University Hospitals Bristol
NHS Foundation Trust

Quality Report 2017/18

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Transforming Care

UH Bristol

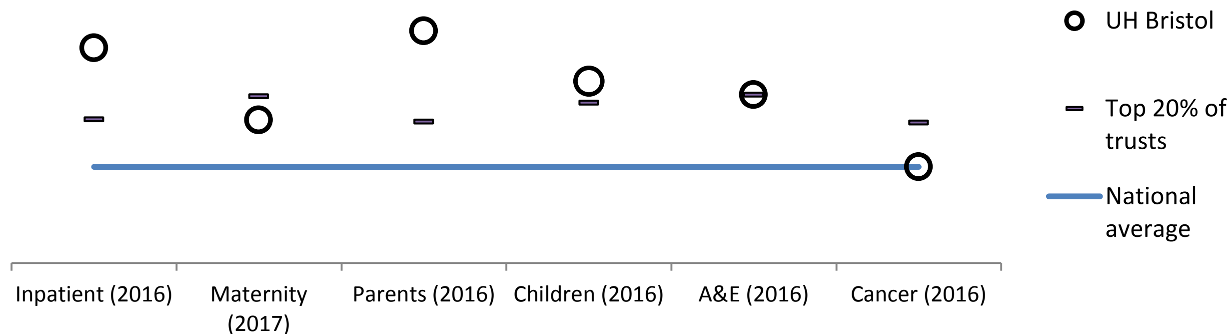
- 9 hospital sites
- 100+ clinical services
- 9,000+ staff
- In 2017/18:
  - 135,000 A&E attendances
  - 44,000 emergency admissions
  - 15,000 elective inpatients / 66,000 elective day cases
  - 19,000 births
  - 710,000 outpatient appointments

Inspected and rated
Outstanding
CareQuality Commission

NHS
University Hospitals Bristol
NHS Foundation Trust

Three key markers of quality

- CQC rating
- NHS staff survey
- National patient surveys



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- Progress against quality objectives for 2017/18
- Our quality ambitions for 2018/19
- Three success stories and one area of challenge
- Opportunity to ask questions about our draft Quality Report

Quality objectives 2017/18

Achieved:

- **To create of a new Quality Improvement Academy**
- **To establish new mortality review programme**
- **To improve staff-reported ratings for engagement and satisfaction**
- To develop a consistent customer service mind set in all our interactions with patients and their families (Year 1)

Quality objectives 2017/18

Partially achieved:

- To reduce cancellations of outpatient appointments and to reduce waiting times in clinic
- To improve the management of sepsis
- To implement a new, more responsive, system for gathering patient feedback at point of care

Not achieved:

- To reduce the number of last minute cancelled operations

Quality objectives 2018/19

Carried forward from 2017/18:

- To develop a consistent customer service mind set in all our interactions with patients and their families (Year 2)
- To improve staff-reported ratings for engagement and satisfaction

Quality objectives 2018/19

New objectives for 2018/19:

- To improve compliance with the 62 day GP referral to first definitive cancer treatment standard
- To introduce a 'mystery shopping' programme with the Trust
- To improve learning from Serious Incidents and Never Events
- To improve early recognition of the dying patient
- To improve the safe prescribing and use of insulin
- To improve patients' experiences of maternity services

QUALITY
IMPROVEMENT

NHS
University Hospitals Bristol
NHS Foundation Trust

TEACH QI

- Provide an overview of common QI methods
- Provide staff with the knowledge and skills to conduct their own Quality Improvement projects
- Signpost staff to existing training and teams within the Trust who can help improve care

QUALITY

IMPROVEMENT

RECOGNISE QI

QI FORUM

- A showcase for project posters of QI work
- Celebrate and recognise the innovation happening across the Trust
- Discuss and network with other QI champions

Improving staff engagement and experience

This year our achievements have included:

- Implementing e-appraisal
- Introducing Leadership Behaviours
- Launching our Dignity at Work policy to combat bullying and harassment
- Delivering our Workplace Wellbeing Strategy to support staff

2017 NHS staff survey - improved overall staff engagement score to 3.85 / 5, placing UH Bristol in top 25% of NHS Trusts

The AHSN Network

NHS Improvement

West of England

Patient Safety Collaborative

Mortality review

- New mortality programme introduced as planned
- All 1,315 adult inpatient deaths at UH Bristol in 2017/18 were screened
- 22 per cent of these cases met criteria for structured review
- Case reviews identified two significant themes for learning:
  - The need to improve early recognition of the dying patient
  - The importance of senior clinical decision making in the decision to move the patient end of life care, moving from physiological monitoring to symptomatic control

Learning from Never Events

- “Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.” (NHS Improvement)

- UH Bristol reported 20 never events or near never events in the period April 2015 to March 2018, 9 of which were in 2017/18

- 9 of these events involved a retained foreign body
- 8 of these events were as a result of wrong site surgery
- 2 of these events were as a result of wrong prosthetic insertion
- 1 event was following the misplacement of an NG tube

Included:

- 5 events in Bristol Dental Hospital
- 4 events regarding dermatology
- 3 events in paediatric theatres

Key themes from root cause analysis

- The role of the senior surgeon or operator in supervising the case
- The role of both trainees and students
- The communication both verbal and recorded that occurs throughout the case
- The methods of robust handover
- The role of the WHO checklist

Actions

- Invited NHS Improvement to carry out a review of practice at Bristol Dental Hospital
- Never Event Summits held
- Sharing learning from Never Events within the organisation the wider health community

Questions?