Quality and Safety Committee Action Log

Open Actions as at 5th April 2018						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
1.	28/18	01.02.2018	Feedback be provided to the Welsh Risk Pool in relation to its annual report	PW/AH	March 2018	Ongoing
2.	10/18	01.02.2018	Letter be written to Cwm Taf University Health Board regarding non-reporting of incidents/tests/letters via all-Wales systems in relation to CAMHS.	AH	March 2018	Ongoing
3.	10/18	02.2018	CAMHS issues be included within the corporate risk register.	AH/JAD	March 2018	Ongoing
4.	10/18	02.2018	An action plan be received at the next meeting dealing with CAMHS performance issues and the coherence of the service.	AH/JAD	March 2018	On Agenda
5.	09/18	01.02.2018	Pam Wenger to discuss with Sandra Husbands future reporting arrangements for 'staying healthy' topics.	SH	March 2018	On Agenda

6.	07/18 (ii)	01.02.2018	Performance measures to be reviewed for mental health and learning disabilities	DR	2018	Next update due in 2019
7.	185/17	07.12.2017	Chronic pain review report be circulated	CM	February 2018	Due to have been received at April 2018 meeting. Update to be provided at the meeting
8.	09/17	23.02.2017	Water policy be revised in in-line with discussions of the committee and with the support of Paula O'Connor.	DK	January 2018	Awaiting feedback from authorising engineer
Closed Actions as at 5th April 2018						
Action No.	**Minute Ref.**	**Date**	**Agreed Action**	**Lead**	**Timescale**	**Status**
9.	24/18	01.02.2018	All-Wales prior approval policy be ratified	SH	February 2018	Completed
10.	22/18	01.02.2018	The 'Putting Things Right' policy be approved.	AH	February 2018	Completed
11.	22/18	01.02.2018	The claims policy and procedure be approved	AH	February 2018	Completed
12.	18/18	01.02.2018	Infection control updates be received at each meeting	AH	February 2018	Work programme updated
13.	18/18	01.02.2018	The proposal for the delivery units to adopt the key focused improvement priorities be supported.	AH	February 2018	Completed
14.	16/18	01.02.2018	Clinical audit policy be ratified.	HL	February 2018	Completed

15.	15/18	01.02.2018	The management of medical devices policy be ratified.	HL	February 2018	Completed
16.	11/18	01.02.2018	Report providing an update in relation to PROMs and value-based healthcare be received at the next meeting.	HL	April 2018	On the agenda
17.	10/18	01.02.2018	An action plan be received at the next meeting in relation to CAMHS	JAD	April 2018	On the agenda
18.	09/18	01.02.2018	Tobacco group to report to Quality and Safety Forum	SH	February 2018	Completed
19.	09/18	01.02.2018	Direction of travel for immunisation be supported.	SH	February 2018	Completed
20.	06/18	01.02.2018	Work programme be updated to change the frequency of reporting of the older person's agenda to bi-annually.	CM	February 2018	Work programme updated.
21.	75/17	22.06.2017	Clarification be sought from Singleton Services Delivery Unit as to the reasons for the deterioration in NEWS performance, whether the safety 'X' was used in relation wards with high numbers of pressure ulcers and if the medical fluoroscopy service was now in place.	AH	January 2018	See appendix 1

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Quality & Safety Committee
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13th February 2018

Dear Quality & Safety Committee,

Thank you for the feedback received in relation to Singleton Service Delivery Unit (SSDU) presentation to Quality & Safety Committee on 22nd June 2017. Once again, we can only apologise that none of the unit's triumvirate were available, but this was due to exceptional unforeseen circumstances.

There were a number of issues that the committee identified which required attention. Therefore in response to the issues raised please find as follows.

1. National Early Warning Score Performance

The National Early Warning Score indicators have improved month by month since June 2017. In October 2017 we achieved 100% compliance.

We have a training programme in place to raise staff awareness and monitor compliance through our Ward Assurance Review Programme.

2. Risk Register

The risk register for SSDU has been reviewed. Since this period the controls to manage and reduce individual risks have been updated. Individual service groups are working through their risk register to reduce the number of risks scoring 16+. This is reported and monitored through SSDU Quality & Safety Committee.

3. The Use of Data

An example to illustrate how the delivery unit is using its data to improve performance can be seen our 'Friends & Family' data. This data is utilised to develop action plans from the 'you said, we did' template. These are distributed across service groups at ward & department level for shared learning. Specific examples include Singleton Assessment Unit (SAU), Ward 2 and Lymphodema Clinic which as a consequence of sharing this learning and acting on feedback, patient experience has improved in these areas.

In addition the data we collated in for complaint performance against the 30 day target assisted us in identifying areas that required support and mechanisms were put in place which has enabled us to improve and maintain our performance at 80% and above.

4. Pressure Ulcer Management

Over several months SSDU has demonstrated a reduction in the number of hospital acquired pressure ulcers.

SSDU have implemented a weekly Pressure Ulcer Scrutiny Panel which identifies the Ward and Units with the highest number of reported pressure ulcers and also their compliance with Pressure Ulcer Policy and Standards. These areas are supported with ward based training, and pressure ulcer prevention equipment has been procured.

Within SAU, risk assessments are undertaken within 2-4 hours of admission, these include full skin inspection which has allowed the accurate classification of hospital and non-hospital acquired pressure ulcers resulting in a decrease in the number of hospital acquired pressure ulcers reported by the Unit.

5. Discharge Summaries

Over the last 6-month period, discharge summaries have improved. In Cancer Services there are no discharges without a letter completed.

The improvement target of 10% has been achieved, but, in order to further improve performance junior doctors have requested mobile solutions to be placed on wards when Wi-Fi installation is completed.

6. Infection Control Improvement

SSDU has developed an infection control improvement plan, which is being implemented. Whilst the delivery unit has not achieved its targets for 2017, there has been a reduction in the distribution of Health Board C Difficile cases attributed to SSDU and an improved position for MSSA and MRSA Bacteraemia had been shown. Compliance with hand hygiene (WHO 5 moments) remains 94-95%. We have implemented enhanced cleaning and a rapid response team is in place, with C4C cleaning score at 97%.

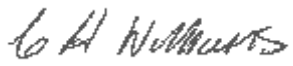
A clinical lead for the Start Smart & Focus programme has been identified and junior doctors are undertaking Antimicrobial Audits.

7. Health & Care Standards & Actions

SSDU Health & Care Standards Action Plan has been reviewed and there is a clear process in place to ensure those actions, that have made little progress are monitored by SSDU Quality & safety committee.

I hope that this answers the queries that you had for SSDU. However if you require additional information please do not hesitate to contact us.

Yours Sincerely



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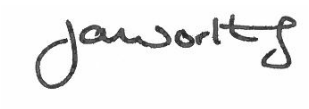

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