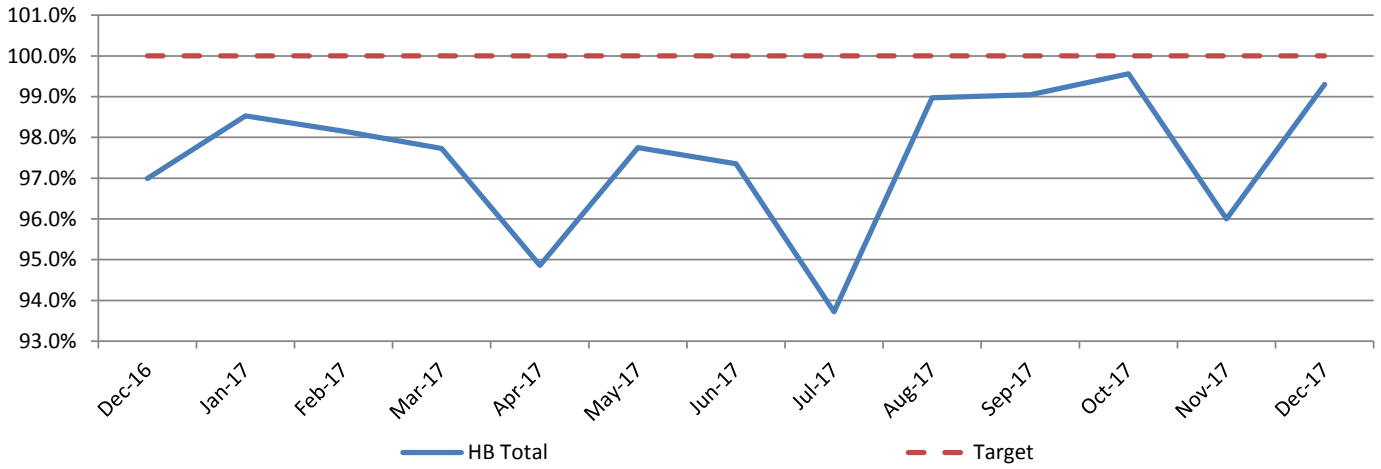
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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

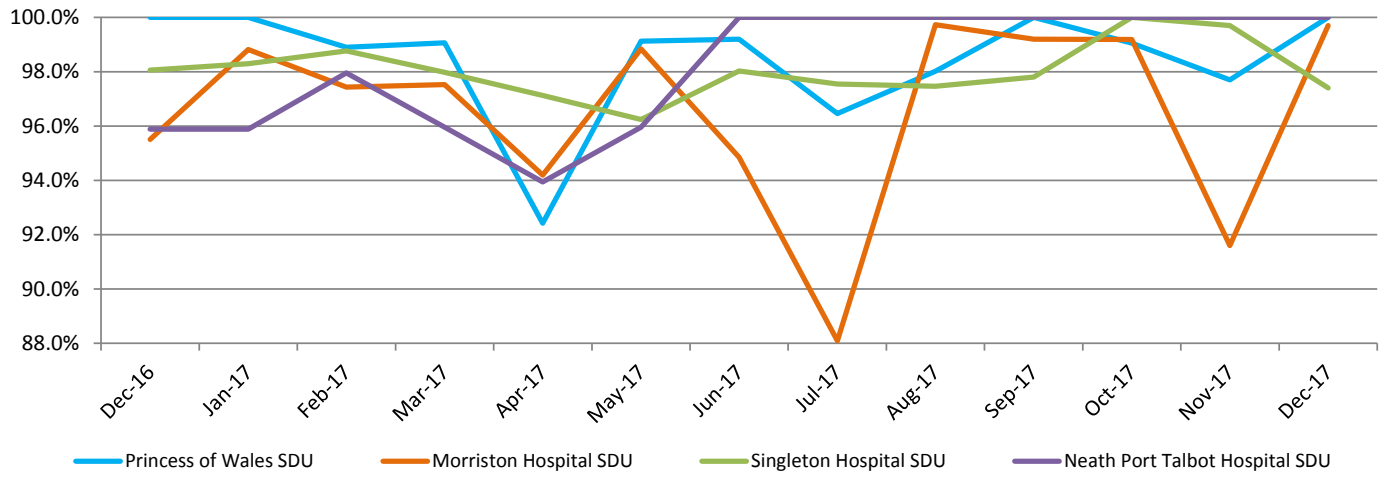
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Dec 2017	IMTP Profile Target : N/A	Local Target : 100%	Current Status :	Movement : Improving

Current Trend: Dec 16 - Dec 17

(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 December 2017 was 99.3%, compared with 96.0% in November 2017.
• In December both NPT and POWH achieved 100%
•Morriston achieved 99.7%
•Singleton achieved 97.4%

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- StSP has been rolled out to 10 wards and champions identified. Education & training has been expanded. HCSWs are responding well to training being delivered by HCSW Sepsis Champions. A Sepsis Focus Fortnight is planned.
• NPTH- New alerts stickers to prompt investigations into Acute Kidney Injury, sepsis and general deterioration have been introduced. Every resuscitation trolley in NPTH will have a "Sepsis Bucket", containing what staff need for sepsis screening, by 1st December. The StSP Training Strategy has been approved, champions are being identified for each ward and education will be delivered on wards as part of the normal working day.
• POWH - there are Sepsis Trays on all wards which will be part of the daily checklist in the same way as resuscitation trolleys. The new sepsis screening tool is being implemented. Hoping to recruit to a Band 6 Outreach post.
• Singleton - Sepsis trolleys are being trialled. Funding to pilot StSP/Sepsis initiatives in line with Morriston has been secured. Sepsis books have been ordered.

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.

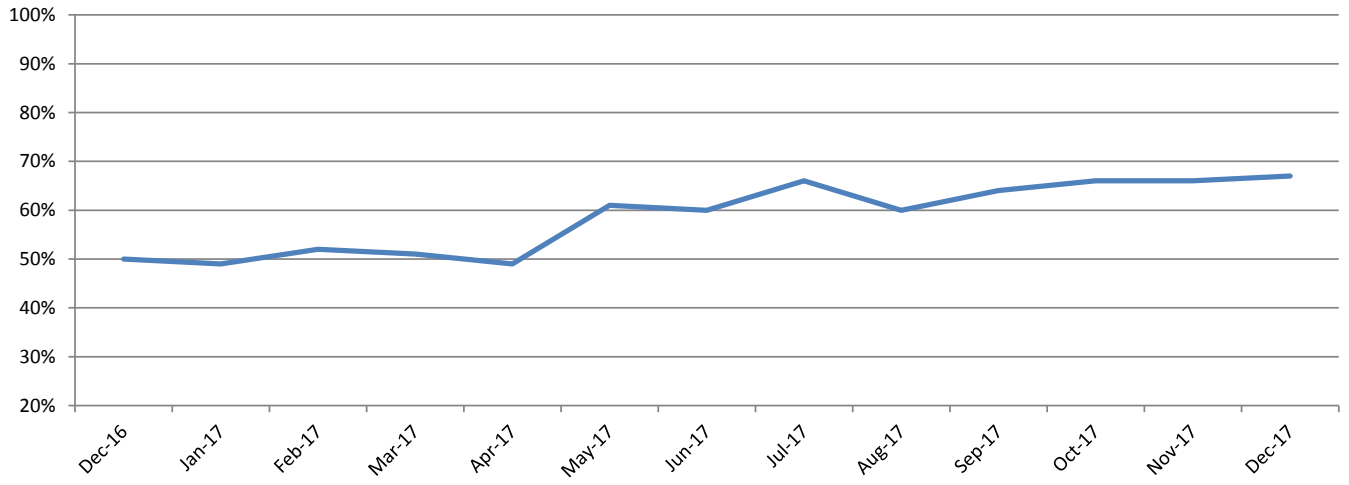
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % of completed discharge summaries

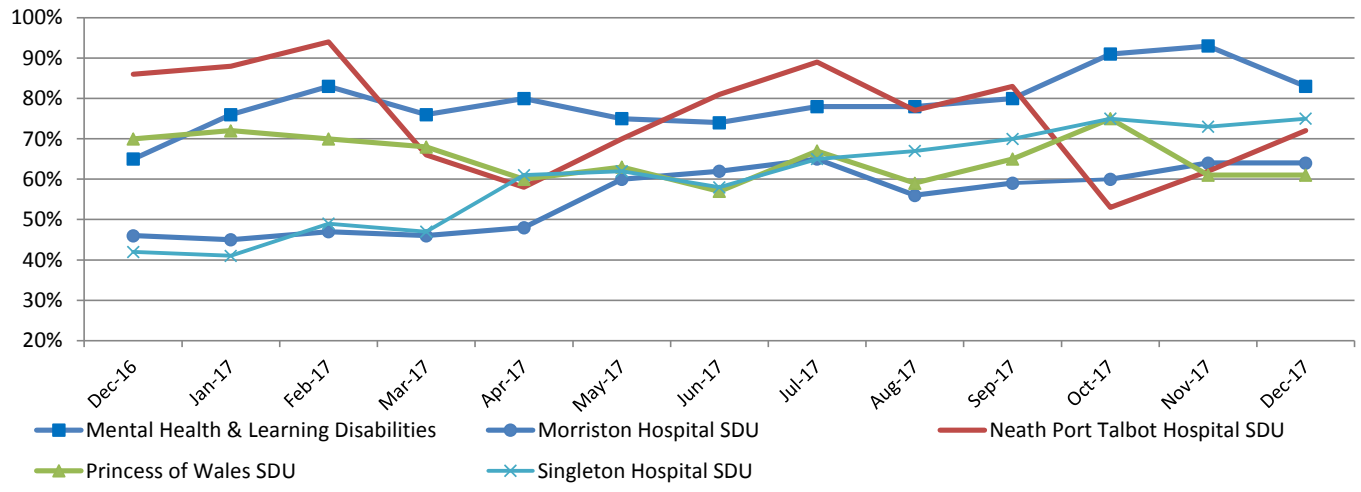
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Hamish Laing	
Period : Dec 2017	IMTP Profile Target : Improve	WG Target : 100%	Current Status : N/A	Movement : Improving

Current Trend: Dec 16 - Dec 17

(1) % of completed discharge summaries ABMU



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



Benchmarking

Welsh Government benchmarking data is not yet available. It is expected at some point during 2017/18

Source : ETOC Dashboard

Measure 1: % of completed discharge summaries

How are we doing ?

• Performance in this quality priority has improved continuously since December 2016 (67% compared with 50%).
• There continues to be performance variance between Service Delivery Units (61%-83%).
• This month the performance has improved in 2/5 Delivery Units, remained static in 2/5 and decreased in one Unit.
• Mental Health & Learning Disabilities was the best performer achieving 83%, despite a reduction in performance compared with November.

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 will be meeting with T&O Leads at Morriston and POWH to emphasise the need to prioritise discharge summaries.
• Morriston's 6 month Discharge Improvement Programme has now ended. It has achieved a steady improvement during this period but has remained the same for the past two months. Performance is being closely monitored by Service Managers to sustain the improvement. Where services are struggling due to gaps in doctors' rotas, other approaches to completing the eToC are being explored (Nurse Practitioners/ Physicians' Associates). The Morriston UMD is working with IT and Informatics to explore the possibility of sending automated emails to individual consultants if an eToC has not been completed within 48hrs . The UMD is having targeted discussions with T&O and Burns & Plastics teams to support them to improve performance
• Singleton is undertaking an improvement project in relation to discharge summaries and how the Physician' Associate role could improve communication.
• Discharge summary performance is monitored and discussed at NPT's monthly Medical Consultant meetings. Performance on the Medical wards that are under NPT's direct management control is consistently excellent although eToCs for deceased patients are not always being completed. The need for these has been reinforced with Consultants.
• The primary measure being used in POWH 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?

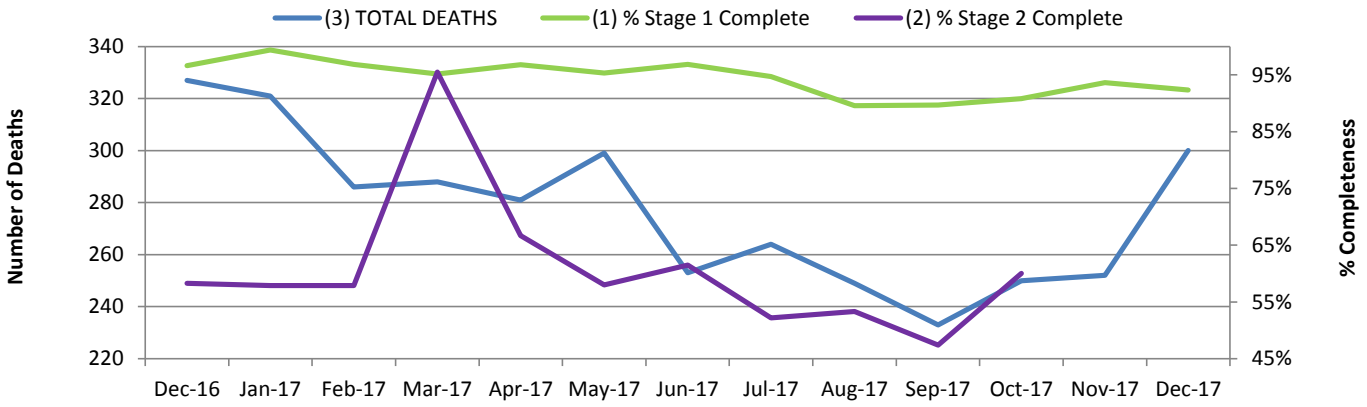
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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 : Dec 2017	IMTP Profile Target : (1) 96%	WG Target : (1) 95%	Current Status : ✖	Movement : Worsening

Current Trend: Dec 16 - Dec 17

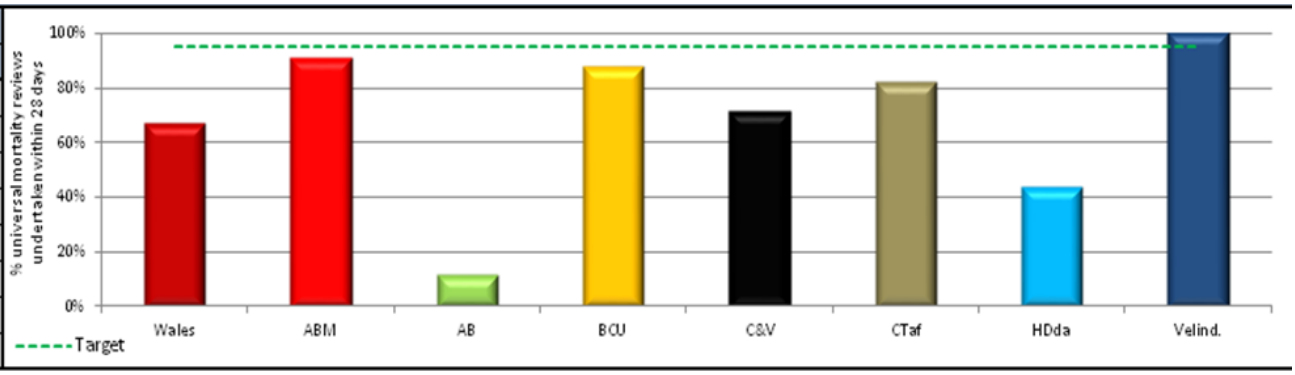
(1) % Universal Mortality Reviews (UMR) undertaken within 28 days of death, (2) % Stage 2 Review forms completed, (3) Number of Hospital Deaths of persons over the age of 16 (Excluding Emergency Department)



Benchmarking

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

LHB	Current Oct-17
Wales	66.5%
ABM	90.4%
AB	11.2%
BCU	87.4%
C&V	71.2%
CTaf	81.7%
HDda	43.2%
Velind.	100.0%



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2017)

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 continues to be the best performing Health Board achieving 90.4% completion of UMRs within 28 days of death in October. Only Velindre Trust performed better but they have very few in-hospital deaths. The Wales compliance was 66.5% in October.
•The Health Board UMR rate in December was 92% compared with 94% in November. Singleton achieved 100%. POW achieved 97%, Morriston 86% and NPT 57% (4/7). There were 24 missing UMR forms; 3 each in POWH and NPT and 18 in Morriston.
• 19 deaths triggered a Stage 2 review in December compared with 21 in November.
•Completion of Stage 2 reviews within 8 weeks (October deaths) was 50% , a slight increase from the previous month (47%). There are 72 outstanding Stage 2 reviews from April - October 2017.
• Mental Health and Community data are unavailable via the eMRA application at present. This is being addressed by Informatics.
• Thematic reviews - These are being worked through by the UMDs. Infections remains the most frequent theme.

What actions are we taking?

• Morriston 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 proposal has been agreed by the Morriston Clinical Cabinet and is expected to be implemented shortly.
•The Oncology Clinical Director, and one of the other Oncology Consultants, are working through the small backlog of Oncology Stage 2 reviews.
•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 is being piloted in the NPT Locality from January 2018.
•A new mortality reporting process has been developed based on the mortality dashboard. One of the Delivery Units presents their feedback and lessons learned at each Clinical Outcomes Group (COG) meeting and onwards to the next Quality & Safety Committee as part of the DU's report
•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.

What are the main areas of risk?

•Timeliness of Stage 2 completion.

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 October 2017 and was above the all-Wales position (90.4% compared with 66.5%).

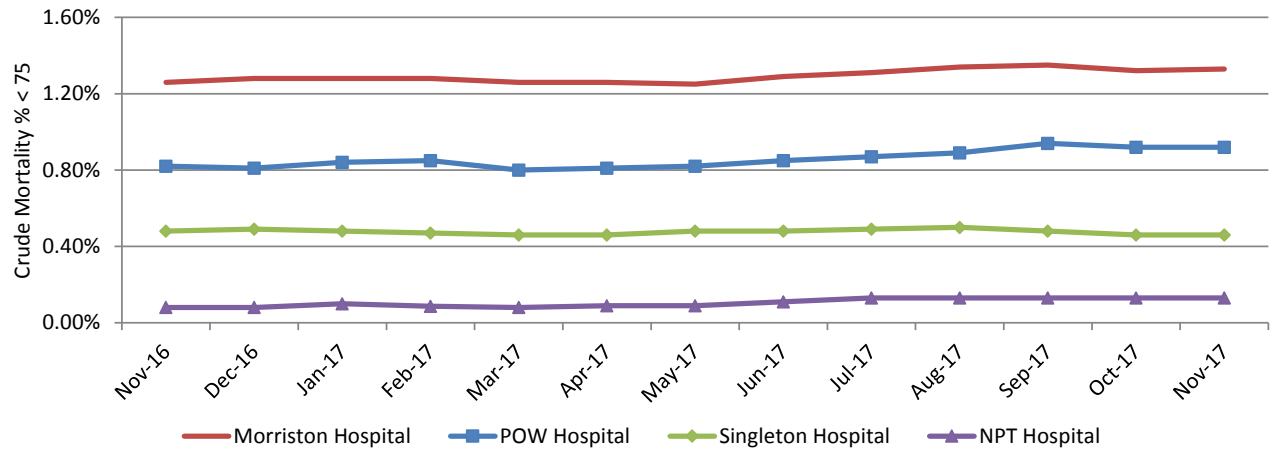
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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 : Nov 2017	IMTP Profile Target :	WG Target : 12 month reduction trend	Current Status : ✖	Movement : ⇨ Stable

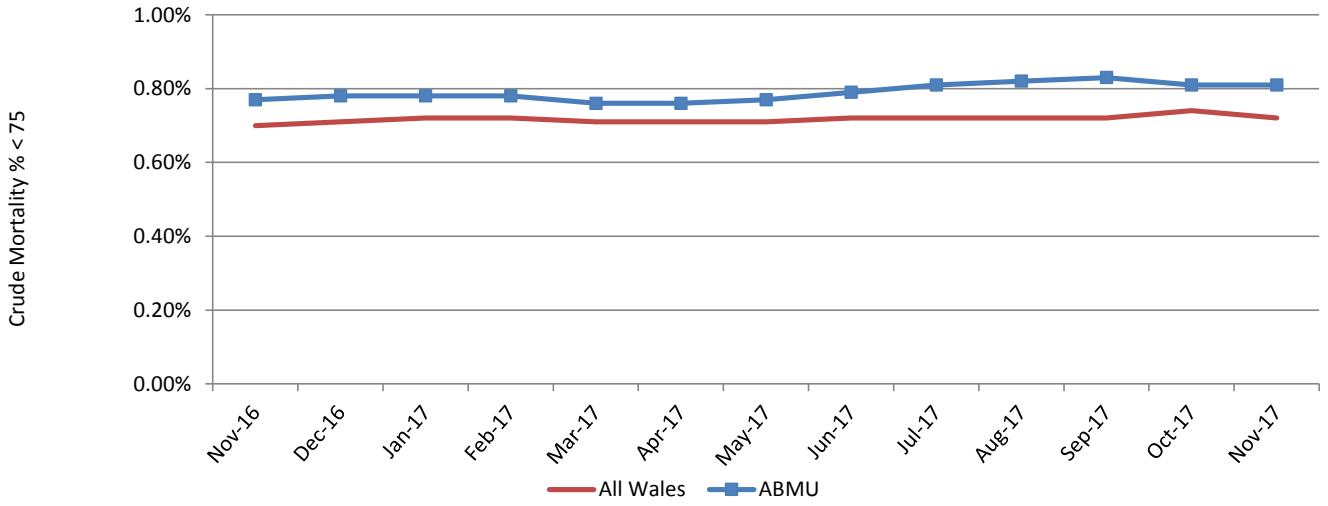
Current Trend: Nov 16 - Nov 17

(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 (JANUARY 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 November 2017 was 0.81%. This is higher than the same period last year which was 0.77%.
• At a site level performance is as follows: (previous year in brackets) Morriston 1.33% (1.26%), Princess of Wales 0.92% (0.82%), Neath Port Talbot 0.13% (0.08%), Singleton 0.46% (0.48%). Site comparison is not possible due to different service models being in place.
• There were 95 in-hospital Deaths in this age group in December 2017 compared to 118 in December 2016: Morriston 53 (59), PWH 25 (26), NPTH 0 (1), Singleton 16 (30).
• 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. This has recently been refined and changed, where applicable the format of the report will be the same across the four main acute Hospital Mortality Reports for consistency.
• 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. Morriston Hospital will present at January's COG.
• 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 beginning of December demonstrated that in the majority of cases nothing untoward was noted. Infections were 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 Q&SC in December and agreed. UMDs will be asked to ensure that outstanding Stage 2 reviews for deaths prior to January 2017 that have not been referred to the Coroner, or did not have a Datix entry, are completed.

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 November 17 – 0.81% compared with 0.72%.
•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%).

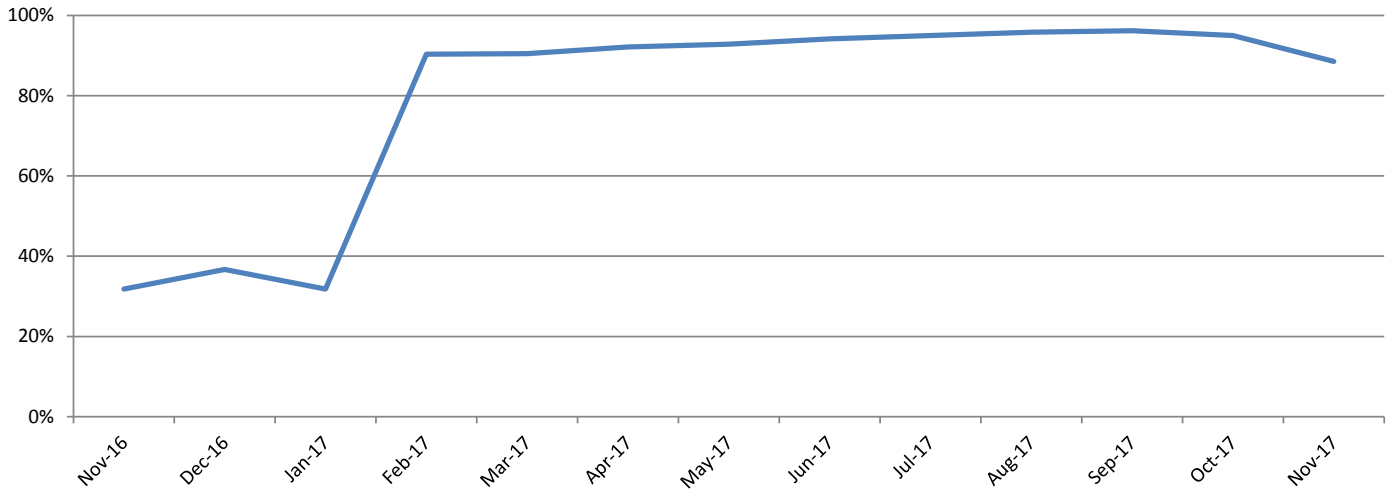
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE

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 : Nov 2017	IMTP Profile Target :	WG Target : 95%	Current Status : ✓	Movement : Improving

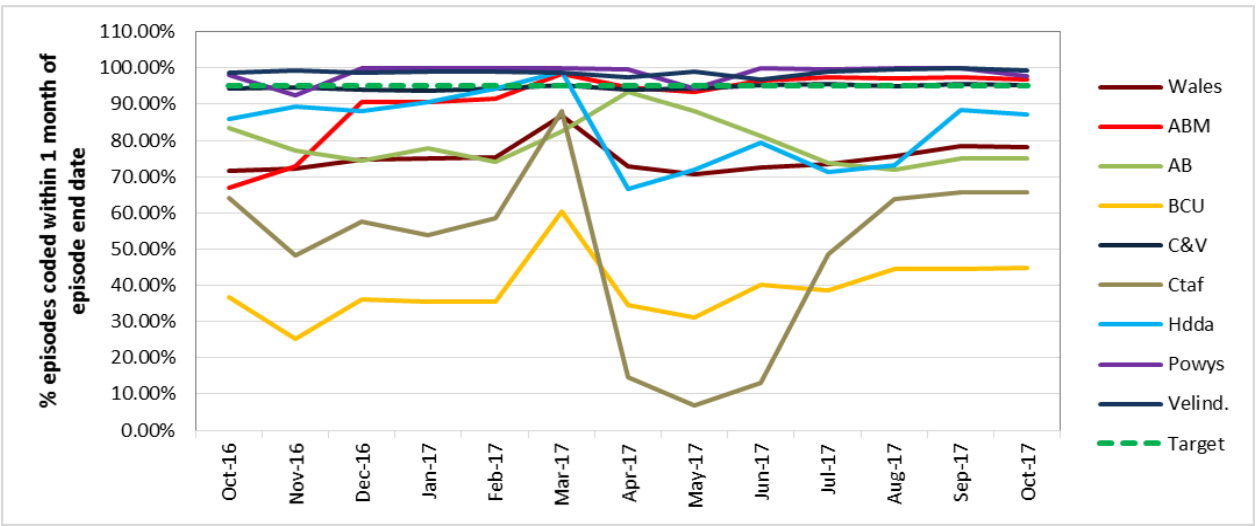
Current Trend: Nov 16 - Nov 17

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



Benchmarking

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



Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2017)

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 - 99.35%, May - 99.16%, June - 98.99%, July - 99.26% , August - 98.71%, September - 98.35%, and October is 98.19%. 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 November is 88.58%. For the first time since June 2017 the 95% target within 30 days has not been met. The target has now been achieved but unfortunately outside of the 30 day timescale. The reasons for not achieving the target were that the department had a high level of sickness and seasonal annual leave during this period. As a result they were not able to meet the required daily demand of throughput. In the long term, once qualified the trainee staff will provide additional resources in the department to mitigate against this situation. It is expected that the December position will improve.

• The 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 acute 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 Board that provides acute service with October 2017 over 96%.

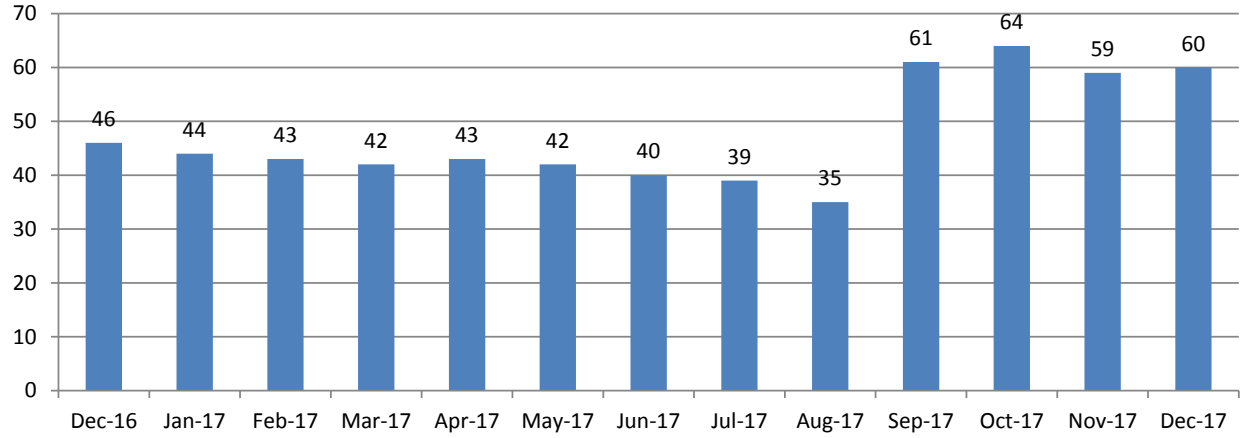
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of risks with score ≥ 20

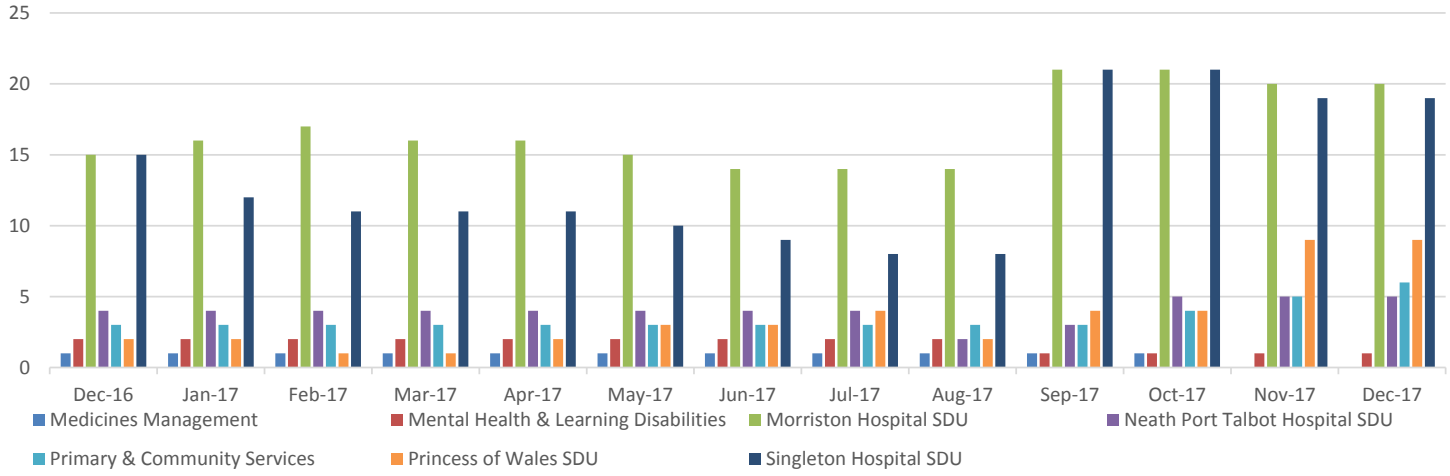
Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			**Executive Lead : Angela Hopkins**
Period : Dec 2017	**IMTP Profile Target : Reduce**	**Local Target : Reduce**	**Current Status :** ✖	**Movement :** ▲ ● **Worsening**

Current Trend: Dec 16 - Dec 17

(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 and above were open in December 2017.
• This is compared to 59 in November 2017. The Health Board Risk Advisor is working with the Units in the form of an Audit of the Risk Module.

What actions are we taking?

• The Health Board Risk Advisor is undertaking a review of the Corporate Risk Register which includes analysis of the unit specific reviews conducted by Service Unit Directors of the risks for their units. This will ensure the risks are appropriately identified, graded, with adequate controls in place and clear actions identified to mitigate the risk to an agreed acceptable level. This exercise continues.
• The Risk Management Strategy and Risk Management Policy are currently being reviewed following the Board development session in the autumn on risk, to take account of changes required as a result of the workshop. A risk management improvement plan will be produced by the end of Quarter 4.
•An Action planning session was held for delivery units to improve the quality of actions reinforcing the SMART principles. This took place in December 2017.
• The Risk Team are supporting the Director of Corporate Governance to develop a Board Assurance Framework and ensure that the Datix system is reviewed and updated to support this work.

What are the main areas of risk?

The highest risks for the Health Board during December related to:
• **Workforce planning and ensuring appropriate levels of skilled staff are in place within the Health Board (Risk Ref 3) linked to the Health Boards objective Sustainable & Accessible Services-** 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 receives regular updates on this risk.
• **Finance (Risk Ref 2) linked to the Health Board Objective Effective Governance**- The controls in place and actions being taken to decrease the risk are provided within the relevant entry on the Corporate Risk Register for the risk identified and the Audit Committee and Board receive reports at each meeting on financial performance and proposed actions to mitigate the risk which is a challenge for 2017/18.
• **Unscheduled Care (Risk Ref 1)**- During quarter 3 of 2017/18 the risk rating for this was increased from 15 to 20 as a result of the winter pressures. The winter plan has been implemented and additional surge capacity of circa 91 beds have been opened above baseline capacity. Health Board and Local Authority Executive to Executive discussions to explore short term and longer term solutions are taking place in January. Health Board wide campaign to highlight risk to patients through prolonged lengths of stay.

How do we compare with our peers?

No comparable data available

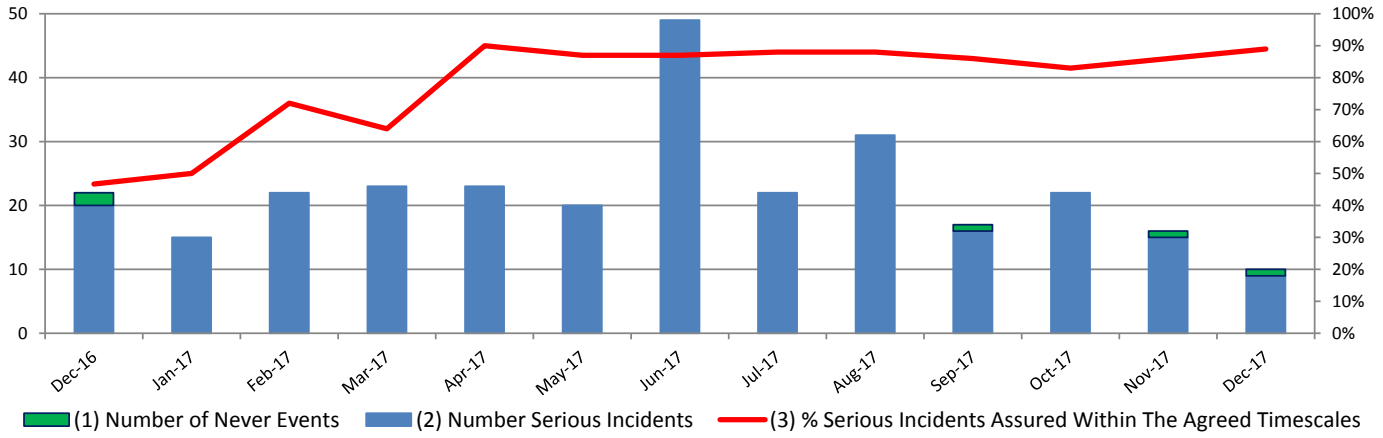
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : Dec 2017	IMTP Profile Target : (1) 0, (2) Improve, (3) 80%	WG Target : (1) 0, (2) Improve, (3) 90%	Current Status : N/A	Movement : Improving

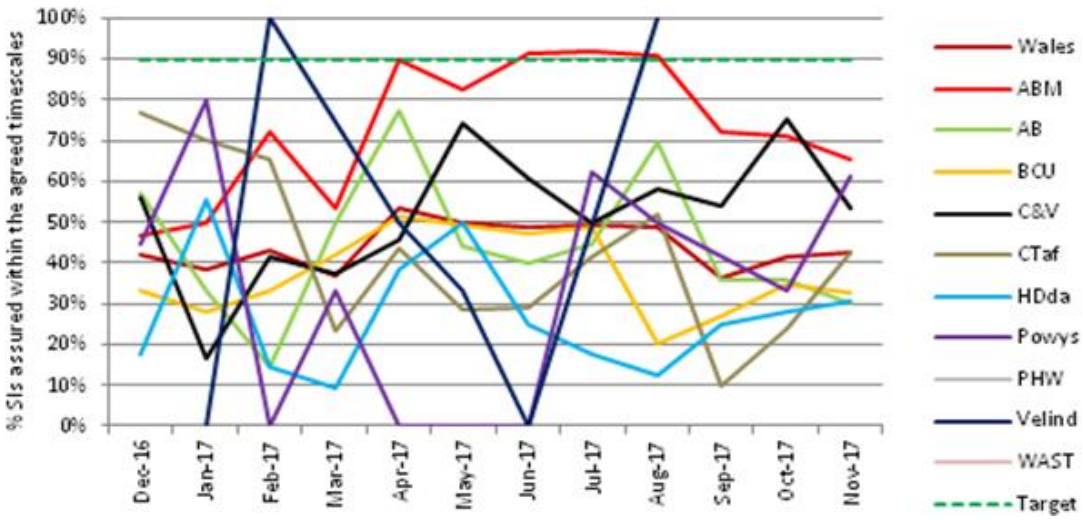
Current Trend: Dec 16- Dec 17

(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

Nov-17	
Wales	4
ABM	1
AB	0
BCU	1
C&V	1
Ctaf	0
Hdda	1
Powys	0
PHW	0
Velind	0
WAST	0

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2017)

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 December 2017 was 2,154. This compares to 1,866 incidents reported in December 2016, an increase of 288 incidents for the month of December (increase of 13.4%).
• 9 Serious Incidents were reported to Welsh Government (WG) in December 2017 representing 0.4% of all incidents. In comparison 20 SI's were reported to WG in December 2016, a decrease of 11 incidents (Decrease of 55%). Of the 9 new serious incidents reported to Welsh Government, 4 (44%) related to pressure ulcer incidents (grade 3 and above), 1 was completed suicide of a patient recently discharged from MH services, 3 related to patient falls which resulted in a fractured neck of femur for two of the patients, and fractured skull for the third patient who subsequently died. The last incident was an Ophthalmic Never Event Incident (wrong intraocular lens).
• In terms of severity of incidents, the percentage of incidents resulting in severe harm for December 2017 was 0.32% (total incidents reported 2,154). The Health Board's target for incidents resulting in severe harm is less than 0.5% of the total number of incidents reported.
• One Never Event was reported in December 2017.
• Performance against the WG target of closing SI's within 60 working days for December 2017 was 89% against the WG target of 80%
• All closure forms submitted to WG in December 2017 received assurance and were closed by WG.

What actions are we taking?

• Performance against the WG target to gain assurance on the reports within 60 working days (80%), remains consistently above the 80% target since April 2017. All submitted closure forms received assurance by WG in December 2017 evidencing continued improvement in the quality of forms submitted.
• The SI Team continued to provide support to the Delivery Unit (DU) in providing documentation/further information as part of their targeted interventions on the Health Boards serious incident and never event processes. The anticipated issue date for the draft report remains the end of January 2018.
• In response to the new Never Event an executive led strategy meeting has been held. The Serious Incident Team have proposed that a learning and reflection event will be held in due course. This approach has now been trialled on the previous Never Event in Morriston where the SI Team facilitated a multidisciplinary team reflection event. The event was attended by colleagues from NHS Wales Delivery Unit who fed back positively. Staff who attended the event have also fed back positively on how the event was inclusive and less punitive. The SI Team are continuing to develop the methodology for wider consultation.

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.
• SUIs in Theatres in Morriston SDU on the basis that four of the Never Events (within the last twelve months) have occurred in this area.

How do we compare with our peers?

• The Health Boards compliance in closing serious incidents down by the Welsh Government target date has been consistently above the all-Wales average and remains above the 80% closure target since April 2017.

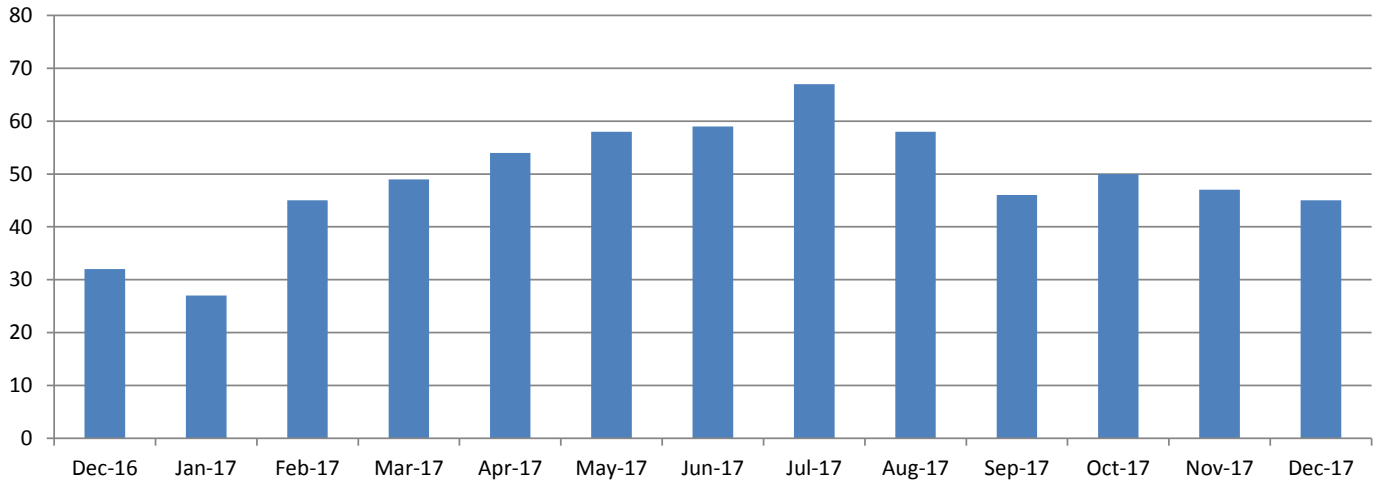
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of Safeguarding Adult Incidents

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Dec 2017	IMTP Profile Target : N/A	Local Target : 0	Current Status : ✖	Movement : ⇧ Worsening

Current Trend: Dec 16 - Dec 17

(1) Number of Safeguarding Adult Incidents



(1) Number of Safeguarding Adult Incidents

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
MH & LD SDU	13	11	28	23	25	34	33	39	34	35	34	29	34
Morriston Hospital SDU	3	1	2	7	1	0	0	3	5	4	5	5	3
NPT Hospital SDU	3	2	6	4	8	5	4	3	2	1	4	2	0
Primary & Community SDU	8	7	7	4	8	10	13	11	9	2	5	7	6
Princess of Wales SDU	1	3	1	10	11	5	9	4	3	2	1	1	0
Singleton Hospital SDU	4	3	1	1	1	4	0	7	5	2	1	3	2
Health Board Total	32	27	45	49	54	58	59	67	58	46	50	47	45

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 incidents over previous months remains consistent with no significant difference over the past 4 months. It is noted that some SDUs have extremely low levels of flagged safeguarding incidents which raises the question regarding the reason behind this.
• The appropriateness of reported Safeguarding Adult incidents also remains consistent; ongoing monitoring of inappropriately flagged incidents has identified common themes such as 'Violence & Aggression' incidents and 'Slips/Trips/falls'. Currently feedback is given to reporters via DATIXWeb to advise them of inappropriately flagged incidents.
• Care & treatment issues and physical abuse remain the most reported categories. Within the latter category, 'patient to patient' assaults remain the highest reported type. Review of these incidents by the Safeguarding Team allows for further discussion with the referring unit to establish whether a safeguarding referral is required, or implementation of a robust safeguarding plan. It has been noted that there has been an increase in the recording of such plans within the DATIX incident record that provides assurance regarding the management of such situations.
• There remains inconsistent reporting of DoLS breaches as Safeguarding Adult incidents. This is evidenced when DATiX reported incidents are compared to the data available from the DoLS database.

What actions are we taking?

• There is guidance available on DATIX regarding reporting Safeguarding Adults incidents which is currently being reviewed to ensure its continued appropriateness. At present feedback regarding inappropriate triggers is only made on an individual basis via DATIXWeb; the Corporate Safeguarding Team will consider a mechanism to feedback to each Service Delivery Unit (SDU) on a wider basis.
• The Corporate Safeguarding Team pilot which plans to improve visibility of the team within the Units commences February 1st In Singleton for a 3 month period. The team plan to spend a designated amount of time within each SDU to provide support and guidance with regards to safeguarding issues and review of safeguarding incidents . This will be reviewed in May 18 and it is planned to roll out across the Health Board.
• The Corporate Safeguarding Team are working with individual Service Delivery Units to ensure the reporting of DoLS breaches is consistent. The team is also liaising with the DATIX team to incorporate a reminder to the DATIX incident screen regarding triggering DoLS breaches as safeguarding incidents; an alternative to this is consideration of a Datix data collection tool which would be beneficial to reduce the administration time of recording DoLS breaches flagged as Safeguarding Adult incidents.
• The Safeguarding Committee and DoLS improvement sub-group continues to monitor the number of DoLS breaches across the organisation. 4 additional members of staff have now been trained to undertake the Supervisory signatory role so an improvement is expected . The SDUs have been requested to ensure all their newly qualified BIAs will be released to e undertake shadowing before commencing assessments. This is expected by May 2018. A BIA rota can then be established to ensure an efficient service whereby all SDUs are able to access a BIA when required.

What are the main areas of risk?

The DoLS breaches continue to be a risk to the organisation.

How do we compare with our peers?

Peer information is not available for comparison.

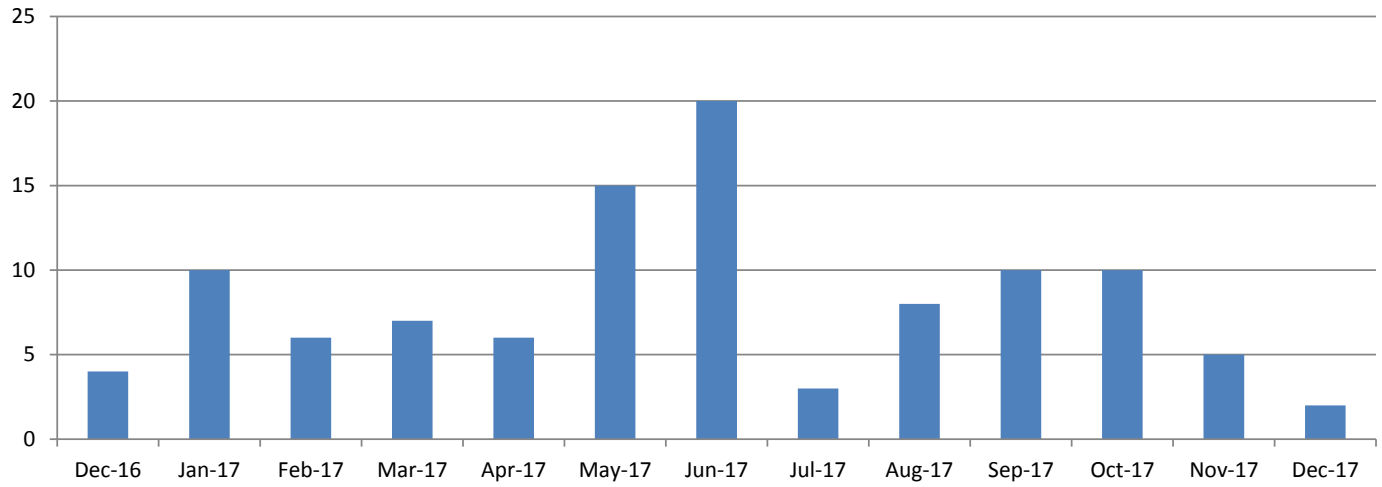
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Number of Safeguarding Children Incidents

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Dec 2017	IMTP Profile Target : N/A	Local Target : 0	Current Status : ✖	Movement : ↓ Improving

Current Trend: Dec 16 - Dec 17

(1) Number of Safeguarding Children Incidents



(1) Number of Safeguarding Children Incidents

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
MH & LD SDU	2	1	0	1	0	3	1	2	0	0	1	0	1
Morriston Hospital SDU	0	0	0	1	0	6	3	0	0	1	0	0	1
NPT Hospital SDU	0	0	0	0	0	1	2	0	0	0	0	1	0
Primary & Community SDU	1	5	6	0	4	4	3	1	4	3	2	0	0
Princess of Wales SDU	0	0	0	0	1	0	7	0	2	4	4	2	0
Singleton Hospital SDU	1	4	0	5	1	1	4	0	2	2	3	2	0
Health Board Total	4	10	6	7	6	15	20	3	8	10	10	5	2

Benchmarking

No Benchmarking Data Available.

Source : ABMU Datix System

Measure 1: Number of Safeguarding Children Incidents

How are we doing ?

• In the last 2 months there has been an increased number of incidents which indicate a failure to share information and/or failure to follow guidelines. Work continues to improve the recording of Safeguarding Children incidents as currently they are only reported through Datix if they have had a direct impact upon the Health Board.
• Children nursed on adult wards continue to be reported through Datix and over the past six months have consistently been the largest reported group.
• The organisation is still unable to record all safeguarding children referrals at source

What actions are we taking?

• The Corporate Safeguarding team have reviewed the incidents to ensure the SDUs have addressed any Safeguarding concerns and have put measures in place to avoid a re-occurrence. The Safeguarding Committee have been informed of relevant incidents to ensure learning, and where required, updates have been included in the level 3 training, or in newsletters and relevant policies updated as required. From Feb 1 the Safeguarding Team is piloting a scheme to increase visibility of the team to support with issues such as this. This will be in Singleton SDU initially for a 3 month period.
• A "Risk Assessment Tool" (RAT) was developed at the request of the Nurse Directors across NHS Wales due to their concern about the high numbers of children and young people who are admitted to non paediatric areas across the NHS in Wales. The Corporate Safeguarding Team have developed guidance to be used by all Health Board staff to support the implementation of this Tool. This will ensure that there is consideration given to the need to safeguard children when they are being nursed on adult wards, by adult trained staff. This work is aligned to ensuring compliance with the ABMU Health Board Childrens Rights Charter.
• An individual had been identified within the HB to take forward (as a project) the development of a system whereby all safeguarding children referrals could be recorded and had begun preliminary discussions with a view to using SharePoint. Unfortunately this individual has now left the organisation and the team are currently seeking to establish a replacement. In addition the Safeguarding Team ensure that relevant stats of children referrals are obtained from the Local Authorities and reported at the Quality & Safety Committee within the Safeguarding bi-annual Report.
• Safeguarding Risk Register is currently being developed

What are the main areas of risk?

• The data collected by the HB continues to only capture safeguarding incidents against the HB and does not represent all the safeguarding children activity within the HB. This will go on the newly developed safeguarding risk register.

How do we compare with our peers?

Comparison data from peer organisations not available

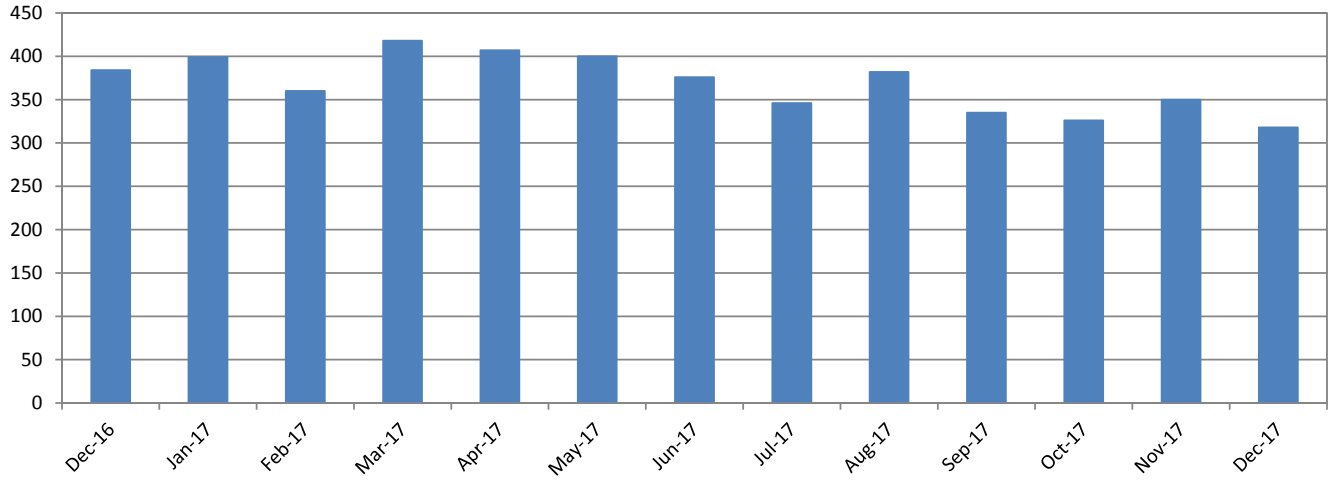
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

Measure 1: Total Number of Inpatient Falls

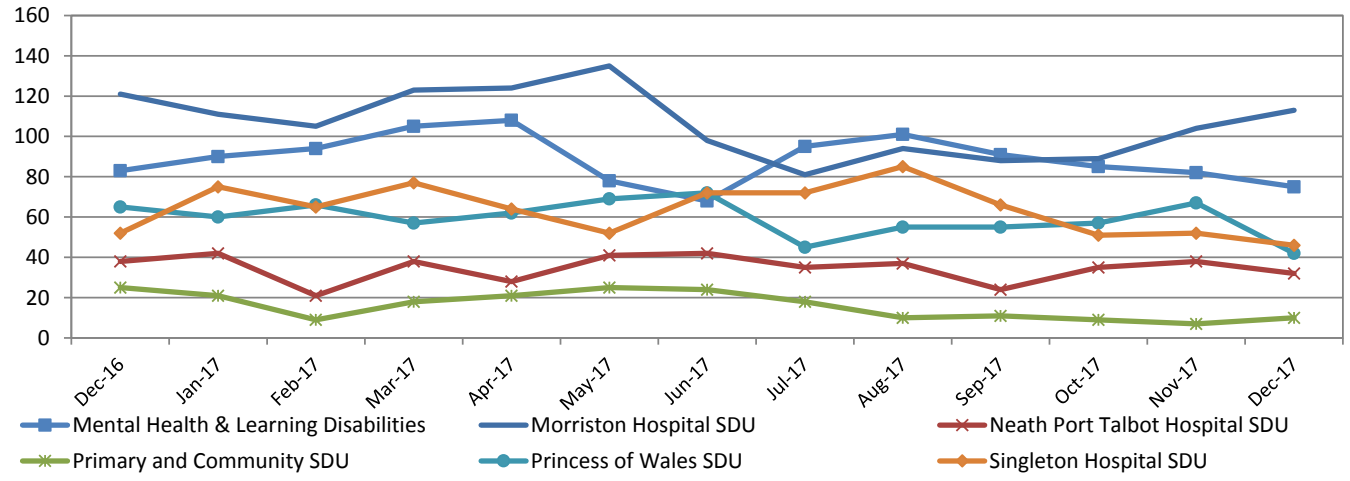
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Dec 2017	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Improving

Current Trend: Dec 16 - Dec 17

(1) Number of Inpatient Falls



(1) Number of Inpatient Falls



Benchmarking

Welsh Government benchmarking data is not yet available.
It is expected at some point during 2017/18

Source : INCIDENT DATA FROM DATIX

Measure 1: Total Number of Inpatient Falls

How are we doing ?

• The number of Falls reported via Datix shows a decrease in December to 318 from 350 in November 2017.
• In comparison with November 2017 the data for December 2017 demonstrated that all Service Delivery Units (SDUs) with the exception of Primary & community and Morriston Hospital reported a decrease in falls recorded via Datix - Singleton SDU (from 52 to 46 reduction of 6) Princess of wales SDU (from 67 to 42 reduction of 25) NPTH (from 38 to 32 reduction of 6) & Mental Health & Learning Disabilities (from 82 to 75 reduction of 8)
• Morriston SDU saw the largest increase (from 104 to 113 increase of 9) with one reported major fall (head injury). Singleton also reported one major fall these will be discussed and presented at January's FPMG.

What actions are we taking?

The FPMG continues to meet monthly actions from the meetings have included:
• The Falls policy has now been reviewed and will be circulated to the members of the Nursing and Midwifery Board for discussion at the February 2018 meeting and will be taken forward for ratification to the Quality and Safety Forum for implementation in March. Baseline audits on the implementation of the new falls policy and associated documentation will be undertaken by the corporate nursing team in March 2018.
• All SDU's have Falls Scrutiny panels, Primary and Community panels all agreed outcomes from the scrutiny panel will be presented to the FPMG to enable shared learning.
• The FPMG will undertake a training needs analysis and review of training provision (by Feb 2018). Falls presentation to be used for training. Presentation has been sent to all DU in Jan 2018.
• Base line audit and review of all equipment relating to falls management will be discussed at the February 2018 FPMG. The Health Board are in the process of purchasing a quantity of high low beds. Further work will be scheduled for April 2018 to review other equipment needs. FPMG membership will be reviewed in February 2018 (and monthly) going forward to establish if the group would benefit from more senior clinical representation. Work continues with the Datix user group to configure the system to collate and report accurately falls with harm versus falls without harm. Each SDU now collates this information monthly and reports into the FPMG group.
Singleton SDU continues to show a steady improvement since June. All patients assessed with high risk of falls within their elderly care wards are cohorted. All these patients are nursed on high-low beds with increased nursing resource (HCSW pool).
POWH are currently adopting some of this work on wards where there has been an increase in falls.

What are the main areas of risk?

The current process on Datix now uses the NICE definitions of "falls with harm" in order to produce accurate data to distinguish "slips, trips without harm" from falls with harm. All Units are now able to quantify their falls with or without harm. This ensures a consistent validated figure will be available.

How do we compare with our peers?

Currently developing an action plan as a result of National inpatient falls audit for discussion at next ABMU FPMG (01/02/18)

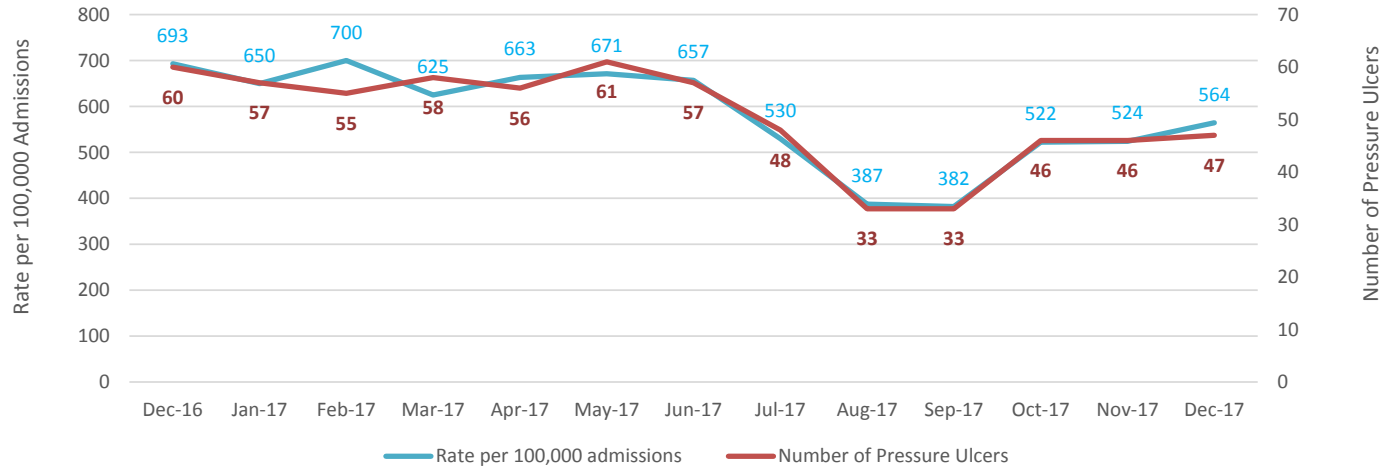
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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.

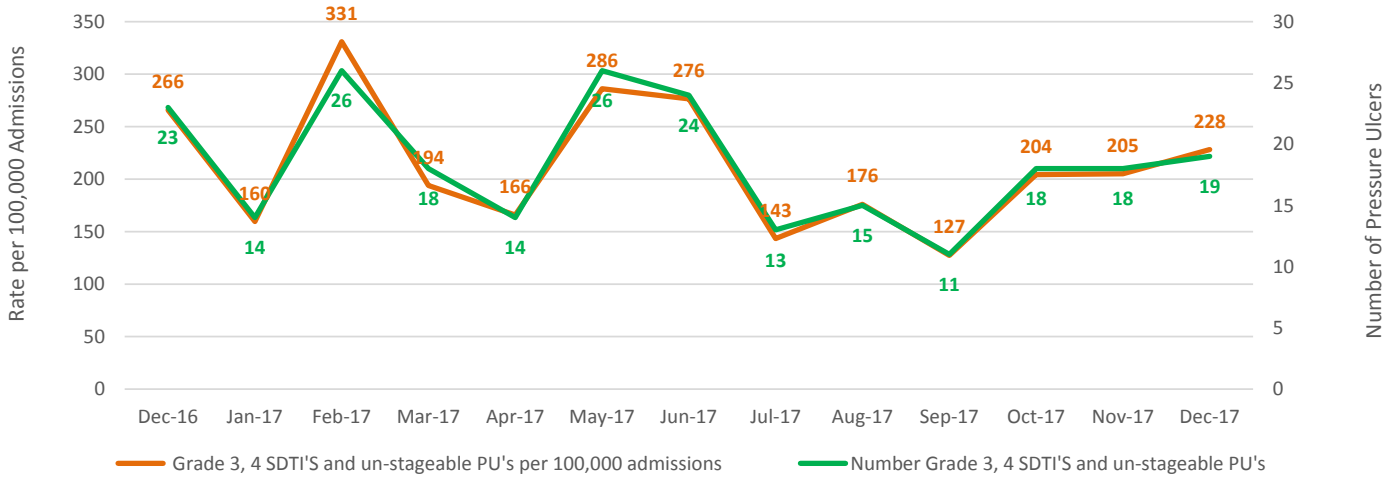
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Dec 2017	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Improving

Current Trend: Dec 16 - Dec 17

(1) Total Pressure Ulcers acquired in hospital.



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



Benchmarking

Welsh Government benchmarking data is not yet available.
It is expected at some point during 2017/18

Source : PRESSURE 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 December 2017. The rate per 100,000 admissions has increased from 524 in November 2017 to 564 in December. This reflects an increase of 1 pressure ulcer incident: from 46 in November to 47 in December 2017.
• Of the pressure ulcers reported, 87% were superficial in nature.
• Singleton Hospital has seen a significant improvement, the number of pressure ulcer incidents reducing from 11 in November to 5 in December 2017.
• The Princess of Wales Hospital remains the hot spot for pressure ulcer development with 46% of all in-patient pressure ulcers developing at the site.
• The rate of Grade 3+ pressure ulcers has increased from 205 per 100,000 admissions in November, to 228 per 100,000 admissions in December 2017. Of the 19 Grade 3+ pressure ulcer incidents reported in December, 6 were classified as deep damage.
• Again, no Grade 4 pressure ulcers were reported.

What actions are we taking?

•The Pressure Ulcer Prevention Strategic Group (PUPSG) held its 3rd meeting on 13 December 2017 and progressed work on the Strategic Quality Improvement Plan.
• A spot check of Serious Incident closure forms is to be conducted in early February to identify themes for causal and contributory factors for pressure ulcer development. The findings from the review will be used to plan peer review scrutiny panel training. A pilot workshop training session will be delivered in late February.
• Pressure Ulcer Peer Review Scrutiny Panels are held in all SDU's and learning from incidents translated into improved prevention plans and shared at the PUPSG meeting.
• Singleton Hospital has increased the frequency of their panels to weekly since the end of October to rapidly identify and address risks identified.
•The Princess of Wales Hospital remains the hot spot for pressure ulcer development in December 2017. This is being closely monitored by the Unit Nurse Director.
• Datix scrutiny was conducted for December 2017 data, duplicate entries were identified and the data rectified to ensure Health Board reporting accuracy. The Health Board Pressure Ulcer Prevention and Management Policy will be revised by January 2018.

What are the main areas of risk?

Winter pressures on the occupancy of in-patient areas increase the challenge for staff in preventing pressure ulcers.

How do we compare with our peers?

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

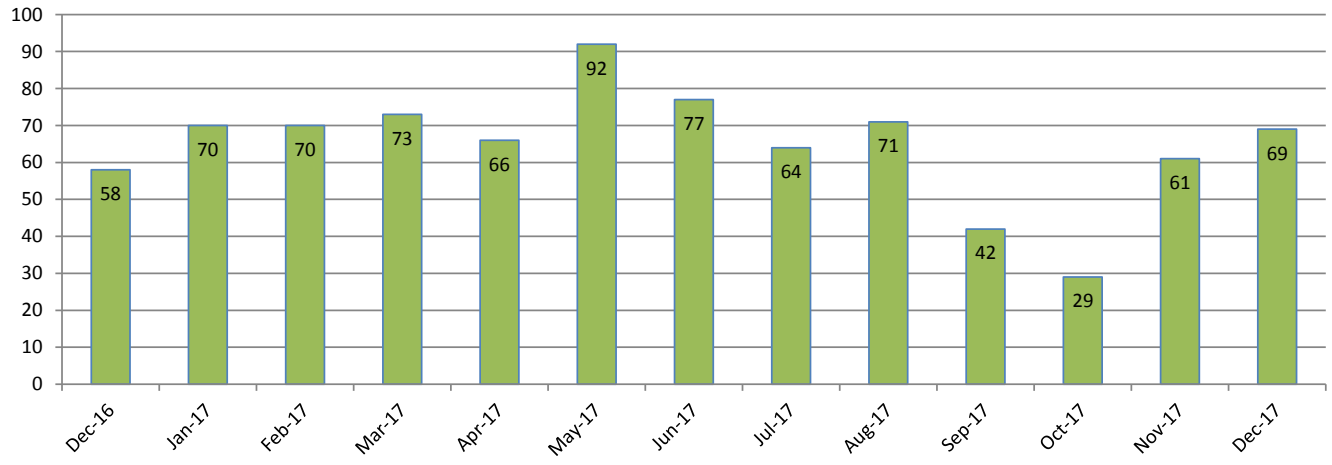
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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.

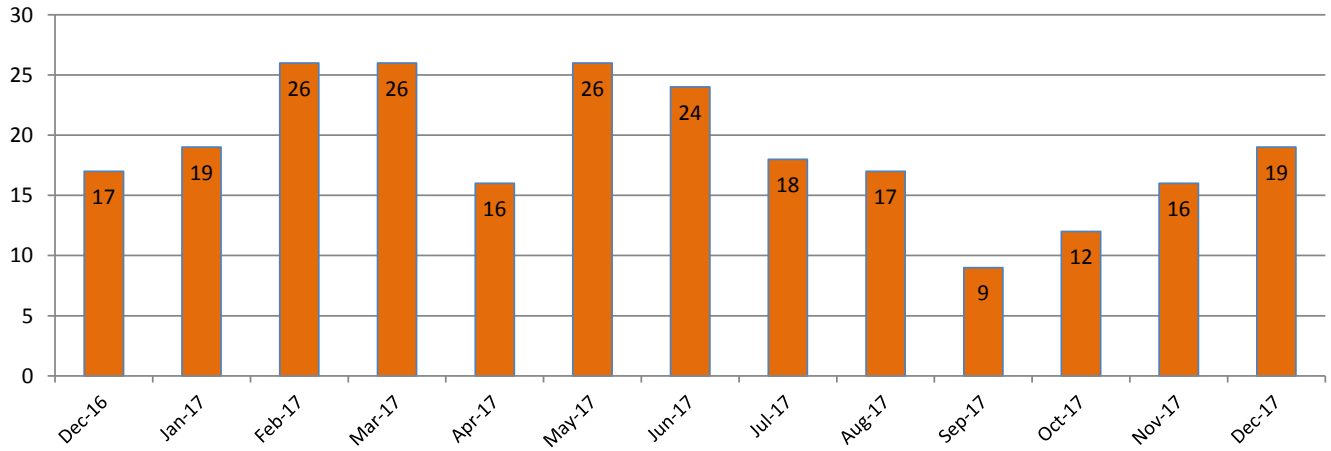
Corporate Objective : Embedding Effective Governance and Partnerships			Executive Lead : Angela Hopkins	
Period : Dec 2017	IMTP Profile Target : Reduce	WG Target : Reduce	Current Status : N/A	Movement : Worsening

Current Trend: Dec 16 - Dec 17

(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

Welsh Government benchmarking data is not yet available. It is expected at some point during 2017/18

Source : PRESSURE 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 December 2017, 69 incidents of pressure ulceration were reported, this is an increase compared to the 61 incidents reported in November 2017.
• Of the pressure ulcers reported in December, 88% recorded superficial damage.
• There has been a small increase in the Grade 3+ pressure ulcers reported, from 15 in November to 19 in December 2017.
• Of the Grade 3+ pressure ulcers reported in December, 8 met the criteria for Serious Incident reporting.
• The hot spot reporting area in the Community is Swansea, where 4 pressure ulcers met the Serious Incident criteria; 2 of which were Grade 4 pressure ulcers.

What actions are we taking?

• The Pressure Ulcer Prevention Strategic Group (PUPSG) held its 3rd meeting on 13 December 2017 and progressed work on the Strategic Quality Improvement Plan.
• A spot check of Serious Incident closure forms is to be conducted in early February to identify themes for causal and contributory factors for pressure ulcer development.
• The findings from the review will be used to plan peer review scrutiny panel training. A pilot workshop training session will be delivered in late February.
• 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 Pressure Ulcer Prevention Strategic Group and disseminated to locality staff.
• 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 PC&CS Service 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.

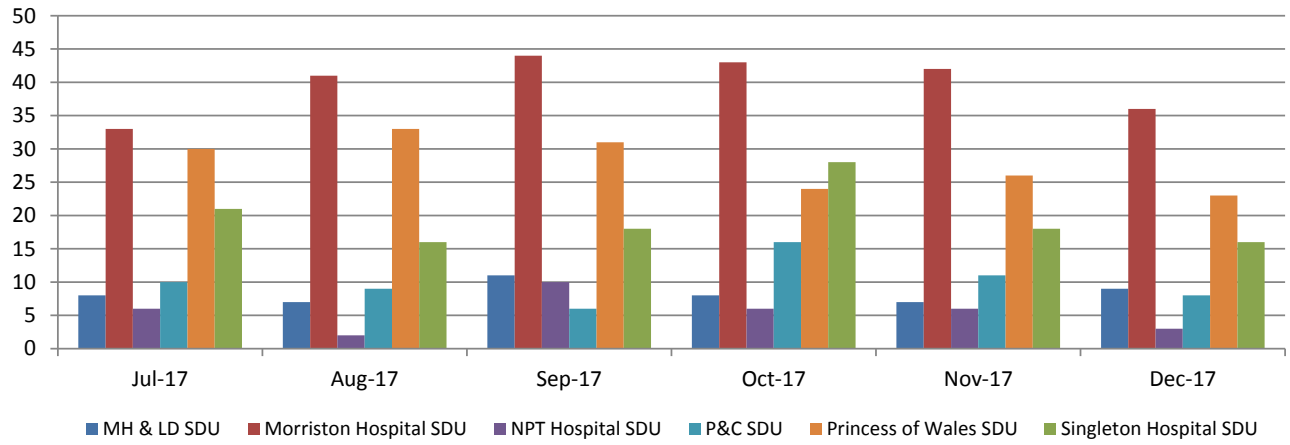
DIGNIFIED CARE: PEOPLE IN WALES ARE TREATED WITH DIGNITY AND RESPECT AND TREAT OTHERS THE SAME

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 : Dec 17	IMTP Profile Target : Reduce	WG Target : (1) Monitor, (2) 80%	Current Status : N/A	Movement : Improving

Current Trend: Jul 17 - Dec 17

(1) Number of new formal complaints received.



(2) % of responses sent within 30 working days

% of responses sent within 30 working days	2016		2017										
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
MH & LD SDU	78%	60%	75%	50%	71%	55%	44%	71%	86%	100%	64%	75%	71%
Morriston Hospital SDU	55%	55%	68%	74%	86%	86%	93%	86%	88%	78%	84%	86%	75%
NPT Hospital SDU	100%	67%	88%	80%	40%	50%	80%	100%	57%	50%	78%	83%	83%
Princess of Wales SDU	87%	69%	86%	94%	95%	96%	100%	83%	83%	81%	68%	67%	62%
P&C SDU	20%	60%	60%	42%	50%	46%	55%	56%	88%	67%	60%	75%	82%
Singleton Hospital SDU	28%	10%	54%	69%	77%	63%	60%	81%	65%	81%	83%	79%	72%
Health Board Total	**56%**	**55%**	**69%**	**71%**	**80%**	**75%**	**77%**	**82%**	**80%**	**80%**	**76%**	**78%**	**73%**

(3) % of acknowledgements sent within 2 working days

Percentage Acknowledgements Sent ≤ 2 Working Days	2016		2017										
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Benchmarking

Welsh Government benchmarking data is not yet available.
It is expected at some point during 2017/18

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 97 formal complaints in December 2017, a decrease of 14 compared to November 2017 when 111 complaints were received.
• Morriston consistently remains the Service Delivery Unit (SDU) receiving the highest number of formal complaints, 32% of the formal complaints received by the Health Board. In November Morriston received 42 complaints and December 36 a decrease of 6 complaints.
• The Health Board achieved the target of 80% compliance with 30 day response rate for March, June, July and August 2017. For the month of November the overall 30 day response rate is 73% a 5% decrease compared to October when 78% was reported. The overall Health Board response rate for 30 day responses, on aggregate, for the period April to November 2018 is 77%.
• The Health Board is consistently maintaining the 2 day acknowledgement target at 100%.
• Princess of Wales (PoW) SDU is showing for the month of December, 23 formal complaints received compared to 26 formal complaints for November. The 30 day response rate for November is 62% this downward projection has continued for the past 3 months and the Executive Directors will discuss this during the performance meeting with the SDU.

What actions are we taking?

• Performance in the 30 day response targets is addressed consistently at all performance reviews.
• Princess of Wales Service Delivery Unit is the lowest performing Unit with 62% for 30 day responses. The Unit Nurse Director and Governance Team have been alerted to this and it will be further discussed at the Unit's performance review with Executive Directors to seek assurances on improvements in the response rate.
• MH & LD SDU is the second lowest performing Unit for 30 day responses , performance for 30 day responses for the month of November is 71% a 3% decrease from October performance which was 73%.
• Neath Port Hospital & Primary Care SDU's for November and December are demonstrating 83% & 82% respectively, response rate for 30 day target.
• Patient Advice Liaison Service (PALS) activity for the period April -December 2017 identified 2,539 contacts. 3.8% (87) converted to formalised complaints. The largest number of these complaints are attributed to the PoW SDU who had 1.7% (44).
• 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 is communication. A training programme for communication for all staff grades is being undertaken in all Units by the PFT Training officer.
• Open investigation cases for the Ombudsman is 34 . Breakdown of the 34 open investigations is as follows- Morriston 9, Princess of Wales 12, Singleton 7, MH &LD 4, Primary Care and Community Service 2. Princess of Wales is the Units showing the highest number of Ombudsman investigations. Recurring themes from the Ombudsman investigations are discharge process, communication, documentation lacking information poor complaints handling. The Health Board has met with the Ombudsman Improvement Officer to discuss the increase in Ombudsman investigations and the actions being taken in terms of developing training and awareness sessions tackling the themes and the deep dive reviews into complaint responses of the Service Delivery Units through the Concerns & Redress Assurance Group.

What are the main areas of risk?

Deviation from the Health Board 80% target for 30 day responses . Maintaining Quality of Complaint responses.

How do we compare with our peers?

No monthly all Wales data to compare.

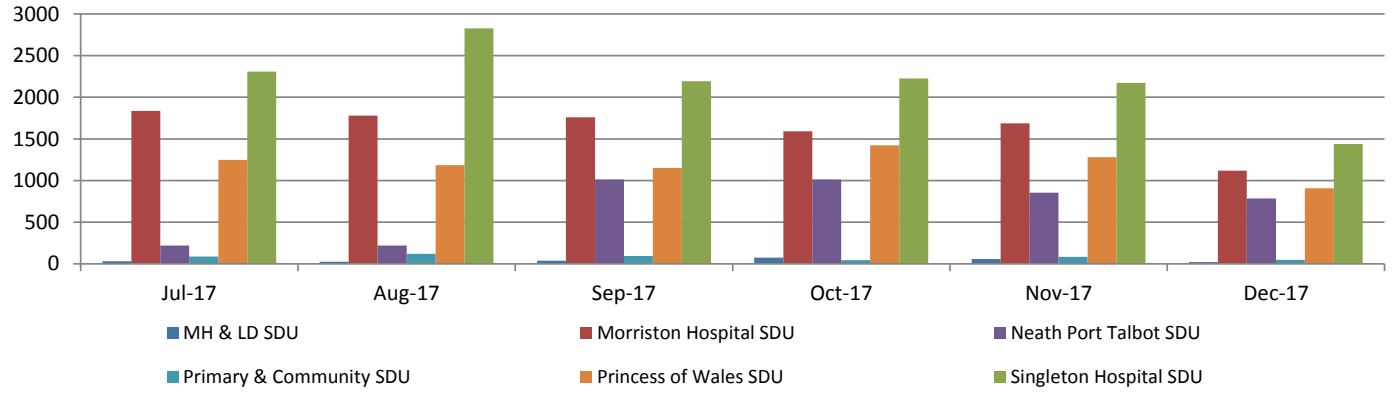
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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 : Dec 17	IMTP Profile Target :	Local Target : (1) Increase, (2) 90%, (3) 90%	Current Status : ✖	Movement : ⇧ ● Improving

Current Trend: (1) Jul 17 - Dec 17, (2) & (3) Dec 16 - Dec 17

(1) Number of friends and family surveys completed



(2) % of who would recommend and highly recommend

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
MH & LD SDU	82%	73%	79%	93%	95%	79%	61%	87%	69%	76%	87%	84%	65%
Morriston Hospital SDU	94%	90%	91%	89%	92%	92%	94%	93%	93%	94%	94%	94%	92%
Neath Port Talbot SDU	93%	98%	96%	95%	97%	88%	92%	95%	95%	97%	98%	99%	99%
Primary & Community SDU	94%	95%	95%	97%	93%	92%	94%	93%	94%	93%	85%	93%	90%
Princess of Wales SDU	96%	96%	96%	96%	93%	95%	96%	95%	94%	96%	95%	95%	94%
Singleton Hospital SDU	91%	94%	94%	96%	94%	96%	94%	95%	94%	96%	95%	97%	96%
Health Board Total	**94%**	**94%**	**94%**	**94%**	**93%**	**94%**	**94%**	**94%**	**94%**	**96%**	**95%**	**96%**	**95%**

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

	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
MH & LD SDU	0%	67%	NS	NS	NS	0%	67%	50%	NS	NS	87%	50%	100%
Morriston Hospital SDU	81%	78%	86%	81%	75%	83%	78%	82%	93%	96%	80%	91%	94%
Neath Port Talbot SDU	83%	70%	47%	61%	86%	91%	77%	84%	79%	88%	86%	83%	76%
Primary & Community SDU	97%	NS	97%	97%	94%	NS	88%	100%	94%	100%	86%	94%	
Princess of Wales SDU	76%	81%	86%	78%	87%	75%	82%	81%	75%	78%	80%	80%	77%
Singleton Hospital SDU	79%	82%	87%	88%	80%	81%	82%	90%	87%	82%	84%	81%	85%
Health Board Total	**83%**	**80%**	**84%**	**82%**	**82%**	**82%**	**82%**	**84%**	**85%**	**88%**	**83%**	**84%**	**84%**

NS= No Surveys

Benchmarking

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
ABMU Response %	10.1%	9.4%	10.7%	10.7%	9.2%	11.9%	17.2%	22.4%	24.1%	27.5%	28.9%	27.0%	28.9%
ABMU Recommendation %	94.2%	94.0%	93.6%	93.6%	94.4%	93.3%	93.9%	93.3%	94.5%	95.0%	95.4%	95.5%	96.0%
Top Equivalent Organisation Response %	32.6%	15.8%	19.3%	16.5%	16.3%	20.8%	18.7%	22.8%	20.1%	18.8%	15.7%	17.5%	17.0%
Top Equivalent Organisation Recommendation %	92.1%	96.0%	96.5%	96.4%	95.4%	96.6%	97.2%	96.7%	97.0%	96.8%	97.7%	97.0%	98.1%
NHS England Benchmark Response %	24.7%	21.9%	23.1%	24.3%	25.4%	25.3%	25.5%	25.4%	25.6%	25.8%	24.6%	24.9%	25.1%
NHS England Benchmark Recommendation %	95.4%	95.2%	95.4%	95.5%	95.6%	95.8%	95.9%	95.1%	95.6%	95.6%	95.6%	95.6%	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 ?

For the second time this year the Health Board Friends & Family patient satisfaction level in November reached 96% although slightly reduced to 95% in December. The December returns for the friends and Family are lower; this is a trend for December seen in 2016/17 and 2015/16.

• Neath Port Talbot Hospital completed 1,649 surveys (Nov/Dec) with a recommendation combined score of 99%. The return rates for the Unit saw a slight decrease of 377 on the number of surveys received in Sept/Oct 2017.

• Singleton Hospital completed 3,625 surveys (Nov/Dec) which was a decrease of 796 surveys, compared to September /October. The feedback returned a recommended score of 96%, which is 1% higher than the overall ABMU Health Board.

• Morriston Hospital completed 2,809 surveys (Nov/Dec), a decrease of 541 compared with September/October, with a recommend score of 93%, which is 2% lower than the ABMU Health Board performance.

• Princess of Wales Hospital completed 2,188 surveys (Nov/Dec), a decrease of 386 compared with September/October, with a recommended score of 95%, which is in line with ABMU Health Board.

• Mental Health & Learning Disabilities completed 84 surveys (Nov/Dec), a decrease of 28 compared with September/October, with a recommendation of 80%.

• Primary & Community Care completed 132 surveys, a decrease of 9 compared with September/October, with a recommended combined score of 91%.

What actions are we taking?

• The number of feedback forms completed for Friends and Family September/October was 12,512 and in November/December, 10,379 which is a decrease of 2,133 (17%) forms. (Historically December sees lower returns during the Christmas period).

• The Patient Experience Team held a further meeting with Primary Care, on the 20th December to support the roll out of Family and Friends. A redrafted survey form is being consulted on within the Unit. The Patient Experience Team will meet with heads of Primary Care, GP, Dentist, Opticians, Pharmacy to discuss any further changes required in quarter 4 of 2017/18. The Health Board PROMS/PREMS Clinical Lead is supporting this work.

• A pilot on the use of iPads in five areas in the Health Board to collect patient experience surveys has been completed. Prior to evaluation the pilot is being extended to Maternity and NPT SDU. A meeting has been arranged for February with Unit Nurse Directors to discuss the next steps.

• The Patient Experience Team (PET) are working with the Modernisation Group to explore the use of SMS Texting to gain retrospective feedback for Friends and Family from service users. ABM IT Department and PET met in January to review progress with the aim of setting this service up in quarter four of 2017/18.

• The Snap Patient Feedback System and ABM IT Department are working together to set up self-reading system for the Friends & Family cards. This process will require the free text to be keyed, all other data captured will be populated from the software. The aim is to test the system in quarter four of 2017/18.

• Patient Experience Team attended the National Cancer meeting in Cardiff. The meeting was an excellent platform for information sharing. Welsh Government, Macmillan and Maggies centre staff were informed of the cancer patient feedback ABM captures weekly. The reports generated were shared and a further development meeting has been arranged in January 2018 with ABM Cancer Leads to discuss how to use the feedback and make improvements using the patient experience captured.

What are the main areas of risk?

• Staff availability over holiday periods may impact on the volume of returns.

How do we compare with our peers?

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

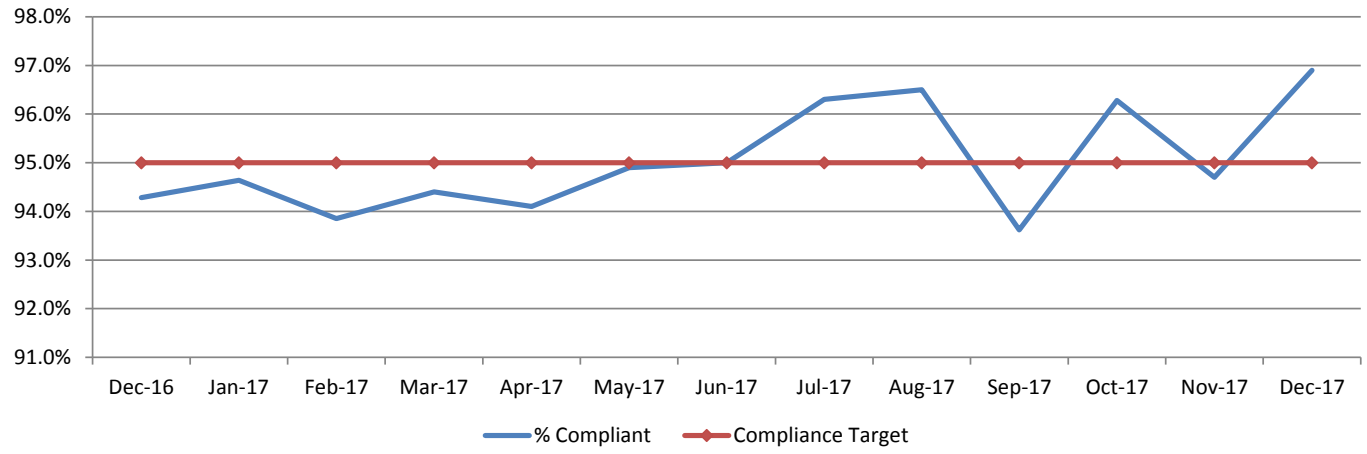
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure 1: % compliance with Hand Hygiene Audits

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Angela Hopkins	
Period : Dec 2017	IMTP Profile Target : 95%	WG Target : N/A	Current Status : ✖	Movement : ↑ Improving

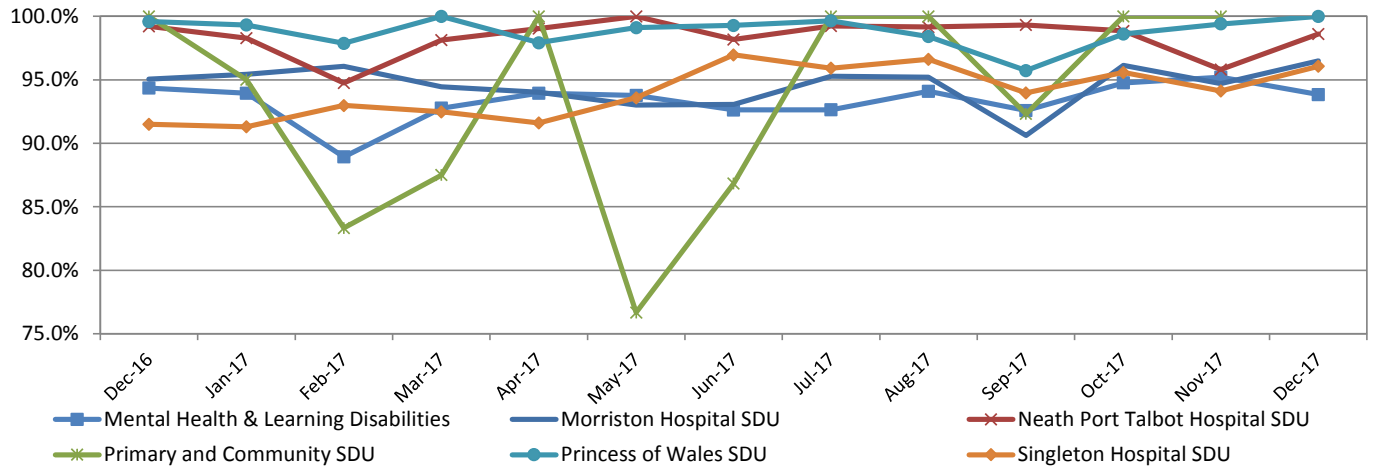
Current Trend: Dec 16 - Dec 17

(1) % compliance with Hand Hygiene Audits.



Benchmarking

(1) % compliance with Hand Hygiene Audits.



Source : ABMU Care Matrix

Measure 1: % compliance with Hand Hygiene Audits

How are we doing ?

• Compliance with hand hygiene (HH) for December 2017 increased to 96.9%.
• In December 2017, one additional area (from Learning Disabilities) have begun reporting hand hygiene compliance.
• For December, 90 wards/units (62%) reported compliance ≥95%.
• 12 wards/departments (8%) reported compliance ≥90% ≤94%; 17 wards/units (12%) reported compliance ≤89%.
• 27 wards/departments had not uploaded the results of their audits undertaken in December.
• Neath Port Talbot Service Delivery Unit (SDU) reported compliance ≥95% in December 2017. Four of the remaining SDUs reported compliance ≥90%; Primary Care & Community Service, had not recorded their December compliance at the time of preparing this report.
• 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 since the end of December.

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?

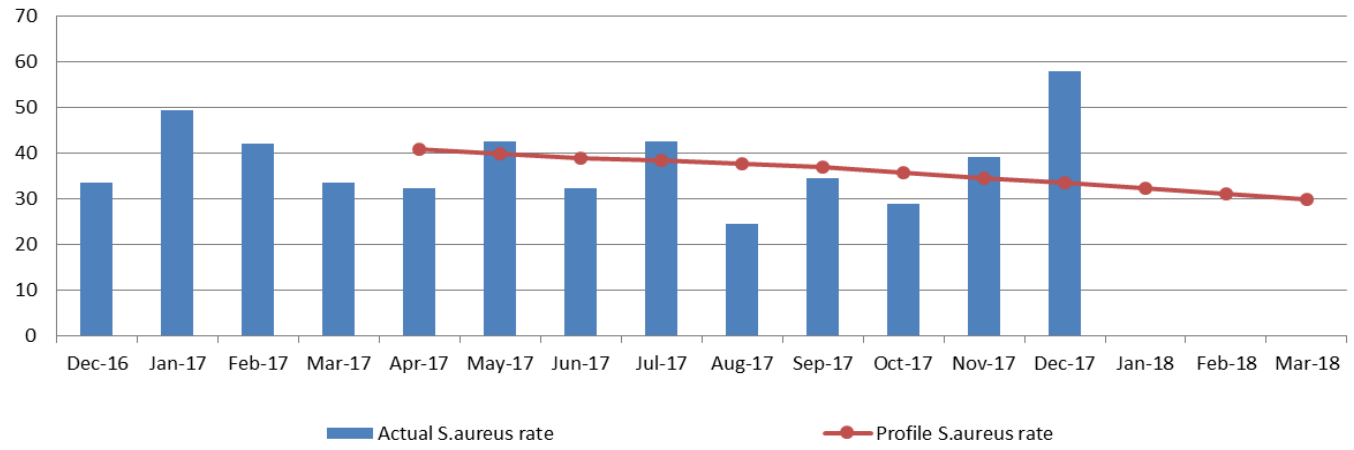
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : Dec 2017	IMTP Profile Target : 34.7	WG Target : Reduce	Current Status : ✗	Movement : ↑ ● Worsening

Current Trend: Dec 16 - Dec 17

(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 - Nov 17	Cumulative Number Against Mar 18 Reduction Expectation
Wales	30.10	+242
ABM	37.36	+71
AB	26.58	+35
BCU	27.66	+41
C&V	31.70	+45
Ctaf	33.39	+31
Hdda	34.24	+42

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected reduction by Mar 18

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

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

How are we doing ?

• For the months between April and December 2017/18, the Health Board average increased to 17 cases per month. The total number of cases between April and December 2017 was 149. By the end of December, the Health Board had exceeded the maximum total number of cases to achieve the annual infection reduction expectation by 44 cases.
• In December, the Health Board had its highest number of cases (26) of Staph. aureus (SA) bacteraemia in more than five years (14 inpatient cases; 12 non-inpatient cases). Local surveillance identified that 14 of the 26 cases were community acquired infections. Morriston accounted for more than half of the hospital acquired cases. Cases were unrelated. Spot-check observation of practice of clinical staff in wards/units with hospital acquired infection did not highlight breaches in practice.
• There has been an 18% increase in the number of cases of Staph. aureus bacteraemia identified within the Health Board between April and December 2017, compared with the same 9-month period in 2016.
• Localised surveillance of all cases has identified that 51% of all cases are community-acquired infection.

What actions are we taking?

• Delivery Units will be expected to include in their annual plans how they will progress the number of staff who have been ANTT competence assessed – for 2018/19 financial year.
• Identify wards with the highest incidence of hospital acquired Staph. aureus bacteraemia and undertake direct observation of practice assessments to identify key practices which would benefit from PDSA-style improvement initiatives - by 31 January 2018.
• Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters – ongoing into Q4, 2017/18.
• Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters – to launch January 2018.

What are the main areas of risk?

• An increasing proportion of MSSA 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.

How do we compare with our peers?

• ABMU now has the highest cumulative incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards. There has been a 16% increase in cases across NHS Wales in the first 9 months of 2017, compared with the same period in 2016. As such, the rate of increase in cases in ABMU is higher than the rate of increase for the NHS in Wales as a whole.
• None of the 6 major health boards can now achieve the 2017/18 reduction expectation.

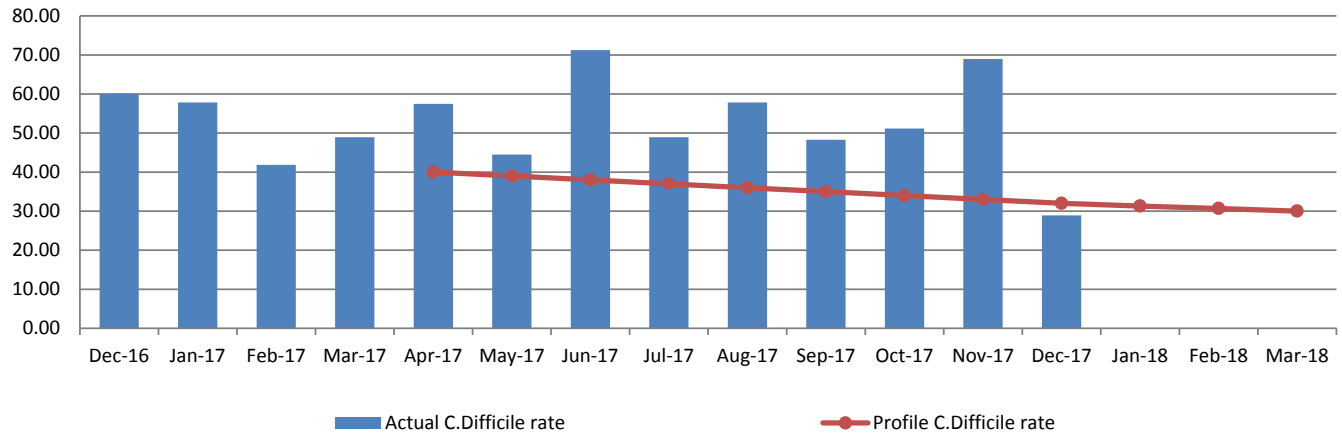
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : Dec 2017	IMTP Profile Target : 33.0	WG Target : Reduce	Current Status : ✖	Movement : ↓ Improving

Current Trend: Dec 16 - Dec 17

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



Benchmarking

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

LHB	Apr 17 - Dec 17	Cumulative Number Against Mar 18 Reduction Expectation
Wales	37.31	+271
ABM	52.91	+109
AB	38.40	+60
BCU	38.72	+68
C&V	26.55	+4
Ctaf	19.14	-1
Hdda	43.24	+51

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 (Jan 2018)

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

How are we doing ?

• Over the first 9 months of 2017/18, the Health Board average was 23 cases per month. The total number of cases between April and December 2017 was 211. By the end of December, the Health Board was 75 cases above the expected cumulative number of cases for 2017/18.
• 14 cases of C. difficile infection were identified in ABMU in December 2017, which is a much improved position for the Health Board. There were 8 cases from inpatient locations; 5 cases from non-inpatient locations. Local surveillance identified that 10 of the 14 cases in December were hospital acquired infections.
• Localised surveillance of all cases has identified that 80% of all cases are identified as being hospital-acquired infection (occurring more than 48 hours after admission), however, antimicrobial prescribing in Primary Care potentially contributes to an indeterminate proportion of these cases.
• The distribution of hospital acquired cases is as follows: Morriston – 43%, Princess of Wales – 31%, Singleton – 18%, Primary Care & Community – 4, Neath Port Talbot – 3%.
• The rate of increase has slowed in December; there had been a 29% increase in the number of cases of Clostridium difficile infection identified within the Health Board between April and December 2017, compared with the same 9-month period in 2016. The rate of increase April – November 2017 was 46%.

What actions are we taking?

• More restrictive antimicrobial guidelines are being amended currently, in preparation for implementation by 31st March 2018.
• Before the restrictive guidelines can be implemented, the additional resource and costs involved with monitoring gentamicin levels will need to be identified and agreed – by 31 January 2018.
• Safe system of work protocol in relation to UVC completed. Updated training programme, based on new safe system, has been developed. The revised safe system of work and associated training have been sent to HSE before training commences. Re-introduction of UVC anticipated by end January 2018.
• The Medical Director has agreed funding for identified clinical leads for Infection Prevention and Antimicrobial Stewardship in the acute Delivery Units. Expressions of interest will be invited in February 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.
• C. difficile spores may be found in 49% rooms of patients with C. difficile infection; 29% rooms of asymptomatic carriers.
• Worsening position impacts on public confidence.

How do we compare with our peers?

• ABMU has a significantly higher cumulative incidence of C. difficile infection (52.91/100,000) in comparison with all other major Welsh Health Boards. Hywel Dda has the second highest incidence, at 43.24. More significantly, Cardiff & Vale UHB has an incidence of 26.55, which is a rate almost half the rate in ABMU.
• There has been a 9% increase in cases across NHS Wales in the first 9 months of 2017, compared with the same period in 2016.
• One of the 6 major health boards is on trajectory to meet the reduction expectation (Cwm Taf UHB). 4 health boards can no longer the 2017/18 reduction expectation (Abertawe Bro Morgannwg UHB, Betsi Cadwaladr UHB, Aneurin Bevan UHB and Hywel Dda UHB).

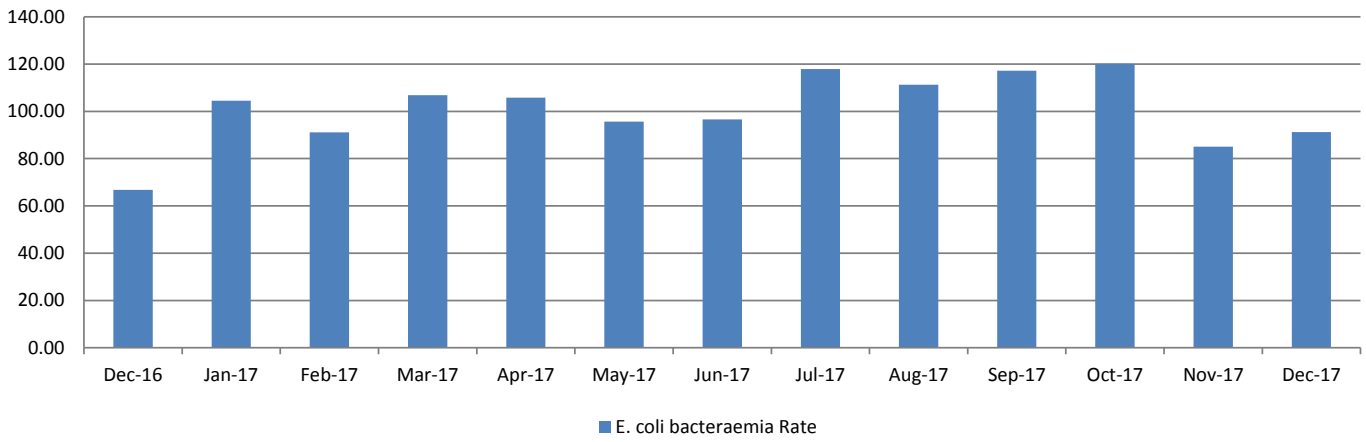
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : Dec 2017	IMTP Profile Target : 67.0	WG Target : Reduce	Current Status : ✖	Movement : ⇧ Worsening

Current Trend: Dec 16-Dec 17

(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 - Nov 17	Cumulative Number Against Mar 18 Reduction Expectation
Wales	86.46	+471
ABM	104.57	+153
AB	82.03	+95
BCU	77.63	+59
C&V	70.98	+44
Ctaf	97.95	+71
Hdda	121.07	+158

Not on trajectory to achieve expected reduction by Mar 18

On trajectory to achieve expected reduction by Mar 18

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

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

How are we doing ?

• Over the first 9 months of 2017/18, the Health Board average was 46 cases per month. The total number of cases between April and December 2017 was 417.
• By the end of December, the Health Board was 65 cases above the expected cumulative number of cases for 2017/18.
• 41 cases of Escherichia coli (E. coli) bacteraemia were identified in December; 22 inpatients and 19 non-inpatients.
• Localised surveillance of all cases has identified that 69% of all cases are community-acquired infection. The distribution of hospital acquired cases is as follows: Morriston – 38%, Singleton – 31%, Princess of Wales – 20%, Neath Port Talbot – 10%.
• There has been a 23% increase in the number of cases of E. coli bacteraemia identified within the Health Board between April and December 2017, compared with the same 9-month period in 2016.

What actions are we taking?

• There has been no national surveillance programme specific to E. coli bacteraemia in the past. This is a year where the Health Board will be establishing baseline data, whilst additionally it is required to achieve a reduction.
• Delivery Units will be expected to include in their annual plans how they will progress the number of staff who have been ANTT competence assessed – for 2018/19 financial year.
• A training package specific to E. coli and associated bacteraemia has been developed as a "bolt-on" to Standard Infection Control Precautions training - first presentation delivered by 22 December 2017. Delivery of ongoing training has been affected by the high incidence of influenza seen across ABMU in January 2018.
• Singleton DU has commenced a pilot improvement programme relating to peripheral catheters and urinary catheters – ongoing into Q4, 2017/18.
• Morriston DU is to commence a pilot improvement programme relating to peripheral catheters and urinary catheters – to launch January 2018.

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?

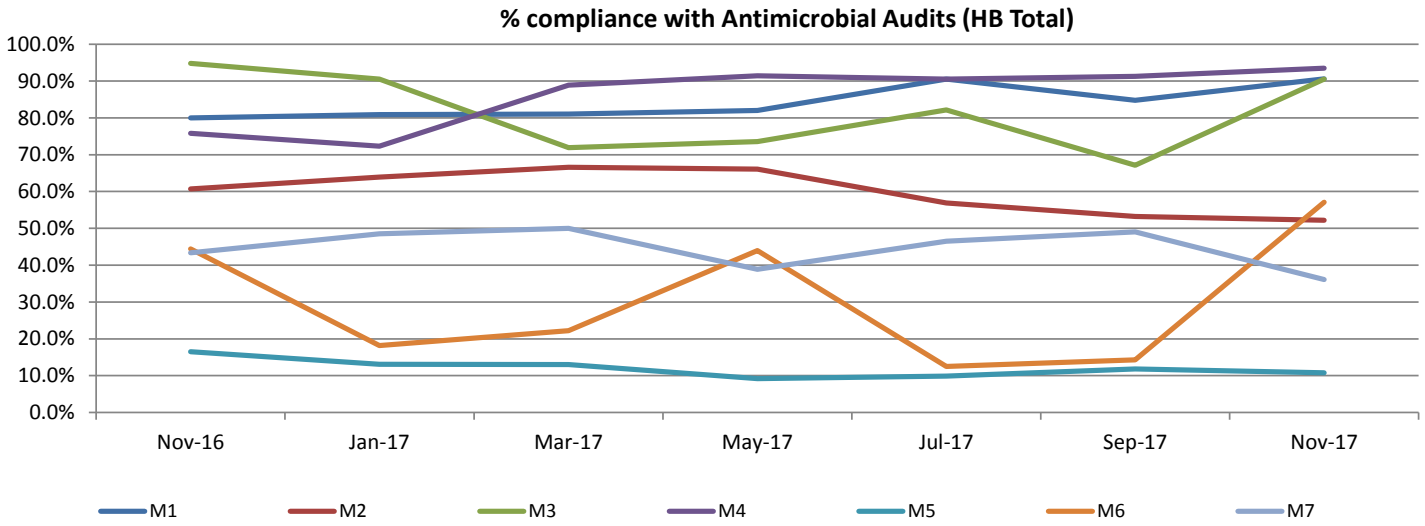
• ABMU has the second highest cumulative incidence of E. coli bacteraemia in comparison with the other major Welsh Health Boards. There has been a 7% increase in cases across NHS Wales in the first 9 months of 2017, compared with the same period in 2016.
• Nine months into the reduction expectation period, none of the 6 major health boards are on trajectory to meet the reduction expectation. 4 health boards can no longer achieve the 2017/18 reduction expectation (Abertawe Bro Morgannwg UHB, Aneurin Bevan UHB, Cwm Taf UHB and Hywel Dda UHB).

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 : Nov 2017	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: Nov 16 - Nov 17



Nov-17	POW	Morriston	Singleton	NPTH	MH & LD	HB Total
1: % indication for antibiotic documented on medication chart	92.5%	89.8%	92.1%	100.0%	-	90.6%
2: % stop or review date documented on medication chart	55.1%	47.4%	57.5%	85.7%	-	52.2%
3: % of antibiotics prescribed on stickers	85.7%	100.0%	100.0%	100.0%	-	90.5%
4: % appropriate antibiotic prescriptions choice	92.4%	94.8%	89.3%	100.0%	-	93.5%
5: % of patients receiving antibiotics for more than 7 days	6.0%	12.2%	12.3%	12.5%	-	10.8%
6: % of patients receiving surgical prophylaxis for more than 24 hours	50.0%	100.0%	-	-	-	57.1%
7: % of patients receiving IV antibiotics > 72 hours	32.3%	37.3%	35.3%	50.0%	-	36.1%

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?

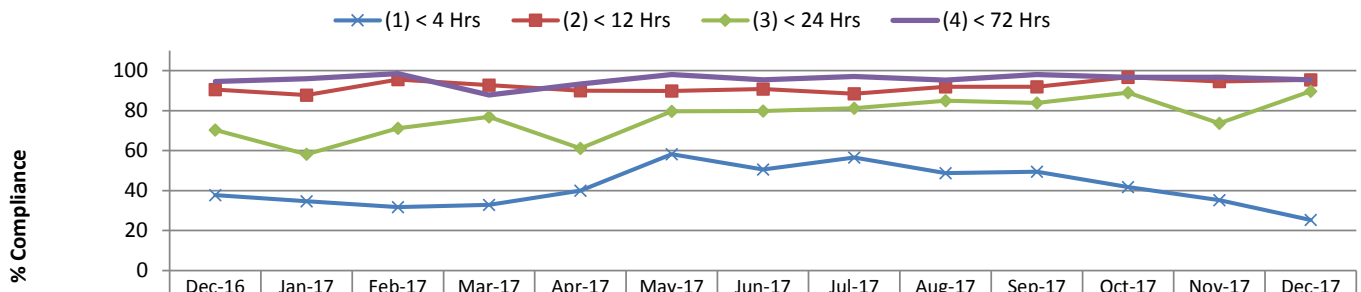
TIMELY CARE - PEOPLE IN WALES HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED AND ARE ACTIVELY INVOLVED IN DECISIONS ABOUT THEIR CARE

Measure 1: % compliance with stroke bundle 1 (< 4 Hours), Measure 2: % compliance with stroke bundle 2 (<12 Hours)
Measure 3: % compliance with stroke bundle 3 (<24 Hours), Measure 4: % compliance with stroke bundle 4 (<72 Hours)

Corporate Objective : Delivering Excellent Patient Outcomes, Experience & Access			Executive Lead : Chris White	
Period : Dec 2017	IMTP Profile Target : (1)70% (2)95% (3)80% (4)97%	WG Target : 95%	Current Status :	Movement : Improving

Current Trend: Dec 16 - Dec 17

72 Hour Pathway Care Indicators



	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
(1) < 4 Hrs	37.8	34.69	31.8	32.9	40	58.2	50.5	56.5	48.8	49.5	41.8	35.2	25.3
(2) < 12 Hrs	90.5	87.76	95.5	92.7	90	89.8	90.8	88.4	91.9	91.9	96.7	94.5	95.4
(3) < 24 Hrs	70.3	58.16	71.2	76.8	61.1	79.6	79.8	81.2	84.9	83.8	89	73.6	89.7
(4) < 72 Hrs	94.6	95.92	98.5	87.8	93.3	98	95.4	97.1	95.3	98	96.7	96.7	95.4

Benchmarking

72 Hour Care Indicators Dec-17	AB	ABM	BCU	C&V	CTaf	HDda
1. < 4 Hours Care Indicators	36.2%	25.3%	38.1%	42.6%	51.1%	72.8%
2. < 12 Hours Care Indicators	94.8%	95.4%	92.8%	100.0%	95.6%	98.8%
3. < 24 Hours Care Indicators	79.3%	89.7%	91.8%	81.5%	66.7%	75.3%
4. < 72 Hours Care Indicators	100.0%	95.4%	97.9%	94.4%	84.4%	86.4%

Thrombolysis Indicators Dec-17	AB	ABM	BCU	C&V	CTaf	HDda
1. Access						
1a - % All Strokes Thrombolsyed	10.3%	11.5%	11.3%	14.8%	15.6%	18.5%
2b - % Eligible Patients Thrombolsyed	100.0%	81.8%	83.3%	100.0%	100.0%	100.0%
2. Time						
1a - Door-to-Needle <= 30 mins	0.0%	0.0%	9.1%	12.5%	0.0%	26.7%
2b - Door-to-Needle <= 45 mins	16.7%	10.0%	18.2%	12.5%	0.0%	40.0%
3c - Onset to-Needle <= 90 mins	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%
4d - % with Pre and Post NIHSS Score	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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

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

Measure 1: % compliance with stroke bundle 1 (< 4 Hours), Measure 2: % compliance with stroke bundle 2 (<12 Hours)
Measure 3: % compliance with stroke bundle 3 (<24 Hours), Measure 4: % compliance with stroke bundle 4 (<72 Hours)

How are we doing ?

• Health Board performance in December 2017 deteriorated against the 4 hour bundles when compared with November 2017 Stroke services were affected by the wider unscheduled care pressures in December which had a particular impact on the 4 hour bundle.
Performance against the 24 hour bundle improved and was the highest performance against this measure during 2017 to date. Performance against the 12 and 72 hour bundles was above the 95% target.

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 include:

Morriston

• Training out of hours nurse practitioners to improve the identification and assessment of stroke patients who arrive overnight.
•Process mapping the stroke pathway with the support of 1000 Lives with a particular focus on the rehabilitation part of the pathway.
•Increasing the number of stroke champions to improve the patient pathway
• Recruitment to CNS roles to enable 7 day extended cover to be reinstated.

Princess of Wales

• Thrombolysis review meetings initiated by clinical team.
• Relocation of TIA service in the New Year which will release Clinical Nurse Specialist time to support patients on the stroke pathway
• Business case developed for support to implement 3 month trial of an electronic system to capture and map patients as they move through the stroke pathway

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. Modelling of the HASU capacity requirements has been refreshed recently with the support of the Delivery Unit.
• Undertake Bridges management training on self care for patients who have suffered a stroke.

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 December. The Health Board performed well against the 12, 24 and 72 hour bundles in December when compared with other Health Boards. The thrombolysis rates reported in December at the Princess of Wales hospital are being reviewed and may result in the overall HB performance improving as a result.