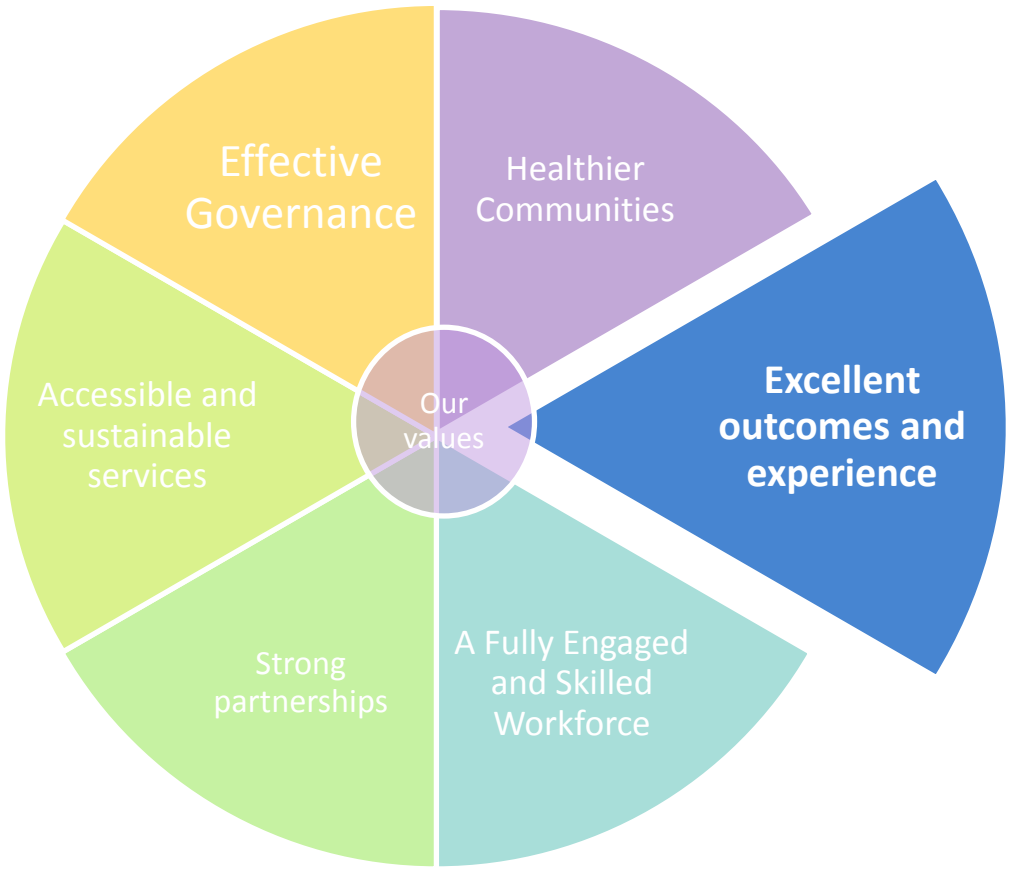
	ABM University Health Board
Health Board	**Meeting on: 30th March 2017**

Subject:	Performance Report- Excellent Outcomes and Experience



ABMU Key Priorities : Excellent Outcomes and Experience

Improved Performance	16 Measures
Sustained Performance	2 Measures
Decline in Performance	6 Measures
Trend	

Measures	Period	Value	Target Attained	Trend
Number of healthcare acquired pressure ulcers	Jan-2017	126	N/A	↓
Number of cases of C Difficile per 100,000 of the population	Jan-2017	56.02	✗	↓
Number of cases of Staph. aureus per 100,000 of the population	Jan-2017	49.30	✗	↑
% compliance with Hand Hygiene	Jan-2017	95.0%	✗	→
% Serious Incidents Assured Within The Agreed Timescales	Jan-2017	50.0%	N/A	↓
Number of new Never Events	Jan-2017	0	N/A	↑
% crude mortality	Dec-2016	0.78%	✓	↑
% Stage 1 Mortality Reviews completed	Jan-2017	97.6%	N/A	↑
% episodes clinically coded within one month post episode end date	Dec-2016	36.7%	✗	↓
% completed discharge summaries	Jan-2017	49.0%	✗	↑
Number of inpatient falls	Jan-2017	374	✓	↑

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)	Jan-2017	34.7%	✗	↑
% compliance with stroke bundle 2 (12 hours)	Jan-2017	87.8%	✗	↑
% compliance with stroke bundle 3 (24 hours)	Jan-2017	58.2%	✗	↑
% compliance with stroke bundle 4 (72 hours)	Jan-2017	95.9%	✗	↑
Fluoroquinolone items as a % of total antibacterial items prescribed	Q216/17	2.4%	✓	↑
Cephalosporin items as a % of total antibacterial items prescribed	Q216/17	3.4%	✓	↑
Co-amoxiclav items as a % of total antibacterial items prescribed	Q216/17	3.9%	✓	↑
% of inhaled corticosteroids prescribed in primary care that are low strength	Q2 16/17	47.7%	✓	↑
Number of Formal Complaints	Jan-2017	90	✗	→

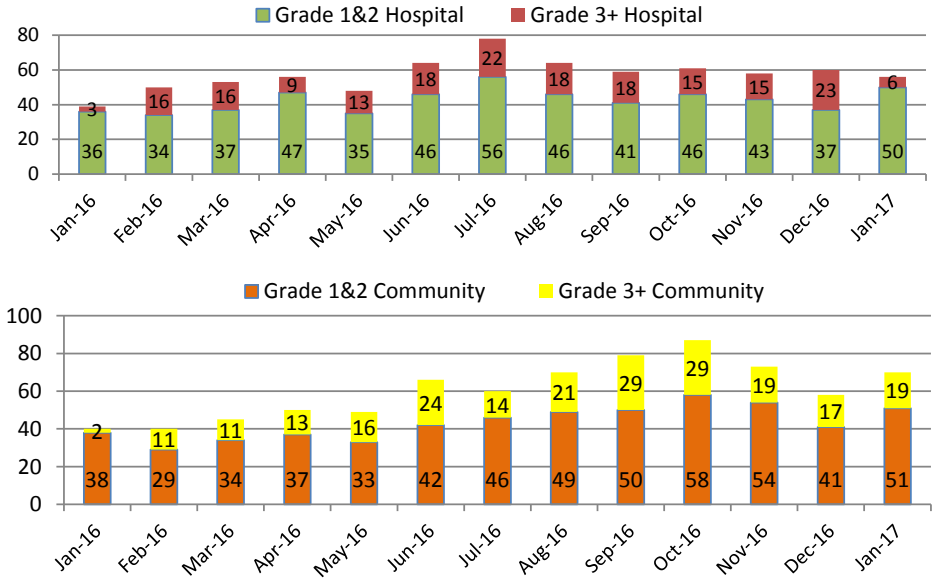
SAFE CARE - I AM PROTECTED FROM HARM & PROTECT MYSELF FROM KNOW HARM

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 : Jan 2017	**IMTP Profile Target : Reduce**	**WG Target : Reduce**	**Current Status : N/A**	**Movement : Worsening**

Current Trend: Jan 16- Jan 17



How are we doing ?

• The numbers of Grade 1 & 2 pressure ulcers reported against inpatients has increased this month from 37 reported in December 2016 to 50 reported in January 2017. Community acquired lower grade ulcers also increased from the 41 in December 2016 to 51 reported in January 2017.

• The numbers of Grade 3+ inpatient ulcers reported decreased from 23 in December 2016 to 6 in January 2017. The number of Grade 3+ pressure ulcers reported in the community setting increased slightly, there were 17 reported in December 2016 and 19 reported in January 2017.

• Neath Port Talbot Service Delivery Unit (SDU) are reporting a static position, Morriston SDU are demonstrating a decreasing position. Singleton SDU are reporting an decreased number of Pressure Ulcers and Princess of Wales SDU are reporting an increased number of pressure ulcers.

Benchmark

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

What actions are we taking?

• Rolling out the Neath Port Talbot Service Delivery Unit (SDU) Scrutiny Panel model to all SDU's by the end of March 2017.

• Monitoring the outcomes of root cause analysis through the Scrutiny Panel process to start reporting avoidable and unavoidable percentage rates of pressure ulcers by quarter 2 2017/18.

• Reviewing and developing a pressure ulcer improvement plan through the pressure ulcer improvement group to agree core priorities and high impact interventions that will continue supporting an improvement an reduction in avoidable pressure ulcers by end of March 2017. Improvement plan will be reported through to the Quality & Safety Forum by April 2017.

• POW SDU have started a pressure ulcer scrutiny panel which will mirror the terms of reference of the ones established at NPT.

• POW SDU have started a pilot for Skin Bundle, commencing March 1st 2017 on 4 wards.

How do we compare with our peers?

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

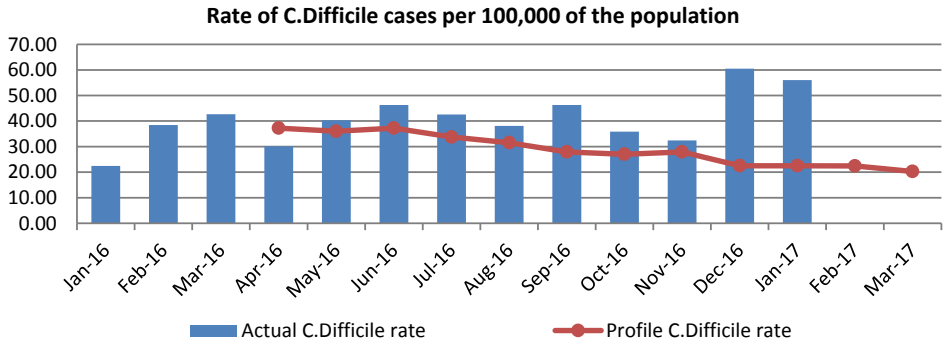
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : Jan 2017	IMTP Profile Target : 22.5	WG Target : Improve	Current Status : ✗	Movement : ↓ Worsening

Current Trend: Jan 16- Jan 17



How are we doing ?

• There were 25 reported cases of C. difficile infection identified in ABMU in January 2017; 17 from inpatient locations; 8 from non-inpatient locations (8 inpatient cases in Morriston, 5 in Princess of Wales, 2 in Neath Port Talbot, and 2 cases in Singleton).

• The cumulative number of cases between April 2016 and January 2017 was 189; 21% fewer cases than the same period in 2015/16. For Wales as a whole, there are approximately 16% fewer cases of C. difficile in October 2016 - January 2017 compared with October 2015 - January 2016.

• The monthly average for the 10 months April 2015 – January 2016 was 24 cases; the monthly average for the same 10 month period in 2016/17 has reduced by 5 cases per month. The Health Board has not achieved the reduction expectation for March 2017; having exceeded the expectation profile by 9 cases with two months still remaining.

Benchmark

LHB	Jan-17	Number Against Mar 17 Reduction Expectation
Wales	31.12	+37
ABM	46.31	+34
AB	21.42	-12
BCU	30.34	+7
C&V	28.77	+2
Ctaf	18.00	-7
Hdda	44.91	+23

Not on trajectory to achieve expected reduction by Mar 17

On trajectory to achieve expected

What actions are we taking?

• All Service Delivery Units (SDU's) had exceeded their reduction profiles for January 2017.

• Big Fight Team progress: 84% Nursing Homes within ABMU have had Infection Prevention & Control training to date. 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.

• The Health Board's Antimicrobial Stewardship Group to be established within secondary care - to be chaired by one of the Unit Medical Directors. The group will promulgate the Start Smart and Focus approach, tackling variable levels of medical engagement in stewardship.

How do we compare with our peers?

•For the month of January 2017 ABMU has highest incidence of C. difficile infection in Wales.

• 4 months into the reduction expectation period, only 2 Health Boards (Aneurin Bevan UHB and Cwm Taf UHB) are on trajectory to meet the reduction expectation.

What are the main areas of risk?

• High rates of secondary care antimicrobial prescribing. Very high number of medical outliers, which impacts on effective antimicrobial stewardship.

• Current increased and regular use of pre-emptive beds on acute sites increases risks of infection transmission.

• A lack of dedicated decants facilities hampers efficiency of decontamination activities and procedures.

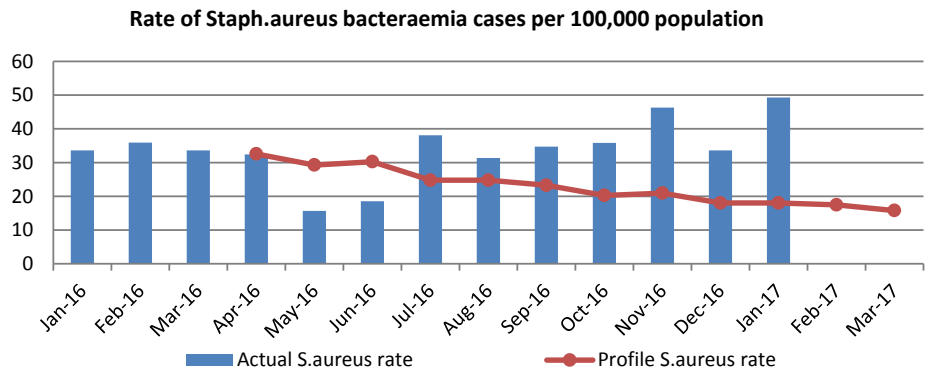
Source : Public Health Wales, C. difficile and S. aureus bacteraemia monthly dashboard (FEBRUARY 2017)

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 : Jan 2017	IMTP Profile Target : 18	WG Target :	Current Status : ✗	Movement : ↑ Improving

Current Trend: Jan 16- Jan 17



How are we doing ?

- There were 22 cases of Staph. aureus (SA) bacteraemia identified in January 2017 ; 11 inpatients and 11 non-inpatients. Three of these were MRSA bacteraemia inpatient cases.
- The number of cases identified between April 2016 and January 2017 was 148; 0.7% fewer compared with the same ten months in 2015/16. 53% of these cases occur in non-inpatients; many of the inpatient cases will have been admitted to hospital with sepsis, which is then confirmed by obtaining a blood culture.
- The incidence in January 2017 increased to 49.30/100,000 population (target is 20/100,000). The cumulative incidence, April 2016 to January 2017 was 33.60.
- The monthly average for the 10 months April 2015– January 2016 was 15 cases; the monthly average for the same 10 month period in 2016/17 was 15 cases also. By the end of January 2017, the reduction expectation profile had been exceeded by 21 cases.

Benchmark

LHB	Jan-17	Number Against Mar 17 Reduction Expectation
Wales	28.82	+95
ABM	41.23	+39
AB	21.42	+13
BCU	24.36	+11
C&V	34.89	+25
Ctaf	32.00	+13
Hdda	30.20	+14

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 Service Delivery Unit (SDU) has specific monthly reduction projections, which are monitored weekly. With the exception of Neath Port Talbot, all SDUs 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 by March 2017.
- 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 has the highest incidence of Staph. aureus bacteraemia in comparison with the other major Welsh Health Boards.
- 4 months into the reduction expectation period, none of the 6 major Health Boards are on trajectory to meet the reduction expectation.

What are the main areas of risk?

- The Health Board has failed to achieve the infection reduction expectation set by Welsh Government.
- 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.

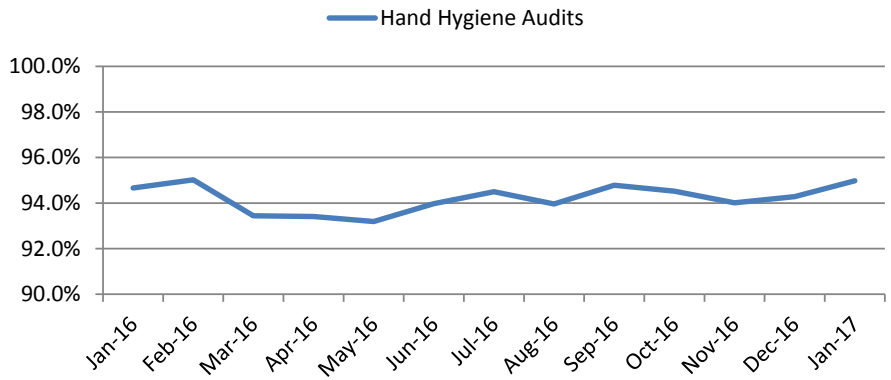
Source : Public Health Wales, C. difficile and S. aureus bacteraemia monthly dashboard (FEBRUARY 2017)

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 : Jan 2017	**IMTP Profile Target : 95%**	**Local Target : 100%**	**Current Status :** ✖ **Movement :** ⇨ **Stable**

Current Trend: Jan 16- Jan 17



How are we doing ?

- Compliance with hand hygiene (HH) for January 2017 was 94.98%.
- For January 2017, 94 wards/units (68%) reported full compliance. 93 wards/departments reported 100% compliance.
- 10 wards/departments (8%) reported partial compliance; 21 wards/units (15%) reported non-compliance (compliance ≤89%).
- 13 wards/departments (9%) had not uploaded the results of their audits undertaken in January 2017.
- Three of the six Service Delivery Units (SDUs) reported full compliance in January 2017 (Morriston, Neath Port Talbot, and Princess of Wales); Primary Care & Community Services, Singleton and Mental Health reported >90% 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; SDU's to consider establishment of cross-ward audits by 31 March 2017.
- There will be a drive between January and March 2017 to competency-assess more Hand Hygiene Coaches.
- The Infection Prevention and Control Team (IPCT) are actively participating in the all-Wales HH product procurement exercise.
- It is now 10 years since the national 'Clean Your Hands' campaign. ABMU's Assistant Director of Nursing (ADN) has been asked by Welsh Government to chair a new campaign group, working with Public Health Wales. The first meeting to set terms of reference was held on the 21st February.

How do we compare with our peers?

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

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

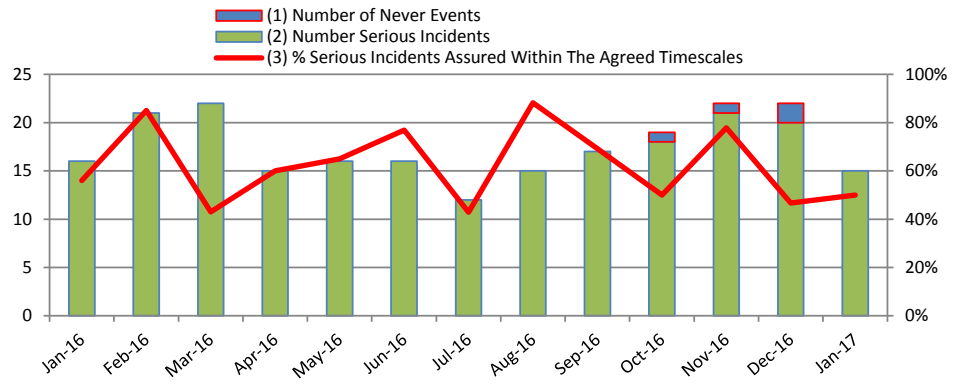
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

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 : Jan 2017	IMTP Profile Target : (1) Zero, (2) Improve, (3) 86%	WG Target : (1) Zero, (2) Improve, (3) 90%	Current Status :	Movement : Worsening

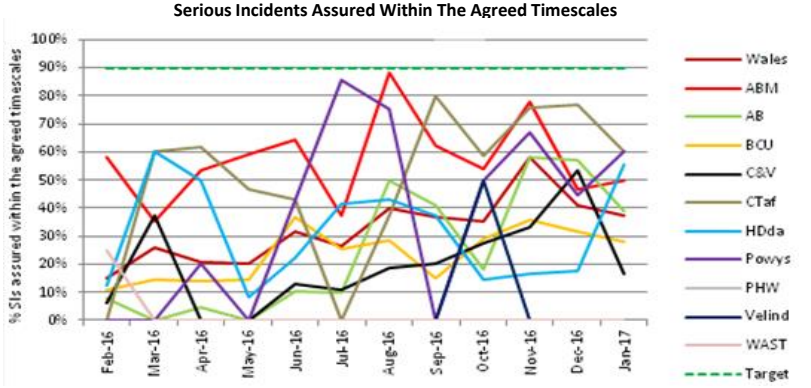
Current Trend: Jan 16- Jan 17



How are we doing ?

• 1,953 incidents were reported in January 2017 (1,838 incidents were reported in December 2016 and 2,019 reported in January 2016).
• 15 (0.77%) Serious Incidents (SI's) were reported to Welsh Government in January 2017, 20 SI's were reported in December 2016 (1.09%) and 16 SI's were reported in January 2016 (0.79%).
• 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 January (0.%), the measure for the percentage of serious incidents related to severe harm was achieved.
• No never events were reported in January 2017.
• Performance against closing SI's down within 60 working days in January was 50% and the performance for February is expected to be 77%.

Benchmark



Never Events

Jan-17	
Wales	1
ABM	0
AB	0
BCU	0
C&V	1
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. The Units performance in relation to closure compliance was discussed with the Units during the January 2017 performance reviews and February's performance is expected to be 77% and from March 2017 onwards the Health Board is expecting to achieve the 80% target.
• 73% 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.
• Health Inspectorate Wales are sharing their surgical inspection framework.

How do we compare with our peers?

• One never event was reported in Wales (C&V Health Board).
• The Health Boards compliance in closing serious incidents down by the Welsh Goverment target date has been consistently above the all Wales average during 2016/17.

What are the main areas of risk?

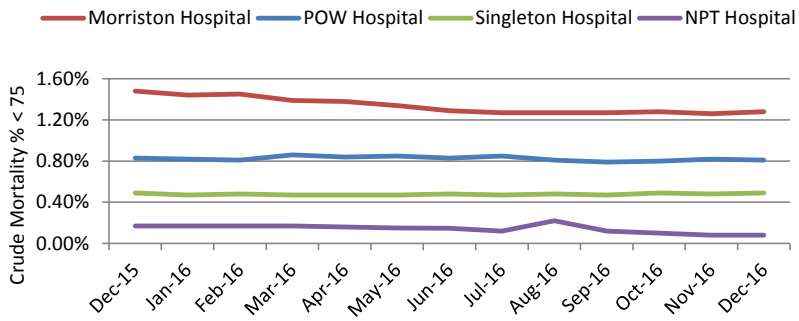
Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2017)

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 : Dec 2016	**IMTP Profile Target :**	**WG Target : 12 month reduction trend**	**Current Status :** ✓ **Movement :** ↑ **Improving**

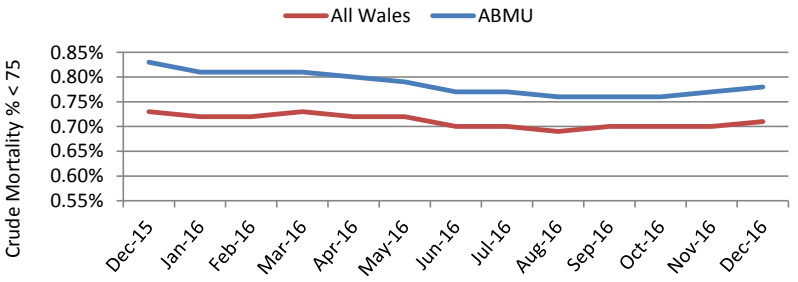
Current Trend: Dec 15 - Dec 16



How are we doing ?

- The ABMU Crude Mortality Rate for under 75s in the 12 months to December 2016was 0.78%. This is lower than the same period last year which was 0.83%.
- At a site level performance is as follows: (prior year in brackets) Morriston 1.28% (1.48%), Princess of Wales 0.81% (0.83%), Neath Port Talbot 0.08% (0.17%), Singleton 0.49% (0.49%). Site comparison is not possible due to different service models being in place.
- There were 114 in-hospital Deaths in this age group in January 2017, the same as January 2016: Morr 55 (60), PWH 41 (34), NPTH 3 (0), SNG 13 (19).
- 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 Health Board data and improving feedback from the mortality review process. To support this process, the proposal is to introduce a new electronic form linked to the eMortality Review Application to gather and share feedback.
- 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.
- Information and analysis for mortality and the two stage mortality review process continues to be available on a daily basis via the Mortality dashboard. Unit Medical Directors (UMDs) have been given an overview of the functionality available in the dashboard at COG with further demonstrations with UMDs at each hospital site.

How do we compare with our peers?

- ABMU are slightly above the all-Wales Mortality rate for the 12 months to December 2016 – 0.78% compared with 0.71%.
- ABMU compares favourably to the all-Wales peer in elective cases at 0.04% compared to 0.06%.

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)

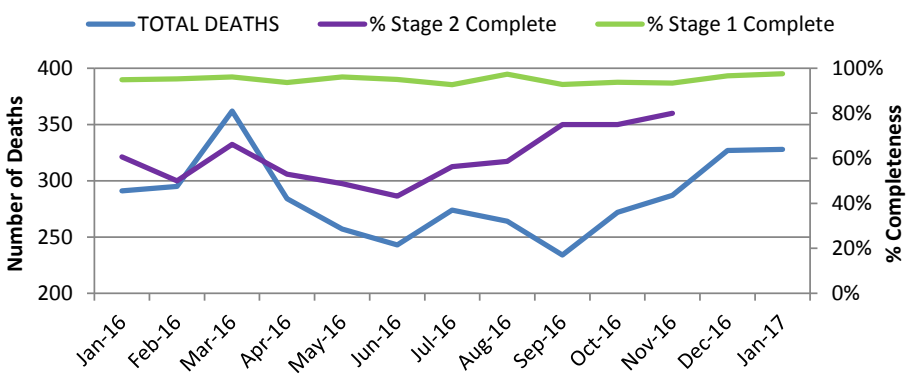
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE SUCCESSFUL

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 : Jan 2017	IMTP Profile Target : (1) 96%	WG Target : Improve	Current Status : N/A	Movement : Improving

Current Trend: Jan 16- Jan 17



How are we doing ?

- 328 deaths were included in the mortality review process in January 2017
- The overall Universal Mortality Review (UMR) rate for the HB was 98%, a 2% improvement from December 2016
- Morriston achieved 97% (4 missing forms), NPT, POWH & Singleton all achieved 100%
- There are 77 UMRs outstanding from April 2016 to date. 73 of these are from Morriston.
- 5.5% of UMRs completed for January 2017 deaths triggered a Stage 2 review, 1.5% less than in December 2016
- Completion of Stage 2 reviews within 8 weeks is steady (75%)
- From April 2016 - November 2016 there are 74 outstanding Stage 2 reviews; 3 in NPT, 23 in Singleton, and 24 in both Morriston and POW
- Mental Health have now begun to undertake UMRs. In January 4/8 deaths had a UMR completed

Benchmark

What actions are we taking?

- Consultants are being notified that a Stage 2 review is required as soon as a completed UMR indicates it. This has speeded up the process. UMDs are addressing performance issues locally e.g. by providing detailed consultant level data
- 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 has undertaken a case note review which has provided assurance that removing the "patient died from a condition other than that for which they were admitted" has not resulted in missed learning opportunities.
- 26% of the 90 "thematic"/Stage 3 reviews of completed Stage 2 forms have confirmed that there were no concerns about the patients' care. Infections were noted in 22% but these were generally not implicated in the death.

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 will 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

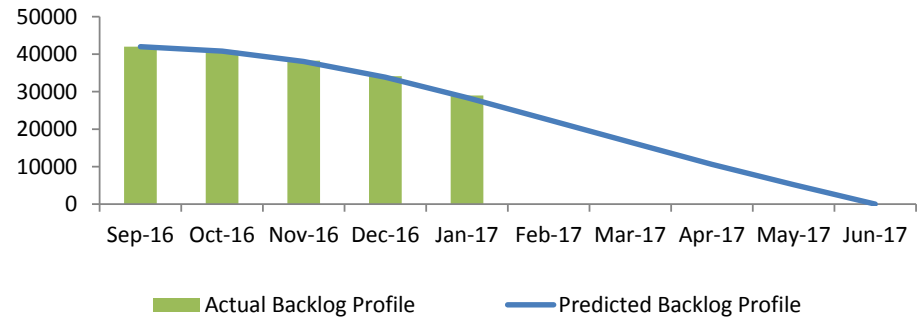
EFFECTIVE CARE - PEOPLE IN WALES RECEIVE THE RIGHT CARE AND SUPPORT AS LOCALLY AS POSSIBLE AND ARE ENABLED TO CONTRIBUTE TO MAKING THAT CARE SUCCESSFUL

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: Jan 2017	IMTP Profile Target : N/A	WG Target : 12 month improvement trend	Current Status : ✗	Movement :

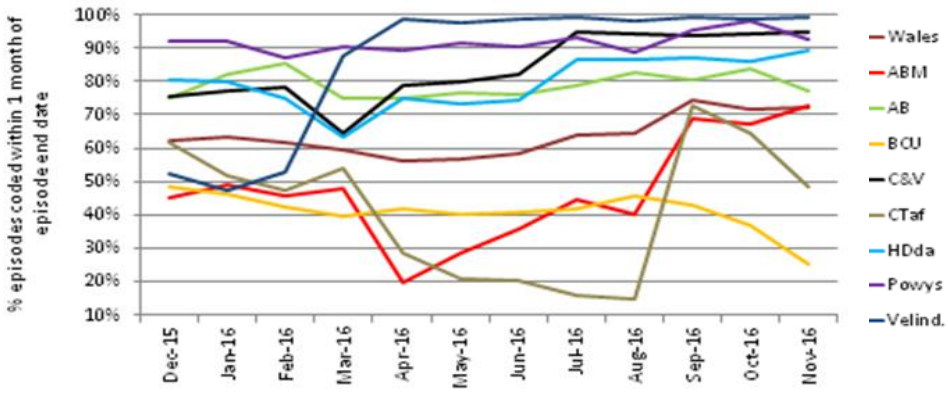
Current Trend: Jan 16- Jan 17



How are we doing ?

- As at 1st February 2016 the Coding completeness is – April 98.20%, May 96.80%, June 94.15%, July 88.93%, August 84.22%, September 91.45%, October 85.00%, November 81.85% and December 89.35%.
- As at 1st February 2017 the outstanding backlog stands at 26,892 episodes for 2016/2017. On target against profile reduction to clear backlog by end of June 2017.
- Coding completeness within 1 month has improved in the last 3 months from 40% for August to December 2016 at 87.35%. We will expect to see further improvement between January and March 2017 due to changes in working practices 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 55% for December 2016. Although this is an improvement, it continues to hinder coding efficiency.

Benchmark



What actions are we taking?

- The updated all-Wales benchmarking data is currently unavailable due to reporting consistency issues, this is being escalated with NWIS for resolution. It is expected that the ABMU position has improved.
- Achieving compliance against the 12-month plan to clear the coding backlog by July 2017.
- 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
- Recruitment of 6.5 WTE permanent staff has been completed, with a start date 6.3.2017. 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 performance of the within 30 days target.
- 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?

- There is an ongoing discrepancy with the comparative data above which NWIS produce for Welsh Government, this is being investigated and has been suspended until resolved.

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 (FEBRUARY 2017)

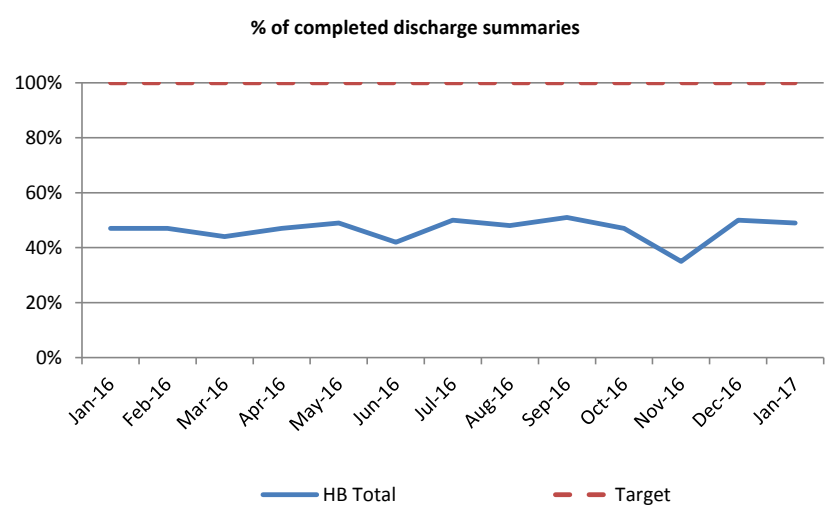
TIMELY CARE - I HAVE TIMELY ACCESS TO SERVICES BASED ON CLINICAL NEED & AM ACTIVELY INVOLVED IN DECISIONS ABOUT MY CARE

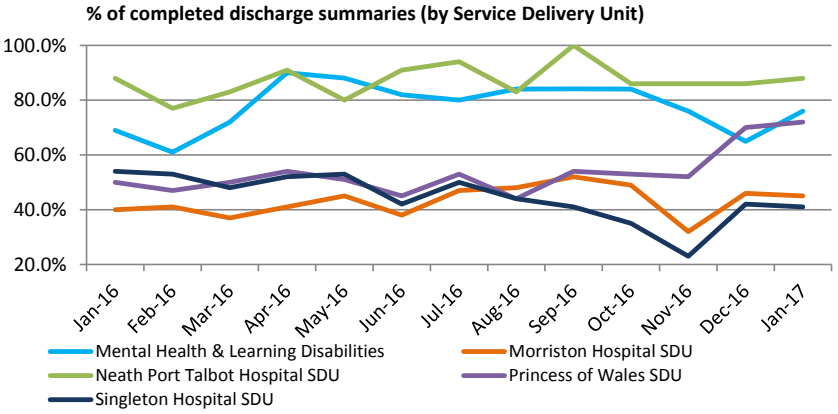
Measure 1: % of completed discharge summaries

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

Period : Jan 2017	**IMTP Profile Target :**	**Local Target : 100%**	**Current Status :** ✗	**Movement :** ↑ **Improving**

Current Trend: Jan 16- Jan 17





How are we doing ?

- In January 2017 49% of discharge summaries were completed and sent compared with 50% in December 2016.
- Performance varies between Service Delivery Units (SDUs) ranging from 41% - 88% in December 2016.
- This month performance has improved in POW, NPT and Mental Health & Learning Disabilities. Performance has worsened by 1% in Morriston and Singleton.
- POW continues to show marked improvement and reached 72% compliance this month. In POW Orthopaedics completion has increased significantly to 60%.

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 early 2017.
- The Executive Medical Director wrote to each of the Unit Medical Directors on 10th February 2017 ask them to accelerate the "no discharge summary, no discharge" approach.
- ABMU will be working with the Royal College of Physicians and NHS Wales Informatics Service (NWIS) to improve the e-discharge process so that it will provide information to secondary care users to support their patient care.
- Healthcare Inspectorate Wales (HIW) is undertaking an all Wales thematic review of discharge information. The first part of the review in March will concentrate on Primary Care. We have not received notification of when the review team will be visiting our hospital sites. 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

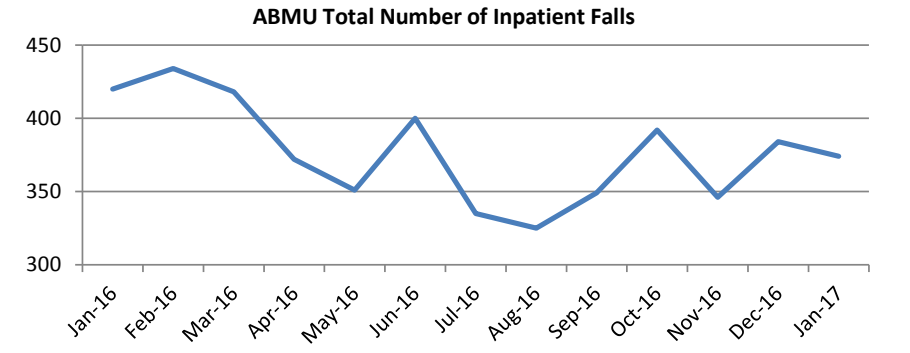
SAFE CARE - PEOPLE IN WALES ARE PROTECTED FROM HARM AND SUPPORTED TO PROTECT THEMSELVES FROM KNOWN HARM

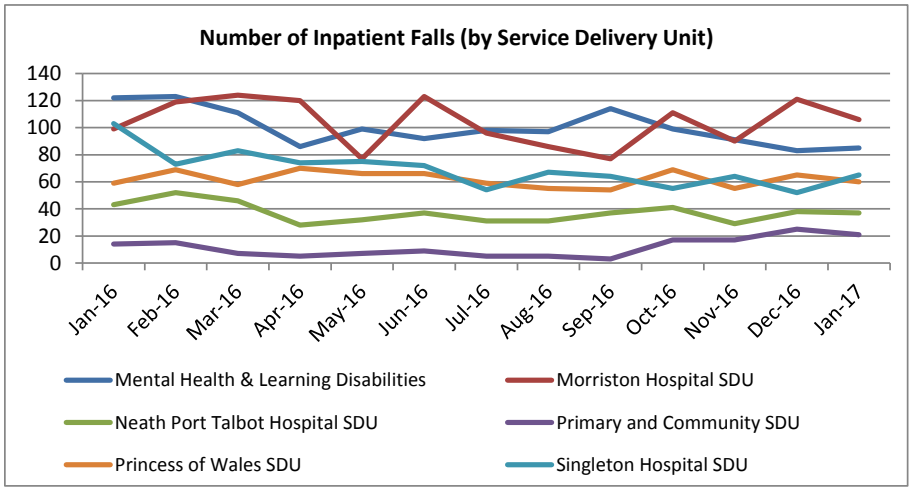
Measure: Number of Inpatient Falls

Strategic Aim : Excellent patient outcomes and experience	Strategic Change Programme: Quality & Safety	Executive Lead : Amanda Hall

Period : Jan 2017	IMTP Profile Target : Reduce	Local Target : Reduce	Current Status : ✓	Movement : ↑ Improving

Current Trend: Jan 16- Jan 17





How are we doing ?

• The number of falls reported via Datix web decreased from 384 in December 2016 to 374 in January 2017. The 12 month movement on this reported figure is 46 less than this time last year.

• Four Service Delivery Units (SDU's) have reported a decreased number of falls from the December 2016 figures, Morriston SDU had the biggest decrease in falls, from 121 in December to 116 in January. Singleton SDU reported an increased number of falls, from 52 in December to 65 in January.

• The Mental Health and Learning Disabilities SDU reported falls increased by 2 from 83 in December 2016 to 85 in January 2017.

What actions are we taking?

• Each Service Delivery Unit (SDU) is analysing their Datix incidents and Root Cause Analysis and findings will be reported to the Learning and Assurance in April 2017.

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, it 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.

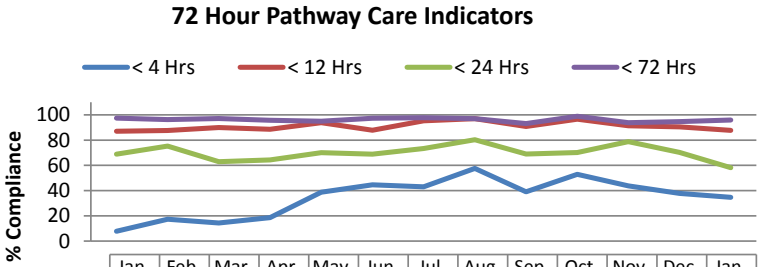
Source : DATIX

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 : Jan 2017	IMTP Profile Target : (1)67.6% (2)94% (3)78% (4)97%	WG Target : > 95%	Current Status : ✗ Movement : ↑ Improving

Current Trend: Jan 16- Jan 17



	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
< 4 Hrs	7.8	17.3	14.3	18.6	38.8	44.6	43.0	57.6	39.1	52.9	43.8	37.8	34.7
< 12 Hrs	87.0	87.7	90.0	88.6	93.8	87.8	95.3	97.0	90.8	96.6	91.3	90.5	87.8
< 24 Hrs	68.8	75.3	62.9	64.3	70.0	68.9	73.3	80.3	69.0	70.1	78.8	70.3	58.2
< 72 Hrs	97.4	96.3	97.1	95.7	95.0	97.3	97.7	97.0	93.1	98.9	93.8	94.6	95.9

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.

• Performance dipped against three of the four stroke Quality Improvement Measures in January 2017. The reasons for this included capacity in the small medical and nursing stroke teams, and increased demands on the medical teams as a result of unscheduled care pressures, particularly in the out of hours period, in addition to the increased demands on stroke services in Morriston in particular.

• The number of confirmed stroke patients attending Morriston hospital in January 2017 increased by 45% when compared with January 2016, with January 2017 experiencing the highest number of recorded confirmed stroke admissions at this hospital.

• The Health Board has performed consistently well in respect of the percentage and number of eligible patients receiving thrombolysis.

Benchmark

72 Hour Care Indicators Dec-16	AB	ABM	BCU	C&V	CTaf	HDda
1. < 4 Hours Care Indicators	40.5%	34.7%	51.6%	40.4%	44.9%	75.0%
2. < 12 Hours Care Indicators	95.9%	87.8%	94.5%	95.7%	100.0%	100.0%
3. < 24 Hours Care Indicators	74.3%	58.2%	74.7%	63.8%	63.3%	73.2%
4. < 72 Hours Care Indicators	95.9%	95.9%	93.4%	78.7%	95.9%	96.4%

Thrombolysis Indicators Dec-16	AB	ABM	BCU	C&V	CTaf	HDda
1. Access						
1a - % All Strokes Thrombolsyed	9.5%	12.2%	14.3%	17.0%	8.2%	19.6%
2b - % Eligible Patients Thrombolsyed	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%
2. Time						
1a - Door-to-Needle <= 30 mins	0.0%	0.0%	7.7%	12.5%	0.0%	18.2%
2b - Door-to-Needle <= 45 mins	0.0%	33.3%	23.1%	37.5%	25.0%	27.3%
3c - Onset to-Needle <= 90 mins	0.0%	0.0%	0.0%	12.5%	0.0%	0.0%
4d - % with Pre and Post NIHSS Score	85.7%	100.0%	92.3%	100.0%	100.0%	100.0%

>= 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 multi disciplinary team meetings in Morriston and Princess of Wales hospitals to review individual patient pathways and to identify opportunities for improvement against the respective stroke quality measures.

Morriston

• Ongoing recruitment to medical and nursing staff to work on the acute stroke unit. This remains critical to the sustainable delivery of the 4 hr target for 2017/18. New Band 3 nursing roles have been recruited at Morriston and will take up post in February 2017. •Changes to working arrangements to improve access to consultant assessment. • Audit of CT scanner access.

PoWH

• Targeted training/awareness of the 'code stroke' protocol and swallow screen training. • Replacement Speech and Language therapist secured to support improved compliance with swallow screen.

ABMU wide

• Shared learning with other Health Boards to highlight opportunities to improve patient flow and access to stroke care.

• Ongoing planning in terms of working towards the HASU model for ABMU Health Board.

How do we compare with our peers?

Performance against the quality improvement measures in January 2017 was broadly comparable with other Health Boards in Wales. However the 4 hour and 24 hour access measures remain challenging as a result of staffing constraints.

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 at ward level and capacity within the clinical nurse specialist team owing to sickness.

Source : NHS WALES OUTCOMES FRAMEWORK, ALL WALES PERFORMANCE SUMMARY (FEBRUARY 2017) + ACUTE STROKE QUALITY IMPROVEMENT MEASURES DU REPORT

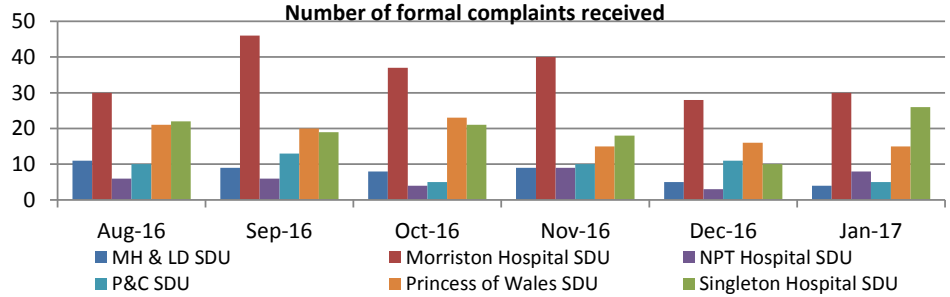
EFFECTIVE CARE - I RECEIVE THE RIGHT CARE & SUPPORT AS LOCALLY AS POSSIBLE & I CONTRIBUTE TO MAKING THAT CARE SUCCESSFUL

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 : Jan 2017	IMTP Profile Target :	Local Target : (1) Monitor, (2) 80%	Current Status :	Movement : Stable

Current Trend: Jan 16- Jan 17



% of responses sent within 30 working days	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	*Jan-17
MH & LD SDU	55%	33%	63%	78%	60%	100%
Morriston Hospital SDU	38%	53%	49%	55%	55%	60%
NPT Hospital SDU	50%	50%	50%	100%	67%	0%
P&C SDU	40%	38%	40%	20%	60%	0%
Princess of Wales SDU	57%	68%	70%	87%	69%	50%
Singleton Hospital SDU	41%	33%	52%	28%	10%	50%
Health Board Total	**45%**	**45%**	**56%**	**56%**	**55%**	**50%**

**January 2017 data only covers 1st to 3rd January 2017*

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

How do we compare with our peers?

No Benchmark Data Available

How are we doing ?

- Morriston consistently remains the Service Delivery Unit (SDU) receiving the highest number of formal complaints. Receiving 28 complaints in December 2016 and increasing to 30 in January 2017. Singleton SDU in December 2016 received 10 however in January 2017 there was an increase to 29 complaints.
- The 30 day response % for the Health Board for December 2016 is 55% which is a very slight decrease from 56% in November 2016.
- The 2 day acknowledgment target has been maintained for the past 8 months at 100%.

What actions are we taking?

- Performance in the 30 day response targets is continually raised at all performance reviews.
- The Unit Nurse Director for Singleton SDU has confirmed that measures are already being put in place to examine the 30 day response rate.
- A weekly team meeting has been initiated which examines the management process of complaint backlogs and 30 day targets. The team will be liaising with Units with stronger performance results to enable further scrutiny of process.
- PALS activity will be collated via the DATIX system and an agreement that this will form part of future reporting to Quality & Safety and monthly performance statements from April 2017.

What are the main areas of risk?

The main area of risk is the Health Board not achieving the 80% target for 30 day response rate.

Source :DATIX