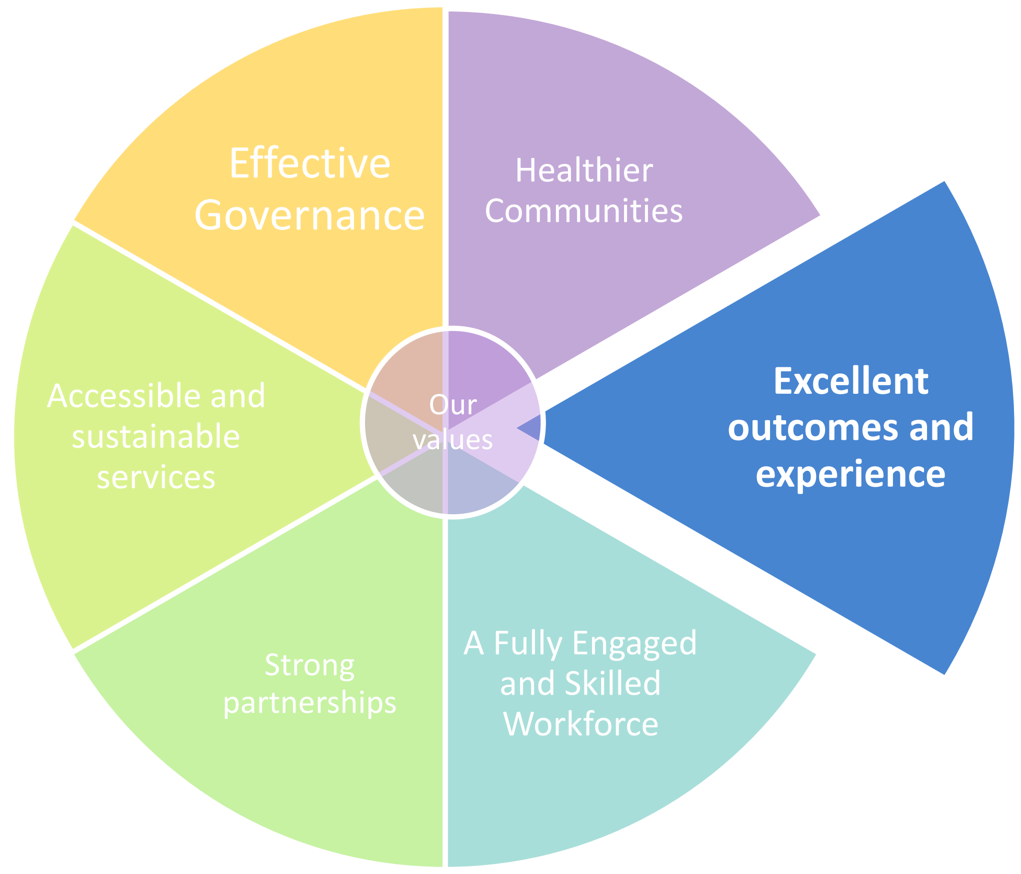
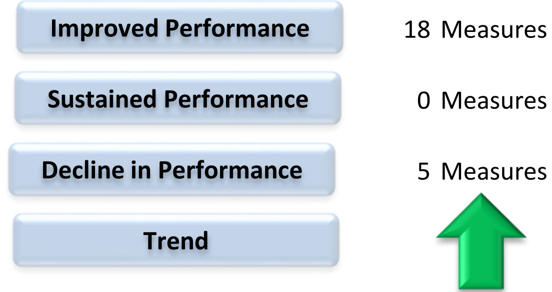
	ABM University Health Board
Health Board	**Meeting on: 26th January 2017**

Subject:	Performance Report- Excellent Outcomes and Experience



ABMU Key Priorities : Excellent Outcomes and Experience



Improved Performance	18 Measures
Sustained Performance	0 Measures
Decline in Performance	5 Measures
Trend	↑

Measures	Period	Value	Target Attained	Trend
Number of healthcare acquired pressure ulcers	Nov-2016	110	N/A	↑
Number of cases of C Difficile per 100,000 of the population	Nov-2016	32.42	✗	↑
Number of cases of Staph. aureus per 100,000 of the population	Nov-2016	46.31	✗	↓
% compliance with Hand Hygiene	Nov-2016	96.7%	✗	↑
% Serious Incidents Assured Within The Agreed Timescales	Nov-2016	77.8%	N/A	↑
Number of new Never Events	Nov-2016	1	N/A	↑
% crude mortality	Oct-2016	0.76%	✓	↑
% Stage 1 Mortality Reviews completed	Nov-2016	92.1%	N/A	↑
% episodes clinically coded within one month post episode end date	Nov-2016	31.8%	✗	↓
% completed discharge summaries	Nov-2016	35.0%	✗	↓
Number of inpatient falls	Nov-2016	346	✓	↑

ABMU Key Priorities : Excellent Outcomes and Experience

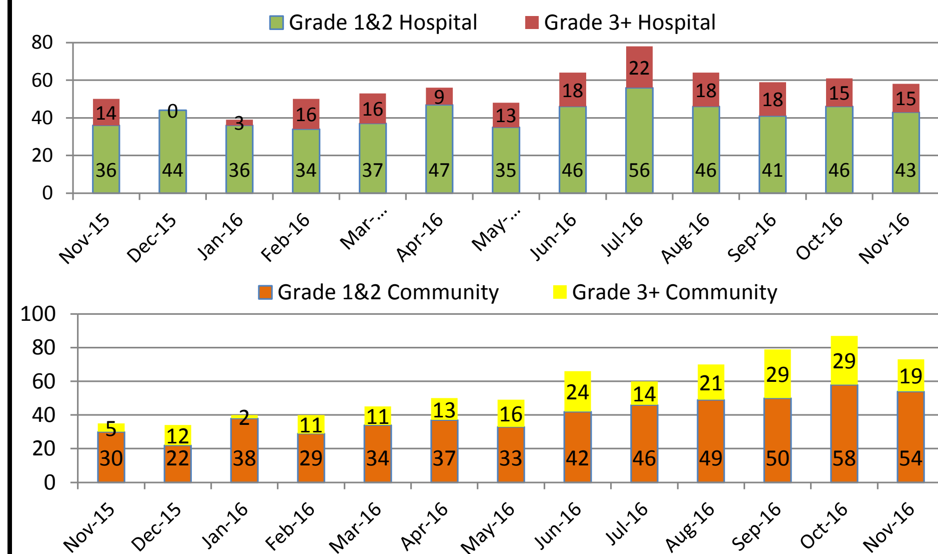
Measures	Period	Value	Target Attained	Trend
Number of NISCHR Clinical Research Portfolio studies	Quarter 1- 16/17	54	✗	↓
Number of NISCHR Commercially Sponsored Studies	Quarter 1- 16/17	13	✓	↑
Number of participants in studies on the NISCHR Clinical Research Portfolio	Quarter 1- 16/17	501	✓	↑
Number of participants in studies on the NISCHR Clinical Research Portfolio	Quarter 1- 16/17	21	✗	↓
% compliance with stroke bundle 1 (4 hours)	Nov-2016	43.8%	✗	↑
% compliance with stroke bundle 2 (12 hours)	Nov-2016	91.3%	✗	↑
% compliance with stroke bundle 3 (24 hours)	Nov-2016	78.8%	✗	↑
% compliance with stroke bundle 4 (72 hours)	Nov-2016	93.8%	✗	↑
Fluoroquinolone items as a % of total antibacterial items prescribed	Q2 16/17	2.4%	✓	↑
Cephalosporin items as a % of total antibacterial items prescribed	Q2 16/17	3.4%	✓	↑
Co-amoxiclav items as a % of total antibacterial items prescribed	Q2 16/17	3.9%	✓	↑
% of inhaled corticosteroids prescribed in primary care that are low strength	Q2 16/17	47.7%	✓	↑

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

Measure 1: Number of healthcare acquired pressure ulcers

Strategic Aim : Excellent patient outcomes and experience		**Strategic Change Programme: Quality & Safety**	**Executive Lead : Rory Farrelly**	
Period : Nov 16	**IMTP Profile Target : Reduce**	**WG Target : Reduce**	**Current Status : N/A**	**Movement : Improving**

Current Trend: Nov 15 - Nov 16



How are we doing ?

- The numbers of Grade 1 & 2 pressure ulcers reported against inpatients has decreased slightly this month from 46 reported in October to 43 in November. Community acquired lower grade ulcers also decreased from the 58 reported in October, to 54 in November.
- The numbers of Grade 3+ inpatient ulcers reported in November remained the same as the October figure of 15. The number of Grade 3+ pressure ulcers reported in the community setting decreased significantly, there were 29 reported in October and 19 in November.

What actions are we taking?

- In Neath Port Talbot Service Delivery Unit Pressure Ulcer performance data is a standing agenda item within key operational forums. A Pressure Ulcer Damage Scrutiny Panel identifies any actions required and record completion of actions on relevant Datix incident record to improve the assurance process. Nursing staff have been issued with mirrors to make inspecting heals easier as they recognised heal damage as a particular problem.
- Neath Port Talbot Service Delivery Unit has shared their scrutiny panel approach. All delivery units will have established a scrutiny panel process by end of January 2017.

Benchmark

Benchmark data no longer included in ALL WALES PERFORMANCE SUMMARY : Developing alternative source via CHKS

How do we compare with our peers?

Although we have previously reported that the Health Board was changing the way data was reported. In order to facilitate benchmarking with peers and to influence national reporting trends, it is planned to display data as rates of incidents for each managed unit.

What are the main areas of risk?

The Policy for Identification and Reporting of Pressure Ulcers is currently being updated after a report was taken to the Health Board Nursing and Midwifery Group, this is being developed in conjunction with a Training Strategy which will capture all staff groups, from basic awareness to identification and management of ulcers.

Source : DATIX

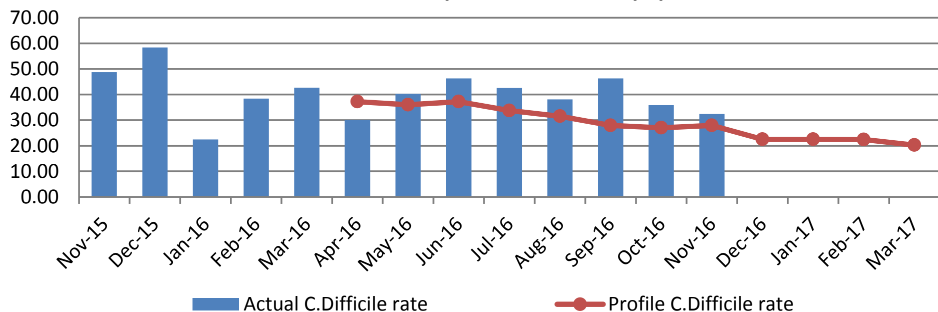
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

Strategic Aim :Excellent patient outcomes and experience	Strategic Change Programme: Quality & Safety	Executive Lead : Rory Farrelly

Period : Nov 16	IMTP Profile Target : 27.9	WG Target : Improve	Current Status :	Movement : Improving

Current Trend: Nov 15 - Nov 16



How are we doing ?

• There were 14 reported cases of C. difficile infection identified in ABMU in November 2016; 12 from inpatient locations and 2 from non-inpatient locations (4 inpatient cases in Morriston, 4 in Singleton, 3 in Princess of Wales, and 1 case in Neath Port Talbot).
• The cumulative number of cases between April and November 2016 was 137; 32.5% fewer cases than the same period in 2015, which indicates that infection reduction measures are having an impact.
• The incidence in November 2016 had reduced further to 32.42/100,000 population. The cumulative incidence, April to November 2016 was 39.00.
• The monthly average for the 8 months April – November 2015 was 25 cases; the monthly average for the same 8 month period in 2016 has reduced to 17 cases. To achieve the reduction expectation for March 2017 requires significant, ongoing reduction to a monthly average of ≤ 10 cases.

Benchmark

LHB	Nov-16	Number Against Mar 17 Reduction Expectation
Wales	31.47	+19
ABM	32.42	+6
AB	26.74	-1
BCU	37.05	+11
C&V	33.33	+5
Ctaf	14.12	-5
Hdda	42.16	+10

Red: Not on trajectory to achieve expected reduction by Mar 17

Green: On trajectory to achieve expected

What actions are we taking?

• All SDUs had exceeded their reduction profiles for November 2016.
• Big Fight Team progress: 68% Nursing Homes within ABMU have had Infection Prevention & Control training to date. For the first time, the rate of reduction in primary care prescribing in ABMU has exceeded the average rate of reduction for Wales.
• Bimonthly antimicrobial audits continue in secondary care, but results since January 2015 demonstrate antimicrobial stewardship improvements are not being met. Variable levels of medical engagement in secondary care continue to be highlighted.
• The Health Board's Action Plan for Antimicrobial Resistance Delivery Plan was accepted by Public Health Wales at a meeting held with the Health Board on 30 November.

How do we compare with our peers?

• Each of the major Health Boards is to ensure a rate of no more than 28/100,000 population is delivered in the final six months of the reductions period, 1 October 2016 to 31 March 2017.
• Two months into the reduction expectation period, ABMU is one of 4 Health Boards not on trajectory to meet the reduction expectation. In November, ABMU was 6 cases over trajectory (see table above).

What are the main areas of risk?

• Antimicrobial stewardship; variable medical engagement in reduction initiatives. High rates of secondary care antimicrobial prescribing particularly in Morriston.
• Increased and regular use of pre-emptive beds on acute sites increases risks of infection transmission.
• A lack of dedicated decant facilities hampers efficiency of decontamination activities and procedures.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2016)

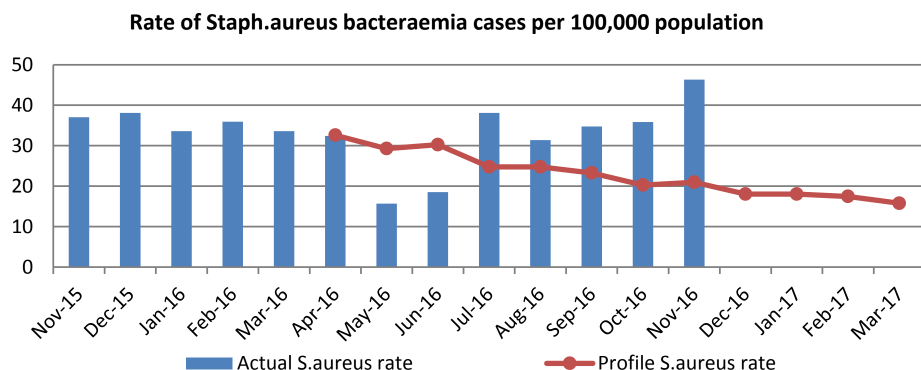
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

Strategic Aim : Excellent patient outcomes and experience	Strategic Change Programme: Quality & Safety	Executive Lead : Rory Farrelly

Period : Nov 16	IMTP Profile Target : 20.9	WG Target :	Current Status :	Movement : Worsening

Current Trend: Nov 15 - Nov 16



How are we doing ?

• There were 20 cases of Staph. Aureus (SA) bacteraemia identified in November; 12 inpatients and 8 non-inpatients. Three of these were MRSA bacteraemia cases; one in an inpatient in Princess of Wales; two were in non-inpatient cases.
• The number of cases identified between April and November 2016 was 111; 5% fewer compared with the same eight months in 2015.
• The incidence in November 2016 was 46.31/100,000 population (target is 20/100,000). The cumulative incidence, April to November 2016 was 31.60.
• The monthly average for the 8 months April – November 2015 was 14 cases; the monthly average for the same 8 month period in 2016 was 15 cases. To achieve the reduction expectation for March 2017 requires further reduction to a monthly average of ≤ 8 cases.

Benchmark

LHB	Nov-16	Number Against Mar 17 Reduction Expectation
Wales	29.73	+51
ABM	46.31	+19
AB	19.54	+4
BCU	27.57	+8
C&V	31.04	+9
Ctaf	40.33	+11
Hdda	32.79	+9

Not on trajectory to achieve expected reduction by Mar 17

On trajectory to achieve expected reduction by Mar 17

What actions are we taking?

• Each Operational Delivery Unit (ODU) has specific monthly reduction projections, which are monitored weekly. With the exception of Neath Port Talbot, all ODUs have exceeded their reduction profiles.
• Over 1,600 staff have passed the e- learning programme for Aseptic Non-Touch Technique (ANTT); there are 155 Direct Observation of Practice (DOP) Competency Assessors.
• The Bevan Health Technology Exemplar programme work, using chlorhexidine impregnated dressings, is due to commence in Morriston's General ITU, following an implementation meeting to be held on 14/12/16.
• The Health Board has discussed with Welsh Government the findings of the review of Staph. aureus bacteraemia which was undertaken. Other Welsh Health Boards also have raised the issue of unavoidable community acquired cases; Welsh Government has agreed to give this consideration in relation to future infection reduction expectations.

How do we compare with our peers?

• ABMU continues to have a high incidence of Staph. aureus bacteraemia in comparison with many other Welsh Health Boards.
• ABMU and 5 other major health boards are not on trajectory to meet the reduction expectation. In November, ABMU was 19 cases over trajectory (see table above).

What are the main areas of risk?

• MRSA bacteraemia may lead to delayed/failed response to empirical antibiotic treatment, which may increase morbidity and mortality.
• A large proportion of MSSA bacteraemia is community acquired and, as such, may be more challenging to achieve reduction.
• Current increased use of pre-emptive beds on acute sites increases risks of infection transmission.

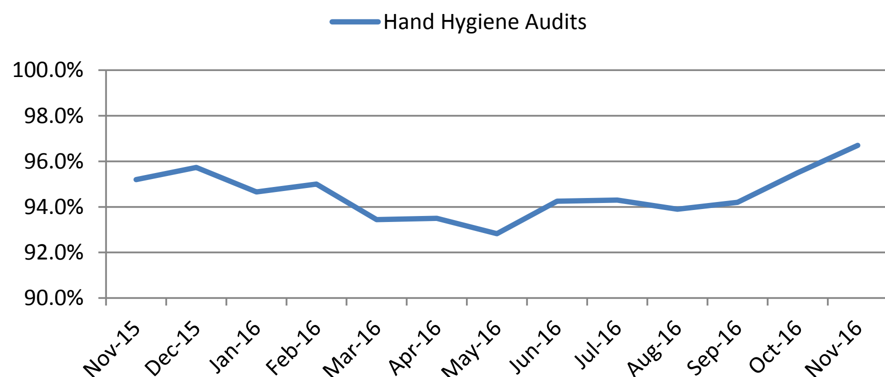
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2016)

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

Measure 1: % compliance with Hand Hygiene (HH)

Strategic Aim : Excellent patient outcomes and experience		Strategic Change Programme: Quality & Safety	Executive Lead : Rory Farrelly	
Period : Nov 16	IMTP Profile Target : 95%	Local Target : 100%	Current Status : ✗	Movement : ↑ Improving

Current Trend: Nov 15 - Nov 16



How are we doing ?

- Compliance with hand hygiene (HH) for November 2016 was 96.7%.
- For November, 77 wards/units (55%) reported full compliance. 76 wards/departments reported 100% compliance.
- 11 (8%) reported partial compliance; 21 wards/units (15%) reported non-compliance.
- 29 (21%) wards/departments had not uploaded the results of their audits undertaken in November.
- Three of the six Service Delivery Units (SDUs) reported full compliance in November 2016 (Morriston, Neath Port Talbot, and Princess of Wales); Singleton and Mental Health & Primary Care & Community Services reported 89% compliance.
- Results over time indicate there are challenges to achieving sustained improvements in compliance; however, there are recognised limitations with self-assessment.

Benchmark

No Benchmark Data Available

What actions are we taking?

- To improve the validity of the results reported on the Care Metrics, consideration should be given to peer review audits; Delivery Units to consider establishment of cross-ward audits- by 31 March 2017.
- HH training continues to be delivered by more than 200 trained and competent 'Hand Hygiene Coaches.
- The Infection Prevention and Control Team (IPCT) actively participating in the all Wales HH product procurement exercise.
- It is now 10 years since the national 'CleanYourHands' campaign. ABMU's Assistant Director of Nursing (ADN) has asked Public Health Wales to consider a new campaign to support local action, with centrally produced materials. Public Health Wales to advise on timescales.

How do we compare with our peers?

- The HH score has been removed from the all Wales dashboard because of the inherent difficulty in using one score to represent a whole HB. The Infection Prevention & Control Team (IPCT) are discussing with colleagues in Hywel Dda HB the possibility of peer review of HH and the validation of process to give the Board greater assurance of compliance with HH.

What are the main areas of risk?

- The main route of infection transmission is by direct contact, particularly by hands of staff.
- Poor compliance by staff with good hand hygiene practice is likely to result in transmission of infection.
- The current scoring system may be giving an overly assuring picture of compliance and that greater validation of the scores needs to be undertaken.
- That the current scoring system as it's presented fails to highlight particular staff groups with lower compliance rates than others.

Source : ABMU Care Matrix

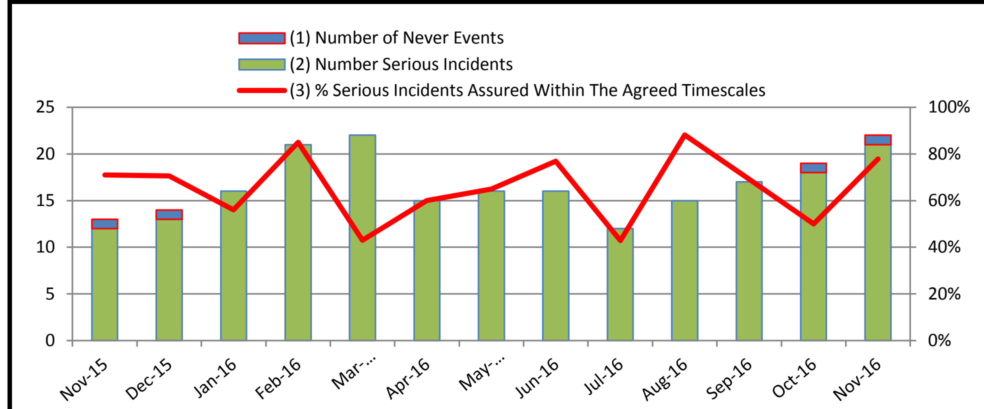
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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

Strategic Aim : Excellent patient outcomes and experience	Strategic Change Programme: Quality Improvement	Executive Lead : Rory Farrelly

Period : Nov 16	IMTP Profile Target : (1) Zero, (2) Improve, (3) 83%	WG Target : (1) Zero, (2) Improve, (3) 90%	Current Status : ✗	Movement : ↓ Worsening

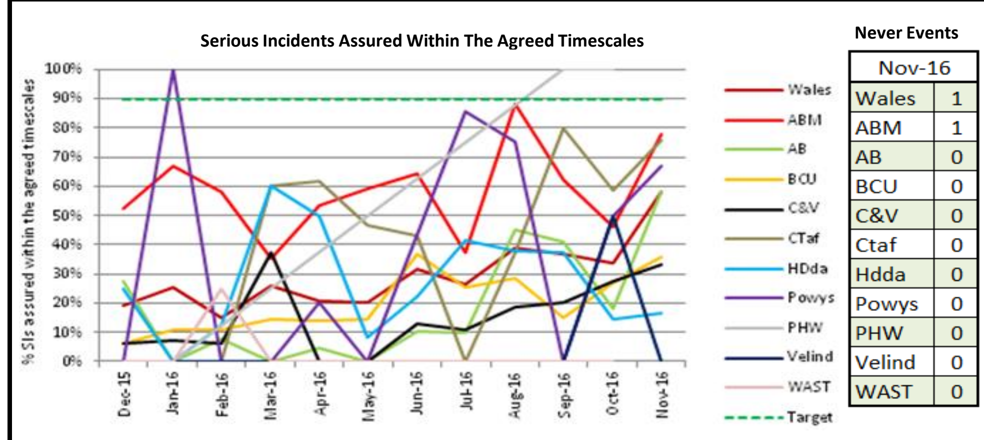
Current Trend: Nov 15 - Nov 16



How are we doing ?

• 2,013 incidents were reported in November 2016 (2,010 incidents were reported in October 2016 and 2,106 reported in October 2015).
• 21 (1.04%) serious incidents (SI's) were reported to Welsh Government in November 2016 (18 (0.9%) serious incidents were reported in October 2016 and 12 in November 2015 (0.89%).
• In terms of severity of incidents, the Health Board's target for severe harm (red) incidents is less than 0.50% of the total number of incidents reported. For the month of November (0.10%), the measure for the percentage of serious incidents related to severe harm was achieved.
• One never event was reported in November 2016 and investigated. A meeting has been held with the Delivery Unit, on behalf of Welsh Government, and the initial investigation findings considered. Two further never events have been reported in December 2016 and investigations have commenced.

Benchmark



Never Events

Nov-16	
Wales	1
ABM	1
AB	0
BCU	0
C&V	0
Ctaf	0
Hdda	0
Powys	0
PHW	0
Velind	0
WAST	0

What actions are we taking?

• Serious Incident Team continue to investigate the severe harm incidents and aim to produce investigation reports within 28 days of notification of the incident. The Team also monitor and support the closure of all SI's.
• Performance against closing SI's down within 60 working days increased from 50% in October 2016 to 77.8% in November 2016. Compliance for the period April 2016 to November 2016 is 66.25%. As the historic SI's have been closed down and the Health Board is investigating SI's from this financial year the priority is now to achieve the 80% target consistently from January 2017 onwards.
• 66.67% of the Serious Incidents (SI's) reported relate to pressure ulcer and the Pressure Ulcer Card provides details of the work ongoing in respect of actions being taken to reduce the occurrence and severity of harm of these incidents.

How do we compare with our peers?

• Three never events have been reported between the period December 2015 and November 2016.

What are the main areas of risk?

• The theme of never events relating to theatres continues. A detailed improvement plan will be submitted to the Quality & Safety Committee in February 2017 for review and to monitor progress against the timescales set. Furthermore, a Consultant Anaesthetist has been appointed clinical lead for the service to implement the improvement plan and provide senior clinical leadership.

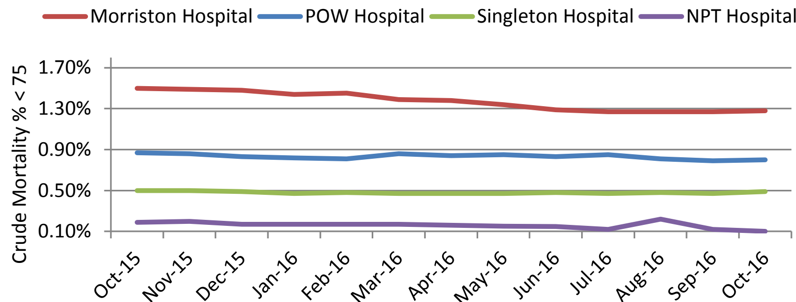
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2016)

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)

Strategic Aim :Excellent Patient Outcomes and Experience		Strategic Change Programme: Quality Improvement	Executive Lead : Hamish Laing	
Period : Oct-16	IMTP Profile Target :	WG Target : 12 month reduction trend	Current Status :	Movement : Improving

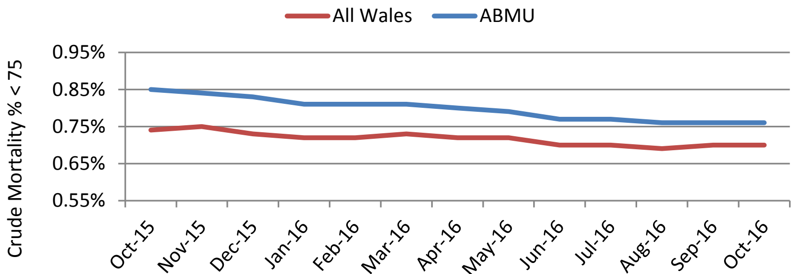
Current Trend: Oct 15 - Oct 16



How are we doing ?

- The ABMU Crude Mortality Rate for over 75s in the 12 months to October was 0.76%. This is lower than the same period last year which was 0.85%
- At a site level performance is as follows: (prior year in brackets) Morriston 1.28% (1.50%), Princess of Wales 0.80% (0.87%), Neath Port Talbot 0.10% (0.19%), Singleton 0.49% (0.50%). Site comparison is not possible due to different service models being in place.
- There were 93 in-hospital Deaths in November 16 (Morr 45 (42), PWH 31 (26), NPTH 0 (3), SNG 17(21). This is 1 higher than November 15.
- The number of deaths for Surgical and Elective cases remains consistently low for this age group.

Benchmark



What actions are we taking?

- The Clinical Outcomes Group (COG) is developing a new approach to review service outcomes, triangulating national audit, incident and internal HB data. This approach should be implemented early in 2017.
- This approach will enable greater understanding of outcomes and support improved mortality rates where possible.
- Key messages will then be reported to the Quality & Safety Committee.
- We are raising awareness of information and analysis available through the Mortality dashboard. Unit Medical Directors have been given a demonstration and further awareness sessions will be ongoing throughout December and January.
- We will be visiting specialty Audit groups in the new year to learn about their processes with a view to sharing best practice through the COG and triangulating this work with mortality review processes.

How do we compare with our peers?

- ABM are slightly above the all-Wales Mortality rate for the 12 months to October – 0.76% compared with 0.7%
- Mortality in Surgical cases is 0.27% compared with 0.28% for the all-Wales peer • ABM compares favourably to the all-Wales peer in elective cases at 0.04% compared to 0.05%

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.

Source : NHS WALES OUTCOMES FRAMEWORK, Comparative Health Knowledge System (CHKS)

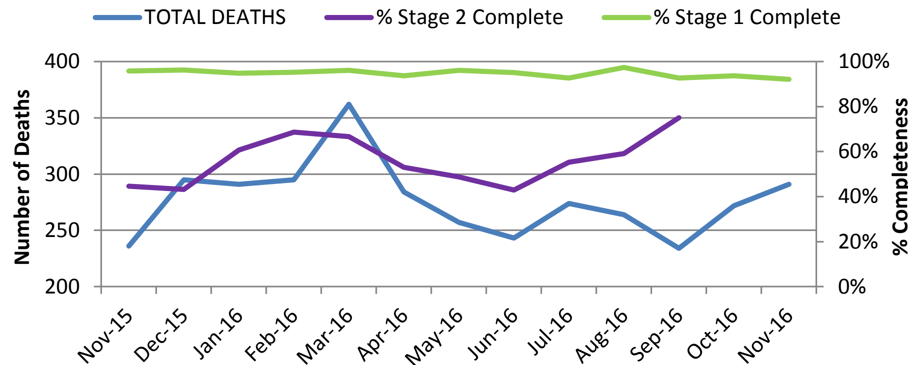
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE SUCCESSFUL

Measure 1: % Universal Mortality Review forms completed
Measure 2: % Stage 2 Review forms completed
Measure 3: Number of Hospital Deaths of persons over the age of 16 (Excluding Emergency Department)

Strategic Aim :Excellent Patient Outcomes and Experience	**Strategic Change Programme: Quality Improvement**	**Executive Lead : Hamish Laing**

Period : Nov 16	**IMTP Profile Target :** **(1) 96%**	**WG Target :** **Improve**	**Current Status : N/A**	**Movement :** **Improving**

Current Trend: Nov 15 - Nov 16



How are we doing ?

- 291 deaths were included in the mortality review process in November 2016
- The overall Universal Mortality Review (UMR) rate for the health board was 92%, 2% lower than in October
- Once again NPT, POWH and Singleton achieved 100% UMR compliance
- Morriston's compliance was 79% compared with 86% in October.
- 7% of UMRs completed for November deaths triggered a Stage 2 review compared with 5% in October. In general the proportion of UMRs triggering a Stage 2 review has been reduced as the HB triggers have been revised
- Prompt completion of Stage 2 reviews has improved significantly, 79% of the Stage 2 reviews for September deaths, 75% for October deaths and 50% for November deaths have been completed

Benchmark

What actions are we taking?

- Consultant are being notified that a Stage 2 review is required as soon as a copleted UMR indicates it. This has speeded up the process
- The Emergency Department in Morriston is piloting the standard mortality review process for a 3 month period with a view to adopting it in Spring 2017
- The AMD for patient safety is undertaking a casenote review to provide assurance that removing the "patient died from a condition other than that for which they were admitted" has not resulted in missed learning opportunities. The work done to date indicates that none of the now excluded cases woudl have benefitted from the greater scrutiny of a Stage 2 review

How do we compare with our peers?

No comparative data available

What are the main areas of risk?

- Timeliness of Stage 2 completion - although this is improving month on month and wil continue to do so as new job plans are worked through

Source : ABM Mortality Review database, **note** data relates only to Princess of Wales, Morriston, Singleton and Neath Port Talbot Hospitals but excludes deaths in the Emergency Departments and neonatal deaths

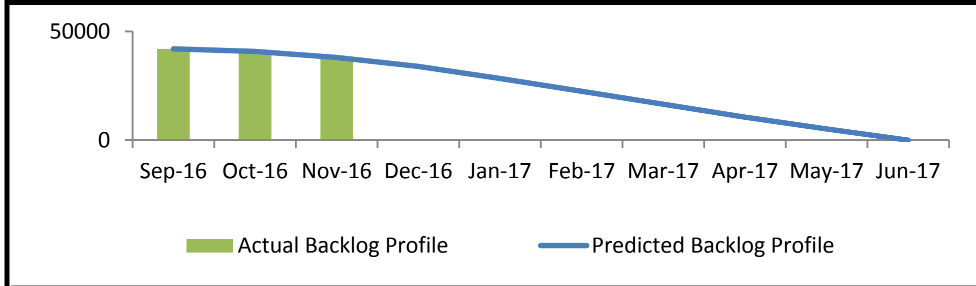
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE SUCCESSFUL

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

Strategic Aim : Excellent Patient Outcomes and Experience	Strategic Change Programme: Quality Improvement	Executive Lead : Hamish Laing

Period: Nov-16	IMTP Profile Target : N/A	WG Target : 12 month improvement trend	Current Status : ✗	Movement : ↑ Improving

Current Trend: Sep 15 - Nov 16

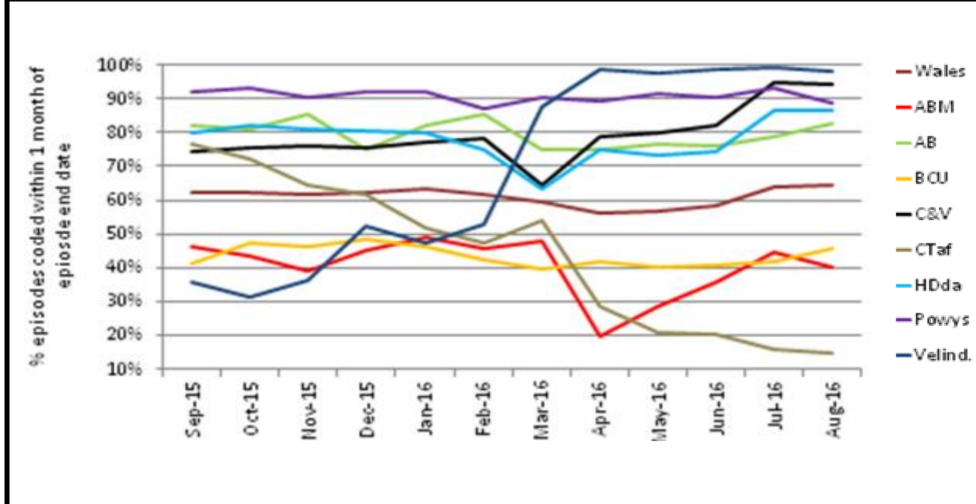


****NOTE**** *Data prior to Mar-16 reflective of completeness 6 weeks after episode end date (one*

How are we doing ?

- Coding completeness as at for completed episodes is currently – April 97.35%, May 95.25%, June 89.74%, July 77.78%, August 64.71%, September 80.10% and October 58.42%.
- The outstanding backlog standing at 36,751 episodes for 2016/2017. On target against profile reduction to clear backlog by July 2017.
- Coding completeness within 1 month has improved in the last 2 months with August at 40%. We expect to see further improvement in the coming months but the target will not be achieved until the new recruits are fully trained and proficient - this will be end of 2017/18.
- Discharge summary completion and distribution was 57% for October. Although this is an improvement, it continues to hinder coding efficiency.

Benchmark



What actions are we taking?

- Achieving compliance against the 12-month plan to clear the coding backlog by July 2017.
- Recruitment of 6.5 WTE permanent staff has been completed, with a start date 1.3.2017. This will address the completeness in month once staff are trained and competent - end of 2017/18.
- Our experienced coders are undertaking overtime to support the new coders.
- Additional one-off investment has allowed the recruitment of contract coders over a period of 9 months to help reduce the significant backlog. All of the contract coders have been secured and are working over a 7 day week period to clear the backlog. Productivity and quality of these staff is high.
- A survey has been commissioned by the POWH Unit Service Director to address concerns surrounding occupancy levels across the site. This is due to be completed in the new year and used to develop an estates strategy.
- The business case to support digitising the health record has been submitted to Welsh Government in December. This will provide longer term quality and efficiency improvements for the Coding service.

How do we compare with our peers?

- ABMU is performing well below the majority of other Welsh HBs with only Cwm Taf performing at a lower level in August 16.
- August performance was 23 percentage points below the all-Wales average at 40%

What are the main areas of risk?

- Failure to secure start dates of new staff due to financial concerns .
- Failure to keep the contract coders as a result of more attractive contracts elsewhere in the UK.
- Health and Safety concerns at POWH. Alternative accommodation is required.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 16)

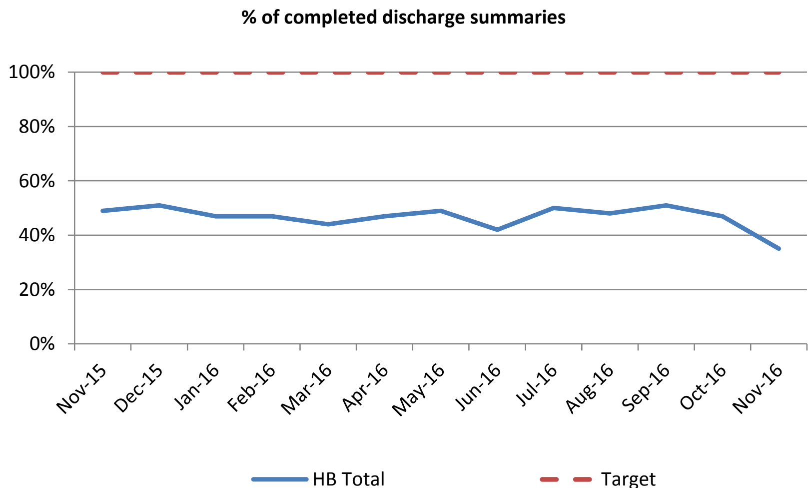
TIMELY CARE - I HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED & AM ACTIVELY INVOLVED IN DECISIONS ABOUT MY CARE

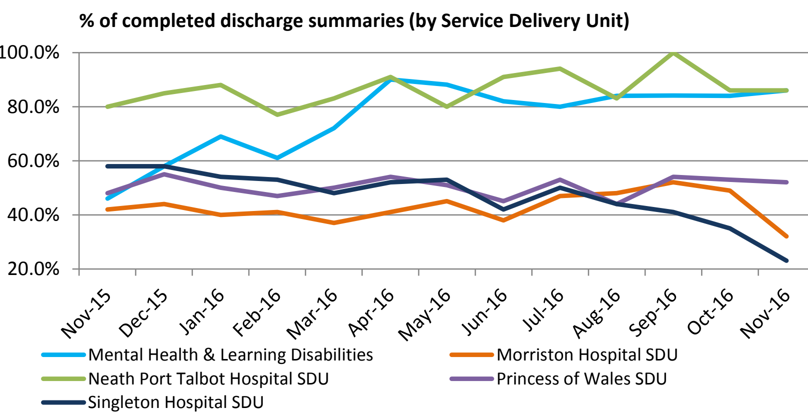
Measure 1: % of completed discharge summaries

Strategic Aim : Excellent patient outcomes and experience | **Strategic Change Programme: Quality & Safety** | **Executive Lead : Hamish Laing**

Period : Nov 16 | **IMTP Profile Target :** | **Local Target : 100%** | **Current Status :** ✗ | **Movement :** ⇩ **Worsening**

Current Trend: Nov 15 - Nov 16





How are we doing ?

- In November 2016 35% of discharge summaries were completed and sent compared with 47% in October.
- Performance varies between Service Delivery Units (SDUs) ranging from 23% - 86% in November 2016.
- This month performance has improved in Mental Health & Learning Disabilities, remained static in NPT and worsened in Morriston, POW and Singleton.
- Unit level data does not highlight significant ward-level improvement in performance
- Mental Health & Learning Disabilities and Neath Port Talbot SDU had the highest percentage of completed discharges (86%)
- Neath Port Talbot SDU's medical wards are consistently achieving 100% compliance.

What actions are we taking?

- Morriston has drawn up a 6 month programme to adopt the "no discharge summary, no discharge" approach that is planned to begin in January 2017
- IT infrastructure, in particular Wi-Fi, is still a constraint at Singleton. The health board is awaiting WG approval of the business case for development which will address this. Following approval, the improvements will be made in the next financial year
- ABMU is proposing to work with the Royal College of Physicians and NWIS to improve the e discharge process so that it will provide information to secondary care users to support their patient care. A business case has been submitted in respect of this proposal.
- HIW will be undertaking an all Wales thematic review of discharge information within its 2016/17 operational plan. HIW has commended ABMU for the positive steps it has taken to address poor performance.

How do we compare with our peers?

At present ABMU is the only Health Board in Wales that collects and reports their data.

- Risk to patient care and the need for readmission.

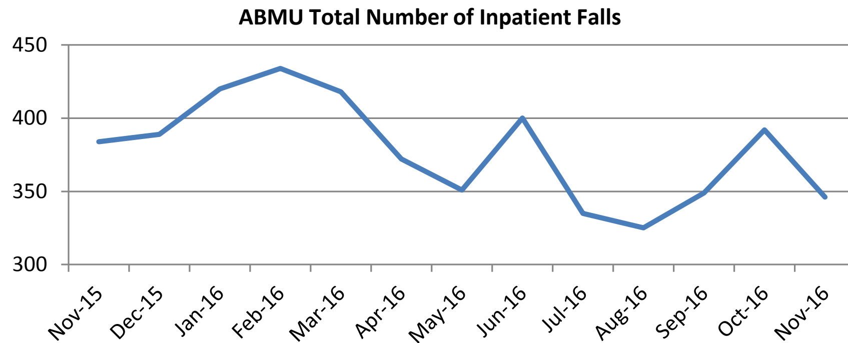
Source : ETOC Dashboard

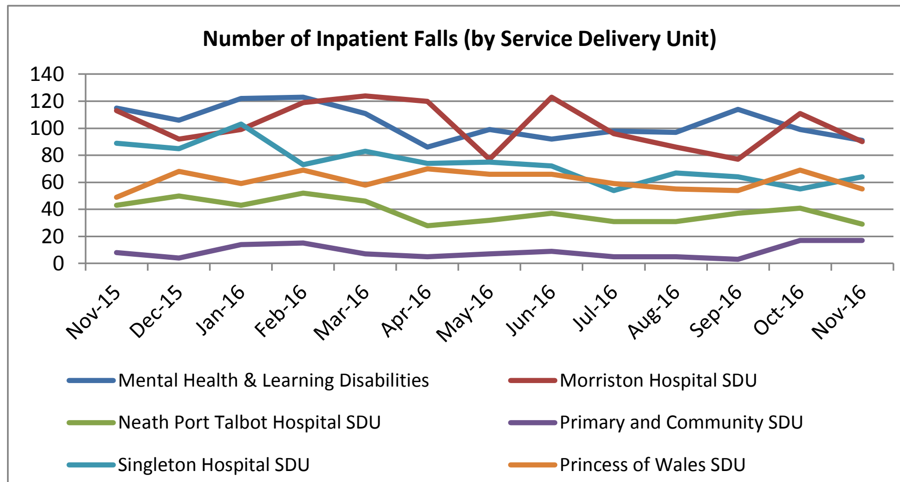
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

Measure: Number of Inpatient Falls

Strategic Aim : Excellent patient outcomes and experience		**Strategic Change Programme: Quality & Safety**	**Executive Lead : Amanda Hall**	
Period : Nov 16	**IMTP Profile Target : Reduce**	**Local Target : Reduce**	**Current Status :**	**Movement :** **Improving**

Current Trend: Nov 15 - Nov 16





How are we doing ?

• The number of falls reported via Datix web decreased significantly from 392 in October to 346 in November.
• Five Service Delivery Units (SDU's) have reported a decreased number of falls from the October 2016 figures, Singleton reporting a slight increase in falls, from 55 in October to 64 in November. Morriston and Princess of Wales had the biggest decrease in numbers of falls, -21 and -14 respectively.
• Primary and Community Service Delivery Unit reported 17 falls in November, the same as the previous month of October.

What actions are we taking?

• From October 2016 Gorseinon Hospital is being reported within Primary Care and Community Services.
• Neath port Talbot Service Delivery unit have a developed nurse practitioner role with a special interest in falls, working alongside the clinical teams to promote good fall prevention practice.
• Within the Princess of Wales Hospital staff are working with the Service Improvement Team to develop a driver diagram to focus actions and measurement of falls improvement work.
•Morriston and Singleton Service Delivery Units are undertaking monthly monitoring of falls incidents per clinical area – with targeted actions for the 5 high incident areas each month.

How do we compare with our peers?

No Benchmark Data Available

What are the main areas of risk?

• It is planned to change the way that falls is reported on the scorecard will change to a graph illustrating rates for each SDU per 1,000 bed nights, however due to the difficulties in reporting the data without a benchmark for Community and Primary Care Services, there will be a delay in changing this report pending an All Wales decision on reporting mechanisms.

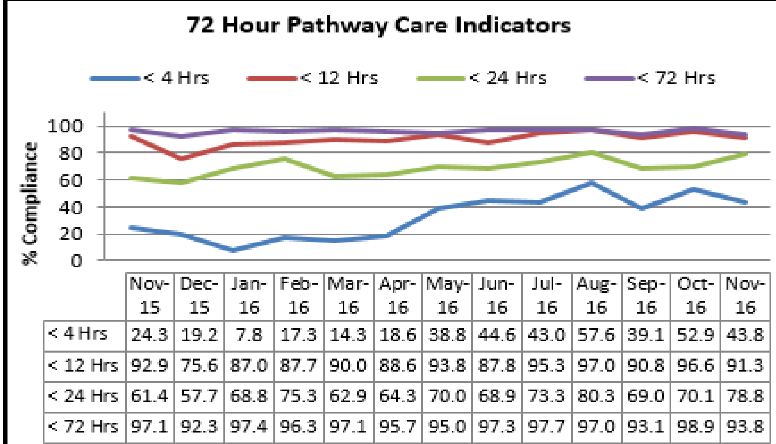
Source : DATIX

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)

Strategic Aim : Excellent Outcomes and Experience		Strategic Change Programme: Quality & Safety	Executive Lead : Alex Howells	
Period : Nov 16	IMTP Profile Target : (1)58.8% (2)93% (3)75% (4)97%	WG Target : > 95%	Current Status : ✗	Movement : ↑ Improving

Current Trend: Nov 15 - Nov 16



	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
< 4 Hrs	24.3	19.2	7.8	17.3	14.3	18.6	38.8	44.6	43.0	57.6	39.1	52.9	43.8
< 12 Hrs	92.9	75.6	87.0	87.7	90.0	88.6	93.8	87.8	95.3	97.0	90.8	96.6	91.3
< 24 Hrs	61.4	57.7	68.8	75.3	62.9	64.3	70.0	68.9	73.3	80.3	69.0	70.1	78.8
< 72 Hrs	97.1	92.3	97.4	96.3	97.1	95.7	95.0	97.3	97.7	97.0	93.1	98.9	93.8

How are we doing ?

• The Stroke Quality Improvement Measures and thrombolysis measures are : less than 4 hours for patients to be admitted directly to an Acute stroke unit and the swallow screening assessment undertaken, less than 12 hours for access to a CT scan, less than 24 hours for assessment by a stroke doctor, stroke nurse and assessment by an occupational therapist, physiotherapist or speech and language therapist, and less than 72 hours for formal swallow assessment, occupational therapist assessment, physiotherapist assessment and speech therapist communications assessment. All measures have an assigned target of 95%. New thrombolysis targets for patients who meet the criteria for this intervention were also introduced in October 2015.
• Following a dip in September, performance improved against the four stroke Quality Improvement Measures in October 2016
• The Health Board performs well in respect of the percentage and number of eligible patients receiving thrombolysis and is now focusing on improving thrombolysis times.

Benchmark

72 Hour Care Indicators Nov-16	AB	ABM	BCU	C&V	CTaf	HDda
1. < 4 Hours Care Indicators	57.6%	43.8%	47.4%	65.9%	48.8%	72.6%
2. < 12 Hours Care Indicators	95.5%	91.3%	92.8%	100.0%	100.0%	100.0%
3. < 24 Hours Care Indicators	92.4%	78.8%	85.6%	93.2%	67.4%	77.4%
4. < 72 Hours Care Indicators	100.0%	93.8%	97.9%	97.7%	88.4%	100.0%

Thrombolysis Indicators Nov-16	AB	ABM	BCU	C&V	CTaf	HDda
1. Access						
1a - % All Strokes Thrombolysed	10.6%	13.8%	7.2%	13.6%	11.6%	16.1%
2b - % Eligible Patients Thrombolysed	83.3%	90.9%	83.3%	100.0%	80.0%	90.0%
2. Time						
1a - Door-to-Needle <= 30 mins	14.3%	0.0%	14.3%	33.3%	0.0%	0.0%
2b - Door-to-Needle <= 45 mins	28.6%	18.2%	14.3%	33.3%	0.0%	50.0%
3c - Onset to-Needle <= 90 mins	28.6%	18.2%	14.3%	33.3%	20.0%	0.0%
4d - % with Pre and Post NIHSS Score	100.0%	90.9%	100.0%	66.7%	100.0%	90.0%

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

What actions are we taking?

Improvements in this area continue to be overseen by monthly meetings of the ABMU Health Board stroke steering group and weekly performance meetings.

Morriston

• Weekly action focussed MDT review of patients on the stroke pathway, to identify process changes that support improvement against the stroke quality measures. This includes addititional staff training sessions for all key personnel to ensure ongoing awareness and communication of the stroke pathway.
• Ongoing recruitment to medical and nursing staff to work on the acute stroke unit, and the redesign of nursing roles. This remains critical to the sustainable delivery of the 4 hr target for 2017/18.

PoWH

• Ongoing action focussed multi disciplinary reveiw of patients on the stroke pathway to identify process changes that support improvement against the stroke quality improvement measures.
• Targeted training/awareness of the 'code stroke' protocol and swallow screening tool.

ABMU wide

• Finalising specifications for Early Supported discharge and the Hyper Acute Stroke Unit which will feed into the IMTP process.
• Ongoing pathway improvements in Singleton and NPT hospitals to improve patient flow from PoW and Morriston hospitals.
•An assessment of the implications of new RCP guidelines (October 2016) on the design of the stroke pathway within the Health Board

How do we compare with our peers?

ABMU performs well in terms of the number of patients who are eligible to receive thrombolysis and performance against all 4 quality improvement measures in October was broadly comparable with other Health Boards in Wales.

What are the main areas of risk?

• Insufficient capacity in medical workforce to support 7 day working which will ultimately require a strategic change to centralise acute stroke services.
•Nurse staffing levels on the stroke ward at Morriston Hospital mean that patients undergoing Thrombolysis are cared for either in Coronary Care, or in the Resuscitation area of ED and therefore do not achieve the 4 hour admission target to a stroke ward.

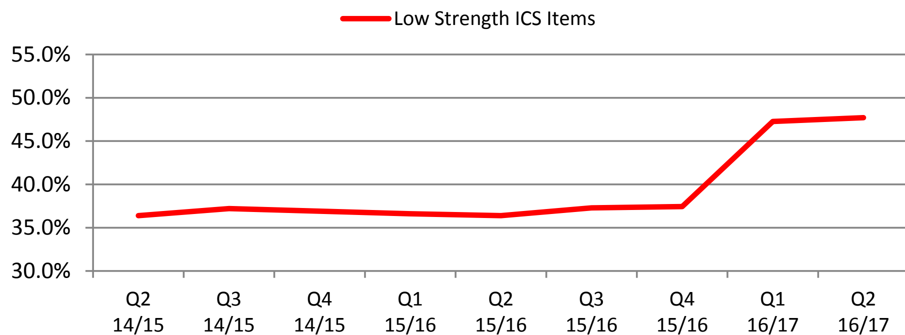
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2016) + ACUTE STROKE QUALITY IMPROVEMENT MEASURES DU REPORT

OUR STAFF & RESOURCES - PEOPLE IN WALES CAN FIND INFORMATION ABOUT HOW THEIR NHS IS RESOURCED AND MAKE CAREFUL USE OF THEM

Measure 1: % of inhaled corticosteroids prescribed in primary care that are low strength

Strategic Aim : Excellent patient outcomes and experience		Strategic Change Programme: Quality & Safety	Executive Lead : Rory Farrelly	
Period : Q2 16/17	IMTP Profile Target : N/A	WG Target : Upper quartile or show an increase (Upper quartile = >61)	Current Status :	Movement : Improving

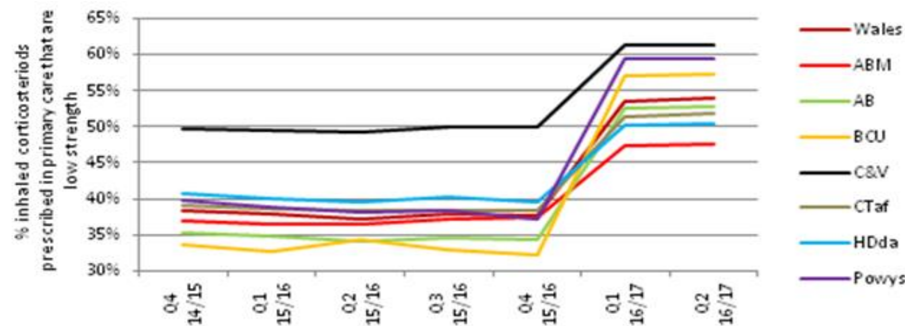
Current Trend: Q2 14/15 - Q2 16/17



How are we doing ?

- The spike in quarter 1 for low strength ICS was due to the fact that the low strength ICS drug basket (and subsequently the threshold) was amended at a national level by Primary Care Services, as certain preparations were originally omitted.
- Prior to this ABMU was also showing a gradual improvement from historically low levels.
- While there has been engagement on increasing levels of cost effective inhalers, achieving step down of doses has been more challenging, due to fears of exacerbation.

Benchmark



What actions are we taking?

- The Respiratory Prescribing Management Scheme + is in its second year of operation and aims to support practices and clusters to rationalise respiratory prescribing, including reviewing use of high dose corticosteroids.
- This has also been discussed during the annual prescribing visit to each practice which took place from May 2016 and at educational sessions in Prescribing Leads and Cluster meetings.

How do we compare with our peers?

- While showing some improvement, ABM continues to prescribe the highest level of high dose ICS. This may in part be due to the relatively high prevalence of asthma and COPD.

What are the main areas of risk?

- Fears that reducing ICS doses will cause exacerbations.
- GP workforce pressure and time taken to step patients down.

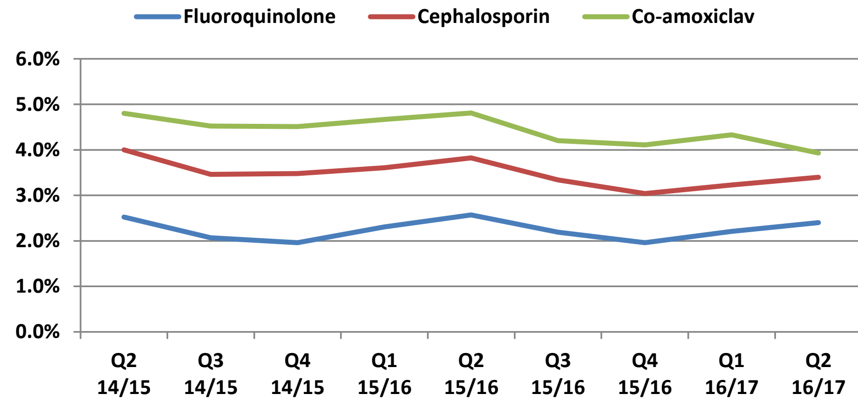
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2016)

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

Measure 1: Fluoroquinolone items as a % of total antibacterial items prescribed. - Measure 2: Cephalosporin items as a % of total antibacterial items prescribed.
Measure 3: Co-amoxiclav items as a % of total antibacterial items prescribed

Strategic Aim : Excellent patient outcomes and experience		Strategic Change Programme: Quality & Safety	Executive Lead : Rory Farrelly	
Period : Q2 16/17	IMTP Profile Target : N/A	WG Target : Lower Quartile or Show a Reduction (lowest quartiles = [1] < 1.3% [2] < 2.1% [3] < 2.3%)	Current Status :	Movement : Improving

Current Trend: Q2 14/15 - Q2 16/17



How are we doing ?

•Long term prescribing trend in all three indicators is reducing and so demonstrating improvements NB: data will show seasonal variation.

Benchmark

	Fluoroquinolone			Cephalosporin			Co-amoxiclav		
	Current	Previous		Current	Previous		Current	Previous	
LHB	Q2 16/17	Q2 15/16	Q2 14/15	Q2 16/17	Q2 15/16	Q2 14/15	Q2 16/17	Q2 15/16	Q2 14/15
Wales	2.16%	2.22%	2.30%	3.62%	4.04%	4.60%	3.62%	4.12%	4.68%
ABM	2.40%	2.57%	2.54%	3.40%	3.81%	4.05%	3.93%	4.81%	4.85%
AB	1.60%	1.66%	1.78%	2.80%	3.12%	4.07%	3.50%	3.66%	3.80%
BCU	2.45%	2.50%	2.71%	4.63%	5.11%	6.23%	2.79%	2.96%	3.49%
C&V	2.09%	2.00%	2.30%	2.35%	2.86%	3.76%	3.13%	3.53%	4.83%
Ctaf	2.04%	2.02%	1.89%	5.10%	5.20%	5.26%	4.28%	5.37%	6.97%
Hdda	2.26%	2.41%	2.12%	3.81%	4.25%	3.92%	4.80%	5.46%	6.13%
Powys	2.29%	2.43%	2.67%	2.71%	3.46%	3.57%	3.79%	4.46%	4.26%

Improvement from same period in previous year — Deterioration from same period in previous year

What actions are we taking?

• A key part of the Heath Board's priority initiative – The Big Fight – aimed at improving antimicrobial stewardship.
• Discussed in all practice annual prescribing visits.
• Included in the GP 2016-17 Prescribing Management Scheme with incentives to improve quality of prescribing.
• Improved antimicrobial stewardship included in Cluster Plans.
• Significant education programme being delivered to GPs .
• Primary Care Prescribing Guidelines developed and updated, including availability of an app. version to improve accessibility.

How do we compare with our peers?

• Quinolnes – above Welsh average, but significantly reduced over the last few years from historic prescribing position.
• Cephalosporins – below Welsh average.
• Co-amoxiclav – above Welsh average, but currently being focussed on.

What are the main areas of risk?

• Lack of engagement with Big Fight work due to GP workforce pressures.
• Microbiologist capacity across HB.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (DECEMBER 2016)

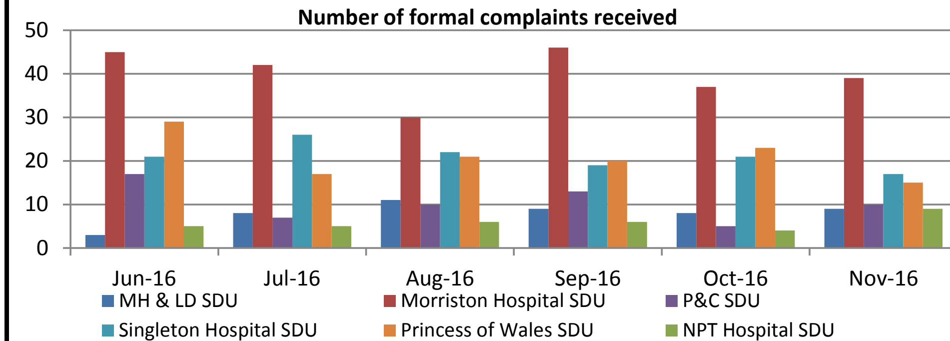
EFFECTIVE CARE - I RECEIVE THE RIGHT CARE & SUPPORT AS LOCALLY AS POSSIBLE & I CONTRIBUTE TO MAKING THAT CARE SUCCESSFUL

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

Strategic Aim : Excellent Patient Outcomes and Experience | **Strategic Change Programme: Quality & Safety Committee** | **Executive Lead : Rory Farrelly**

Period : Nov 16 | **IMTP Profile Target :** | **Local Target : (1) Monitor, (2) 80%** | **Current Status :** | **Movement :** **Stable**

Current Trend: Nov 15 - Nov 16



% of responses sent within 30 working days	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	*Nov-16
MH & LD SDU	100%	63%	55%	33%	63%	100%
Morriston Hospital SDU	62%	44%	38%	53%	49%	50%
NPT Hospital SDU	20%	60%	50%	50%	50%	80%
P&C SDU	59%	43%	40%	38%	40%	67%
Singleton Hospital SDU	19%	60%	41%	33%	52%	50%
Princess of Wales SDU	37%	65%	57%	68%	70%	25%
Health Board Total	**49%**	**53%**	**45%**	**45%**	**56%**	**56%**

** November 2016 represents performance for the first 6 working days of the month*

Percentage Acknowledgements Sent ≤ 2 Working Days	2015		2016										
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
	95%	95%	91%	97%	96%	97%	98%	100%	100%	100%	100%	100%	100%

How are we doing ?

- Morriston remains the Service Delivery Unit (SDU) receiving the highest number of formal complaints. Receiving 35 complaints in October and 39 complaints for November 2016.
- Singleton & POW in November received 17 & 15 formal complaints respectively.
- The Health Board 30 day response target is 80% by March 2017. To achieve this target a 7.60% is required by each month for the SDU.
- The 30 day response % for the HB in October is 51% which is a 6% increase from September.
- This 6% increase needs to be maintained and improved to achieve the 80% target for March 2017
- The 2 day acknowledgment target has been maintained for the passed 6 months.

What actions are we taking?

- Improvements in the 30 day response targets continues to be overseen by the Executive Nurse Director for Patient Experience.
- The Executive Nurse Director has concluded urgent meetings during December 2016 with the Service Delivery Units (SDU's) with the lowest compliance to discuss their October performance.
- Each SDU has provided assurance of their improvement action plans to achieve the 80% HB target.
- Targeted training events are being undertaken in SDU's, to be completed by April 2017 and review process planned.
- Patient Advice Liaison Service (PALS) is now implemented in the acute SDU's. Auditing of the number of formal complaints received within the HB will commence in January 2017 to evaluate the impact of the PALS teams

What are the main areas of risk?

- Variability in sustaining the required target improvement to achieve the 80% HB target by March 2017 within the SDU's.

How do we compare with our peers?

No Benchmark Data Available

Source :DATIX