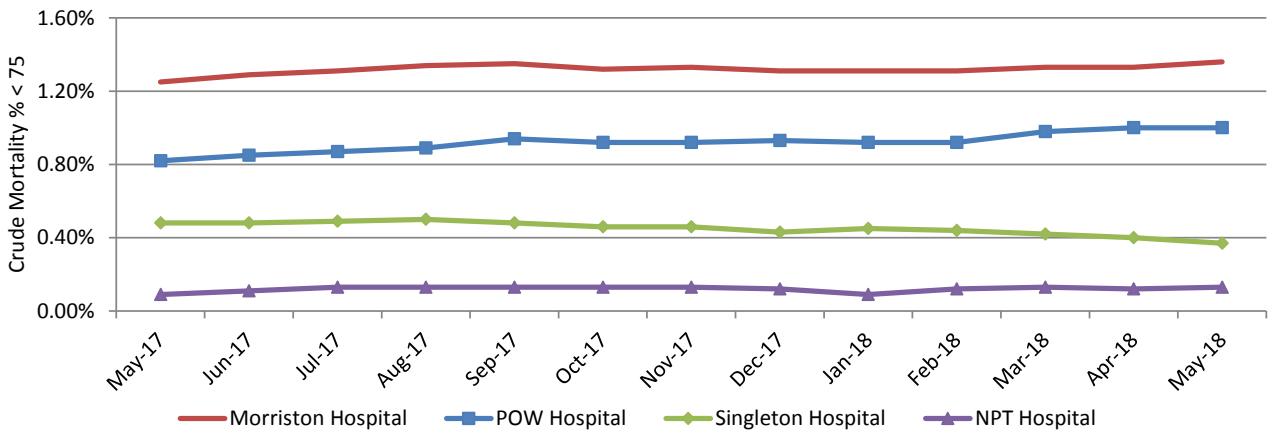
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing
Period : May 2018	IMTP Profile Target :	WG Target : 12 month reduction trend	Current Status : ✗
Movement : ↑ ● Worsening			

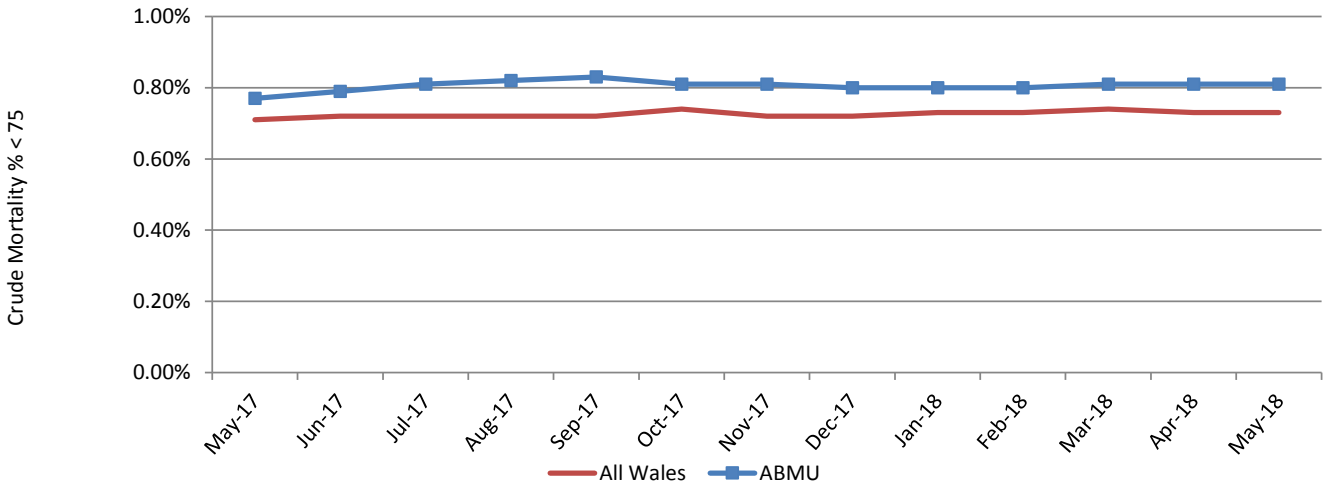
Current Trend: May 17 - May 18

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



Benchmarking

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



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

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

How are we doing ?

• The ABMU Crude Mortality Rate for under 75s in the 12 months to May 2018 was 0.82%, compared with 0.78% for the same period last year
• Site level performance is as follows: (previous year in brackets) Morriston 1.36% (1.24%), Princess of Wales 1.00% (0.82%), Neath Port Talbot 0.13% (0.09%), Singleton 0.37% (0.48%). Site comparison is not possible due to different service models being in place.
• There were 92 in-hospital Deaths in this age group in June 2018 compared with 97 in June 2017: Morriston 43 (53), Princess of Wales Hospital 29 (21), Neath Port Talbot Hospital 1 (4), Singleton 20 (18).
• The number of deaths for Surgical and Elective cases remains consistently low for this age group.
• In the last 12 months the mortality rate at Princess of Wales has risen. Analysis undertaken has shown the number of deaths is not increasing but just demonstrating natural seasonal variation, while the number of patient episodes (the denominator in the calculation) has noticeably decreased. There are two reasons for this, the first being a change of process – some dermatology cases were being incorrectly recorded as day cases, while at other sites they were being recorded as outpatients which are not included in the calculated rate. Secondly, there are currently missing obstetric episodes which the Maternity Service have agreed to retrospectively input. This will increase the number of episodes included in the calculated rate.

What actions are we taking?

• A mortality report is considered by Clinical Outcomes Group (COG), chaired by the Executive Medical Director (EMD).
• Each Service Delivery Unit (SDU) continues to receive Mortality Reports enabling them to monitor mortality in the Unit, and to allow each Unit Medical Director to feedback learning from the mortality review process and review of fluctuations in their mortality data, to the Clinical Outcomes Group (COG). Delivery units are requested to present to COG in rotation at the meeting. Neath Port Talbot SDU presented in the June meeting and no concerns were identified.
• The Units are expected to continue to review Mortality data via the Mortality Dashboard. Information and analysis for Universal Mortality Reviews, Stage 2 mortality reviews and thematic mortality reviews undertaken by Unit Medical Director Process continues to be available on a daily basis via the Mortality dashboard.
• Thematic, Stage 3 reviews of completed Stage 2 mortality reviews up to the end of March 2018 demonstrated that in the majority of cases nothing untoward was noted. Infections are still the most frequent theme, usually pneumonia in elderly patients
• A proposal to ensure that as many Stage 2 mortality reviews as possible are completed promptly following the patient's death to maximise learning was presented to the Quality & Safety Committee (Q&SC) in December and agreed. Good progress has been made in completing outstanding Stage 2 reviews in Morriston and NPTH but slower than anticipated in POWH and Singleton. Unit Medical Directors have been asked by the Exec MD to ensure that the backlog is completely cleared by the end of May. However, there are still a number of outstanding Stage 2s awaiting completion

What are the main areas of risk?

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

How do we compare with our peers?

• ABMU are above the all-Wales Mortality rate for the 12 months to May 18 – 0.82% compared with 0.73%.
• ABMU is the best Performing Health Board in respect of UMRs completed within 28 days of the patients death (94%). All-Wales compliance was (72%)

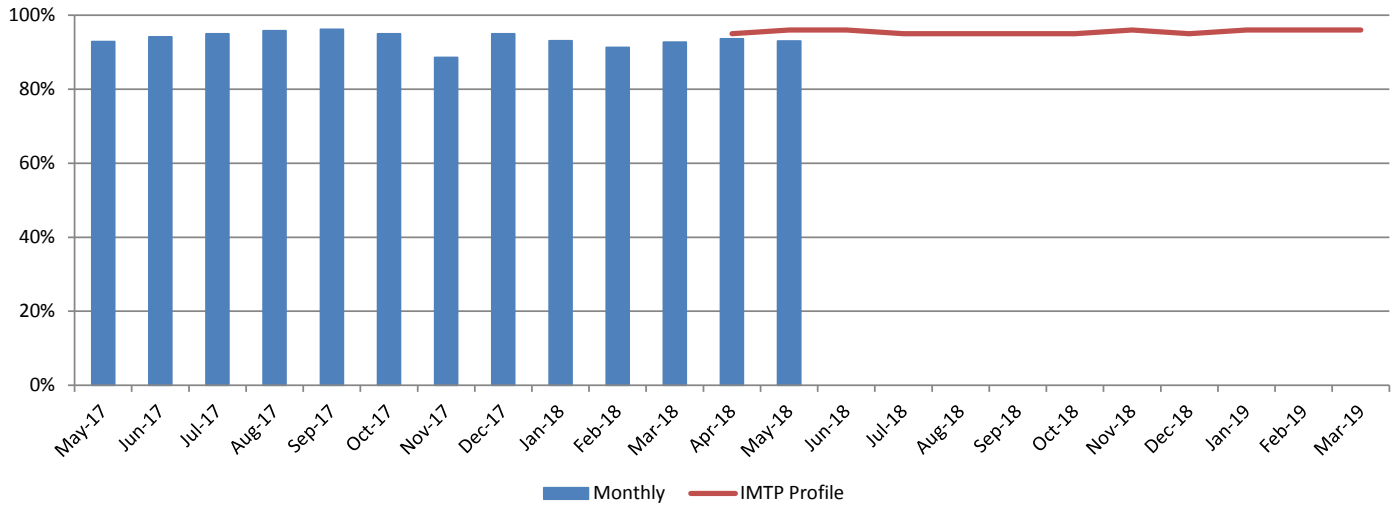
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing
Period : May 2018	IMTP Profile Target : 96%	WG Target : 95%	Current Status : ✖
			Movement : ↓ Worsening

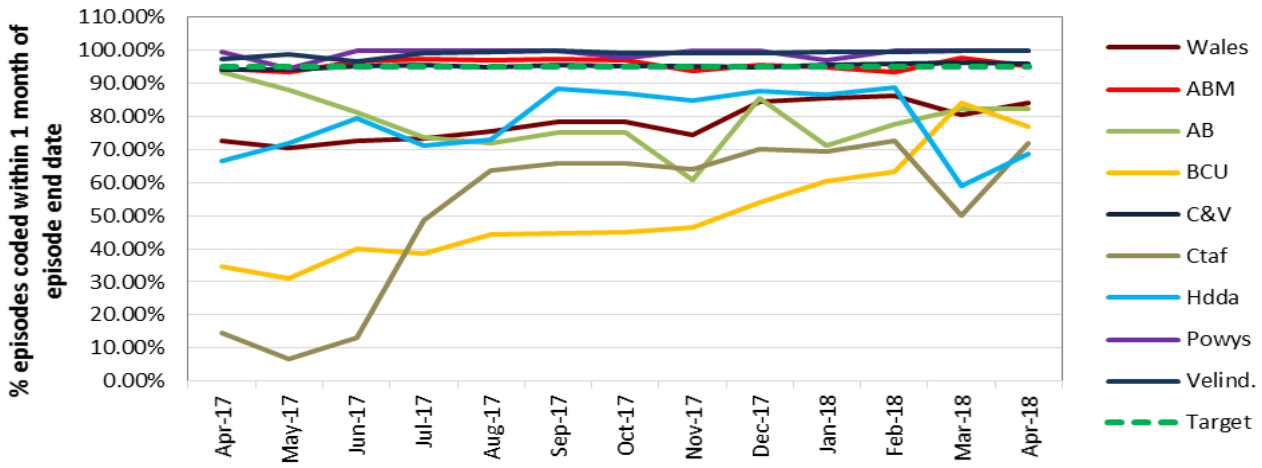
Current Trend: May 17 - May 18

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



Benchmarking

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



Source : NWIS Clinical Coding Extract JUNE 2018

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

How are we doing ?

• The completeness within 30 days for 2018/19 (snapshot positon) was, April 94%, May 93%.
• The department has achieved overall cumulative coding completeness for 2018/2019 as follows: April - 98%, May 93%
• Therefore despite narrowly missing the in month compliance by a number of days the cumulative position is hitting the required performance levels. The IMTP profile is not currently being met as it was set above the national WG target and will be achieved once the trainees are qualified.
• The NHS Wales Informatics Service (NWIS) national audit team carried out coding accuracy audits across all four main acute hospital sites during 2017. The Health Board has now received the full audit report and findings. The percentage compliance for the Health Board has improved from 90.2% to 93% in accuracy. ABMU compares favourably with peers and is the highest ranked Health Board. The accuracy rate will provide assurance of the quality of the coding completed during the period, particularly as during this time there has also been a considerable improvement in efficiency and coding completeness target. The findings and recommendations will be incorporated into the Clinical Coding audit and development plans for 2018/19.

What actions are we taking?

• Review of roles and responsibilities in the department to ensure that processes are performing at optimum levels.
• Continued training of the 6.5 WTE permanent staff which will address the completeness in month once staff are trained and competent - end of 2018.
• Experienced coders are undertaking overtime to support the overall performance and effectiveness of the clinical coding service.

What are the main areas of risk?

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

How do we compare with our peers?

The indicator above is now showing performance against the new target introduced for 2016/17 - 95% complete within 1 month (shown as a snapshot). ABMU is one of the top performing. Health Boards. Currently WG cannot identify the date coded field in the APC extract and therefore the national coding extract is taken 2 weeks after the Health Board position is captured, therefore improving the completion compliance. As a result national reporting of ABMU compliance is higher than that reported internally. ABMU records and monitors the target correctly. NWIS are reviewing the APC extract to address this discrepancy.

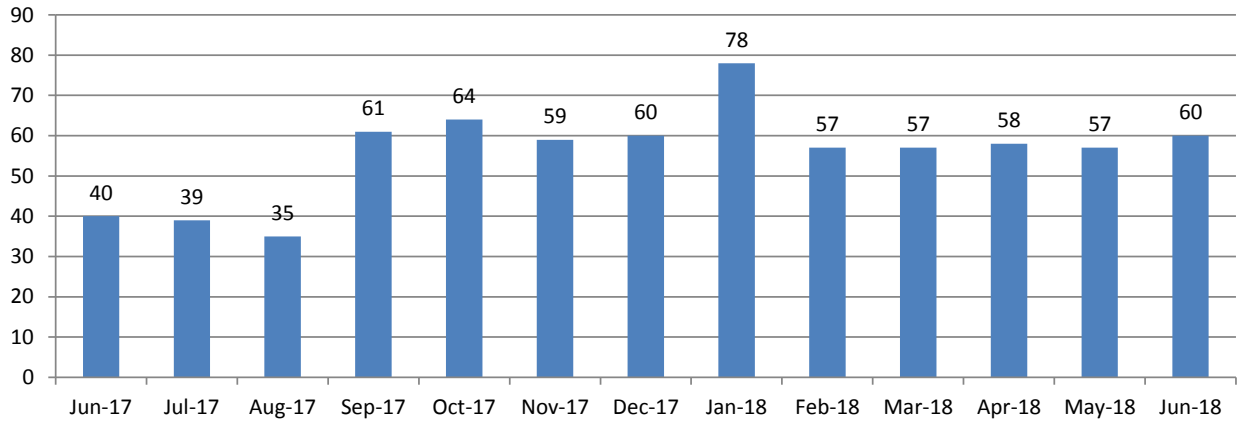
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of risks with score ≥ 20

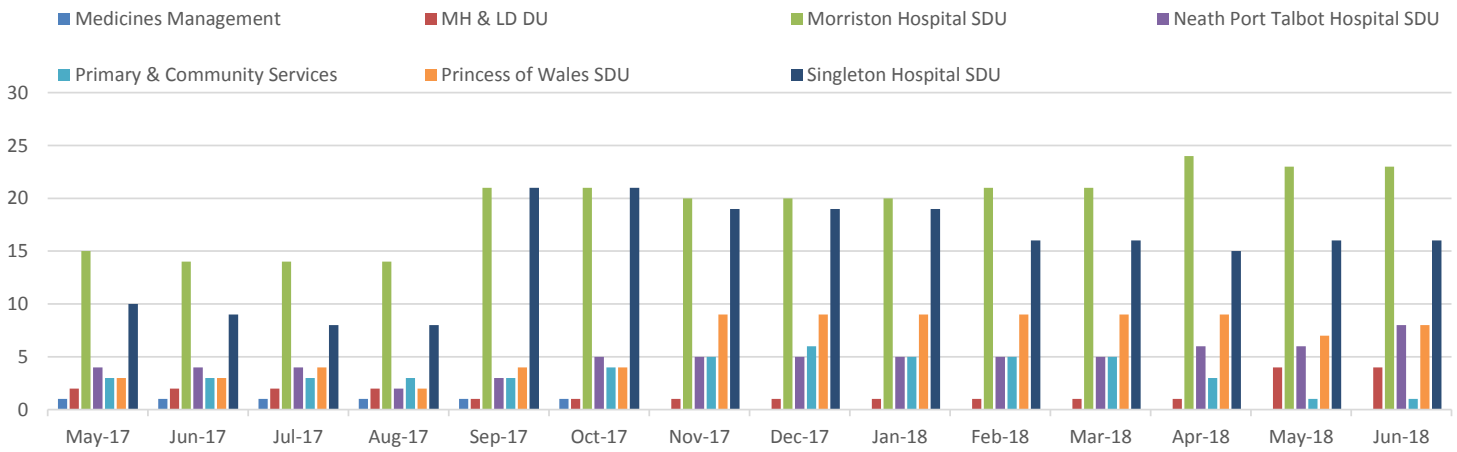
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Gareth Howells	
Period : June 2018	**IMTP Profile Target : Reduce**	**Local Target : Reduce**	**Current Status :** ✖	**Movement :** ⬆ ● **Worsening**

Current Trend: Jun 17 - Jun 18

(1) Number of risks with score ≥ 20



(1) Number of risks with score ≥ 20 (by Service Delivery Unit)



Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of risks with score ≥ 20

How are we doing ?

• 60 operational risks, rated 20. An increase from 57 in March 2018.
• Morriston Unit has the highest number of risk rates 20 (23).
• The New Risks are as follows:
-1570 POWH Retention and turnover in leadership team roles (management and nursing)
Increased turnover in posts within the leadership team including matron level and service (and junior managers).
-1582 NPTH Singleton walk in refrigerators
The two walk in fridges are over 20 years old. Value of stock is approximately £0.5M and failure would result in significant cost to the HB and potentially failure to be able to supply medication to patients.
-1547 NPTH Batch isolator manufacturing capacity at Pharmacy Sterile Services Unit (PSSU) Morriston. The Machaire isolator (M1) at Morriston Hospital is condemned. The unit produces batches of medication that are used on our neonatal wards. These batches are critical batches as there are no off the shelf alternatives and cannot be outsourced to other manufacturing units

What actions are we taking?

The Board have approved the initiation of a Risk Management Committee to manage and scrutinise risk across the Health Board. The first meeting will be held July 16th 2018 to agree the terms of reference, the Board Assurance Framework and review the corporate risk register. A letter has been sent to Chairs of several Health Board committees (Medicines Safety Group, Medical Devices Committee, Work Force and OD Committee, Health and Safety Committee) from the Head of Patient Experience, Risk, and Legal Services to review and scrutinise appropriate risks. A further review of Datix Risk module is underway to ascertain if there are further committees risks can be allocated to.

What are the main areas of risk?

The highest risks on the register are rated 20 and remain and relate to:
• Workforce planning and ensuring appropriate levels of skilled staff are in place within the Health Board linked to the Health Boards objective Sustainable Workforce. The controls in place and actions being taken to decrease the risk are provided within the entry on the Corporate Risk Register for the risk identified. A letter has been sent to the Board and Workforce and OD Committee receive regular updates on this risk.
• Emergency Department (ED) Clinical Systems. There is an increased risk of system failure in the clinical systems at Princess Of Wales Hospital and Morriston SDU. Full details are provided on the Corporate Risk Register.
• Discharge Information. If patients are discharged from hospital without the necessary information being made available then there is a risk in relation to the continuation of their care to a high standard.
Please note that risk ED Clinical Systems and Discharge Risks will be subject to review as part of a wider review of informatics risks and how they are managed and prioritised.

How do we compare with our peers?

No comparable data available.

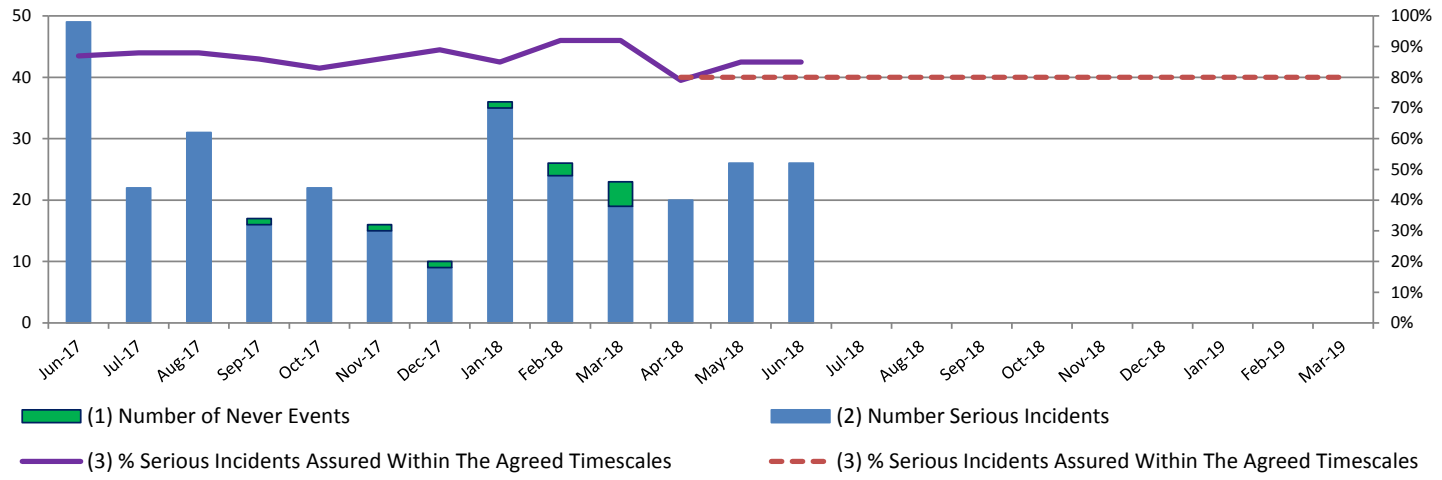
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Gareth Howells	
Period : June 2018	IMTP Profile Target : (1) 0, (2) Improve, (3) 80%	WG Target : (1) 0, (2) Improve, (3) 90%	Current Status : N/A	Movement : Worsening

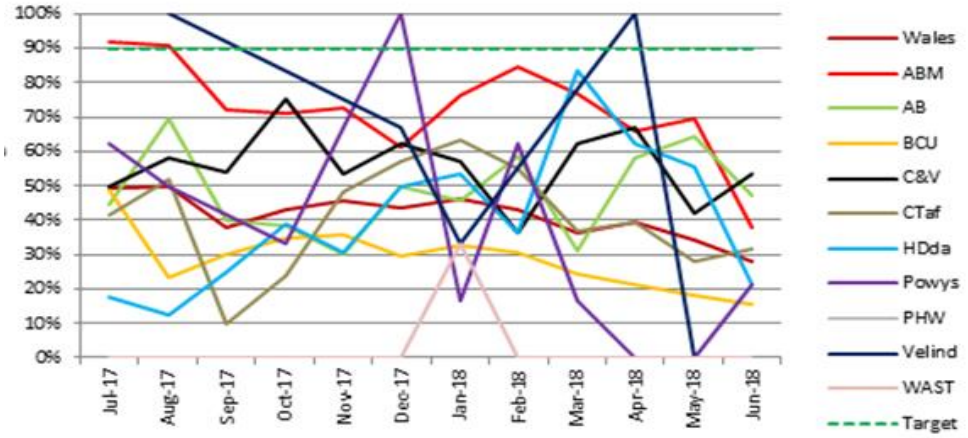
Current Trend: Jun 17 - Jun 18

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



Benchmarking

Serious Incidents Assured Within The Agreed Timescales



Never Events

Jun-18	
Wales	2
ABM	0
AB	0
BCU	1
C&V	0
Ctaf	0
Hdda	1
Powys	0
PHW	0
Velind	0
WAST	0

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

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

How are we doing ?

SI Scorecard – completed on 16th July 2018.
Total number of incidents reported in June 2018 was 2,134. This compares to 2,132 incidents reported in June 2017, an increase of 2 incidents for the month of June (increase of 0.1%).

• 26 Serious Incidents were reported to Welsh Government (WG) in June 2018 representing 1.2% of all incidents. In comparison, 49 SI's were reported to WG in June 2017, a decrease of 23 incidents. This decrease is not of concern as the increased number report in June 2017 was following audit of pressure ulcer incidents. Of the 26 new serious incidents reported to WG in June 2018, 20 (77%) related to pressure ulcer incidents (grade 3 and above), 4 (15%) related to patient falls, 1 (4%) related to Diagnostic Processes/Procedures and 1 (4%) related to Infection control.
• In terms of severity of incidents, the percentage of incidents resulting in severe harm for June 2018 was 0.6% (total incidents reported 2,219). The Health Board's target for incidents resulting in severe harm is 0.5% of the total number of incidents reported.
• No Never Events were reported in June 2018.
• Performance against the WG target of closing SI's within 60 working days for June 2018 was 85% against the WG target of 80%

What actions are we taking?

The SI Team continues to trial the new reflective methodology approach to review serious incidents managed by the SI Team. Presentations promoting the approach are being undertaken across the Health Board to help promote an organisational learning culture. External presentation at Powys Health Board is also planned.
The SI Team are leading on work to reduce variation in approaches to falls investigations. This includes the development of guidance to support reporting, investigation and learning from falls related incidents that resulted in severe harm. New investigation templates to support this work are currently being developed.

What are the main areas of risk?

• Maintaining Welsh Government 80% target closure date whilst ensuring quality of investigation reports and robust learning from the incidents.
• Differences between WG data and HB data.

How do we compare with our peers?

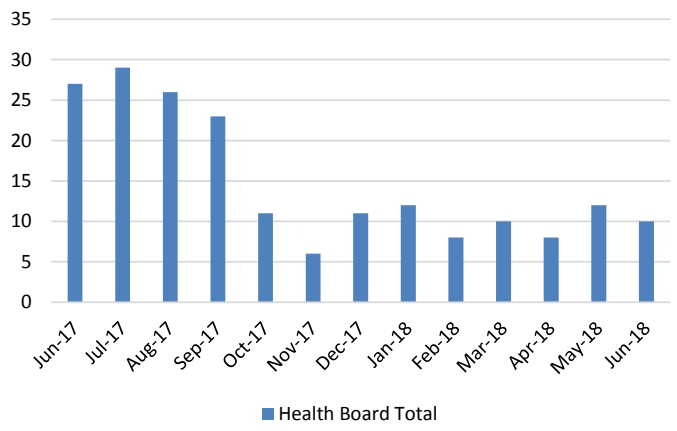
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of Safeguarding Adult referrals relating to Health Board staff/ services
Measure 2: Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit
Measure 3: Themes of Safeguarding Adult (POVA) reports (Health Board Total)
Measure 4: Themes of Safeguarding Adult (POVA) reports by Service Delivery Unit

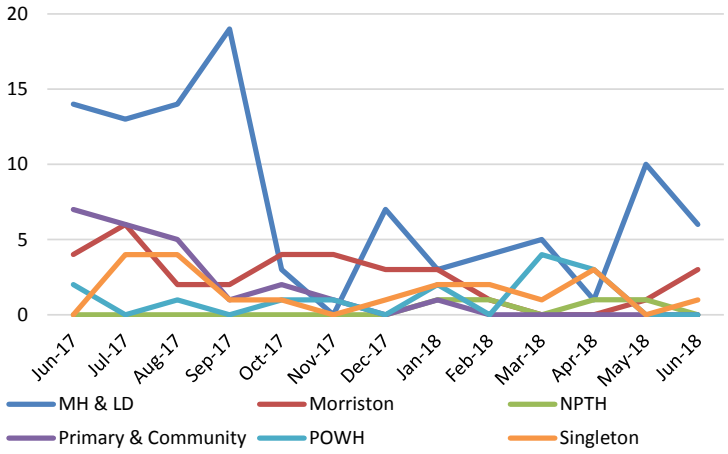
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Gareth Howells	
Period : June 2018	IMTP Profile Target : N/A	Local Target : (1) (2) Reduce (3) (4) Monitor	Current Status : ✓	Movement : Improving

Current Trend: Jun 17 - Jun 18

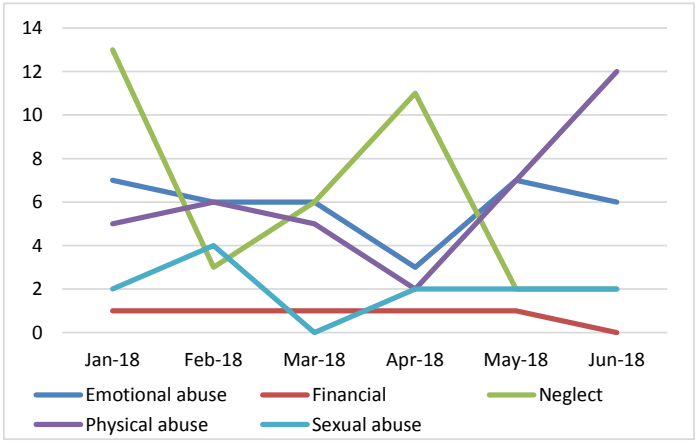
(1) Number of Safeguarding Adult referrals relating to Health Board staff/ services (Health Board Total)



(2) Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit



(3) Themes of Safeguarding Adult (POVA) reports (Health Board Total)



(4) Themes of Safeguarding Adult (POVA) reports by Service Delivery Unit

Jun-18					
	Emotional abuse	Neglect	Physical abuse	Sexual abuse	Total
MH & LD SDU	5		11		16
Morriston Hospital SDU		1	1	1	3
NPT Hospital SDU		1			1
Princess of Wales SDU	1				1
Singleton Hospital SDU				1	1
Total	6	2	12	2	22

Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Adult referrals relating to Health Board staff/ services
Measure 2: Number of Safeguarding Adult referrals relating to Health Board staff/ services by Service Delivery Unit
Measure 3: Themes of Safeguarding Adult (POVA) reports (Health Board Total)
Measure 4: Themes of Safeguarding Adult (POVA) reports by Service Delivery Unit

How are we doing ?

• The Safeguarding Adults report cards have been revised to more accurately reflect safeguarding activity for adults at risk across the Health Board by reporting on adult at risk referrals that have been made rather than safeguarding adult incidents.
• The number of safeguarding adult at risk referrals has reduced and remained at a relatively consistent level since September 2017; this is likely to be attributable to continued education of staff to understand legislative requirements to report adults at risk appropriately and identify alternative processes to utilise should the adult not meet the definition of an adult at risk.
• Mental Health & Learning Disabilities Service Delivery Unit consistently have the highest number of adult at risk referrals which is expected due to the complexities and vulnerabilities of their client group.

What actions are we taking?

• Service Delivery Units are now all required to report on lessons identified from closed safeguarding cases on their unit performance reports in order to share learning across the Health Board.
• Revision of the report cards will allow improved monitoring of themes and trends of adult safeguarding cases across the Health Board, which will be reported and analysed in the Corporate Safeguarding Bi-annual report.

What are the main areas of risk?

• Achieving legislative requirements of timescales to complete initial enquiries for safeguarding adult referrals – this is recorded within the Corporate Safeguarding Team, and Service Delivery Units are required to report breaches on their performance reports.
• The Health Board is engaging with the 3 Local Authority areas to implement a robust process in order to fulfil its duty to report adults at risk to the Local Authority.

How do we compare with our peers?

Peer information is not available for comparison

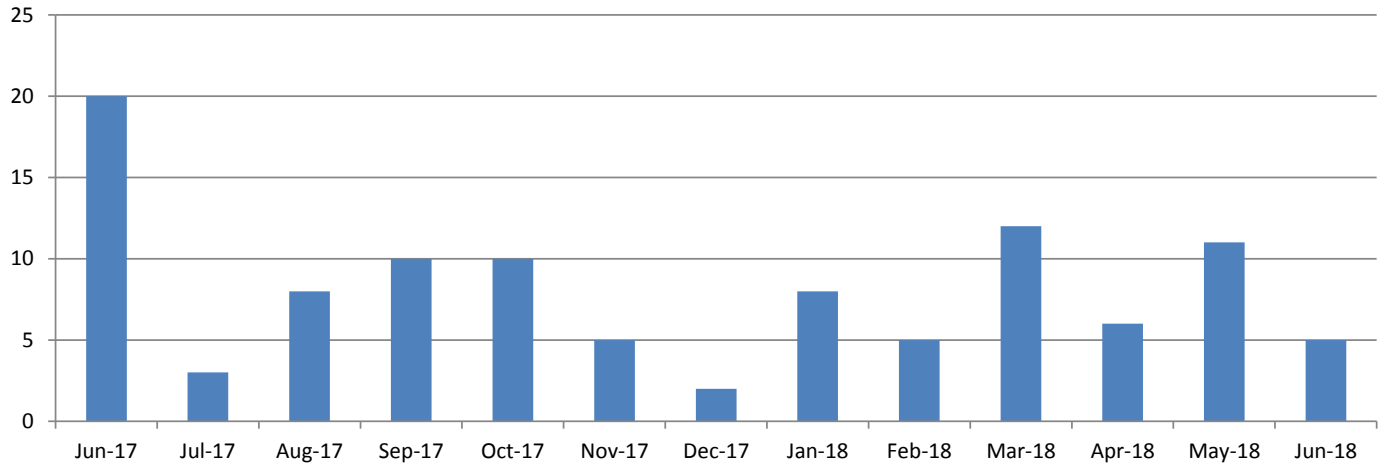
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of Safeguarding Children Incidents

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Gareth Howells	
Period : June 2018	IMTP Profile Target : N/A	Local Target : 0	Current Status :	Movement : Improving

Current Trend: Jun 17 - Jun 18

(1) Number of Safeguarding Children Incidents



(1) Number of Safeguarding Children Incidents

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
MH & LD SDU	1	2	0	0	1	0	1	3	3	0	0	4	1
Morriston Hospital SDU	3	0	0	1	0	0	1	1	0	1	0	2	1
NPT Hospital SDU	2	0	0	0	0	1	0	1	0	0	0	1	0
Primary & Community SDU	3	1	4	3	2	0	0	0	0	4	1	2	2
Princess of Wales SDU	7	0	2	4	4	2	0	2	1	1	1	0	1
Singleton Hospital SDU	4	0	2	2	3	2	0	1	1	6	4	2	0
Health Board Total	**20**	**3**	**8**	**10**	**10**	**5**	**2**	**8**	**5**	**12**	**6**	**11**	**5**

Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Children Incidents

How are we doing ?

• The reporting of Children's incidents remains consistent but remain relatively low numbers with no obvious themes or trends identified over the past two months. Although there was an increase in reporting following the launch of the 'trigger list' in 2017 this has now remained relatively static and it is suspected that there is under reporting of Children's incidents throughout the Health Board (HB).
• Any Health Board safeguarding children referrals to Children's Services in the Local Authority are not captured on the Report Cards but are currently collated using a different method.

What actions are we taking?

• The Children's Trigger list is currently being reviewed to ensure it reflects children incidents accurately. It will be promoted at face to face safeguarding children training in order to promote awareness and improve compliance of reporting through DATiX. In addition the new list will be presented to the Safeguarding Committee in September.
• A snapshot audit of Datix will be undertaken by the Corporate Safeguarding Team to review any underreporting of Children's Incidents and reasons for underreporting.
• A meeting has taken place between the Datix team and the Corporate Safeguarding team with regards to a Data Reporting Tool to capture relevant information from all HB referrals made to Children's Services. This is now in the process of being developed and a further meeting has been arranged. Anticipated date of completion December 2018.

What are the main areas of risk?

• There is currently no robust method to capture all Safeguarding Children activity across ABMU HB within Datix reporting. The Service Delivery Unit do report on any Safeguarding Children's referrals within their bi-monthly performance reports to the Safeguarding Committee but these too are not reflective of all activity.

How do we compare with our peers?

Comparison data from peer organisations not available

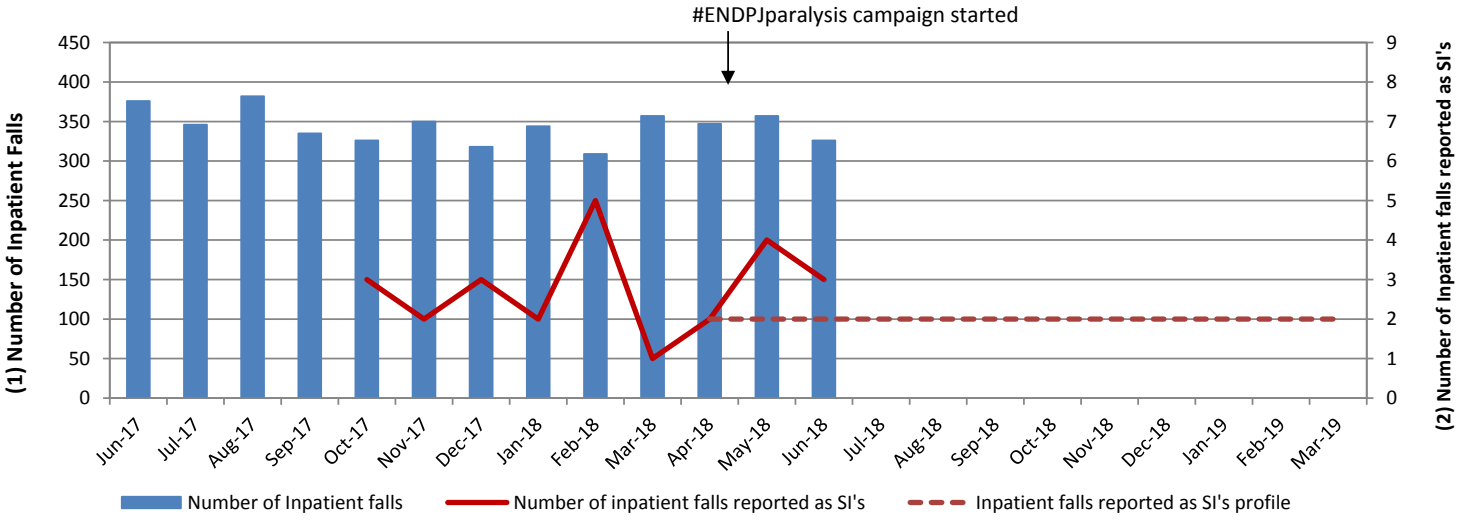
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Total Number of Inpatient Falls
Measure 2: Number of inpatients falls reported as serious incidents

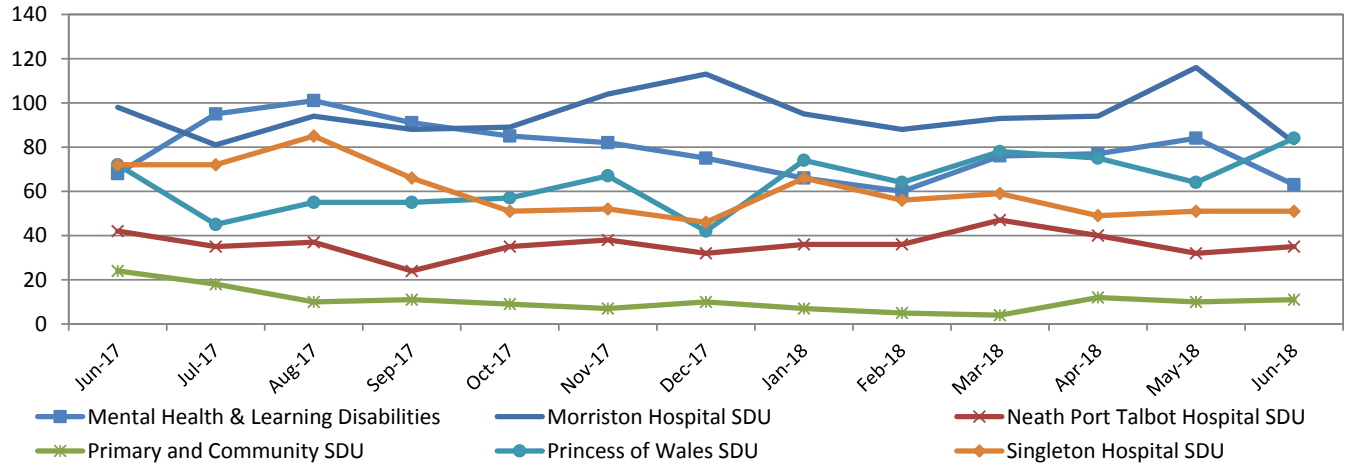
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Gareth Howells	
Period : June 2018	IMTP Profile Target : 12 month reduction trend	WG Target : Reduce	Current Status : ✓	Movement : Improving

Current Trend: Jun 17- Jun 18

(1) Number of Inpatient Falls (2) Number of inpatients falls reported as serious incidents



(1) Number of Inpatient Falls



Benchmarking

Benchmarking data is not available.

Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of Inpatient Falls
Measure 2: Number of inpatients falls reported as serious incidents

How are we doing ?

The number of falls reported via Datix in May 2018 showed an increase of 10 from the figures reported in April 2018; those reported for June 2018 showed a decrease of 31 compared to May 2018. The following Units reported a decrease in all falls recorded via Datix in May, Neath Port Talbot Hospital, Princess of Wales and Singleton, Primary and Community and Mental Health. Morriston reported an increase in falls during this period. In June, Mental Health and Morriston unit's reported a decrease in falls; with Neath Port Talbot Hospital, Princess of Wales and Primary and Community reporting an increase.

What actions are we taking?

The FBMG continues to meet monthly: The Falls Policy was taken to the Health Board Quality and Safety Forum for ratification in July, the Chair of the Q&S forum will take the policy to the Health Board Quality and Safety Committee for ratification. Review of equipment ongoing - hi-lo beds purchased and insitu in Delivery Unit's, currently reviewing hoists.

What are the main areas of risk?

Training needs remain a priority for the Health Board. A baseline audit of manual handling equipment also needs to be revisited. Once policy ratified a comprehensive implementation plan will be developed requiring sign up by multidisciplinary teams

How do we compare with our peers?

Annual work plan updated for 2018/19 to include recommendations from the National inpatient falls audit. Plan will be monitored by the FPMG

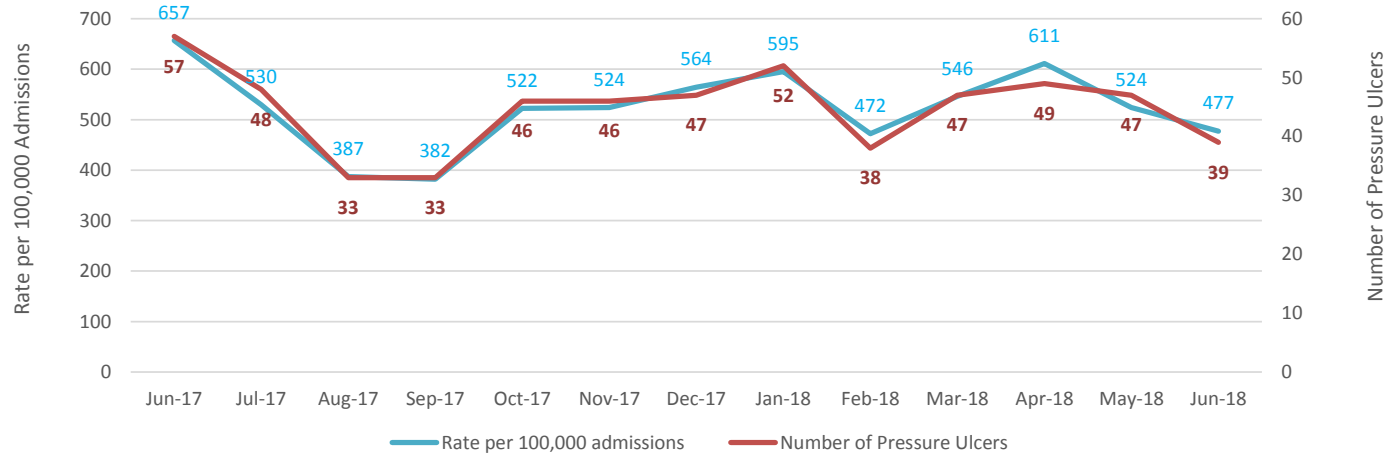
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

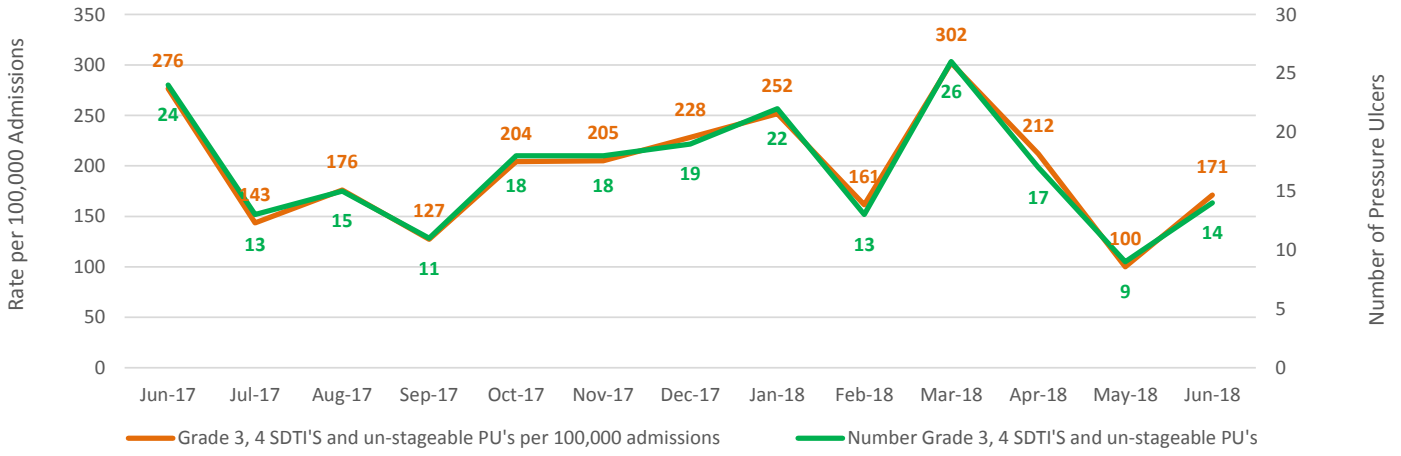
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Gareth Howells	
Period : June 2018	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Improving

Current Trend: Jun 17 - Jun 18

(1) Total Pressure Ulcers acquired in hospital.



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



Benchmarking

No benchmarking data available

Source : PRESURE ULCERS FROM DATIX and ADMISSIONS FROM MYRDDIN

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

How are we doing ?

• The "In Hospital" acquired Pressure Ulcers are reported as a rate per 100,000 hospital admissions to comply with the requirements of the NHS Wales Delivery Framework. The number of pressure ulcer incidents is also included to enable comparison with the reported measure of per 100,000 admissions.
• There has been a decrease in the rate of pressure ulcer development for in-patients during June 2018. The rate per 100,000 admissions fell from 524 in May to 477 in June 2018. This reflects a decrease in the number of pressure ulcers developing from 47 in May 2018 to 39 in June 2018.
• More than one pressure ulcer developed in 4 patients during June 2018, accounting for 8 of the pressure ulcer incidents reported.
• Device related pressure ulcers account for 2 of the reported pressure ulcers in June, a decrease from the 5 reported in May 2018.
• The rate of Grade 3+ pressure ulcers has increased from 100 per 100,000 admissions in May, to 171 per 100,000 admissions in June 2018.
• Comparison with the same period last year indicates significant reduction in the rate per 100,000 admissions of Grade 3+ incident reports, from 276 in June 2017 to 171 in June 2018
• Of the 14 Grade 3+ pressure ulcer incidents reported in June, 2018, 2 were classified as deep damage and met the criteria for Serious Incident reporting.

What actions are we taking?

• The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) was held in June 2018. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
• An Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 was presented at PUPSG in June. The review examined 164 incidents and identified 23.2% cases as being avoidable and 65.5% as unavoidable.
• The review utilised the causal factor map developed by PUPSG and offers strong assurance that it is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The causal factor analysis also provides insight for individual Service Delivery Unit's (SDU's) to focus on location specific work.
• The most common causal factor for avoidable pressure ulcers was identified as inadequate frequency of patient repositioning. The revised Prevention and Management of Pressure Ulcers Policy clearly identifies the minimum requirement for repositioning for in-patients.
• Singleton Hospital is the pilot site for the development of a local strategic quality improvement plan. Progress on the plan was presented to the PUPSG in June 2018.
• Pressure Ulcer Investigator and Scrutiny Panel Development workshops have been delivered across the Health Board to support and develop the skills of senior staff involved in the new pressure ulcer investigation and scrutiny process that went live on Datix on June 4th 2018. Attendance was excellent and 149 senior staff attended.
• Pressure Ulcer Peer Review Scrutiny Panels are held in all Service Delivery Unit's and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
• Datix scrutiny was conducted for June 2018 data, duplicate entries were identified and the data rectified to ensure accuracy.

What are the main areas of risk?

How do we compare with our peers?

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

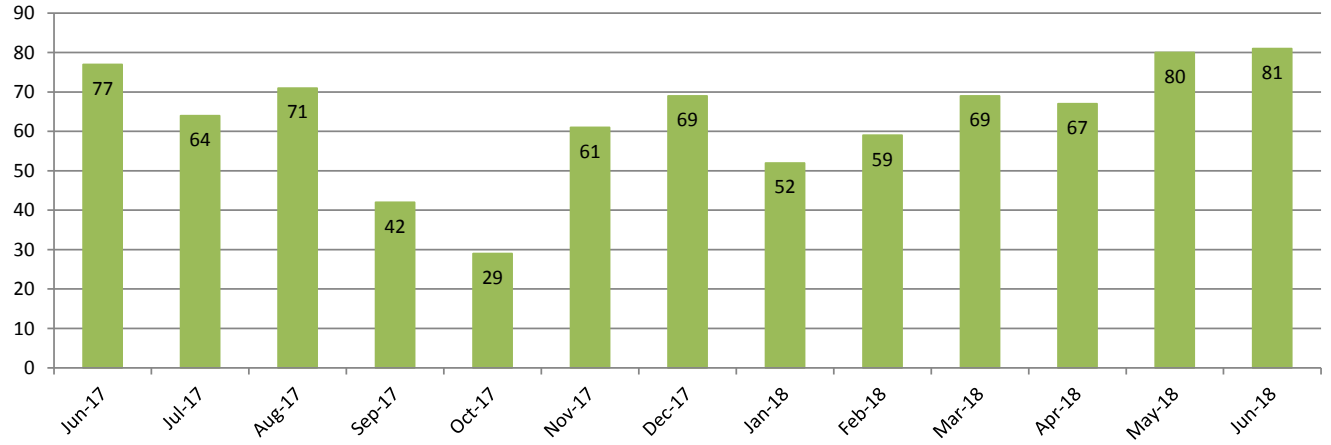
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

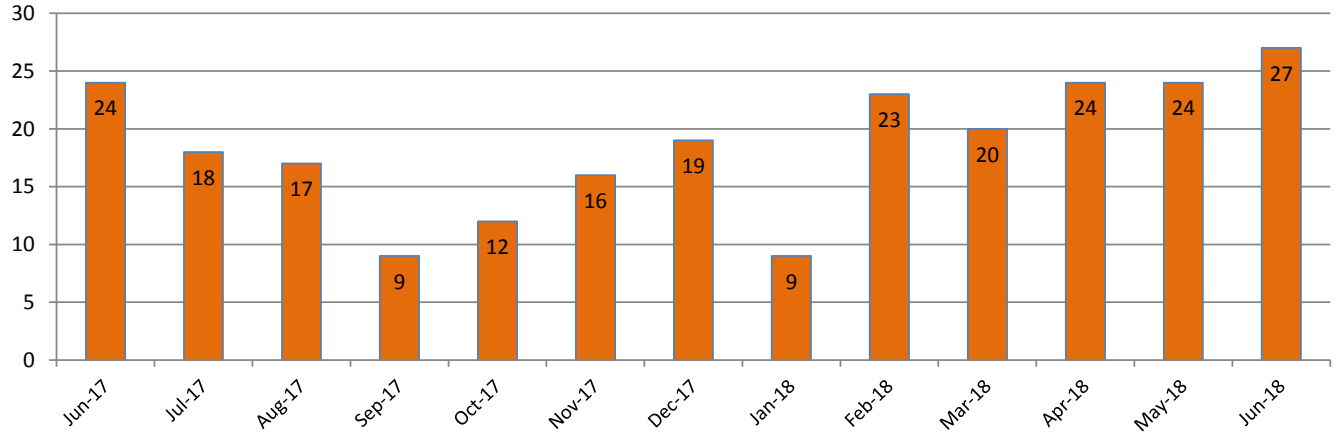
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Gareth Howells	
Period : June 2018	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : ✖	Movement : ⬆ Worsening

Current Trend: Jun 17 - Jun 18

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



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



Benchmarking

No benchmarking data available.

Source : PRESURE ULCERS FROM DATIX

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

How are we doing ?

• During June 2018, 81 incidents of pressure ulceration were reported in the community, this is an small increase compared to the 80 incidents reported in May 2018 .
• More than one pressure ulcer developed in 9 patients during June 2018, accounting for 19 of the pressure ulcer incidents reported.
• Swansea locality reported 36 pressure ulcers, Bridgend locality 28 and Neath Port Talbot locality 17.
• Of the pressure ulcers reported in June, 11 were grade 1 (intact reddened skin). There is an increasing trend for reporting Grade 1 damage indicating improved skin inspection and recognition of the early stage of injury to the skin .
• Device related damage accounts for 10 pressure ulcers, of those 3 were caused by devices owned by patients.
• There has been a increase in the number of Grade 3+ pressure ulcers reported, from 24 in May to 27 in June 2018.
• Of the Grade 3+ pressure ulcers reported in June, 15 were considered deep damage and met the criteria for Serious Incident (SI) reporting.

What actions are we taking?

• The Pressure Ulcer Prevention Strategic Group meeting (PUPSG) was held in June 2018. PUPSG are continuing to work closely with Welsh Risk Pool to deliver the Health Board Pressure Ulcer Strategic Quality Improvement Plan.
• An Independent review of Welsh Government Serious Incident reportable pressure ulcers for 2017-18 was presented at PUPSG in June. The review examined 164 incidents and identified 23.2% cases as being avoidable and 65.5% as unavoidable.
• The review utilised the causal factor map developed by PUPSG and offers strong assurance that it is a valid tool for the identification of work streams to reduce avoidable pressure ulcers. The causal factor analysis also provides insight for individual SDU's to focus on location specific work.
• The most common causal factor for avoidable pressure ulcers was identified as inadequate frequency of patient repositioning. The revised Prevention and Management of Pressure Ulcers Policy clearly identifies the minimum requirement for repositioning for in-patients. However, the frequency of repositioning in patient's homes is sometimes challenging due to patient choice and the availability of care services.
• Pressure Ulcer Peer Review Scrutiny Panels are held in all localities and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting. NPT locality has the most established scrutiny panel process and has seen a significant improvement in pressure ulcer prevention.
• Pressure Ulcer Investigator and Scrutiny Panel Development workshops have been delivered across the Health Board to support and develop the skills of senior staff involved in the new pressure ulcer investigation and scrutiny process that went live on Datix on June 4th 2018. Attendance was excellent and 149 senior staff attended.
• Education for pressure ulcer prevention and classification of pressure ulcers remains an ongoing priority. Bespoke sessions are delivered by TVN's to community staff, carer organisations and care homes on a rolling programme.
• The Governance team continue work to improve the validity of the Datix incident data to reduce errors and duplicate reports.

What are the main areas of risk?

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

How do we compare with our peers?

No benchmark data available.

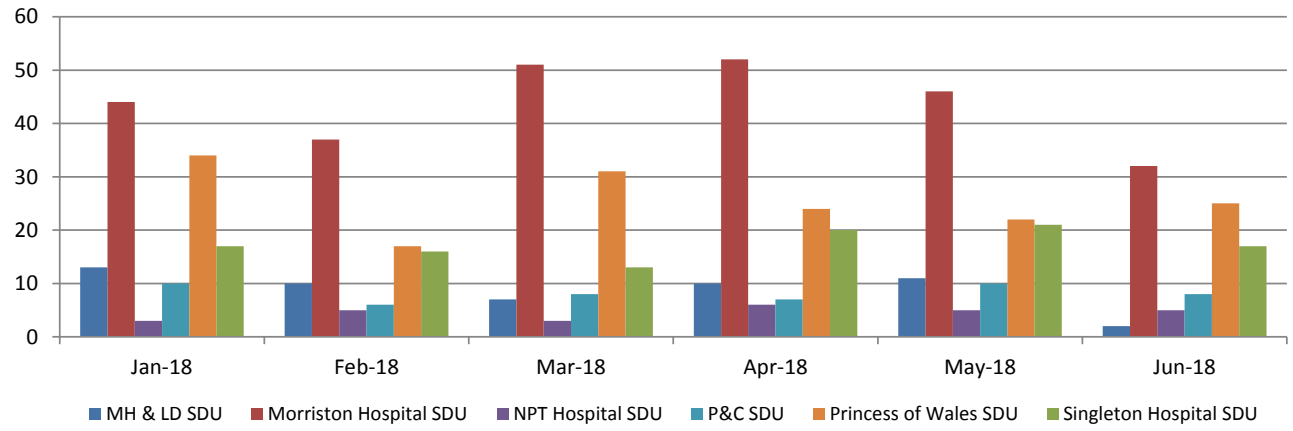
DIGNIFIED CARE: PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

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

Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Gareth Howells	
Period : Jun 2018	IMTP Profile Target : Reduce	WG Target : (1) Monitor, (2) 80%	Current Status : N/A	Movement : Worsening

Current Trend: Jun 17 - Jun 18

(1) Number of new formal complaints received.



(2) % of responses sent within 30 working days

% of responses sent within 30 working days	2017								2018				
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
MH & LD SDU	44%	71%	86%	100%	64%	75%	71%	88%	60%	50%	33%	71%	100%
Morriston Hospital SDU	93%	86%	88%	78%	84%	86%	75%	88%	76%	58%	76%	93%	83%
NPT Hospital SDU	80%	100%	57%	50%	78%	83%	83%	67%	100%	100%	67%	100%	100%
Princess of Wales SDU	100%	83%	83%	81%	68%	67%	62%	64%	93%	60%	74%	75%	90%
P&C SDU	55%	56%	88%	67%	60%	75%	82%	100%	75%	88%	67%	57%	63%
Singleton Hospital SDU	60%	81%	65%	81%	83%	79%	72%	73%	75%	53%	64%	60%	65%
Health Board Total	**77%**	**82%**	**80%**	**80%**	**76%**	**78%**	**73%**	**80%**	**80%**	**61%**	**71%**	**80%**	**83%**

(3) % of acknowledgements sent within 2 working days

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

Benchmarking

Benchmarking data is not available.

Source : COMPLAINTS MODULE FROM DATIX

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

How are we doing ?

• The Health Board received 88 formal complaints in June 2018, this is a decrease of 25 formal complaints compared to 113 for June 2017.
• The overall Health Board response rate for responding to concerns within 30 working days was 83% for May 2018, which is above the Welsh Government target of 80%.
• The Health Board continues to consistently maintain the 2 day acknowledgement target at 100%.
• Patient Advice Liaison Service (PALS) activity for the period April 2018 -June 2018, identified 1,002 contacts of which 2.2% (23) converted to formalised complaints.

What actions are we taking?

• Performance of the 30 day response target is addressed consistently at all Service Delivery Unit (SDU) performance reviews. May performance for the Health Board was 83%.
• Service Delivery Unit's (SDU) identify trends and themes from their formal complaints for discussion at each local Quality and Safety meeting and formal reporting through the Health Boards' Assurance and Learning Group where themes, trends and Health Board actions can be identified and shared for learning. A recurring theme in complaints received continues to be communication. A training programme for communication for all staff grades continues in all SDU's by the Patient Experience Training officer, with further SDU discussions during attendance at Concerns and Redress Group (CRAG).
• Currently there are 33 open Ombudsman investigation cases; Morriston 13, Princess of Wales 9, Singleton 6, Mental Health & Learning Disabilities 3 and ; Primary Care and Community Service 2. Recurring themes from the Ombudsman investigations are discharge process, communication, record keeping and poor complaint handling. The Corporate Concerns function has recently embarked on a re-structure one of the aims of the re structure is to support improvement in the Units and ensure consistency across all of the SDU's in terms of the way the Health Board investigates and responds to complaints. In addition, the Health Board continues to liaise closely with the Ombudsman Improvement Officer and the Community Health Council to discuss on-going investigations. Trends and themes deriving from these interactions will be developed into training and awareness sessions to improve across the Health Board. A new 2018/2019 work plan for Ombudsman referrals has been developed which will be implemented by the newly appointed Ombudsman's Referrals Manager and overseen by the Assistant Head for Concerns Assurance. A key focus on the annual plan will be to demonstrate better learning from the process to help improve future concerns processes.

What are the main areas of risk?

Improve Quality of Complaint responses while achieving the 30 day response rate target, and decrease the number of complaints referred to and upheld by the Public Service Ombudsman.

How do we compare with our peers?

No monthly all Wales data to compare.

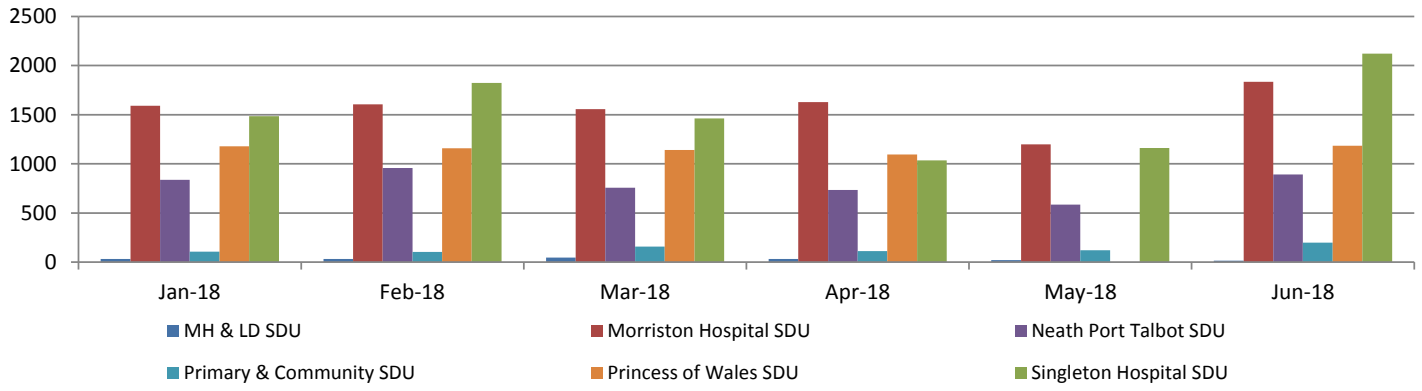
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of friends and family surveys completed
Measure 2: % of who would recommend and highly recommend
Measure 3: % of all Wales surveys scoring 9 or 10 on overall satisfaction

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Gareth Howells	
Period : June 18	IMTP Profile Target :	Local Target : (1) Increase, (2) 90%, (3) 90%	Current Status : ✖	Movement : ⇧ ● Improving

Current Trend: (1) Jan 18 - Jun 18, (2) & (3) Jun 17 - Jun 18

(1) Number of friends and family surveys completed



(2) % of who would recommend and highly recommend

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
MH & LD SDU	61%	87%	69%	76%	87%	84%	65%	73%	91%	76%	72%	52%	79%
Morriston Hospital SDU	94%	93%	93%	94%	94%	94%	92%	93%	94%	93%	94%	94%	94%
Neath Port Talbot SDU	92%	95%	95%	97%	98%	99%	99%	98%	98%	99%	99%	98%	99%
Primary & Community SDU	94%	93%	94%	93%	85%	93%	90%	90%	91%	90%	89%	93%	94%
Princess of Wales SDU	96%	95%	94%	96%	95%	95%	94%	95%	94%	94%	95%	95%	96%
Singleton Hospital SDU	94%	95%	94%	96%	95%	97%	96%	96%	96%	95%	94%	94%	97%
Health Board Total	**94%**	**94%**	**94%**	**96%**	**95%**	**96%**	**95%**	**95%**	**95%**	**95%**	**95%**	**95%**	**96%**

(3) % of All Wales surveys scoring 9 or 10 on overall satisfaction

	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
MH & LD SDU	67%	50%	NS	NS	87%	50%	100%	NS	NS	0%	-	-	
Morriston Hospital SDU	78%	82%	93%	96%	80%	91%	94%	77%	87%	91%	93%	96%	74%
Neath Port Talbot SDU	77%	84%	79%	88%	86%	83%	76%	91%	88%	80%	62%	80%	80%
Primary & Community SDU	88%	100%	94%	100%	86%	94%		95%	100%	93%	92%	97%	
Princess of Wales SDU	82%	81%	75%	78%	80%	80%	77%	79%	69%	79%	87%	82%	86%
Singleton Hospital SDU	82%	90%	87%	82%	84%	81%	85%	79%	84%	79%	85%	86%	90%
Health Board Total	**82%**	**84%**	**85%**	**88%**	**83%**	**84%**	**84%**	**83%**	**87%**	**84%**	**87%**	**89%**	**84%**

NS= No Surveys
Target = 90%

Benchmarking

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
ABMU Response %	17.2%	22.4%	24.1%	27.5%	28.9%	27.0%	28.9%	20.0%	22.1%	25.0%	23.3%	19.4%	16.7%
ABMU Recommendation %	93.9%	93.3%	94.5%	95.0%	95.4%	95.5%	96.0%	95.0%	95.7%	95.5%	95.7%	95.1%	95.0%
Top Equivalent Organisation Response %	18.7%	22.8%	20.1%	18.8%	15.7%	17.5%	17.0%	14.1%	14.6%	21.3%	27.7%	17.6%	Awaiting publication of national data
Top Equivalent Organisation Recommendation %	97.2%	96.7%	97.0%	96.8%	97.7%	97.0%	98.1%	97.0%	97.5%	95.0%	93.7%	97.4%	
NHS England Benchmark Response %	25.5%	25.4%	25.6%	25.8%	24.6%	24.9%	25.1%	21.4%	22.7%	23.9%	22.6%	24.4%	
NHS England Benchmark Recommendation %	95.9%	95.1%	95.6%	95.6%	95.6%	95.6%	95.6%	95.0%	95.5%	95.5%	95.3%	95.6%	

Source : ABMU Datix System

Measure 1: Number of friends and family surveys completed
Measure 2: % of who would recommend and highly recommend
Measure 3: % of all Wales surveys scoring 9 or 10 on overall satisfaction

How are we doing ?

PLEASE NOTE THIS IS ONE MONTH REPORT FOR JUNE
Health Board Friends & Family patient satisfaction level in June was 96% which is the third time in 9 months we have reached this high % score.

- Neath Port Talbot Hospital completed 893 surveys for June, with a recommended score of 99%.
- Singleton Hospital completed 2,123 surveys for June, with a recommended score of 97%.
- Morriston Hospital completed 1,835 surveys for June, with a recommended score of 94%.
- Princess of Wales Hospital completed 1,184 surveys for June, with a recommended score of 96%.
- Mental Health & Learning Disabilities completed 14 surveys for June, with a recommended score of 79%
- Primary & Community Care completed 197 surveys for June, with a recommended score of 94%

What actions are we taking?

PLEASE NOTE THAT THIS IS A ONE MONTH REPORT FOR JUNE

- Cancer: Update from the joint project with Macmillan and Upper Valley Cluster. A database of 660 cancer patient have been identified from the Cluster to take part in the survey. The questions have been agreed and translated in to Welsh. Surveys built using QR codes, Text and Email links. Staged roll out to the GP practices within the cluster planned for July and August. Survey results to be available September.

- Workshop with the PALS and PEAS teams: June 12th, saw all the PALS/PEAS staff members along with the Governance Managers attend a corporate workshop with Non Officer Member Maggie Berry and Cathy Dowling. The workshop shone a light on the excellent work the teams are doing across the hospitals. Future workshop are being planned.

What are the main areas of risk?

New Information Governance regulations require updates to the Friends & Family cards and Surveys which are being integrated to the Snap system.

How do we compare with our peers?

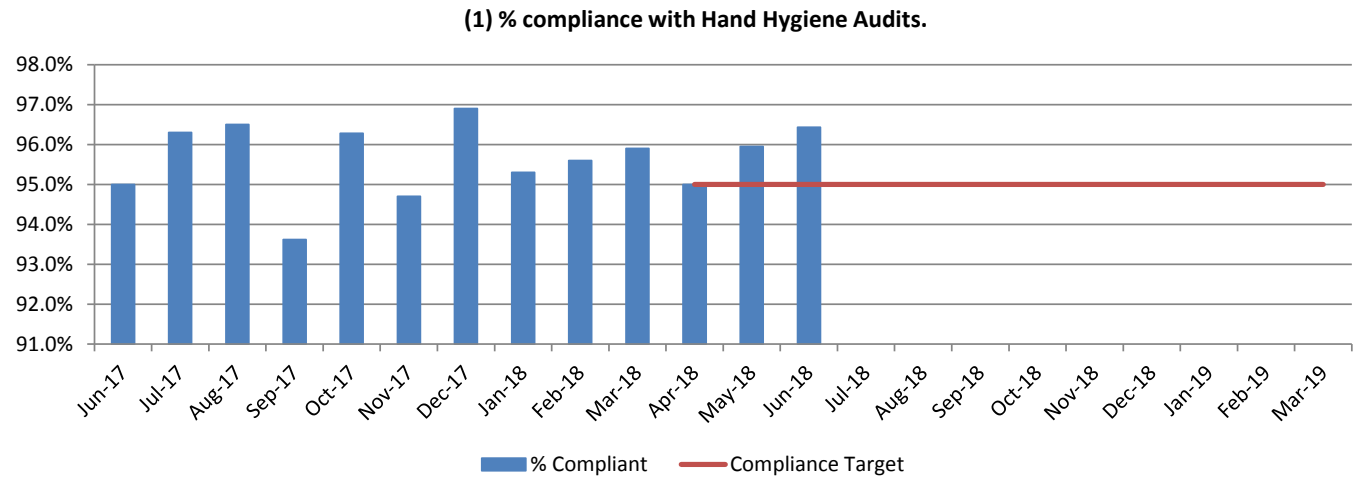
Monthly/bi monthly data not available on an all Wales basis to compare.

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

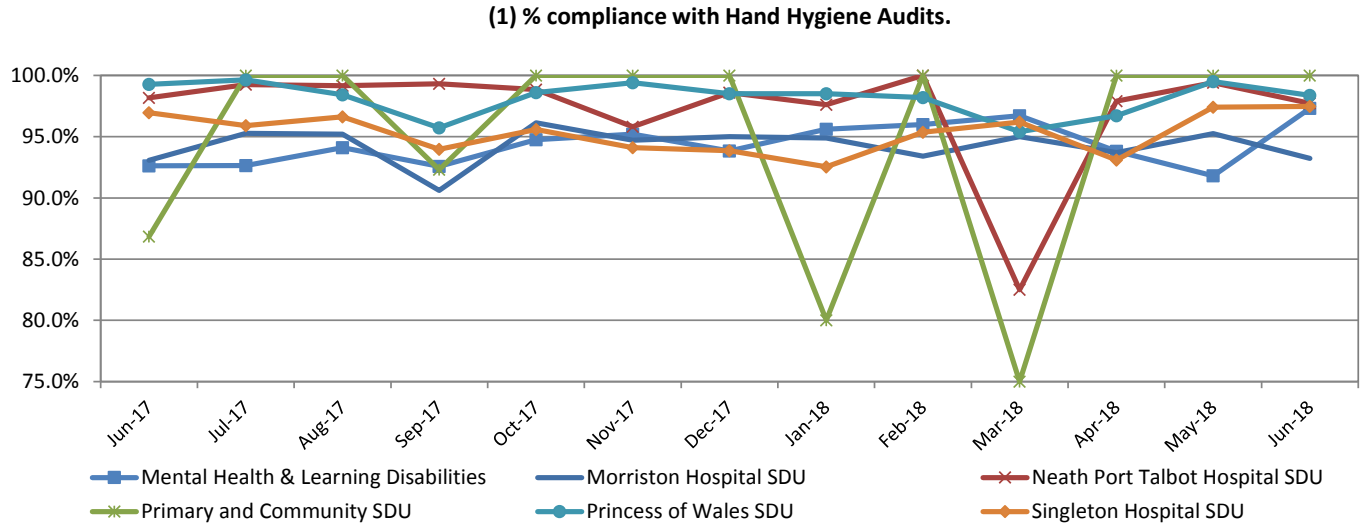
Measure 1: % compliance with Hand Hygiene Audits

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

Current Trend: Jun 17 - Jun 18



Benchmarking



Source : ABMU Care Matrix

Measure 1: % compliance with Hand Hygiene Audits

How are we doing ?

• Compliance with hand hygiene (HH) for June 2018 was approximately 96%.
• For June 2018, 74 wards/units (51%) reported compliance ≥95%.
• 13 wards/departments (9%) reported compliance between 90% and 94%; 12 wards/units (8%) reported compliance of 89% or below.
• 47 wards/departments had not uploaded the results of their audits undertaken in June 2018.
• Five of the six Service Delivery Units (SDU) reported compliance ≥95%. Morriston reported compliance of 93% in June 2018.
• Results over time indicate there are challenges to achieving sustained improvements in compliance however, there are recognised limitations with self-assessment.

What actions are we taking?

• ABMU Infection Prevention & Control (IPC) team has agreed with two neighbouring Health Board IPC teams to undertake further peer reviews of hand hygiene compliance. This had not taken place during or since the influenza season.
• Peer review auditing is being considered within the Health Board (between wards/departments units).
• The updated Hand Hygiene Training programme is being delivered.

What are the main areas of risk?

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

How do we compare with our peers?

• The HH score has been removed from the all-Wales dashboard because of the inherent difficulty in using one score to represent a whole Health Board.

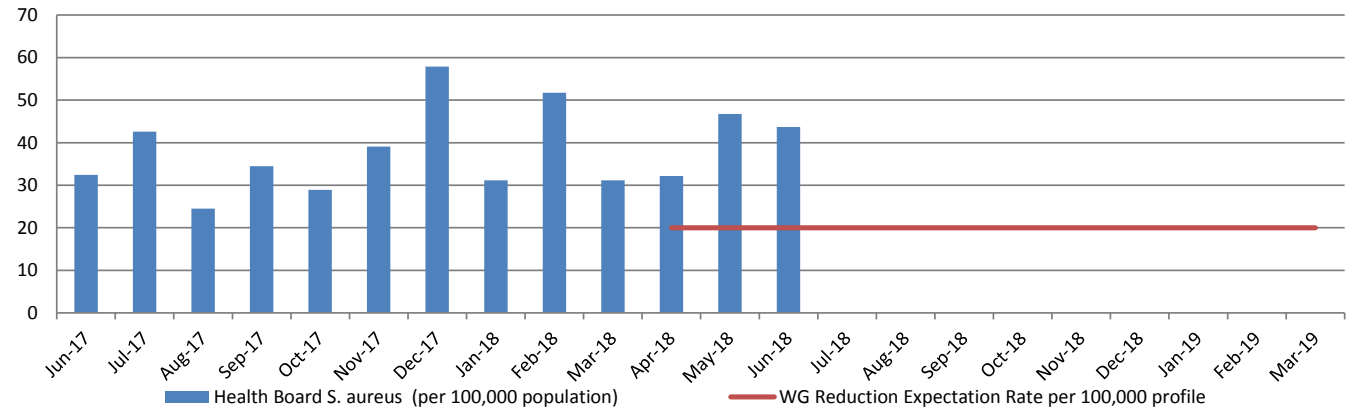
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population
Measure 2: Number of S. aureus bacteraemia cases
Measure 3: Number of cumulative cases of S. aureus bacteraemia against March 2019 reduction expectation

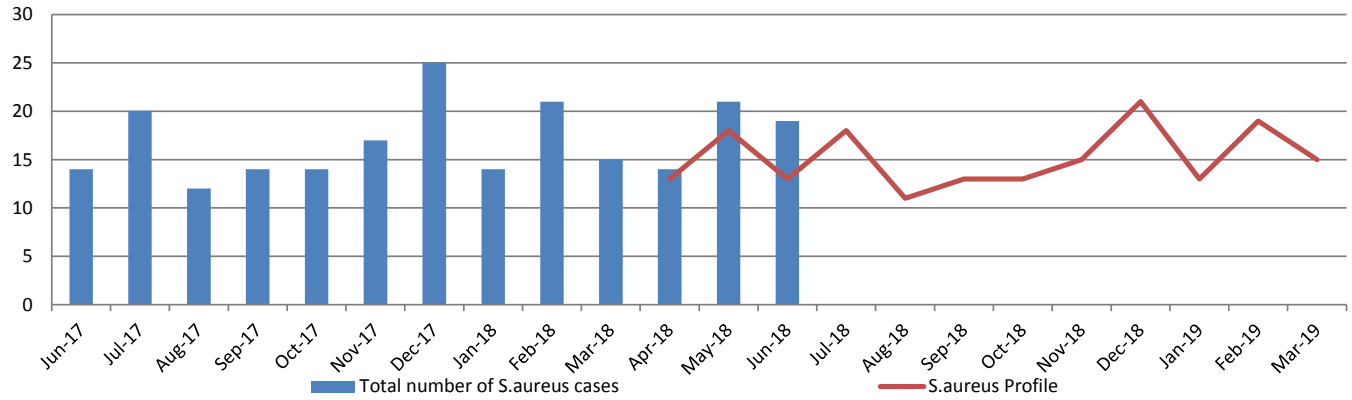
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Gareth Howells	
Period : June 2018	**IMTP Profile Target :** (2) 13	**WG Target :** (1) <20	**Current Status :** ✖	**Movement :** ↑ Worsening

Current Trend: Jun 17 -Jun 18

(1) Rate of S.*aureus* bacteraemia per 100,000 of the population



(2) Number of S.*aureus* cases



Benchmarking

(2) Number of cumulative cases of S.*aureus* bacteraemia against March 2019 reduction expectation

LHB	Cumulative Cases (Apr 18-Jun 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	236	143	+93
ABM	54	26	+28
AB	41	27	+14
BCU	44	34	+10
C&V	39	24	+15
Ctaf	25	14	+11
Hdda	33	18	+15

Source : Public Health Wales: C. difficile, S. aureus and E.coli bacteraemia monthly dashboard (June 18)

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population
Measure 2: Number of S. aureus bacteraemia cases
Measure 3: Number of cumulative cases of S. aureus bacteraemia against March 2019 reduction expectation

How are we doing ?

• In June 2018, the Health Board's total number of cases was 19 cases. This exceeded the IMTP profile for June by 6 cases.
• Of the 19 cases, 8 (37%) were hospital acquired infections; 12 (63%) were community acquired infections. Morriston Hospital accounted for 71% of the hospital acquired cases. There were four Cases of MRSA bacteraemia; 4 of these were community acquired cases.
• There were 5 more cases of Staph. aureus bacteraemia in June 2018 compared with June 2017.

What actions are we taking?

• Delivery Units (DU) are to focus on improving compliance with the number of staff that have completed ANTT training - 10% improvement on staff trained by 31 March 2019.
• Delivery Units are to focus on improving compliance with the number of staff that have been ANTT competence assessed. Currently, there is no baseline data. To establish a system for recording ANTT competence assessments via ESR – by end of Q2, 2018/19.
• Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters – ongoing into Q1, 2018/19.
• Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters in 6 wards – ongoing into Q1, 2018/19.
• Neath Port Talbot and Princess of Wales Delivery Units will commence QI programmes to reduce the prevalence of invasive devices in Q2.

What are the main areas of risk?

• 63% of Staph. aureus bacteraemia is community acquired, with many patient related contributory factors, such as recreational drug use, arthritis, chronic conditions, etc. As such, it is a challenge to prevent a significant proportion of these.
• Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.
• Bed occupancy, which frequently is close to, or exceeds, 90%. Analysis by the Department of Health, reported in Tackling Healthcare associated infections through effective policy action (BMA, June 2009), suggested that when all other variables are constant, an NHS organisation with an occupancy rate above 90 per cent could expect a 10.3% higher MRSA rate compared with an organisation with an occupancy levels below 85%.
• High bed turnover. In the same BMA report, the impact on MRSA rates of turnover intervals were suggested to have a greater impact on MRSA rates than bed occupancy levels.

How do we compare with our peers?

• In June 2018, ABMU had the second highest incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards.
• To date in 2018/19 ABMU has the highest cumulative incidence of Staph. aureus bacteraemia in comparison with the other Welsh Health Boards.

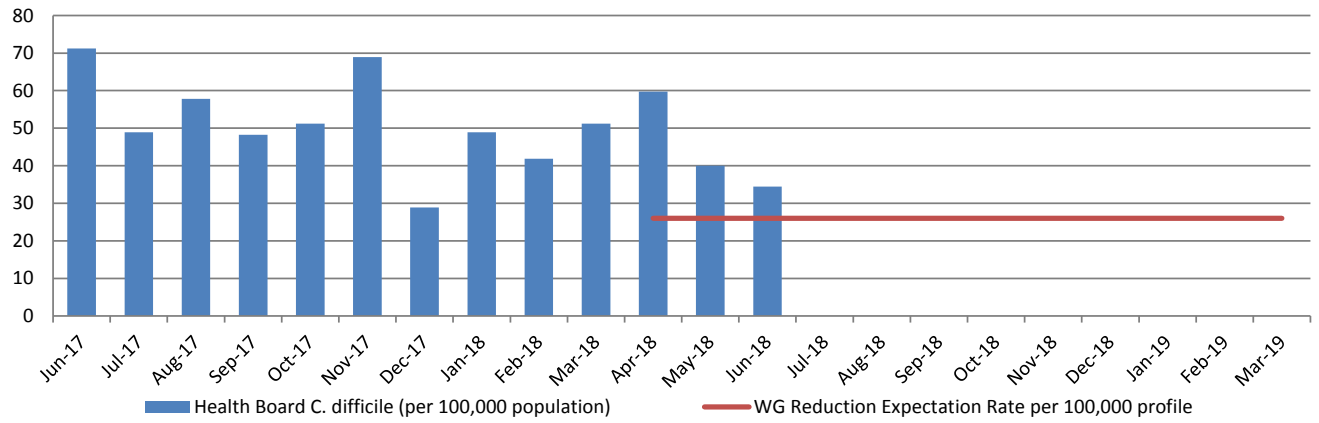
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Rate of C.*difficile* cases per 100,00 of the population
Measure 2: Number of C.*difficile* cases
Measure 3: Number of cumulative cases of C.*difficile* against March 2019 reduction expectation

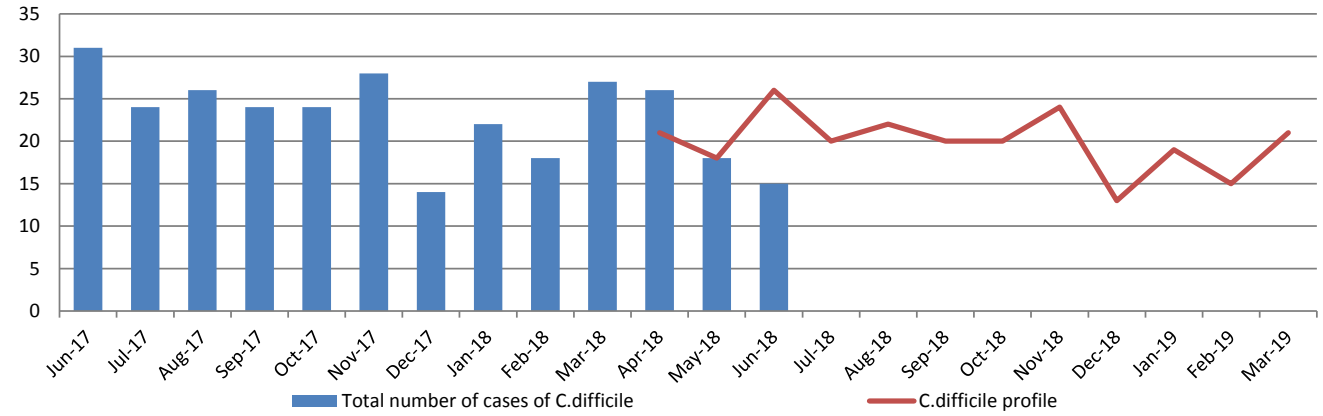
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Gareth Howells	
Period : June 2018	**IMTP Profile Target :** (2) 26	**WG Target :** (1) < 26	**Current Status :** ✖	**Movement :** ↓ ● Improving

Current Trend: Jun 17 - Jun 18

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



(2) Number of C.d*ifficile cases*



Benchmarking

(3) Number of cumulative cases of C.*difficile* against March 2019 reduction expectation

LHB	Cumulative Cases (Apr 18-Jun 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	238	179	+59
ABM	59	34	+25
AB	36	36	0
BCU	46	45	+1
C&V	25	27	-2
Ctaf	18	13	+5
Hdda	54	24	+30

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

Measure 1: Rate of C.difficile cases per 100,00 of the population
Measure 2: Number of C.difficile cases
Measure 3: Number of cumulative cases of C.difficile against March 2019 reduction expectation

How are we doing ?

• In June 2018, the Health Board's total number of cases was 15 cases. This was fewer cases than the IMTP profile for June by 11 cases.
• Of the 15 cases, 10 (67%) were hospital acquired infections (HAI); 5 (33%) were community acquired infections. Morriston Hospital DU accounted for 60% of the hospital acquired cases. Singleton Hospital DU accounted for 30% of HAI.
• Morriston Hospital DU had periods of increased incidence of infection in June (Ward T & AMAU West).
• There were 17 fewer cases of C. difficile infection in June 2018 than in June 2017.

What actions are we taking?

• Restrictive antimicrobial guidelines were implemented on 12 June 2018.
• The Risk Assessment and Safe System of Work protocol in relation to UVC was accepted as satisfactory by HSE in June 2018. Updated training programme, based on new safe system, has been developed. Staff side continued to express concern regarding re-introduction of UV-C and the process was not implemented on 30 June 2018 as planned. The Health Board continue to pursue a way forward with this.
• Invitations have been circulated for expressions of interest for the QI Lead for Infection in each of the Delivery Units – these expressions of interest were to be considered by the Delivery Units by 30 June 2018.

What are the main areas of risk?

• Contributory factors: secondary care antibiotic prescribing; impact of high numbers of outliers on good antimicrobial stewardship; use of pre-emptive beds; suspension of enhanced decontamination technologies; lack of decant facilities which restricts ability to undertake deep-cleaning of clinical areas. The deep cleaning process is disjointed and depends on three separate staff groups to each play their part in the right timescale for the process to be effective and robust. This requires a redesign, moving all resourcing to one team. This will improve outcome and increase assurance.
• C. difficile spores may be found in 49% rooms of patients with C. difficile infection; 29% rooms of asymptomatic carriers.
• Public Health Wales implemented a new, more sensitive testing methodology for C. difficile. The likely impact of this will be a 10-20% increase in the detection of C. difficile carriage.

How do we compare with our peers?

• In June 2018, ABMU had the second highest incidence of C. difficile in comparison with the other major Welsh Health Boards.
• To date in 2018/19 ABMU has the second highest cumulative incidence of C. difficile bacteraemia in comparison with the other Welsh Health Boards.

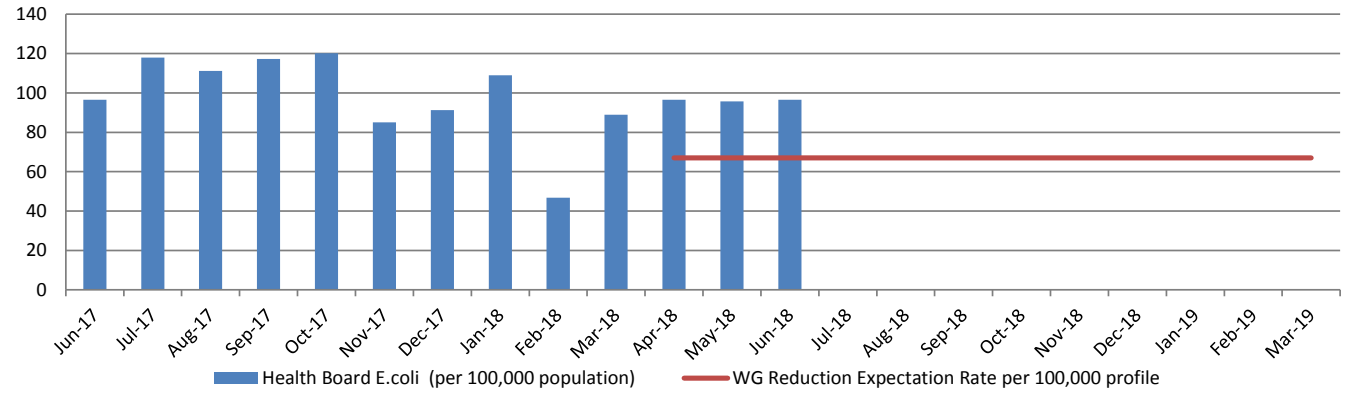
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population
Measure 2: Number of E.coli cases
Measure 3: Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

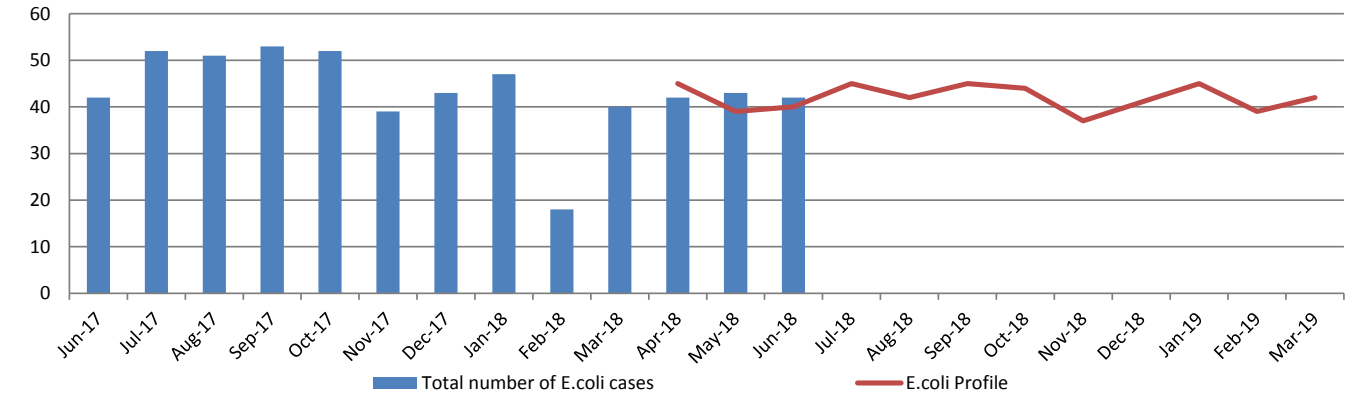
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Gareth Howells	
Period : June 2018	IMTP Profile Target : (2) 40	WG Target : (1) < 67	Current Status : ✖	Movement : ↓ ● Improving

Current Trend: Jun 17 - Jun 18

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



(2) Number of E.coli bacteraemia cases



Benchmarking

(3) Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

LHB	Cumulative Cases (Apr 18-Jun 18)	Max cumulative cases to achieve Mar-19 reduction expectation	Variance
Wales	633	479	+154
ABM	127	88	+39
AB	120	89	+31
BCU	132	116	+16
C&V	90	73	+17
Ctaf	72	49	+23
Hdda	92	64	+28

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

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population
Measure 2: Number of E.coli cases
Measure 3: Number of cumulative cases of E. coli bacteraemia against March 2019 reduction expectation

How are we doing ?

• In June 2018, the Health Board's total number of cases was 41 cases. This was 1 cases more than the IMTP profile for June.
• Of the 41 cases, 31 (76%) were community acquired infections (HAI); 10 (24%) were hospital acquired infections. Of the 10 hospital acquired cases, there were 4 cases associated with Morriston Hospital Delivery Unit (DU). Princess of Wales Hospital DU and Neath Port Talbot Hospital DU each had 2 cases; Singleton Hospital DU and Gorseinon Hospital each had one hospital acquired case.
• To date, in 2017/18, 40% of the total cases of E. coli bacteraemia had a probable urinary source and 16% of these were associated with urinary catheters. Identifying the probable source of E. coli bacteraemia is key to developing focussed Quality Improvement programmes.
• There were 2.3% fewer cases of E. coli bacteraemia in June 2018 compared with June 2017.

What actions are we taking?

• PDSA-based Quality Improvement programmes focussed on preventing urinary tract infections has commenced in a small number of key wards. For example, Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters –into Q1, 2018/19; Morriston DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters in 6 wards – into Q1, 2018/19 with a plan to roll this out to more wards in the next quarter. Also a hydration awareness programme has been commenced at Morriston DU; Princess of Wales DU has commenced a pilot of using urinary catheter labels to record review of continued use – into Q1, 2018/19.
• Delivery Units are to focus on improving compliance with the number of staff that have completed ANTT training - 10% improvement on staff trained by 31 March 2019.
• Delivery Units are to focus on improving compliance with the number of staff that have been ANTT competence assessed. Currently, there is no baseline data. To establish a system for recording ANTT competence assessments via ESR – by end of Q2, 2018/19.

What are the main areas of risk?

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

How do we compare with our peers?

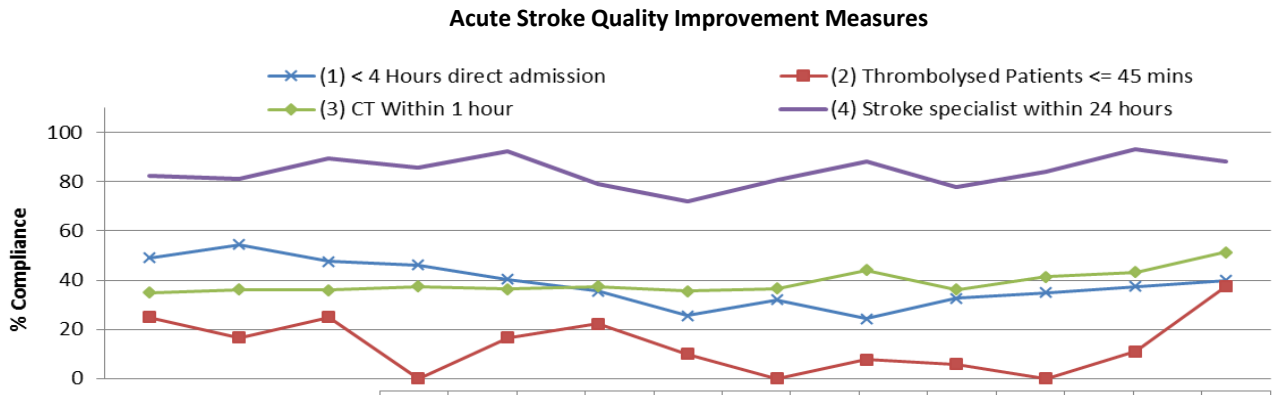
• In June 2018, ABMU had the second highest incidence of E.coli bacteraemia in comparison with the other major Welsh Health Boards.
• To date in 2018/19 ABMU has the second highest cumulative incidence of E.coli bacteraemia in comparison with the other Welsh Health Boards.

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

Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours
Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes
Measure 3: % of patients who receive a CT scan within 1 hour
Measure 4: % of patients who are assessed by a stroke specialist consultant physician within 24 hours

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : June 2018	IMTP Profile Target : (1)45% (2)25% (3)40% (4)75%	WG Target : 95%	Current Status : ✗	Movement : ↑ Improving

Current Trend: Jun 17 - Jun 18



	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
(1) < 4 Hours direct admission	49.1	54.5	47.6	46.2	40.4	35.6	25.6	31.9	24.4	32.6	34.9	37.5	40.0
(2) Thrombolysed Patients <= 45 mins	25.0	16.7	25.0	0.0	16.7	22.2	10.0	0.0	7.7	5.9	0.0	11.1	37.5
(3) CT Within 1 hour	34.9	36.2	36.0	37.4	36.3	37.4	35.6	36.5	44.0	36.3	41.4	43.3	51.3
(4) Stroke specialist within 24 hours	82.6	81.2	89.5	85.9	92.3	79.1	71.9	80.8	88.1	78.0	83.9	93.3	88.2

Benchmarking

Thrombolysis Quality Improvement Measures June 18	AB	ABM	BCU	C&V	Ctaf	Hdda
1a - Percentage of All Strokes Thrombolsyed - H16.3	16.7%	21.1%	10.1%	16.7%	23.5%	15.9%
2b - Percentage of Eligible Patients Thrombolsyed - H16.55	100.0%	100.0%	72.7%	100.0%	100.0%	100.0%
1a - Thrombolysed Patients with Door-to-Needle <= 30 mins	10.0%	6.3%	11.1%	0.0%	8.3%	9.1%
2b - Thrombolysed Patients with Door-to-Needle <= 45 mins	20.0%	37.5%	11.1%	16.7%	33.3%	18.2%
3c - Thrombolysed Patients with Onset to-Needle <= 90 mins	10.0%	25.0%	22.2%	0.0%	8.3%	18.2%
4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Sc	90.0%	93.8%	100.0%	100.0%	100.0%	100.0%

Stroke Quality Improvement Measures June 18	AB	ABM	BCU	C&V	Ctaf	Hdda
1. < 4 Hours Care Performance Indicator	60.0%	39.5%	34.8%	41.7%	62.7%	55.1%
1a - Direct Admission to Acute Stroke Unit - H7.18	61.7%	40.0%	34.1%	44.1%	62.7%	46.4%
1b - Swallow Screening - H14.20	68.4%	82.6%	85.3%	51.4%	80.0%	82.0%
2. < 12 Hours Care Performance Indicator	100.0%	97.4%	95.5%	97.2%	98.0%	100.0%
2a - CT Scan - H6.12	100.0%	97.4%	95.5%	97.2%	98.0%	100.0%
3. < 24 Hours Care Performance Indicator	91.7%	85.5%	65.2%	69.4%	56.9%	82.6%
3a - Assessed by Stroke Consultant - H9.3	98.3%	88.2%	66.3%	72.2%	66.7%	94.2%
3b - Assessed by Stroke Nurse - H8.3	98.3%	98.7%	94.4%	94.4%	94.1%	94.2%
3c - Assessed by One of OT, PT, SALT	91.7%	97.4%	94.4%	100.0%	62.7%	89.9%
4. < 72 Hours Care Performance Indicators	98.3%	96.1%	93.3%	86.1%	96.1%	89.9%
4a - Formal Swallow Assessment - H15.24	100.0%	100.0%	93.9%	93.8%	95.2%	71.4%
4b - OT Assessment - H10.24	100.0%	96.6%	95.0%	85.7%	95.7%	92.5%
4d - SALT Communication Assessment - H12.24	100.0%	100.0%	98.8%	91.4%	97.9%	95.2%
5. < 1 Hour Care Performance Indicator	56.7%	51.3%	44.9%	41.7%	70.6%	63.8%
5a - CT Scan	56.7%	51.3%	44.9%	41.7%	70.6%	63.8%

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

Source : ALL WALES PERFORMANCE SUMMARY (JUNE 2018) + ACUTE STROKE QUALITY IMPROVEMENT MEASURES DU REPORT

Measure 1: % of patients who have a direct admission to an acute stroke unit within 4 hours
Measure 2: % of thrombolysed stroke patients with a door to door needle time of less than or equal to 45 minutes
Measure 3: % of patients who receive a CT scan within 1 hour
Measure 4: % of patients who are assessed by a stroke specialist consultant physician within 24 hours

How are we doing ?

• Revised stroke measures have been implemented nationally from 1st April 2018, and improvement trajectories for the revised measures have been set.
• Performance against the 4 hour bundle remains a challenge due to unscheduled care pressures and staffing gaps in some key areas as a result of staff turnover and lead in times to recruitment into key clinical roles. However, there has been some strong recent recruitment into key medical posts which ought to support improvements in delivery once in post.
• Morriston stroke unit had 49 confirmed stroke admissions during June 2018 and the Princess of Wales received 27. All eligible patients received thrombolysis.

What actions are we taking?

Weekly multi disciplinary meetings are held in Morriston and Princess of Wales hospitals to review individual patient pathways and to identify opportunities for improvement. Actions being progressed in Quarter 2 include:
Morriston
• Appointment of nine additional Senior Clinical fellows during June and who would be taking up post in August should improve timeliness of patient assessment. A review of the On Call arrangements to include an additional SpR overnight and on Saturday / Sunday with effect from August 18 is in development.
• Stroke Retrieval pilot planned for June is being evaluated by the team to assess viability of continuation. Some improvements in turn around but further work required to be considered by local management team.
• Plans for a refresh of swallow screening training with ED is being taken forward.
Princess of Wales
• The Unit undertook two separate workshops during June - and five Task and Finish groups have been agreed to undertake more focused work in keys areas. An action plan is being prepared with key leads, delivery times for each action with a focus on improving the 4 hours bundle.
• The planned relocation of the TIA clinic in the next few months will release clinical nurse specialist time to support patient flow.
• The Delivery Unit review of the stroke pathway and its initial findings has reported back into the two workshops held in the Unit - and a final draft report is in the process of being completed by the end of July for review.
ABMU wide
• Improved and ongoing communication and awareness of the stroke pathway within hospital units and between services.
• Ongoing planning in terms of working towards the “Hyper-acute Stroke Unit” model. Non recurrent funding secured from national funding to fund a dedicated project manager to support this work – appointment has been made and the successful applicant will take up her post in mid September.
• Business cases have been developed for consideration by the IBG to utilise spend to save funding to invest into an Early Supported
• Discharge service within both the Morriston and Princess of Wales Delivery Units.

What are the main areas of risk?

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

How do we compare with our peers?

Performance against the 4 hour bundle continued to be the main challenge for ABMU Health Board in May and June (although with a small improvement month on month). The Health Board thrombolysis rates for eligible patients were amongst the highest, with performance against the 45 door to needle times the best in Wales in June. Access to specialist assessment within 24 compares well with the majority of HB's. CT scanning time within 1 hour is improving but requires further work to match the best performing HB's.