ABM University Health Board	
Date of Meeting:7th June 2018 **Name of Meeting: ABMU Quality & Safety Committee** **Agenda item: 6a**	
Subject	**Singleton Services Delivery Unit Quality & Safety Report**
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Approved by	Christine Williams, Unit Nurse Director
Presented by	Christine Williams, Unit Nurse Director

1.0 Situation

This report provides an update on Singleton Services Delivery Unit (SSDU) Quality & Safety key exceptions, the actions undertaken to address these and the ongoing work in service improvements.

2.0 Background

2017/18 has been the second full year to plan and deliver services for our Delivery Unit. The Unit has built on the previous year and seen significant change over the last 12 months that has brought new opportunity and challenge.

The Unit has a robust cohesive team with clear expectations around the delivery of safe, high quality and effective patient care that advocates the ABMU Values. The Unit has promoted an approach of 'can do' and has an enthusiasm for service improvement and service change.

Some highlights for this past year have included;

- Effective winter planning supporting increased ambulance conveyances and demand through the front door.
- Ministerial approval for 9.7 million investment in Neonatal Transitional Care Unit at Singleton Hospital.
- Radiotherapy Physics completed the commission of a linear accelerator to deliver radiotherapy; the first patient was treated in March 2018.
- Achievement of patient waiting times targets in Ophthalmology attained for first time in 4 years.
- Finalised plans for homecare delivery treatment to commence qtr1 2018/19 releasing capacity in Chemotherapy Day Unit for delivery for chemotherapy.
- Achievement of no patients waiting over 8 weeks for an Endoscopy procedure.

3.0 Assessment

Effective Care: External Review

- ***HIW ward 12*** feedback centred on medication left in drug room, Welsh Language promotion, address clutter and nurse documentation.
- ***HIW Singleton Assessment Unit(SAU)*** feedback provided was mainly positive however immediate improvements focused on medication storage, resuscitation equipment checks and risk management in relation to storage of cleaning agents. Further recommendations were in relation to the environment, patient experience, risk assessment and documentation.
- ***Community Health Council (CHC) Inspections*** unannounced visits to Wards 2, 6, 7, gynaecology outpatients. CHC feedback focused on patient experience and environmental issues. Wards and departments have developed action plans; these have been monitored and reviewed by the Units Learning & Assurance group.
- ***Public Service Ombudsman Reviews*** have made specific recommendations to review the following; Obstetric booking system, use of paper referrals for CT(computerised tomography) scans and histology delays. There was a further recommendation to create a PXE (Pseudoxanthoma elasticum) pathway in ophthalmology.
- ***UKAS (United Kingdom Accreditation Service) Inspection of Laboratory Medicine*** highly praised the service for having developed the best example (of all the laboratories they have assessed across the UK), of integrated joint automated laboratories and an integrated laboratory medicine workforce. Further positive feedback included best Immuno-phenotype laboratory with a highly motivated workforce keen to learn.

Internal Review The Unit conduct monthly multi disciplinary Quality Assurance Audits. The assurance audits aim to provide assurance and support the delivery of safe and effective care with excellent patient and staff experience. This supports the quality strategy, quality delivery plan and patient experience plan. The number of multidisciplinary assurance audits conducted to date is 11. Themes identified to date include; administration of medication protected time, completion of documentation at appropriate times and reassessment of risk assessments.

Patient Experience and Feedback

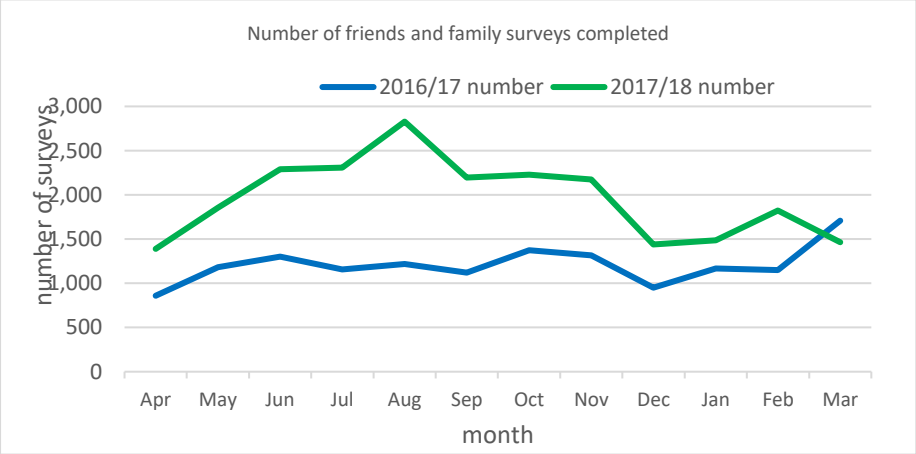
During the year 2017-2018 the Unit received **225** formal complaints in addition to **244** informal concerns/ enquiries. The Unit received requests to re-open 15 concerns (approximately 3.2%). **74%** of formal complaints received a response within 30 working days. **9** concerns were referred for Redress.

The unit recognises additional work is required to ensure timely responses to all concerns.

Patient engagement achievements include;

- Excellent PJ Paralysis 70 day challenge results.
- Partnership working with Patient Advice & Liaison Service (PALs), Gower College & Tesco to transform dayroom on ward 3
- Monthly drop in sessions Alzheimers Society to support patients and families
- Volunteers holding “Pamper Days” on the wards –hair and nails for patients

Number of Friends & Family Surveys collected by month



Patient experience feedback is routinely collected from 49 locations on the Singleton Hospital site. Between November 2017 and March 2018, the Units Friends & Family satisfaction rating was above health board rating. However, the Unit recognises the number of responses declined in December/January. Measures were taken to address the decline and numbers considerably improved on this position in February/ March.

The PALs and volunteers continue to support wards and departments to improve and maintain the number of responses. The PALs have identified wards and departments that are proactively promoting Friends & Family feedback and the areas that are not having as many feedback returns. The team is providing additional support to the areas which are not doing as well and are working with staff to develop Friends & Family Champions to increase the number of returns on a weekly basis.

Number of Surveys- 23,500+

Recommendation Rate- 95% (March 2018)

Key Trends & Themes- Staff (positive), Parking, Waiting Times

Timely Access

Unscheduled Care

- Effective winter planning supported increased ambulance conveyances and demand through the front door.
- Embed frailty and ambulatory care model and pathways.
- Emergency admissions via SAU remain at increased levels between January and March 2018.
- The implementation of the Patient Flow Team (increased in establishment with winter funding) supported the flow of patients from the front door through the hospital and reduced delays.

Scheduled Care

- Reduced backlog of patients waiting Neuro developmental assessment and target of 80% within 26 weeks achieved.
- Appointed to 3 x Consultant Oncologist Posts in 2017/18.
- Reduction in Average Length of Stay for medical inpatient beds from 12 to 9.8 days
- E-grading for Haematology referrals established resulting in a reduction of the number of patients being added to the outpatient waiting list
- Gynaecology – Post Menopausal Bleeding (PMB) clinics in place
- Theatre Assessment Unit (TAU) introduced to manage surgical throughput.
- Medical Day Unit (MDU) attendance increased.

Safe Care: Key Quality Priorities and Service Risks

Never Events

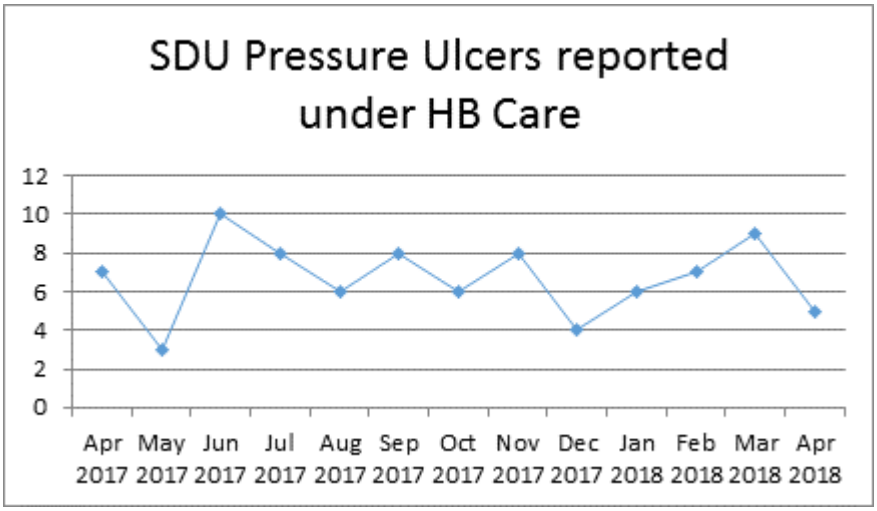
No never events recorded for the Unit.

Inpatient Falls

Falls Scrutiny panel meet every month and feeds into ABMU Falls Group. The Unit has demonstrated that the number of inpatient falls is reducing. The Cot-side signs “do not use” are in use on all medical wards. Maple leaf signage has also been introduced. An additional 10 high /low beds have been purchased and cohorted areas are utilised on all elderly care wards that are staffed on a 24/7 basis. Within the Unit, physiotherapists and occupational therapists are introducing and leading on “in house” falls training.

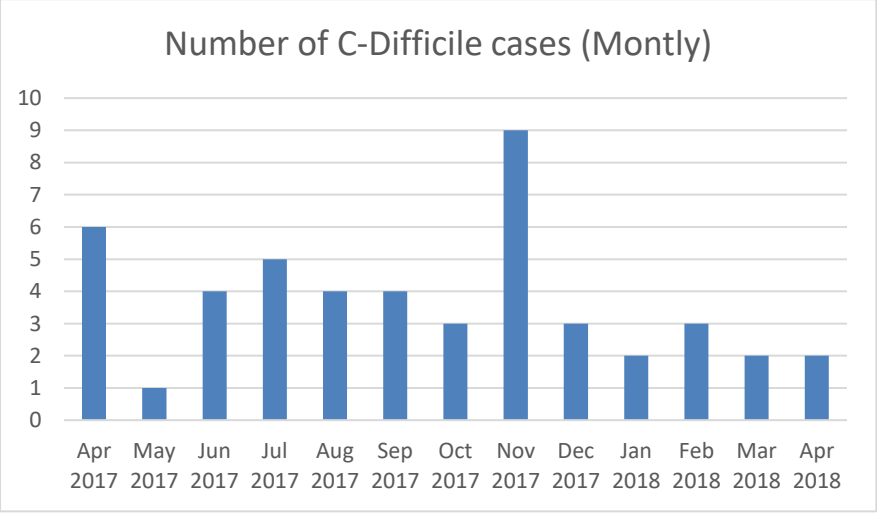
Pressure Ulcers

Reducing the severity and impact for patients from avoidable pressure ulcer damage is a key patient safety priority for the Unit. From September 2017, the monthly scrutiny panel has been increased to weekly. The scrutiny panels objectives are to identify (with consensus) whether the hospital acquired (HA) pressure damage is avoidable or unavoidable, identify actions required for learning to be shared that address the learning points identified. Weekly pressure ulcer training has been delivered by the Tissue Viability Nurse (TVN). Senior Matron and TVN attend the Pressure Ulcer Prevention Strategic Group (PUPSG) and are supporting the work led by Jonathan Webb, Welsh Risk Pool to implement and deliver a Strategic Quality Improvement plan (SQuIP). Workshops for this have commenced and had very good attendance.

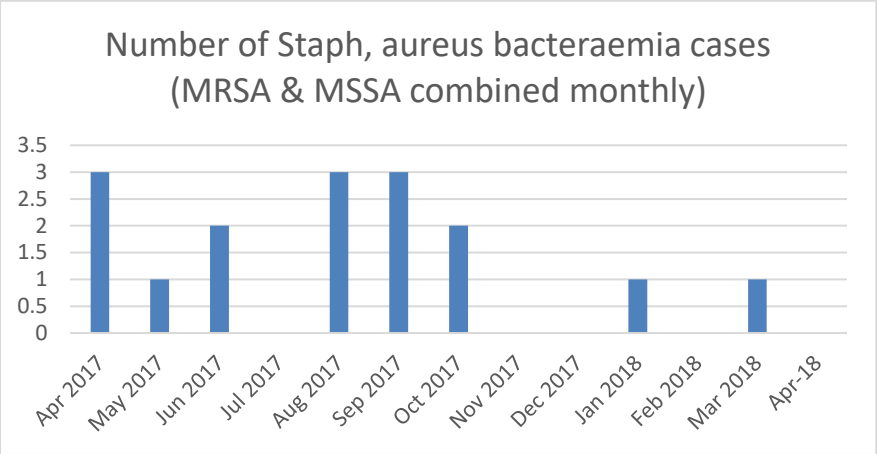


From June 2016 to June 2017 the average reported HA pressure ulcers were 11.2 with lowest numbers reported being 8 and highest being 16. Since scrutiny panel, commenced July 2017 to April 2018 there has been a 25% reduction in HA pressure damage reported with average of 8.4 pressure ulcers reported. The highest reported being 10 and lowest being 5.

Infection Control



The Unit has shown a reduction in the number of cases (6) of Clostridium difficile (C Diff) hospital- acquired infection (HAI) *year on year.* There was a reduction in the number of cases (1) of HAI MSSA (methicillin-susceptible staphylococcus aureus) bacteraemia year on yearQ1 trajectory C Diff is 7 cases, 2 cases to the end of April Q1 trajectory SA (staphylococcus aureus) Bacteraemia is 7 cases, 0 cases to the end of April. The Unit has a Task and Finish group to review intravenous (IV) devices, use and training. The Infection control scrutiny panel reviews all HAI Root cause Analysis (RCA) investigations. The Units HAI C risks are bed occupancy > 85%.



High Risk Services

- Ophthalmology services require wholesale transformation – the support already given by the Board is appreciated, further support will be required to ensure we continue to move forward on ensuring that all aspects of the service are sustainable.
- Recognise continuing over-performance in gynae-oncology; linked to the expansion of the team to improve performance and maintain excellent outcomes and patient experience.
- Procurement of Linear Accelerator 'B' replacement (A linear accelerator is the device most commonly used for external beam radiation treatments for patients with cancer).
- Implement Advanced BMs (Biomedical Sciences) practitioners as qualify end of 2018/19.
- Undertake review of impact of the new drug treatment fund on available capacity.
- Site-Cladding.

Workforce Risks

- Successful implementation of Health Roster and standardisation of shifts (Allocate).

- Service remodelling – Support effective change whilst maintaining engagement levels with our workforce.
- Medical workforce efficiency programme (e Job Planning / Agency Cap / Junior Doctor Rotas / Attendance).
- Integrated workforce planning / skill mix review to support sustainable services and to reduce the effect of Nursing / Medical / Healthcare Scientist vacancies.
- Continue with Unit's Workforce Governance process to achieve sustained increase in employee attendance / PADR compliance of 85% / High quality PADRs / and mandatory training compliance.

Key Areas of Work

Nurse Staffing Levels Act (2016)

There is ongoing work to ensure the Unit complies with the Act. The All Wales templates have been completed in partnership with nursing, finance and workforce colleagues. These are currently going through a process of Scrutiny which will include a Peer Review. Implement mobile devises are to be used within adult acute medical and surgical wards included within the Act in readiness for the June Adult Acuity Audit.

Discharge Summaries

The Wi-Fi installation is now complete and computer carts have been supplied to the wards. The Unit intends to further improve discharge summary completion rates; particularly within 24hrs.There will be continued engagement with consultants and junior doctors to improve performance.

Antimicrobial Prescribing

All Doctors in the Unit have been provided with name stamps to enable effective feedback regarding prescribing. The Unit plans to engage fully with the planned restriction of antibiotic usage. The Consultants will provide ongoing challenge and education regarding antibiotic prescribing by junior doctors.

Improvements in Theatre Efficiency

Weekly staffing meeting with Morriston Deliver Unit are in place to maximise allocation of staff/ sessions. Within Ophthalmology, an agreement in place to do 7 non-complex cataracts on non-training lists consultant lists (pre-assessment limiting factor at moment). A Theatre Improvement Group has been established, the key areas to focus on for 2018/19 are to be finalised but will include late starts due to ward delays, short notice session cancellations and on the day case cancellations.

Recommendations

The Quality & Safety Committee is asked to note the key areas of improvement and the identified actions outlined in this report.