



# Quality Report 2017/18

# 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

# Three key markers of quality

- CQC rating
- NHS staff survey
- National patient surveys





- 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

I M P R O V E M E N T



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



### Criteria Led Discharge is safe and effective for wheezy children

**Aim:** To implement criteria led discharge from the Children's Emergency Department observation ward, and assess its effectiveness and safety for children admitted with wheeze.

**Background:** The effective use of our eight bedded CED observation unit is crucial for flow, and for minimising inpatient admissions. Many children of patients are eligible for observation ward admission, with 5000 admitted in 2018. Efficient discharge can be challenging as clinicians cover multiple clinical areas. Viral wheeze/asthma is the most common condition admitted to the observation unit with a considerable clinical course.

**Criteria Led Discharge (CLD):** Protocols and processes by which nurses undertake safe and timely discharge of selected patients using a pre-set clinical checklist. Eliminates need (and wait) for final physician review. Could minimise discharge delays in conditions with predictable courses and clear endpoints.

**Key Messages:** CLD is safe and effective. Median time to departure (CLD) 12.5 min (IQR 10-15). Median time to departure (observed) 100 min (IQR 70-130). CLD unplanned return rate 1.3% (observed patients).

**Introduction:** CLD has been established in previous audits that within the Bristol Royal Infirmary (BRI) (in compliance with the majority of the BOAST 7 (fracture clinic services) standards, we consistently fail to achieve standard 1: Patients should be seen within 72 hours of presentation with the injury).

**Initial Audit:** 375 Patients. Two week waitlist of acute fracture clinic. Notes reviewed at clinic and followed up electronically (ICL/CGS/brown). Audited against BOAST 7 standards and additional criteria to look at improving services. 100 DMA (10%), 4 follow up patients excluded.

**Trial of Virtual Fracture Clinic:** One week trial of VFC. Referrals and images reviewed remotely and outcome decided. Average decision time 79 seconds (SD = 156 sec).

**VFC outcome vs Hot Clinic outcome:** Comparison of outcomes between VFC and Hot Clinic across various categories: HB, PT, Generic, Specialist, DLA, Other.

**Benefits:** 9% DMA Rate, Improved compliance, Right diagnosis, right time, Further imaging required with the exception for follow up.

**Limitations:** Medicological implications, Decisions need to be communicated to patients, Uncollected payment scheme.

**Costing:** £1350/week @ cost of £200 per patient & £500/follow-up. £15800 hot clinic + £3500 1st 17h. £17950/week @ VFC cost of £100/visit VFC & £300/follow-up. £12450 VFC + £4900 1st 17h.

**Conclusion:** We have identified a significant area for improvement in fracture clinic services, proposed a potential solution in the form of a VFC, trialed this successfully and presented at the departmental audit meeting. The establishment of a BRI VFC would reduce waiting times and ultimately improve patient care by ensuring the correct patient is seen by the correct clinician with appropriate imaging in a timely fashion.

### Improving the Identification and Treatment of Sepsis in the Adult Inpatient Population.

**Project Aim:** To reduce high risk sepsis admissions to ICU from the wards.

**Introduction:** In April last year we launched 'Sepsis: The Timely Identification and Treatment of Sepsis in the Adult Inpatient Population' which required the treatment of sepsis to be standardized across all wards. This was supported by a national 'Sepsis 6' for the first time and implementation as part of the new 'Sepsis 6' for the first time and implementation as part of the new 'Sepsis 6' for the first time.

**Project Change:** Improving recognition of sepsis in a busy study hospital, will result in earlier treatment which will potentially improve the patient outcome. We aim to reduce the number of patients who die as a result of sepsis or are admitted to ICU (patients who die as a result of sepsis or are admitted to ICU).

**Key Messages:** Early recognition is key to the timely identification and treatment of sepsis as for every hour delay in antibiotic therapy mortality rises by 7.6%.

**Change Model:** We have implemented a change model which will result in the identification and treatment of sepsis in the adult inpatient population.

**Improvement Measures:** The project aims to reduce the number of high risk sepsis admissions to ICU from the wards by 7.6%.

**Compliance with BOAST Std 1:** 55% in 2018, 6% in 2019, 5% in 2020. Average time from referral to clinic: 8 Days.

**Were patients optimally managed prior to clinic?** 23% of patients referred to clinic as per ED guidelines. 30% of patients not managed optimally.

**Referral to Fracture Clinic:** 35% No Follow Up, 25% General Orthopaedic Clinic, 20% Specialist Orthopaedic Clinic, 10% Seen in Person + 9 Day wait, 10% Physiotherapist, 10% CHS/Other, 10% Not Seen.

**VFC outcome vs Hot Clinic outcome:** 40% of patients did not need a Bone Fracture clinic appointment with a doctor following VFC review. 25% Would have been referred directly to a specialist orthopaedic clinic directly. 5% Did not attend the actual hot clinic - there is a 0% DMA rate in a VFC. Correlation between the VFC outcomes and actual fracture clinic outcomes.

### Optimisation of BRI Acute Fracture Clinic

N Ashran, P Gavestock, T Badenoch, J Livingstone, S Mitchell

**Introduction:** Improving Hospital Based (IHB) services. It has been established in previous audits that within the Bristol Royal Infirmary (BRI) (in compliance with the majority of the BOAST 7 (fracture clinic services) standards, we consistently fail to achieve standard 1: Patients should be seen within 72 hours of presentation with the injury).

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## 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

A photograph of a male doctor with a stethoscope around his neck and an elderly female patient. They are both looking down at a piece of paper held by the doctor. The background is a blurred clinical setting with another person visible in the distance. The entire image has a blue color overlay.

# A collaborative approach to learning from deaths

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?