Agenda item: 5b

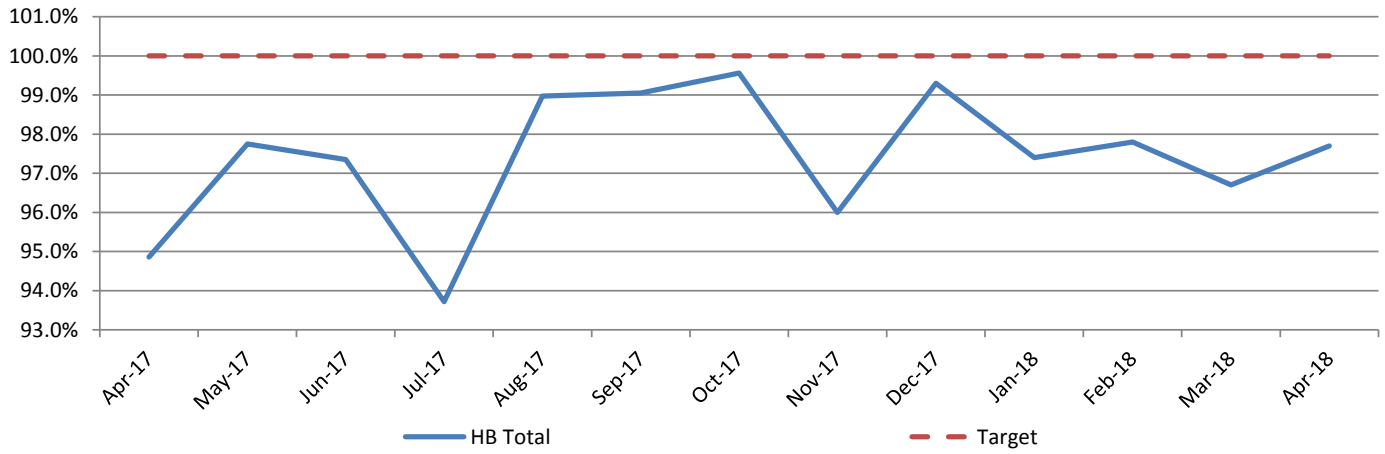
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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

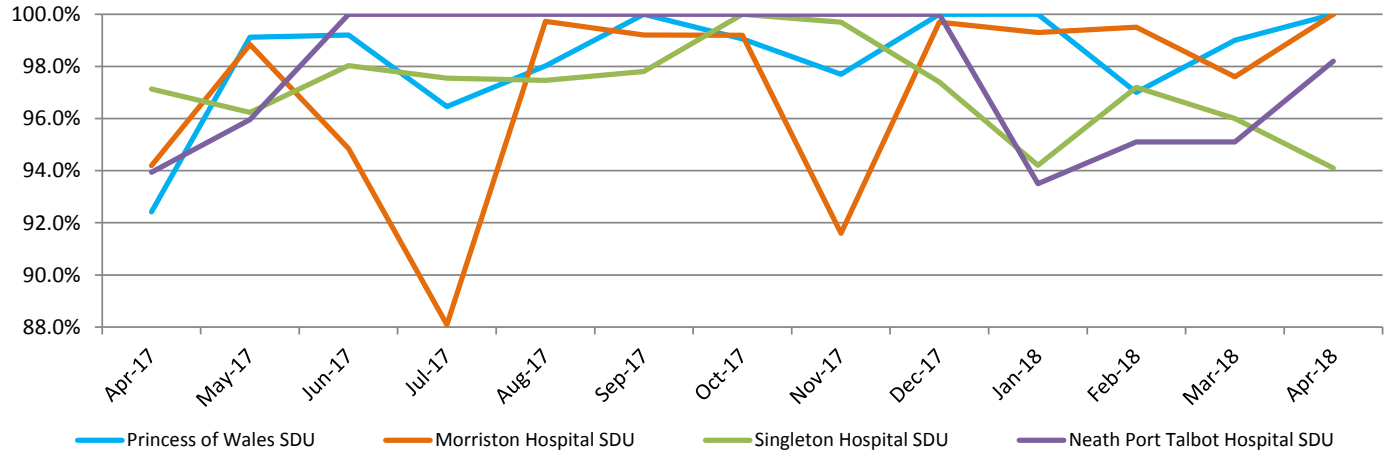
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Apr 2018	IMTP Profile Target : N/A	Local Target : 100%	Current Status : ✖	Movement : ↑ Improving

Current Trend: Apr 17 - Apr 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 April 2018 was 97.7% compared with 96.7% in March
• In month performance improved in 3/4 Delivery Unit's (DU).
• In April 2018, Morriston and Princess of Wales Hospital (POWH) both achieved 100%. Morriston did not achieve 100% in any month during 2017-18
• Neath Port Talbot Hospital (NPTH) achieved 98.2% an increase from 95.1% in March
• Singleton achieved 94.1% a decrease from 96.0% in March

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. Health Care Support Workers (HCSWs) are responding well to training being delivered by HCSW Sepsis Champions. Since May 2017, 1107 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 - A Practice Development Nurse and HCSW Skills Coordinator have been appointed. Early Recognition of the Deteriorating Patient will be a priority in the ongoing staff development programmes. 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.

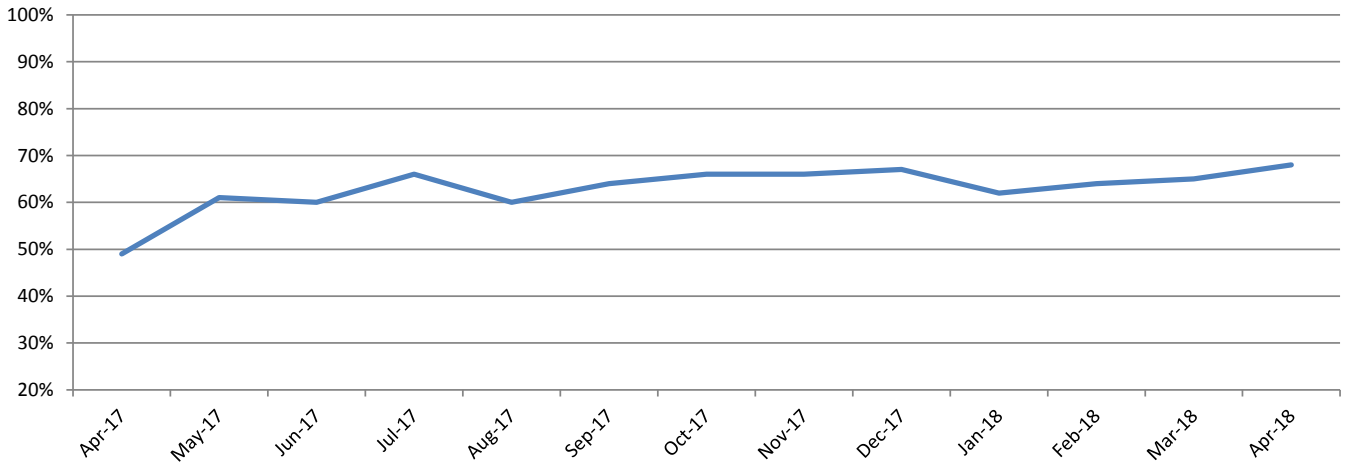
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % of completed discharge summaries

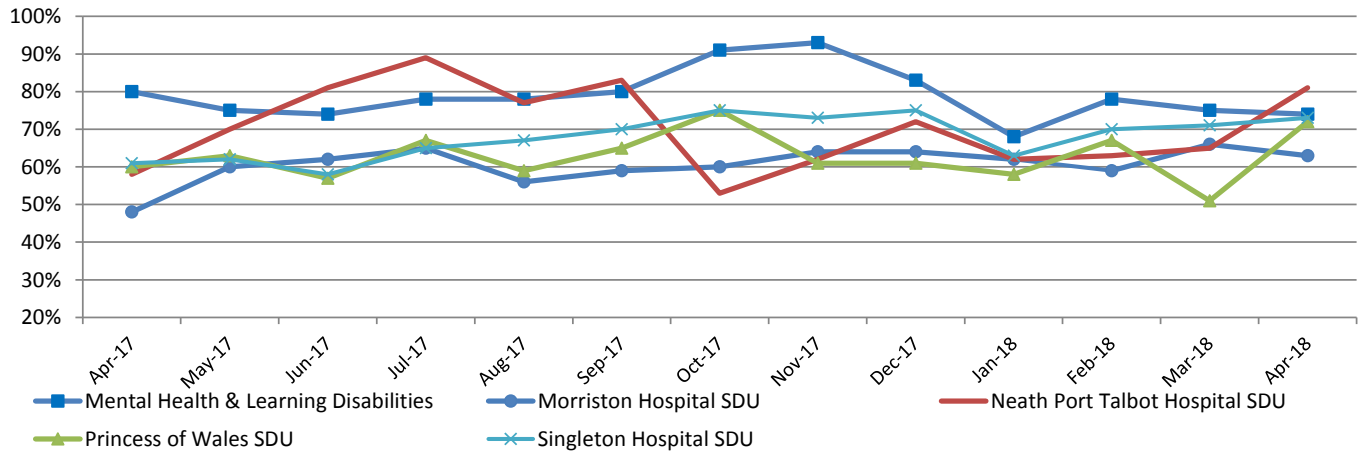
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Apr 2018	IMTP Profile Target : Improve	WG Target : 100%	Current Status : N/A	Movement : Improving

Current Trend: Apr 17 - Apr 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 improved on a Health Board-wide basis in April 2018 (68%) compared with March (65%)
• There continues to be performance variance between Service Delivery Units (63%-81%)
• This month the performance has improved in 3/5 Delivery Units, and declined in the remaining two
• Neath Port Talbot (NPT) was the best performer achieving 81%
• The most significant improvement in performance was in Princess of Wales Hospital (POWH), 72% in April compared with 51% in March
• NPT's performance also improved significantly from 65% in March to 81% in April

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
• Sickness absence amongst the Medical team at Neath Port Talbot Hospital had impacted on completion of eToCs but performance has now recovered
• The primary measure being used in POWH is % discharge summaries completed within 24hrs of discharge. There have been notable improvements on individual wards and overall performance in POWH has now reached 72%

• 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

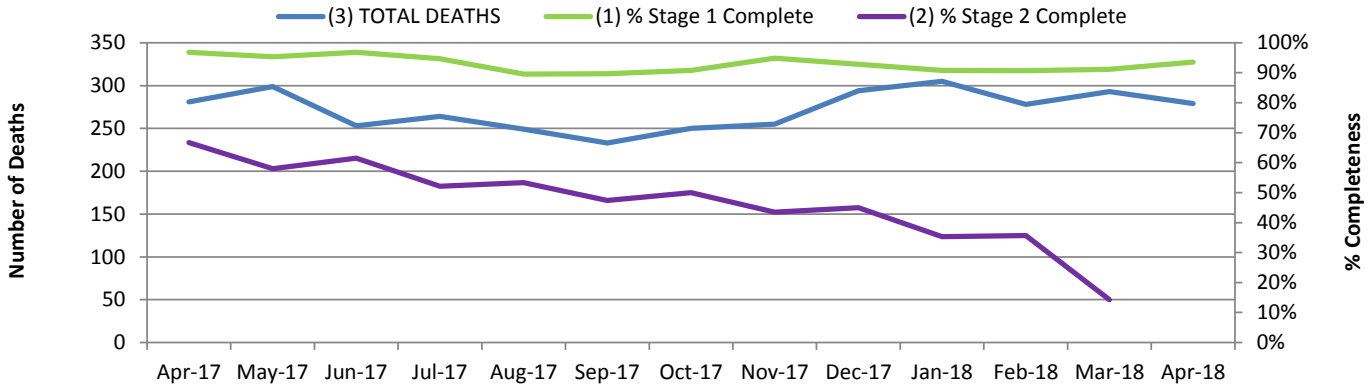
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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 : Apr 2018	IMTP Profile Target : (1) 96%	WG Target : (1) 95%	Current Status :	Movement : Worsening

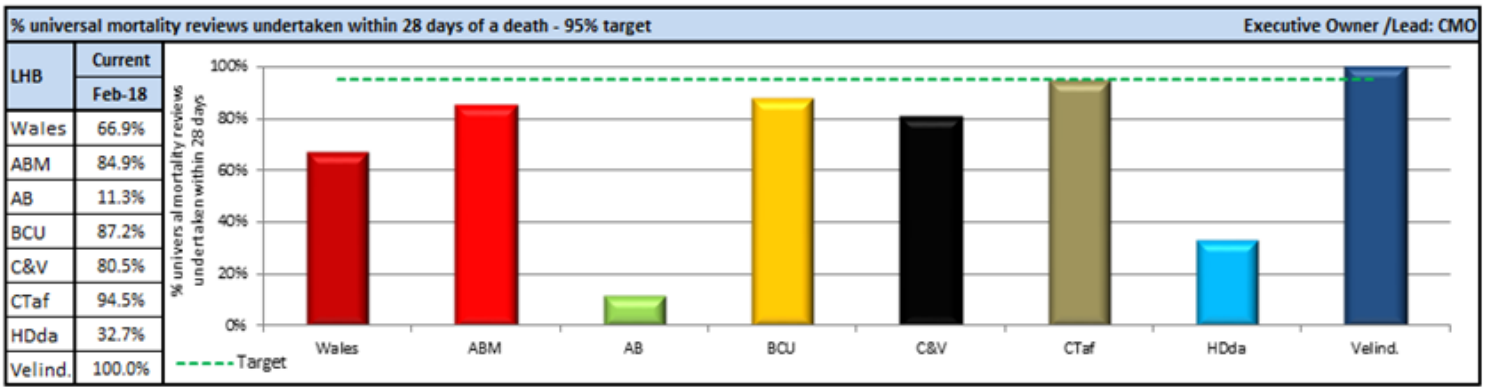
Current Trend: Apr 17 - Apr 18

(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 (APRIL 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 91.4% completion of UMRs within 28 days of death in February 2018. The Wales compliance was 66.9%
• The Health Board UMR rate in April was 93.5%, an improvement compared with 91.1% in March
• Singleton and Neath Port Talbot Hospital (NPTH) achieved 100%, Princess of Wales Hospital (POWH) 98.9% and Morriston 87.8%. There were 18 missing UMR forms, compared with 29 in March (17 in Morriston and one in POWH)
• 25 deaths triggered a Stage 2 review in April
• Completion of Stage 2 reviews within 8 weeks (February deaths) was 57% compared with 47% last month. 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%).

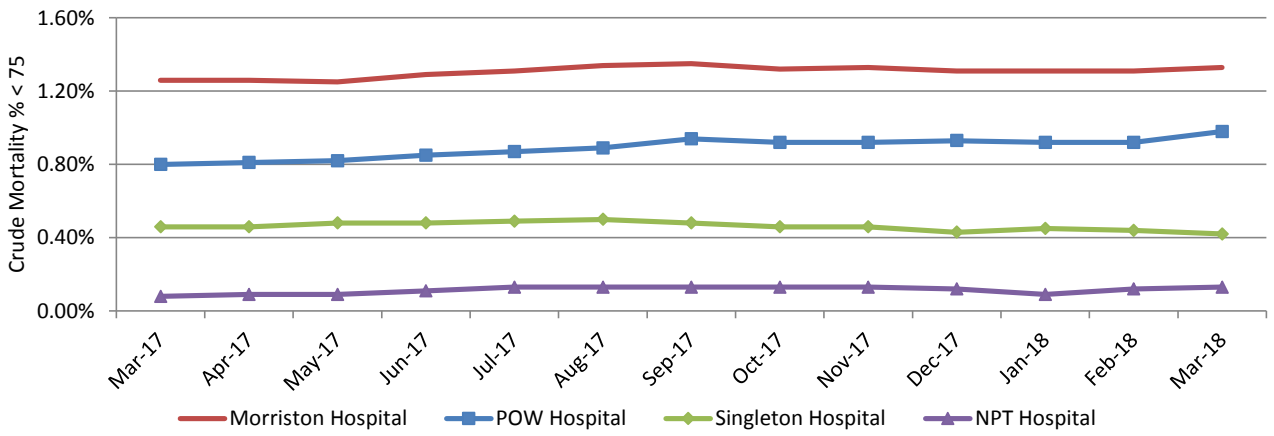
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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 : Mar 2018	IMTP Profile Target :	WG Target : 12 month reduction trend	Current Status :  Movement :  Stable

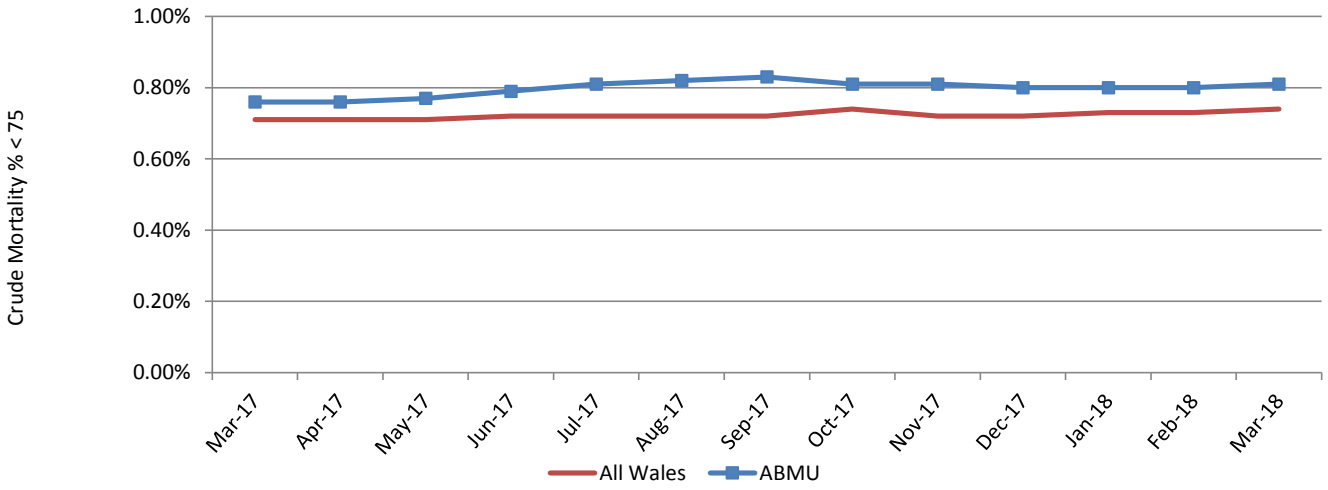
Current Trend: Mar 17 - Mar 18

(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 (APRIL 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 March 2018 was 0.80%, compared with 0.77% for the same period last year
• Site level performance is as follows: (previous year in brackets) Morriston 1.32% (1.27%), Princess of Wales 0.95% (0.83%), Neath Port Talbot 0.12% (0.09%), Singleton 0.42% (0.46%). Site comparison is not possible due to different service models being in place.
• There were 104 in-hospital Deaths in this age group in April 2018 compared with 111 in April 2017: Morriston 57 (61), Princess of Wales Hospital 32 (25), Neath Port Talbot Hospital 2 (3), Singleton 13 (22).
• The number of deaths for Surgical and Elective cases remains consistently low for this age group.

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. Singleton Hospital will present at May's COG as this was not presented in the April meeting.
• 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.

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 March 18 – 0.80% compared with 0.74%.
• 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%)

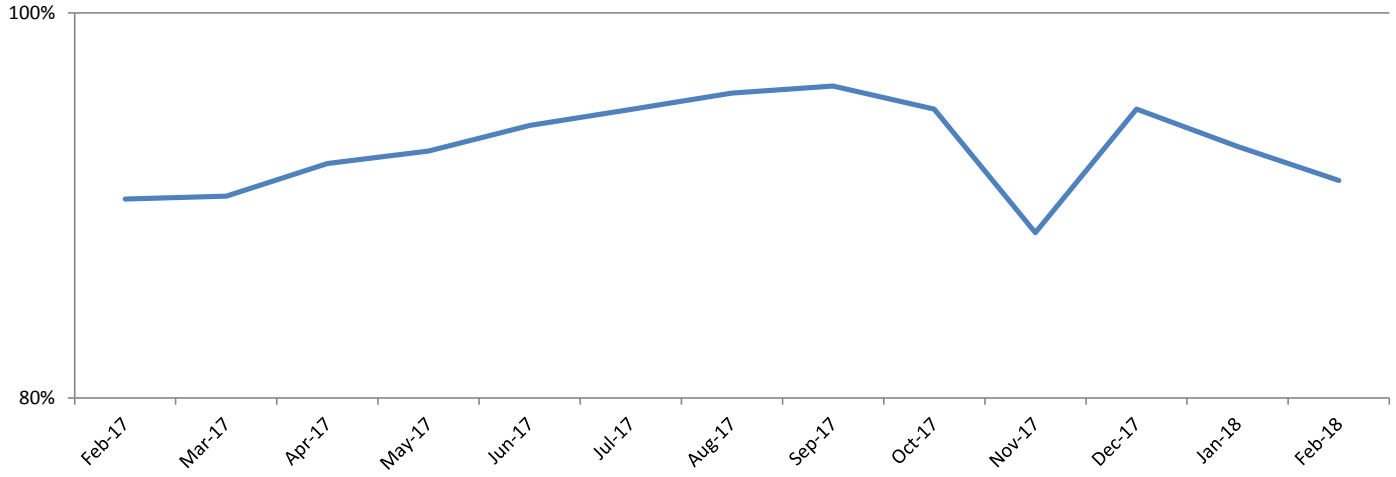
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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 : Feb 2018	IMTP Profile Target :	WG Target : 95%	Current Status : ✖
			Movement : ↑ ● Improving

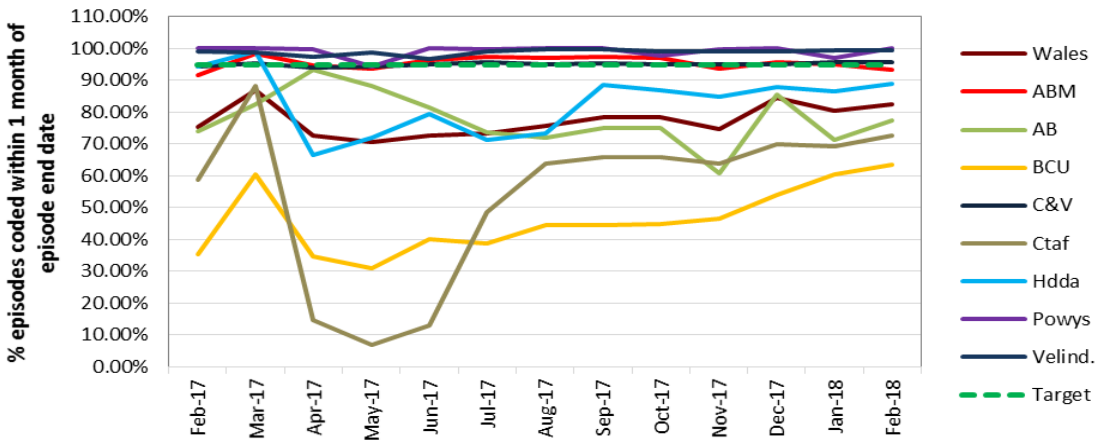
Current Trend: Feb 17 - Feb 18

(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 MARCH 2018

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

How are we doing ?

• The department has achieved overall Coding completeness for 2017/2018 as follows: April - 99.39%, May - 99.22%, June - 99.36%, July - 99.09% , August - 98.96%, September - 98.92%, October is 99.03%, November is 97.85%, December is 97.87%, and January is 96.97% . This performance has been achieved as a result of considerable changes in working practices and integration with the Health Records Department
• The completeness within 30 days for February was 91.29%. This is less than January reported position of 93%, however staffing levels in the department remains a challenge
• 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?

• From November 2017 the central Informatics Clinical Coding has taken on responsibility for Clinical Coding in Mental Health, this will address compliance issues previously reported.
• The all-Wales benchmarking data has been updated to include up to August 2017 and demonstrates a significant improvement for ABMU from the previous positon of 40% compliance in August 2016. The ABMU position will improve further in 2018.
• 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 the top performing Health Boards.

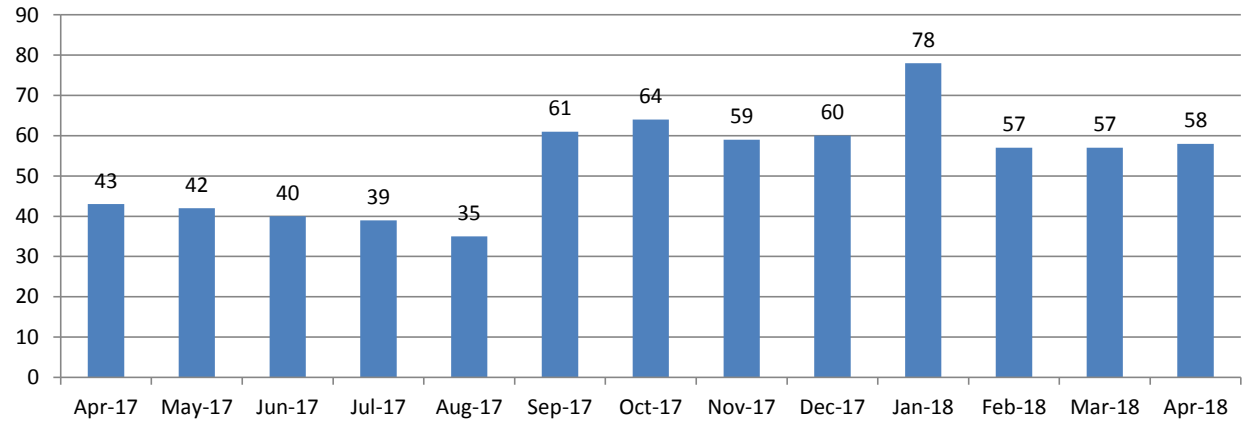
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of risks with score ≥ 20

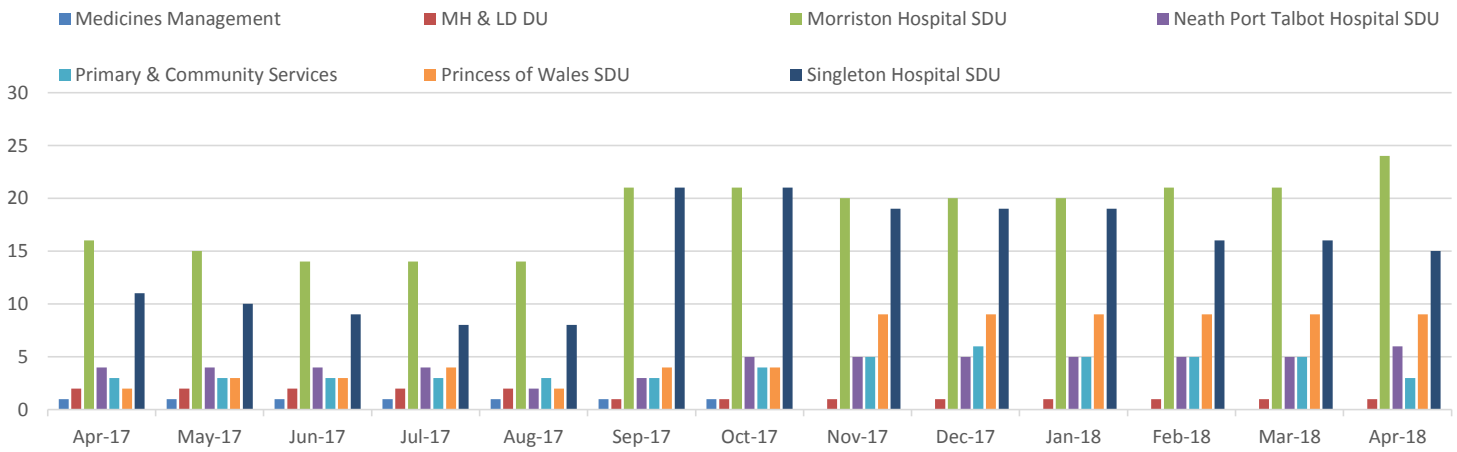
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Apr 2018	**IMTP Profile Target : Reduce**	**Local Target : Reduce**	**Current Status :** ✖	**Movement :** ⬆ ● **Worsening**

Current Trend: Apr 17 - Apr 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 ?

• 58 operational risks, rated 20. This is compared to 43 in April 2017 and 57 in March 2018.
• Morriston Unit has the highest number of risk rates 20 (24).
• The Health Board Risk Advisor monitors the Risk Module.

What actions are we taking?

As a result of the re structure of the Patient Experience, Risk & Legal Services Team the arrangements for managing risk in the Health Board have been strengthened with the merge of the Risk and Datix teams. An Assistant Head of Risk and Assurance has been appointed with a remit to implement a review of the structure of Risk including supporting the implementation of the Board Assurance Framework (BAF) and a review of the Risk Management Strategy and Policy.
There has been a further Board Assurance Framework Workshop led by the Director of Corporate Governance and Board Secretary. The workshop focused on mapping risks currently on the Corporate Risk Register to Health Board Committees. There is a further Workshop planned for June 2018. The Executive Team will consider proposals for monitoring risks and gaining assurance in June 2018.

What are the main areas of risk?

The highest risks on the register are rated 20 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. 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. 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

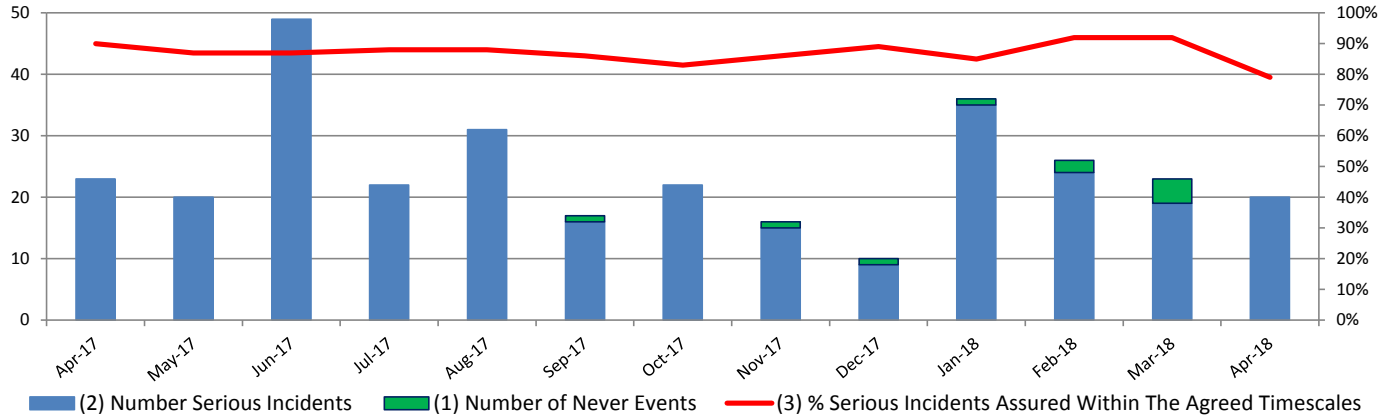
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : Angela Hopkins	
Period : Apr 2018	IMTP Profile Target : (1) 0, (2) Improve, (3) 80%	WG Target : (1) 0, (2) Improve, (3) 90%	Current Status : N/A	Movement : Improving

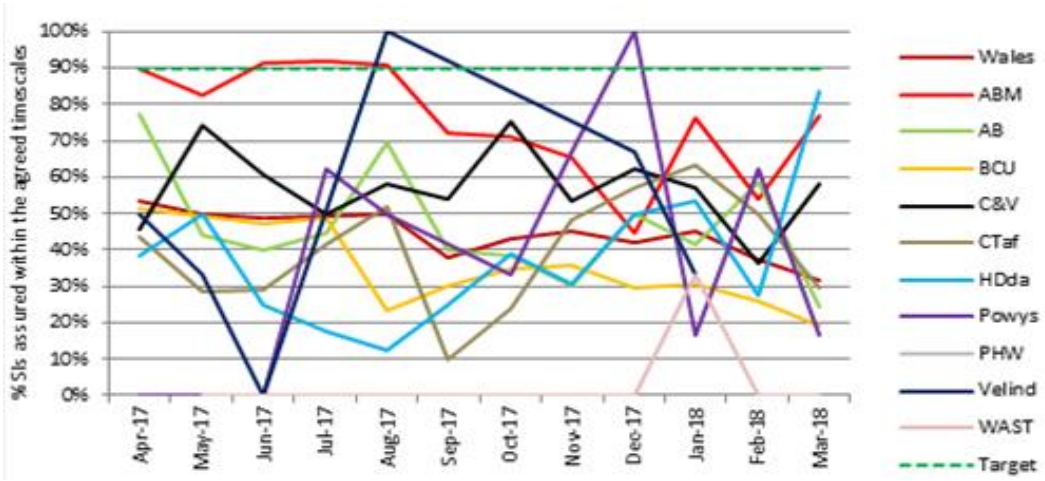
Current Trend: Apr 17 - Apr 18

(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

	Mar-18
Wales	7
ABM	4
AB	1
BCU	1
C&V	1
Ctaf	0
Hdda	0
Powys	0
PHW	0
Velind	0
WAST	0

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (APRIL 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 ?

Total number of incidents reported in April 2018 was 2,219. This compares to 1,873 incidents reported in April 2017, an increase of 346 incidents for the month of April (increase of 18%).

• 21 Serious Incidents were reported to Welsh Government (WG) in April 2018 representing 0.9% of all incidents. In comparison, 23 SI's were reported to WG in April 2017. Of the 21 new serious incidents reported to WG, 12 (57%) related to pressure ulcer incidents (grade 3 and above), 2 (10%) related to patient falls, 1 (5%) related to Neonatal/Perinatal care, 4 (19%) related to unexpected deaths, 1 (5%) related to Service Disruptions and 1 (5%) related to Infection control.

• In terms of severity of incidents, the percentage of incidents resulting in severe harm for April 2018 was 0.4% (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 April 2018.

• Performance against the WG target of closing SI's within 60 working days for April 2018 was 79% against the WG target of 80%. This slight dip in performance for the first time in 13 months is in part due to the cluster of Never Event incidents, which occurred at the start of 2018. The Health Board is committed to the quality of our investigations and when cases will not achieve the WG deadline the Health Board notifies WG accordingly.

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.

The Pressure Ulcer Improvement methodology has seen excellent results in the reduction of pressure ulcer incidents. The Welsh Risk Pool has supported this work and the methodology will be applied to the Falls Improvement work and will coincide with the upcoming relaunch of the Health Board's Fall Prevention and Management Policy.

Once the ten never events investigations have been completed for 2017/18 a thematic review will be undertaken to identify any further learning/actions for the Health Board to take forward.

What are the main areas of risk?

• Returning to and 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?

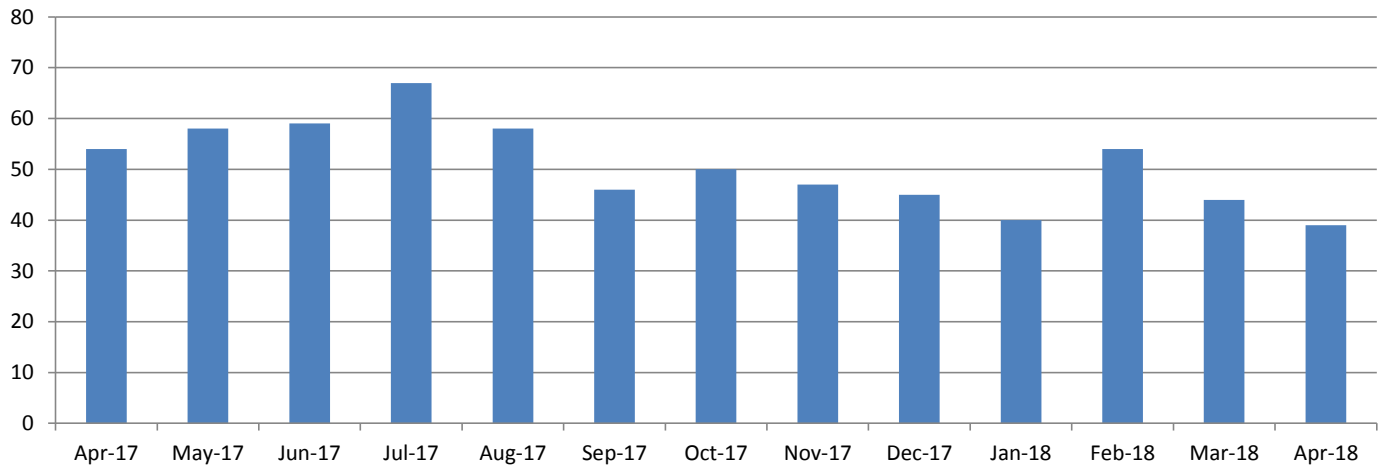
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of Safeguarding Adult Incidents

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

Current Trend: Apr 17 - Apr 18

(1) Number of Safeguarding Adult Incidents



(1) Number of Safeguarding Adult Incidents

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
MH & LD SDU	25	34	33	39	34	35	34	29	34	27	37	30	26
Morriston Hospital SDU	1	0	0	3	5	4	5	5	3	5	4	5	1
NPT Hospital SDU	8	5	4	3	2	1	4	2	0	1	3	0	0
Primary & Community SDU	8	10	13	11	9	2	5	7	6	2	4	7	8
Princess of Wales SDU	11	5	9	4	3	2	1	1	0	3	4	0	1
Singleton Hospital SDU	1	4	0	7	5	2	1	3	2	2	2	2	3
Health Board Total	54	58	59	67	58	46	50	47	45	40	54	44	39

Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Adult Incidents

How are we doing ?

• The rate of reporting of safeguarding adult incidents over recent months continues on a downward trend and is currently at its lowest rate in the last 12 months. Although the number of appropriately flagged incidents far outweighs incorrect triggers, the risk of under-reporting remains.
• DoLS breaches continue to be inconsistently flagged as Safeguarding Adult incidents. This is evidenced when DATiX reported incidents are compared to the data available from the DoLS database.
• Pressure ulcers are another category that have relatively low numbers of flagged incidents. This has been highlighted within the recently introduced All Wales Pressure Ulcer Policy, whereby all Stage 3, 4 and ungradable pressure ulcers that develop when a patient is under Health Board care will be flagged as Safeguarding Adult incidents. This is likely to increase the total number of Safeguarding Adult incidents.

What actions are we taking?

• Work to quantify under-reporting is in progress; discussion has been held with the DATIX team to hold a 3 month pilot of using the current method of incident approvers manually flagging incidents, and a comparison of these figures with incidents that have safeguarding – related CCS2 codes assigned to them. This is due to begin in July 2018.
• The Safeguarding Committee and DoLS improvement sub-group continues to monitor the number of DoLS breaches across the organisation and key actions identified and undertaken. The Service Delivery Units have been requested to ensure they have adequate systems in place to accurately record DoLS breaches within their areas. Progress has been made in ensuring the training of Best Interests Assessors, and the establishment of a BIA rota to undertake assessments is under development and should be completed within the next 3 months.
• The All Wales Pressure Ulcer Policy containing the safeguarding guidance will be circulated to all Service Delivery Units once ratified, and the safeguarding guidance will also be highlighted via the DATIX/Snap User group to ensure incident approvers are aware.

What are the main areas of risk?

The DoLS breaches continue to be a risk to the organisation and is recorded on the Corporate Risk Register

How do we compare with our peers?

Peer information is not available for comparison

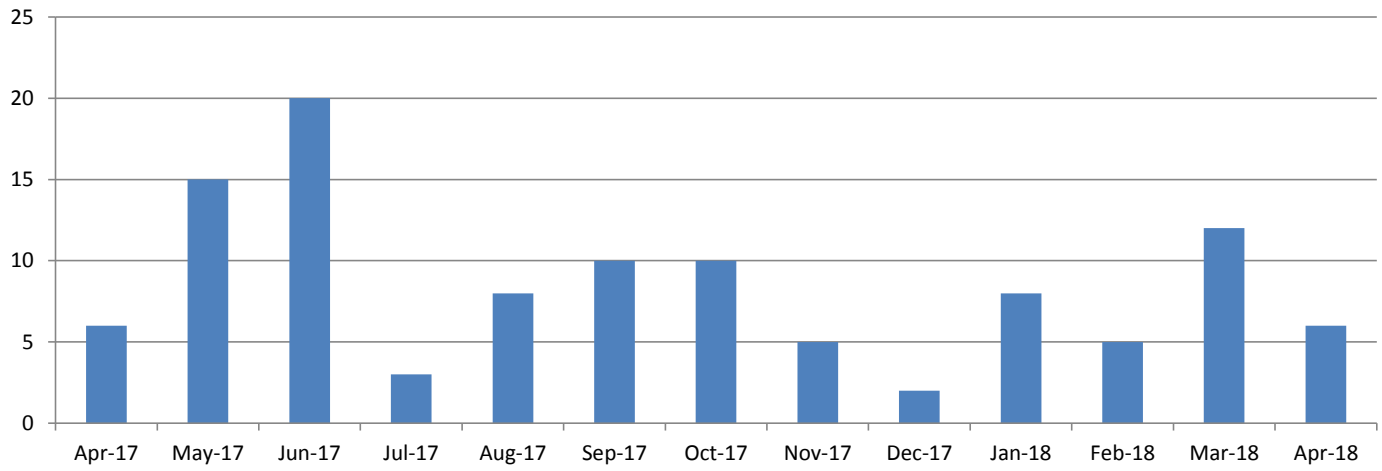
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of Safeguarding Children Incidents

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

Current Trend: Apr 17 - Apr 18

(1) Number of Safeguarding Children Incidents



(1) Number of Safeguarding Children Incidents

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
MH & LD SDU	0	3	1	2	0	0	1	0	1	3	3	0	0
Morriston Hospital SDU	0	6	3	0	0	1	0	0	1	1	0	1	0
NPT Hospital SDU	0	1	2	0	0	0	0	1	0	1	0	0	0
Primary & Community SDU	4	4	3	1	4	3	2	0	0	0	0	4	1
Princess of Wales SDU	1	0	7	0	2	4	4	2	0	2	1	1	1
Singleton Hospital SDU	1	1	4	0	2	2	3	2	0	1	1	6	4
Health Board Total	**6**	**15**	**20**	**3**	**8**	**10**	**10**	**5**	**2**	**8**	**5**	**12**	**6**

Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Children Incidents

How are we doing ?

• The reporting of safeguarding children's incidents via the Trigger list has shown a minimal increase but in the main remains fairly consistent. The Corporate Safeguarding Team have plans to revise the children's safeguarding trigger list as some areas of safeguarding have not been included and may have been underreported.
• Any HB 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 Corporate Safeguarding team has an 'on call' rota which offers to support HB staff with safeguarding concerns. Following discussions with staff the Safeguarding Team have been advising the reporting of incidents that would not have previously been reported and are raising awareness of the Safeguarding Children's Trigger list.
• Work with IT and the DATiX Team remains on-going to develop a system whereby referrals to Children's Services are captured on the Report Cards. In the interim period each Service Delivery Unit will now report on any Safeguarding Children Referrals made to the Local Authority within their performance reports and presented bi monthly to the HB Safeguarding Committee.

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. However this is captured using different methods.

How do we compare with our peers?

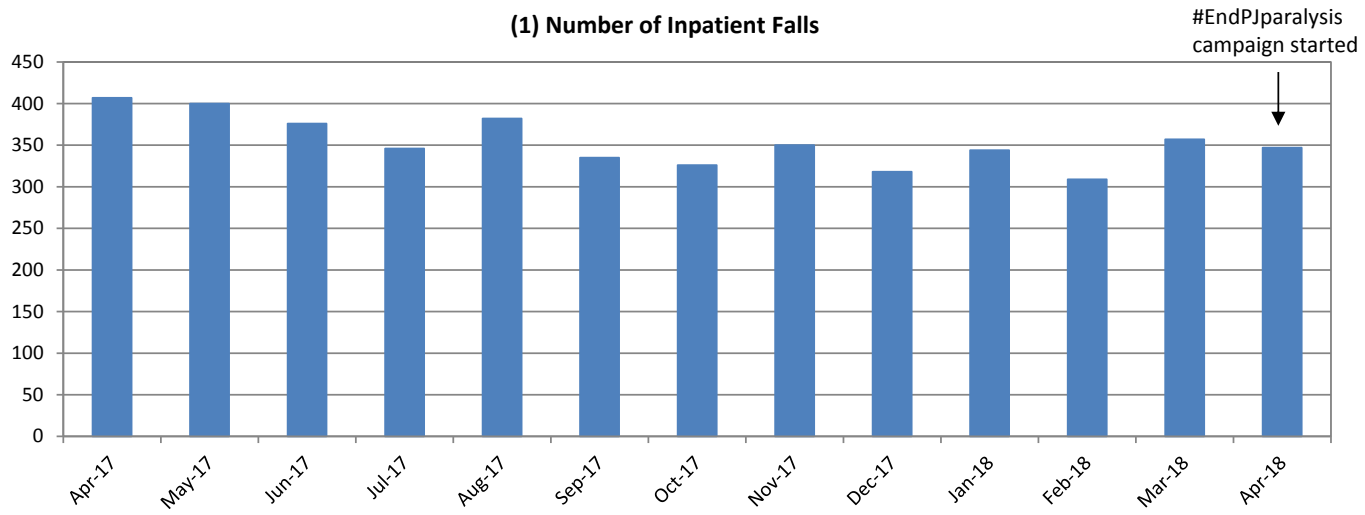
Comparison data from peer organisations not available

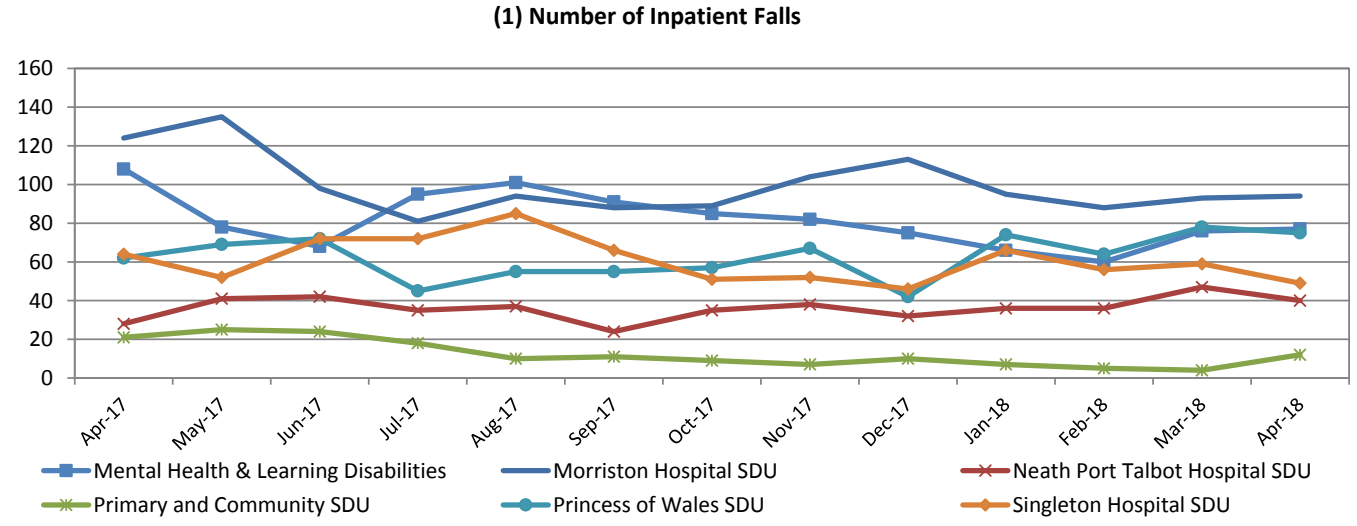
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Total Number of Inpatient Falls

Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Apr 2018	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : ✓	Movement : Improving

Current Trend: Apr 17- Apr 18





Benchmarking

Benchmarking data is not available.

Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of Inpatient Falls

How are we doing ?

The number of falls reported via Datix in April 2018 showed a decrease of 10 from the figures reported in March 2018. When comparing the data for March 2018 and April 2018 the following Units reported a decrease in all falls recorded via Datix: Neath Port Talbot Hospital, Princess of Wales and Singleton. Primary and Community , Mental Health and Morriston reported an increase in falls recorded via Datix. No major falls were reported in April 2018.
This shows an overall reduction for the month of April and the year to date.

What actions are we taking?

The FBMG continues to meet monthly: The Falls Policy has been amended to include Putting Things Right and Serious Incident (SI) reporting mechanisms in place and recirculated to the group will be ratified in the May FPMG. Terms of reference and minutes from all Delivery Unit (DU) Scrutiny panels have been received. The FPMG has undertaken a training needs analysis which was completed and shared with DU's in March 2018 for implementation. Review of equipment ongoing - hi-lo beds purchased and insitu in DU'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.

How do we compare with our peers?

Action plan has been developed as a result of National inpatient falls audit the results and action plan was shared in the April 2018 FPMG meeting.

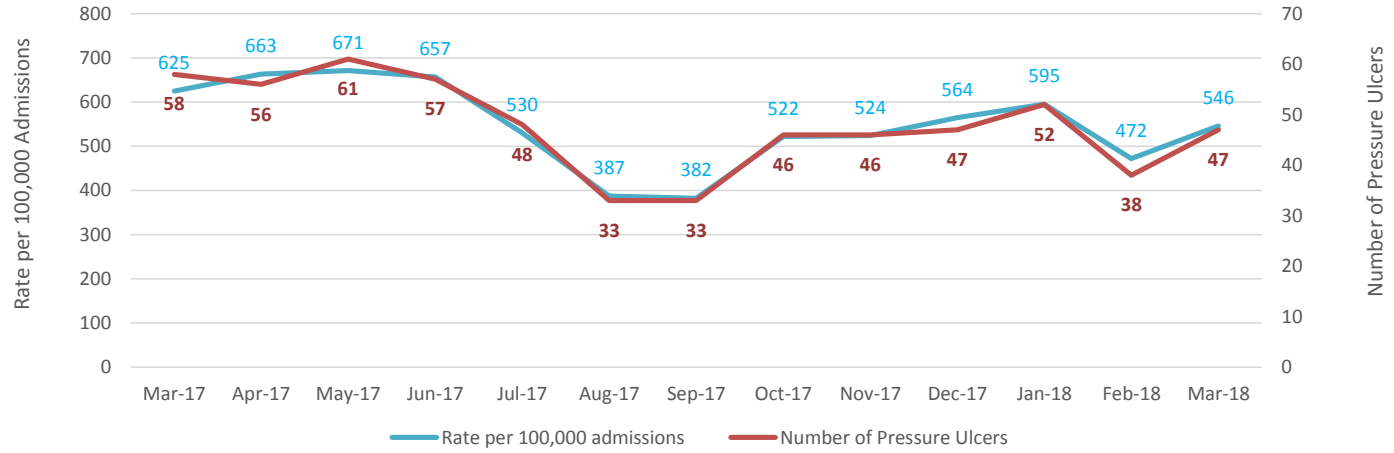
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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.

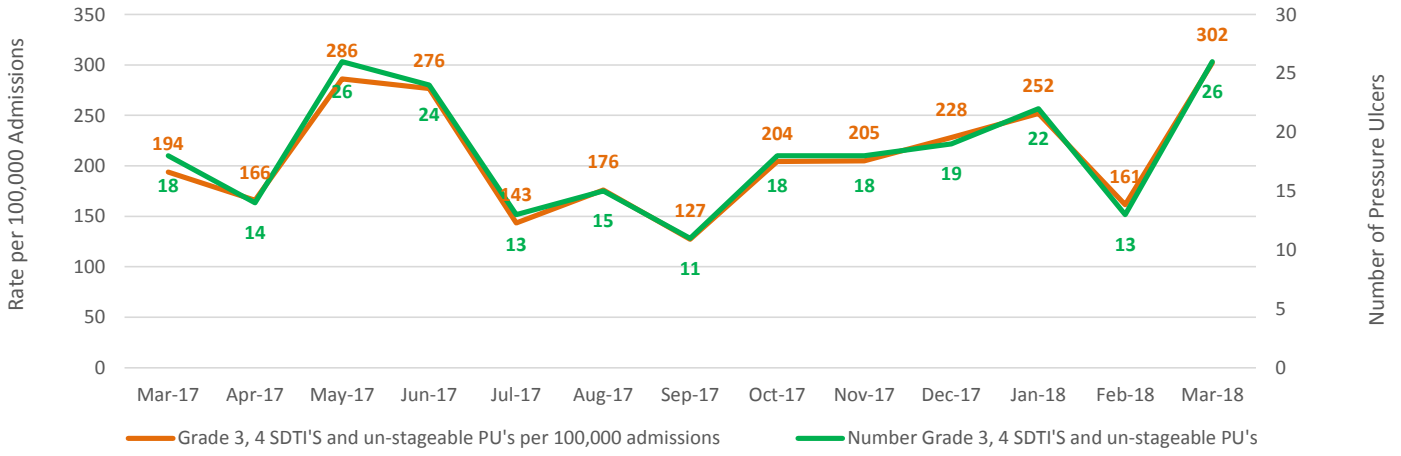
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Mar 2018	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Improving

Current Trend: Mar 17 - Mar 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 2017/18 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 an increase in the rate of pressure ulcer development for inpatients during March 2018. The rate per 100,000 admissions has increased from 472 in February to 546 in March 2018. This reflects an increase of 9 pressure ulcer incidents, from 38 in February 2018 to 47 in March 2018.
• Device related pressure ulcers account for 5 of the reported pressure ulcers in March 2018.
• The rate of Grade 3+ pressure ulcers has increased from 161 per 100,000 admissions in February, to 302 per 100,000 admissions in March 2018.
• Of the 26 Grade 3+ pressure ulcer incidents reported in March, 6 were classified as deep damage and met the criteria for Serious Incident reporting.

What actions are we taking?

• The 4th quarter Pressure Ulcer Prevention Strategic Group meeting (PUPSG) was held in March 2018. PUPSG are continuing to work closely with Welsh Risk Pool to develop a Health Board Strategic Quality Improvement Plan. The plan will be informed by the outcome of the analysis of SI reported pressure ulcers for 2017 -2018. The analysis will produce a heat-map of causal factors that will be used to identify and target work streams to reduce pressure ulcer risk.
• The Serious Incident Pressure Ulcer Causal Factor Analysis report will be presented to PUPSG at the next meeting in June 2018.
• Singleton Hospital is the pilot site for the development of a local strategic quality improvement plan. The plan will be presented to the PUPSG in June 2018.
• Pressure Ulcer Scrutiny Panel Development workshops are being rolled out across the Health Board to support and develop the skills of scrutiny panel members. The first workshop was held on April 17th, eight more sessions are planned ending on 18th May
• The new two step hierarchical pressure ulcer investigation and scrutiny process will go live on Datix at the end of May 2018 to coincide with the completion of the panel development workshops.
• Pressure Ulcer Peer Review Scrutiny Panels are held in all Service Delivery Unit's (SDU's) and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
• Datix scrutiny was conducted for March 2018 data, duplicate entries were identified and the data rectified to ensure Health Board reporting accuracy.

What are the main areas of risk?

Winter pressures on the ambulance service and occupancy of in-patient areas increase the challenge for staff in preventing pressure ulcers. Morriston Hospital has seen a direct correlation with increased USC pressures and pressure ulcer development. Both from the perspective of ward staff's ability to manage the acuity and numbers of extra patients on the wards and because of long waits for ambulances at home and in ambulances at A&E.

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.

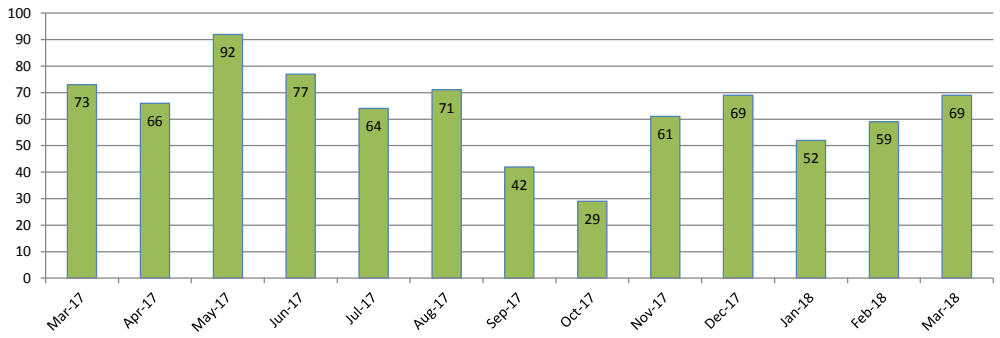
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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.

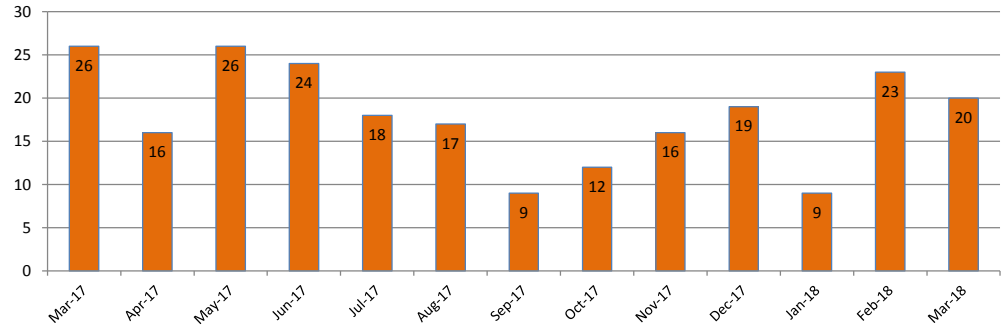
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Mar 2018	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Improving

Current Trend: Mar 17 - Mar 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 March 2018, 69 incidents of pressure ulceration were reported in the community, this is an increase compared to the 59 incidents reported in February 2018 .
• Of the pressure ulcers reported in March, 90% were recorded as superficial damage.
• Device related damage accounts for 4 pressure ulcers, of those, 3 were caused by devices owned by patients.
• There has been a decrease in the number of Grade 3+ pressure ulcers reported, from 23 in February to 20 in March 2018.
• Of the Grade 3+ pressure ulcers reported in March, 7 were considered deep damage and met the criteria for Serious Incident (SI) reporting.
• No Grade 4 pressure ulcers were reported.

What actions are we taking?

• The 4th quarter PUPSG meeting was held in March 2018. PUPSG are continuing to work closely with Welsh Risk Pool to develop a Strategic Quality Improvement Plan. The plan will be informed by the outcome of the analysis of SI reported pressure ulcers for 2017 -2018. The analysis will produce a heat-map of causal factors that will be used to identify and target work streams to reduce pressure ulcer risk.
• The Serious Incident Pressure Ulcer Causal Factor Analysis report will be presented to PUPSG at the next meeting in June 2018 .
• Pressure Ulcer Scrutiny Panel Development workshops are being rolled out across the Health Board to support and develop the skills of scrutiny panel members. The first workshop was held on April 17th, eight more sessions are planned ending on 18th May
• The new two step hierarchical pressure ulcer investigation and scrutiny process will go live on Datix at the end of May to coincide with the completion of the panel development workshops.
• Monthly Quality Improvement Pressure Ulcer meetings, chaired by the Head of Community Nursing provide assurance for effective pressure ulcer prevention and investigation of incidents. The learning from the panel is shared through the Nursing and Community Services Quality and Safety Group, the Unit Quality and Safety meeting and the Pressure Ulcer Prevention Strategic Group.
• Peer review scrutiny panels are held in Swansea, Bridgend and NPT localities, the frequency has been increased to weekly to proactively manage the risks identified. This will increase the number of pressure ulcer incidents scrutinised and enhance local accountability. The learning from each local panel is shared at the Unit Quality Improvement meeting.
• 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.

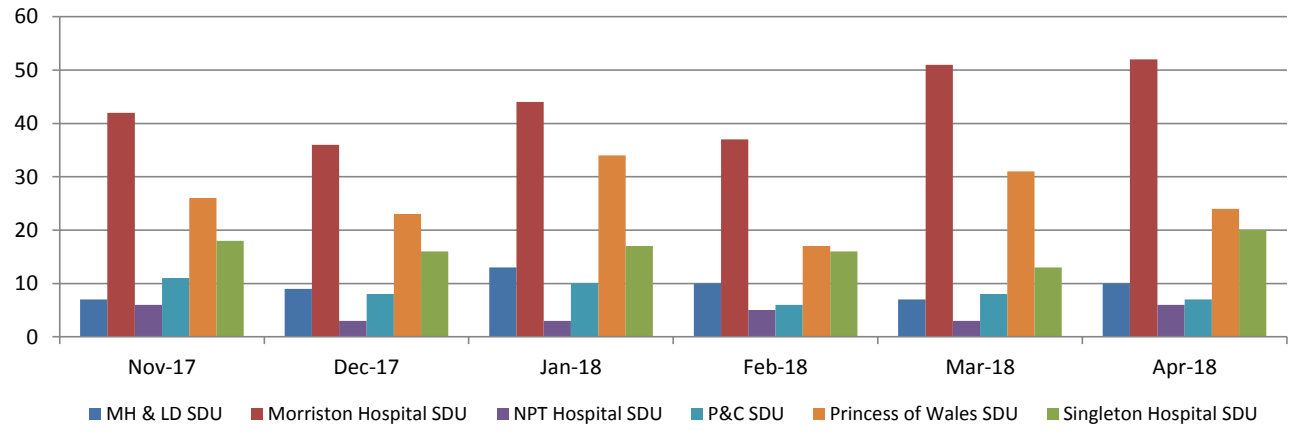
DIGNIFIED CARE: PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

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 : Angela Hopkins	
Period : Apr 2018	IMTP Profile Target : Reduce	WG Target : (1) Monitor, (2) 80%	Current Status : N/A	Movement : Worsening

Current Trend: Nov 17 - Apr 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	
	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
MH & LD SDU	50%	71%	55%	44%	71%	86%	100%	64%	75%	71%	88%	60%	50%
Morriston Hospital SDU	74%	86%	86%	93%	86%	88%	78%	84%	86%	75%	88%	76%	58%
NPT Hospital SDU	80%	40%	50%	80%	100%	57%	50%	78%	83%	83%	67%	100%	100%
Princess of Wales SDU	94%	95%	96%	100%	83%	83%	81%	68%	67%	62%	64%	93%	60%
P&C SDU	42%	50%	46%	55%	56%	88%	67%	60%	75%	82%	100%	75%	88%
Singleton Hospital SDU	69%	77%	63%	60%	81%	65%	81%	83%	79%	72%	73%	75%	53%
Health Board Total	**71%**	**80%**	**75%**	**77%**	**82%**	**80%**	**80%**	**76%**	**78%**	**73%**	**80%**	**80%**	**61%**

(3) % of acknowledgements sent within 2 working days

Percentage Acknowledgements Sent ≤ 2 Working Days	2017									2018			
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
	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 overall Health Board response rate for responding to concerns within 30 working days for March 2018 has been calculated as 71%, although further checks are being undertaken to validate the data at the time of writing this report.
• The Health Board continues to consistently maintain the 2 day acknowledgement target at 100%.
• Patient Advice Liaison Service (PALS) activity for April 2018, identified 347 contacts of which 3.5% (12)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. The March compliance data is showing an improvement for all Units with the exception of Mental Health & Learning Disabilities which will be addressed at the performance meeting.
• SDU's 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 35 open Ombudsman investigation cases; Morriston 13, Princess of Wales 11, Singleton 7, Mental Health & Learning Disabilities 2 and ; Primary Care and Community Service 2. Recurring themes from the Ombudsman investigations are discharge process, communication, record keeping and poor complaint handling. A more recent theme is waiting lists.
• The Corporate Concerns function has recently embarked on a re-structure and 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.

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.

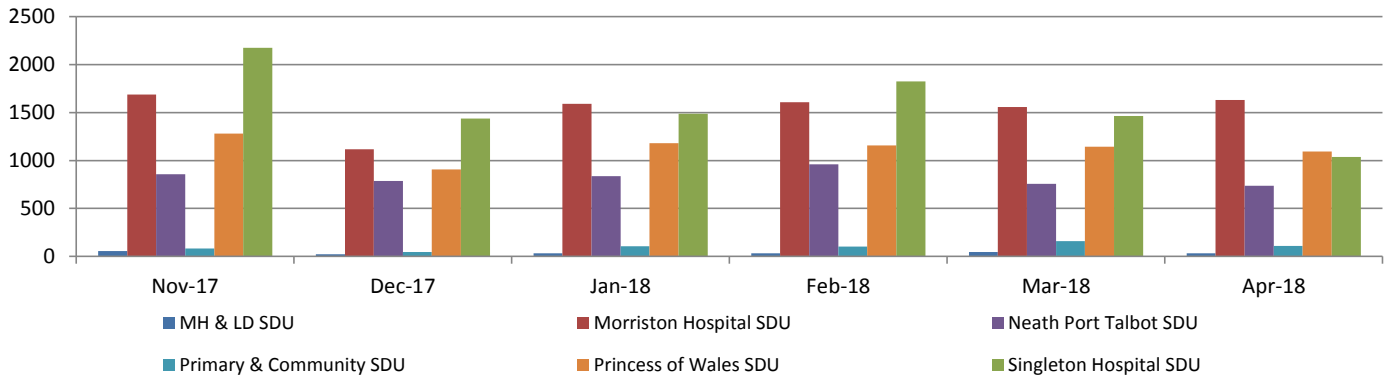
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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 : Angela Hopkins	
Period : Apr 18	IMTP Profile Target :	Local Target : (1) Increase, (2) 90%, (3) 90%	Current Status : ✗	Movement : ↑ Improving

Current Trend: (1) Nov 17 - Apr 18, (2) & (3) Apr 17 - Apr 18

(1) Number of friends and family surveys completed



(2) % of who would recommend and highly recommend

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
MH & LD SDU	95%	79%	61%	87%	69%	76%	87%	84%	65%	73%	91%	76%	72%
Morriston Hospital SDU	92%	92%	94%	93%	93%	94%	94%	94%	92%	93%	94%	93%	94%
Neath Port Talbot SDU	97%	88%	92%	95%	95%	97%	98%	99%	99%	98%	98%	99%	99%
Primary & Community SDU	93%	92%	94%	93%	94%	93%	85%	93%	90%	90%	91%	90%	89%
Princess of Wales SDU	93%	95%	96%	95%	94%	96%	95%	95%	94%	95%	94%	94%	95%
Singleton Hospital SDU	94%	96%	94%	95%	94%	96%	95%	97%	96%	96%	96%	95%	94%
Health Board Total	**93%**	**94%**	**94%**	**94%**	**94%**	**96%**	**95%**	**96%**	**95%**	**95%**	**95%**	**95%**	**95%**

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

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

NS= No Surveys

Target = 90%

Benchmarking

	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
ABMU Response %	10.7%	10.7%	9.2%	11.9%	17.2%	22.4%	24.1%	27.5%	28.9%	27.0%	28.9%	20.0%	22.1%
ABMU Recommendation %	93.6%	93.6%	94.4%	93.3%	93.9%	93.3%	94.5%	95.0%	95.4%	95.5%	96.0%	95.0%	95.7%
Top Equivalent Organisation Response %	19.3%	16.5%	16.3%	20.8%	18.7%	22.8%	20.1%	18.8%	15.7%	17.5%	17.0%	14.1%	14.6%
Top Equivalent Organisation Recommendation %	96.5%	96.4%	95.4%	96.6%	97.2%	96.7%	97.0%	96.8%	97.7%	97.0%	98.1%	97.0%	97.5%
NHS England Benchmark Response %	23.1%	24.3%	25.4%	25.3%	25.5%	25.4%	25.6%	25.8%	24.6%	24.9%	25.1%	21.4%	22.7%
NHS England Benchmark Recommendation %	95.4%	95.5%	95.6%	95.8%	95.9%	95.1%	95.6%	95.6%	95.6%	95.6%	95.6%	95.0%	95.5%

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 APRIL
Health Board Friends & Family patient satisfaction level in April was 95% which is the same for March.

- Neath Port Talbot Hospital completed 735 surveys for April with a recommendation score of 99%. The return rates for the Unit noticed a slight decrease of 23 on the number of surveys received in March.
- Singleton Hospital completed 1,034 surveys for April with a recommended score of 94%. The feedback returned a recommended score of 95% for March.
- Morriston Hospital completed 1,629 surveys for April which is an increase of 71 compared with March, with a recommend score of 94%, for April.
- Princess of Wales Hospital completed 1,095 surveys for April, which is an decrease of 47 compared with March, with a recommended score of 95% for April.
- Mental Health & Learning Disabilities completed 32 surveys for April, which is a decrease of 14 compared with March.
- Primary & Community Care completed 111 surveys for April, which is an increase decrease of 48 compared with March, with a recommended score of 89% for April.

What actions are we taking?

PLEASE NOTE THAT THIS IS A ONE MONTH REPORT FOR APRIL
The number of feedback forms completed for Friends and Family in April was 4,722 and in March 5,190, which is a decrease of 468 (9%) forms.

Year end figures show 2016-2017 received 56,174 F&F forms. For 2017-2018 we received 69,914 F&F forms, this is a significant increase.

- During April the Data drop down subject and sub subject box was added to the snap system. The purpose is to capture more data on themes and trends.
- During March and April 12 unique bespoke surveys were developed to capture feedback on various projects across ABM.
- Patient feedback is now collect in 341 areas across ABM.
- Online alerts are now changing from ward managers and lead nurses to go direct to PALS & PEAS teams, agreed in the Datix/Snap user group. This will stop duplication, help to improve the service for the patients.

What are the main areas of risk?

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

How do we compare with our peers?

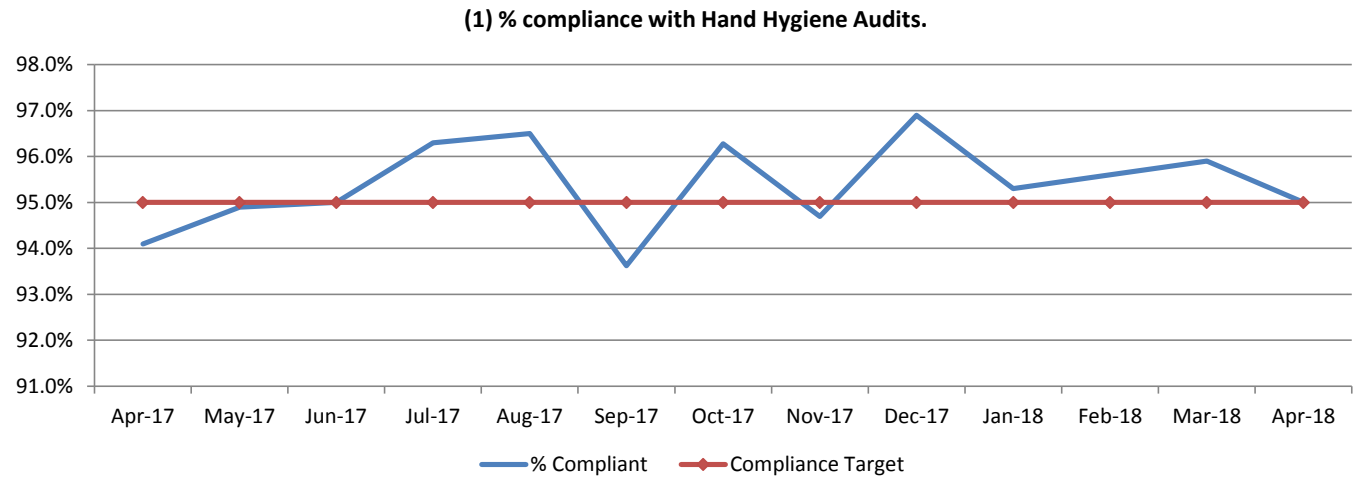
Monthly/bi monthly data not available on an all Wales basis to compare.

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

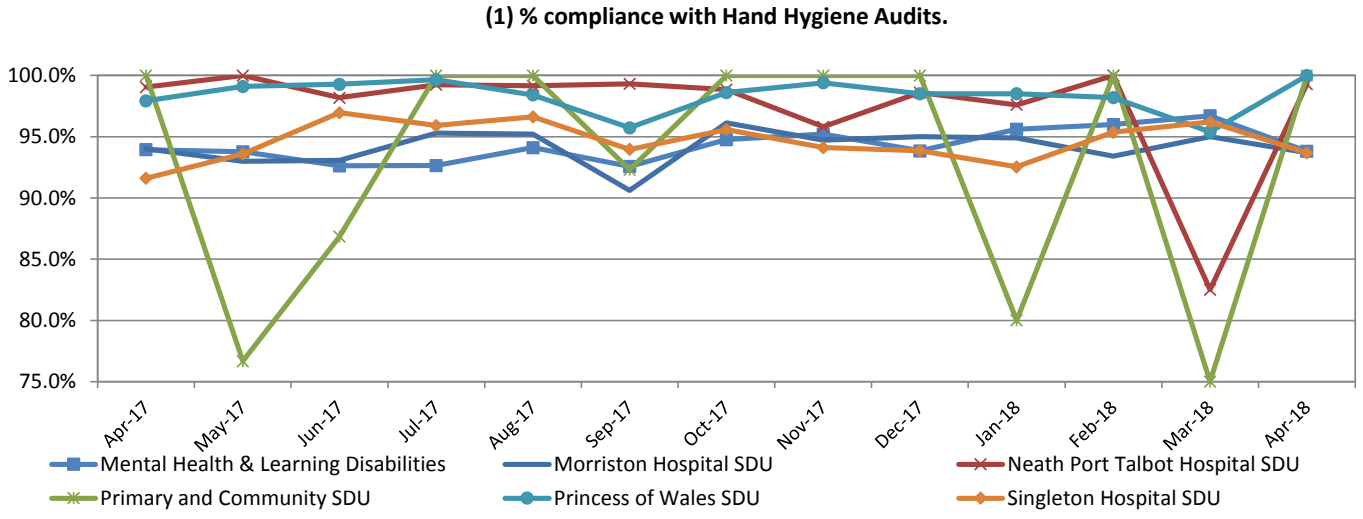
Measure 1: % compliance with Hand Hygiene Audits

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Apr 2018	IMTP Profile Target : 95%	WG Target : N/A	Current Status : ✓	Movement : ↑ Improving

Current Trend: Apr 17 - Apr 18



Benchmarking



Source : ABMU Care Matrix

Measure 1: % compliance with Hand Hygiene Audits

How are we doing ?

• Compliance with hand hygiene (HH) for April 2018 was approximately 95 %.
• For April 2018, 86 wards/units (62%) reported compliance ≥95%.
• 10 wards/departments (7%) reported compliance ≥90% ≤94%; 23 wards/units (17%) reported compliance ≤89%.
• 20 wards/departments had not uploaded the results of their audits undertaken in April 2018.
• Three of the six Service Delivery Units (SDU) reported compliance ≥95% (Primary Care and Community Services, Princess of Wales, and Neath Port Talbot); Morriston, Singleton and Mental Health & Learning Disabilities reported compliance ≥90% in April 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.
• 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?

Data not available.

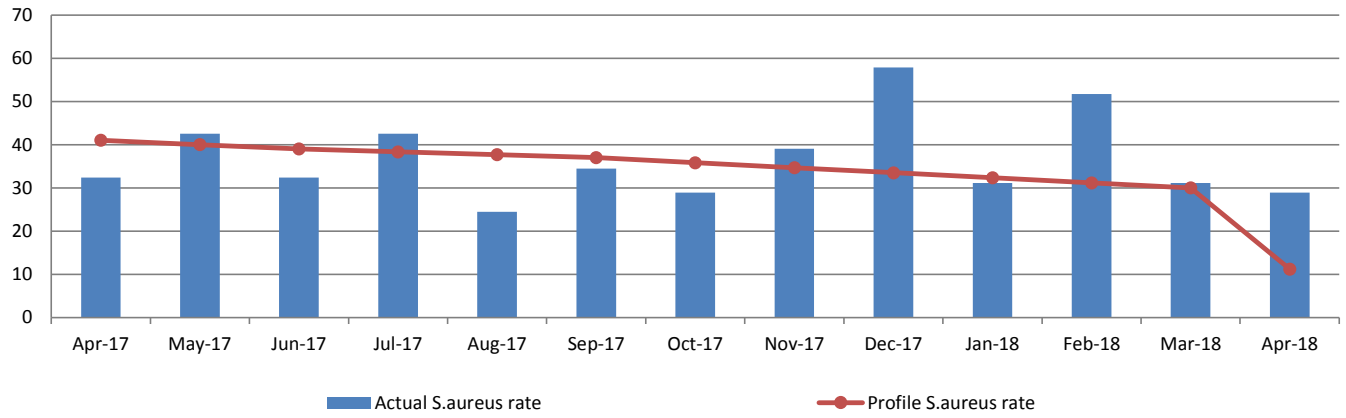
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Apr 2018	IMTP Profile Target : 11.2	WG Target : Reduce	Current Status : ✓	Movement : Improving

Current Trend: Apr 17 - Apr 18

(1) Number of cases of S. aureus bacteraemia per 100,000 of the population.



Benchmarking

(1) Number of cases of S. aureus bacteraemia per 100,000 of the population.

LHB	Apr 17 - Mar 18	Cumulative Number Against Mar 18 Reduction Expectation
Wales	30.13	+319
ABM	37.22	+92
AB	25.85	+41
BCU	28.60	+61
C&V	31.64	+59
Ctaf	33.88	+42
Hdda	34.14	+55

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected

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

Measure 1: Number of cases of S. aureus bacteraemia per 100,000 of the population

How are we doing ?

• In April 2018, the Health Board's total number of cases was 14 cases. This exceeded the IMTP profile for April by 1 case.
• Of the 14 cases, 6 (43%) were hospital acquired infections; 8 (57%) were community acquired infections. Morriston and Princess of Wales Hospitals accounted for 50% each of the hospital acquired cases. One of the hospital acquired cases in Princess of Wales Hospital was an MRSA bacteraemia.
• There were 14% fewer cases of Staph. aureus bacteraemia in April 2018 compared with April 2017.

What actions are we taking?

• 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.
• 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.

What are the main areas of risk?

• 57% of Staph. aureus bacteraemia is community acquired, with many patient related contributory factors, such as recreational infecting 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 2017/18, ABMU had the highest cumulative incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards.
• No national surveillance data has been published for NHS Wales for the month of April 2018.

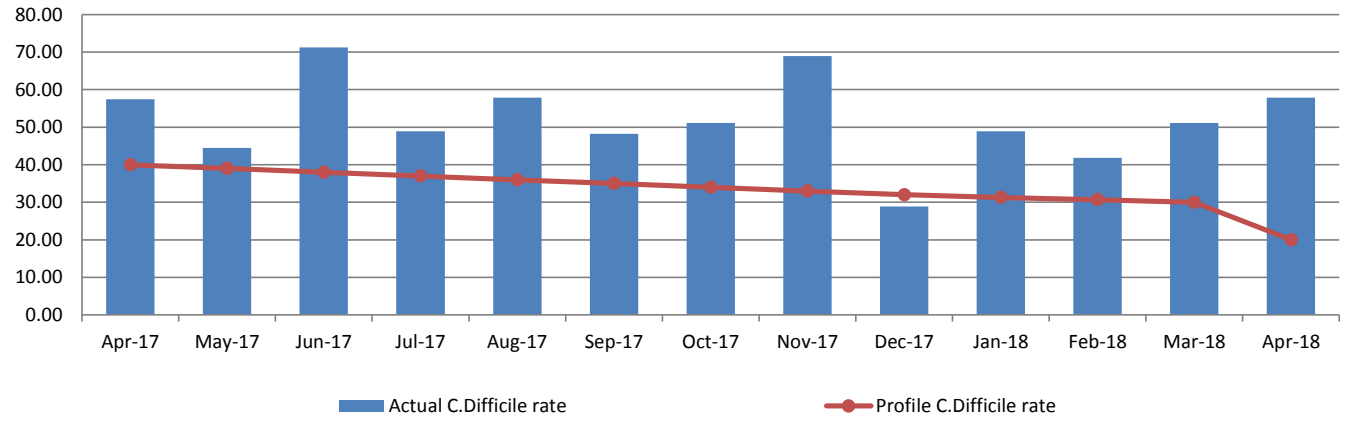
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of C Difficile per 100,000 of the population

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Apr 2018	IMTP Profile Target : 20.0	WG Target : Reduce	Current Status : ✖	Movement : ⇨ Stable

Current Trend: Apr 17 - Apr 18

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



Benchmarking

(1) Number of cases of C Difficile per 100,000 of the population.

LHB	Apr 17 - Mar 18	Cumulative Number Against Mar 18 Reduction Expectation
Wales	36.59	+334
ABM	52.52	+142
AB	36.81	+70
BCU	39.38	+94
C&V	25.72	0
Ctaf	18.78	-3
Hdda	40.66	+57

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected

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

Measure 1: Number of cases of C Difficile per 100,000 of the population

How are we doing ?

• In April 2018, the Health Board's total number of cases was 26 cases. This exceeded the IMTP profile for April by 5 cases.
• Of the 26 cases, 20 (77%) were hospital acquired infections (HAI); 6 (23%) were community acquired infections. Morriston Hospital DU accounted for 50% of the hospital acquired cases. Neath Port Talbot Hospital DU and Princess of Wales Hospital DU each accounted for 20% of all HAI. Singleton Hospital DU accounted for 10% of HAI.
• Neath Port Talbot had a period of increased incidence of infection in April; there was at least one transmission event associated with Ward B2.
• There number of cases of C. difficile infection in April 2018 was equal to the number of cases in April 2017, and was one case fewer than the number of cases in March 2018.

What actions are we taking?

• More restrictive antimicrobial guidelines have been amended – proposed implementation date is 12 June 2018.
• The Risk Assessment and Safe System of Work protocol in relation to UVC were accepted as satisfactory by HSE in May 2018. Updated training programme, based on new safe system, has been developed. Staff side continue to express concern regarding re-introduction of UV-C, which is planned by 30 June 2018.
• Invitations have been circulated for expressions of interest for the QI Lead for Infection in each of the Delivery Units – these expressions of interest will 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.
• Studies have identified a correlation between peak incidence for Influenza and pneumonia and a subsequent peak in C. difficile incidence, approximately 9 weeks later, or with a 1-2 month lag (respectively). At the peak of seasonal influenza in 2018, the incidence was almost x4 more than the peak in 2017. The HB should anticipate increased incidence of C. diff between March and May 2018

How do we compare with our peers?

• In 2017/18, ABMU had the highest cumulative incidence of Clostridium difficile infection comparison with the other major Welsh Health Boards.
• No national surveillance data has been published for NHS Wales for the month of April 2018.

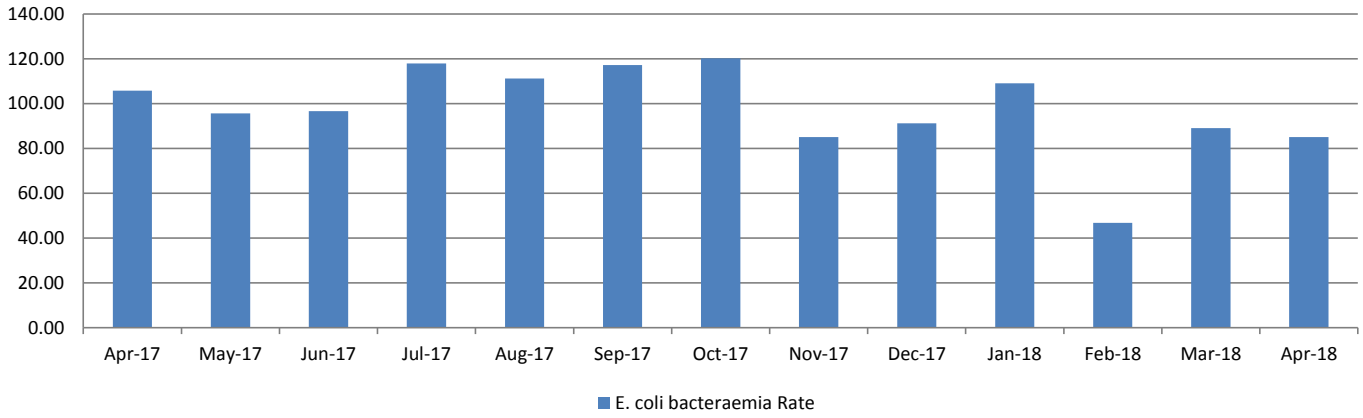
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Apr 2018	IMTP Profile Target :	WG Target : Reduce	Current Status : ✓	Movement : Improving

Current Trend: Apr 17 - Apr 18

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



Benchmarking

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

LHB	Apr 17 - Mar 18	Cumulative Number Against Mar 18 Reduction Expectation
Wales	82.84	+503
ABM	99.00	+172
AB	75.67	+88
BCU	75.59	+61
C&V	70.62	+56
Ctaf	91.58	+75
Hdda	118.06	+197

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected

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

Measure 1: Number of cases of E. coli bacteraemia per 100,000 of the population

How are we doing ?

• In April 2018, the Health Board's total number of cases was 42 cases. This was 3 cases less than the IMTP profile for April.
• Of the 42 cases, 32 (76%) were community acquired infections (HAI); 10 (24%) were hospital acquired infections. Of the 10 hospital acquired cases, Princes of Wales Hospital DU and Singleton Hospital DU each had 3 cases; there were 2 cases associated with Morriston Hospital DU; Neath Port Talbot Hospital DU and Mental Health & Learning Disabilities each had one hospital acquired case.
• In 2017/18, 37.5% of the total cases of E. coli bacteraemia had a probable urinary source and almost a third of these were associated with urinary catheters. Identifying the probable source of E. coli bacteraemias is key to developing focussed Quality Improvement programmes.
• There were 12.5% fewer cases of E. coli bacteraemia in April 2018 compared with April 2017.

What actions are we taking?

• Basic level analysis of local surveillance in 2017/18 identified that in 37.5% of cases, the urinary tract was considered to be the source of the bacteraemia; 20% were considered to be associated with hepato-biliary disease; 10% were considered to be associated with respiratory infections.
• 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; Princess of Wales DU has commenced a pilot od 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?

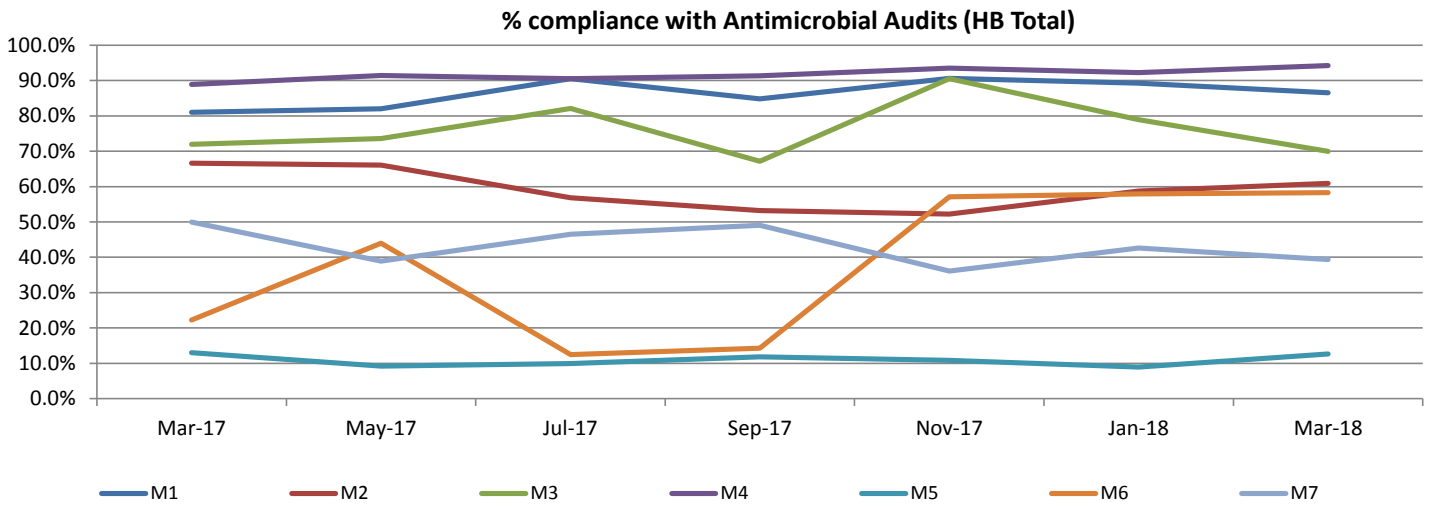
• In 2017/18, ABMU had the second highest cumulative incidence of E. coli bacteraemia in comparison with the other major Welsh Health Boards.
• No national surveillance data has been published for NHS Wales for the month of April 2018.

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

Measure 1: % indication for antibiotic documented on medication chart, Measure 2: % stop or review date documented in medication chart, Measure 3: % of antibiotics prescribed on stickers, Measure 4: % appropriate antibiotic prescriptions choice, Measure 5: % of patients receiving antibiotics for more than 7 days, Measure 6: % of patients receiving surgical prophylaxis for more than 24 hours, Measure 7: % of patients receiving IV antibiotics > 72 hours

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Sandra Husbands	
Period : Mar 2018	IMTP Profile Target :	Local Target : (1) >95% (2) >95% (3) >95% (4) >95% (5) ≤20% (6) ≤20% (7) ≤30%	Current Status : ✖	Movement : ⇨ Stable

Current Trend: Mar 17 - Mar 18



Mar-18	POW	Morriston	Singleton	NPTH	MH & LD	HB Total
1: % indication for antibiotic documented on medication chart	92.1%	89.0%	81.5%	93.3%	64.7%	86.5%
2: % stop or review date documented on medication chart	60.5%	62.2%	56.5%	70.0%	66.7%	60.9%
3: % of antibiotics prescribed on stickers	100.0%	-	63.6%	100.0%	47.1%	70.0%
4: % appropriate antibiotic prescriptions choice	94.4%	95.0%	93.7%	100.0%	84.6%	94.2%
5: % of patients receiving antibiotics for more than 7 days	9.2%	17.6%	4.1%	20.0%	8.3%	12.6%
6: % of patients receiving surgical prophylaxis for more than 24 hours	0.0%	75.0%	-	100.0%	-	58.3%
7: % of patients receiving IV antibiotics > 72 hours	25.0%	48.2%	20.7%	66.7%	-	39.4%

Source : ABMU Pharmacy

Measure 1: % indication for antibiotic documented on medication chart, Measure 2: % stop or review date documented in medication chart, Measure 3: % of antibiotics prescribed on stickers, Measure 4: % appropriate antibiotic prescriptions choice, Measure 5: % of patients receiving antibiotics for more than 7 days, Measure 6: % of patients receiving surgical prophylaxis for more than 24 hours, Measure 7: % of patients receiving IV antibiotics > 72 hours

How are we doing ?

• There continues to be poor completion of the 'Start Smart Then Focus' review box after 48 hours. This section acts as a prompt for early review of antibiotics, encouraging an IV to oral switch. Prescribers must review patients daily and switch IV antibiotics to oral alternatives where this is possible and clinically appropriate, as per the IV to Oral Switch Policy. Nurses and pharmacists must prompt review of IV antibiotics and encourage prescribers to complete the 48-72 hour review section. A recent study has shown that stop rates can be increased to as high as 30% through a simple intervention suggesting that current rates of stopping antibiotics on review (around 5%) are inappropriately low.
• Indiscriminate prescribing of co-amoxiclav outside of the antimicrobial guidelines continues to be observed. Co-amoxiclav is a broad-spectrum antibiotic which poses a high risk of precipitating C. difficile-associated disease.

What actions are we taking?

• The health board is currently undergoing a consultation to remove co-amoxiclav from use (except on Consultant Microbiologist advice) in order to improve antibiotic stewardship (resistance rates to co-amoxiclav are as high as 40% in some settings) and reduce C. difficile rates. Further information will be circulated via Delivery Unit Medical Directors in due course.
• Junior doctors across the health board are undertaking a Quality Improvement Project in antibiotic stewardship.

What are the main areas of risk?

• Patients receiving IV antibiotics for longer than 72 hours where it may be possible to switch to an oral alternative.
• The 'Start Smart Then Focus' review after 48 hours is not being documented on the antimicrobial chart by prescribers.

How do we compare with our peers?

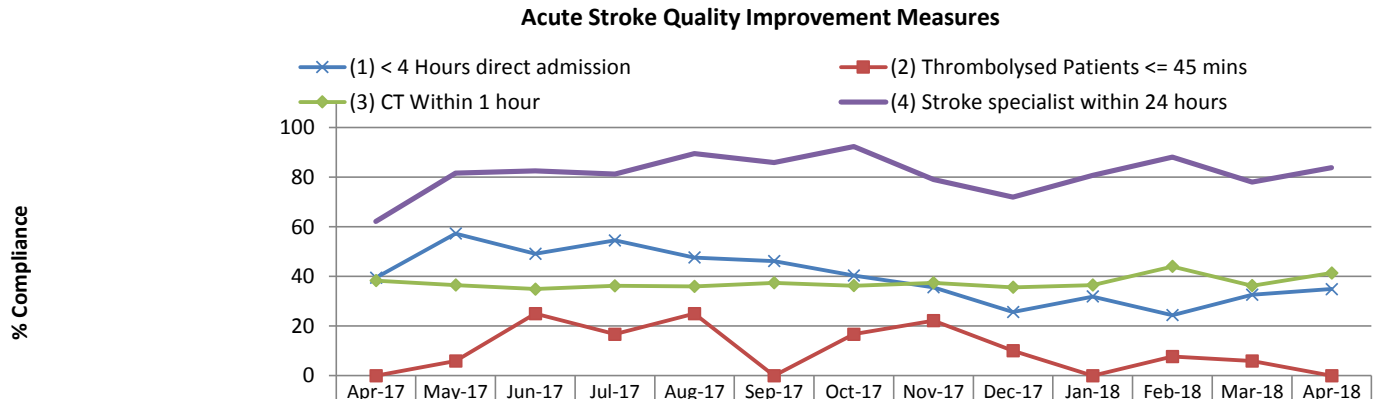
No national data available for comparison.

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 : Apr 2018	IMTP Profile Target : (1)45% (2)20% (3)40% (4)75%	WG Target : 95%	Current Status : ✗	Movement : ↑ ● Improving

Current Trend: Apr 17 - Apr 18



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
(1) < 4 Hours direct admission	39.5	57.3	49.1	54.5	47.6	46.2	40.4	35.6	25.6	31.9	24.4	32.6	34.9
(2) Thrombolysed Patients <= 45 mins	0	5.9	25	16.7	25	0	16.7	22.2	10	0	7.7	5.9	0
(3) CT Within 1 hour	38.3	36.56	34.9	36.2	36	37.4	36.3	37.4	35.6	36.5	44	36.26	41.4
(4) Stroke specialist within 24 hours	62.2	81.6	82.6	81.2	89.5	85.9	92.3	79.1	71.91	80.77	88.1	78.02	83.9

Benchmarking

Thrombolysis Quality Improvement Measures April 18	AB	ABM	BCU	C&V	Ctaf	Hdda
1a - Percentage of All Strokes Thrombolsyed - H16.3	20.0%	13.8%	14.6%	19.1%	5.7%	17.1%
2b - Percentage of Eligible Patients Thrombolsyed - H16.55	92.9%	92.3%	92.3%	100.0%	100.0%	100.0%
1a - Thrombolysed Patients with Door-to-Needle <= 30 mins	0.0%	0.0%	7.7%	0.0%	0.0%	16.7%
2b - Thrombolysed Patients with Door-to-Needle <= 45 mins	25.0%	0.0%	23.1%	44.4%	0.0%	50.0%
3c - Thrombolysed Patients with Onset to-Needle <= 90 mins	0.0%	0.0%	0.0%	11.1%	0.0%	25.0%
4d - Thrombolysed Patients with Pre and Post Thrombo NIHSS Score	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%

Stroke Quality Improvement Measures April 18	AB	ABM	BCU	C&V	Ctaf	Hdda
1. < 4 Hours Care Performance Indicator	41.3%	35.6%	39.3%	46.8%	48.6%	65.7%
1a - Direct Admission to Acute Stroke Unit - H7.18	42.5%	34.9%	37.2%	52.2%	48.6%	59.6%
1b - Swallow Screening - H14.20	73.1%	69.1%	90.8%	67.4%	80.0%	87.7%
2. < 12 Hours Care Performance Indicator	97.5%	94.3%	97.8%	100.0%	100.0%	98.6%
2a - CT Scan - H6.12	97.5%	94.3%	97.8%	100.0%	100.0%	98.6%
3. < 24 Hours Care Performance Indicator	80.0%	80.5%	77.5%	80.9%	57.1%	82.9%
3a - Assessed by Stroke Consultant - H9.3	97.5%	83.9%	79.8%	91.5%	60.0%	95.7%
3b - Assessed by Stroke Nurse - H8.3	98.8%	94.3%	94.4%	91.5%	91.4%	98.6%
3c - Assessed by One of OT, PT, SALT	81.3%	97.7%	95.5%	93.6%	68.6%	85.7%
4. < 72 Hours Care Performance Indicators	93.8%	96.6%	95.5%	89.4%	94.3%	94.3%
4a - Formal Swallow Assessment - H15.24	100.0%	88.9%	100.0%	85.2%	91.7%	100.0%
4b - OT Assessment - H10.24	93.8%	97.1%	95.0%	95.1%	96.7%	94.7%
4d - SALT Communication Assessment - H12.24	100.0%	97.7%	97.6%	100.0%	96.7%	100.0%
5. < 1 Hour Care Performance Indicator	60.0%	41.4%	39.3%	66.0%	74.3%	72.9%
5a - CT Scan	60.0%	41.4%	39.3%	66.0%	74.3%	72.9%

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

Source : ALL WALES PERFORMANCE SUMMARY (APRIL 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 during April remained challenging and was impacted by unscheduled care pressures at the early part of April and also by staffing gaps in some key areas as a result of staff turnover and recruitment into key clinical roles.
• Overall confirmed stoke admissions reduced by 8% in April 2018 when compared with April 2017, although Morriston stroke unit saw an 11% increase in admissions in this comparative period.

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 1 include:

Morriston

• Increase the number of protected ring-fenced stroke beds and improved governance arrangements to support the ring-fenced protocol.
• Planned increase in medical cover from July which should improve timeliness of patient assessment.
• Stroke Retrieval pilot planned for June through development of a dedicated assessment area on Ward F and enhanced medical staffing to support (dedicated) early stroke assessment in ED.
•Refresh swallow screening training.

Princess of Wales

• Focus on improving 4 hours – number of actions to support including role of Clinical Site Managers/Assessment Bed protocol – Consultant Job planning (including review of TIA service)/review of stroke pathway to Neath Port Talbot hospital.
• The planned relocation of the TIA clinic in the next few months will release clinical nurse specialist time to support patient flow.
• Reviewing stroke pathway with the support of the Delivery Unit - to identify and address any barriers – initial feedback workshop in June

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 – post out to advert.
• Review the rehabilitation pathway to identify opportunities to support the provision of early supported discharge for stroke patients.
Review thrombectomy pathway alternatives following withdrawal of access to pathway by North Bristol stroke unit

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 April, and in line with a number of other Health Boards was affected by the significant unscheduled care pressures experienced in early April 2018. The Health Board thrombolysis rates were amongst the highest in April but improving access to thrombolysis within the 45 minute measure and access to CT scan within 1 hour requires further improvement to bring performance closer to peers .