Kent Surrey Sussex Academic Health Science Network

Patient Safety Collaborative

Working together for safer services

2015 – 2017

Version 2 - updated January 2016

‘The scale and scope of our work is considerable’

Since we established the Kent Surrey Sussex Patient Safety Collaborative (KSS PSC) in November 2014 we have charged ourselves with answering a number of key questions:

1. **What are the current elements of patient safety that represent the main priority areas for providers, patient and carers in Kent, Surrey and Sussex?**

2. **How can the KSS PSC deliver the maximum benefit to assist in the improvement of patient care in these priority areas?**

3. **How can we demonstrate and measure these improvements in a manner which has the greatest meaning to patients, carers, healthcare providers and commissioners?**

The majority of our time over the last year has involved understanding these questions and developing meaningful answers which this document describes.

There are 4.8 million people in Kent, Surrey and Sussex. We all, as both service users and those who deliver health and social care, rightly expect services to be both safe and consistently improving in quality. The PSC is working to help all the health and care providers, as well as those who commission healthcare, to deliver the safest care they can and seek to improve all the time.

The eight workstreams we are focussing on over the next five years were determined in consultation with the people who provide and use services in Kent, Surrey and Sussex. Safety will always be a key priority for all organisations across the region. There is a collective recognition that co-ordinated and collaborative engagement across the region will deliver significant and accelerated improvements. Additionally these eight workstreams support organisations’ commitments made in their pledges to Sign up to Safety.

The scale and scope of the PSC discussed in this document is considerable. People accessing health and care services are at the centre of all our work, they require care from a variety of organisations and sectors. Often it is at the interface of these services that many of the risks of harm arise. One of our key challenges is to ensure we engage with the full range of healthcare providers in acute, community, primary and social care. Approaching improvements with a system-wide view is both essential and ambitious. Equally these improvements to services need to be lasting and sustained and make sense for those who use them.

We are developing communities of practice through which we can work collaboratively to both identify and share best practice. We are exploring safety culture with front line teams and assist in developing organisational capability to deliver meaningful and effective change. A significant product of the work of the PSC will be the development of a faculty for safety, a group of individuals connected and supported by the PSC who hold expertise in quality improvement and safety.

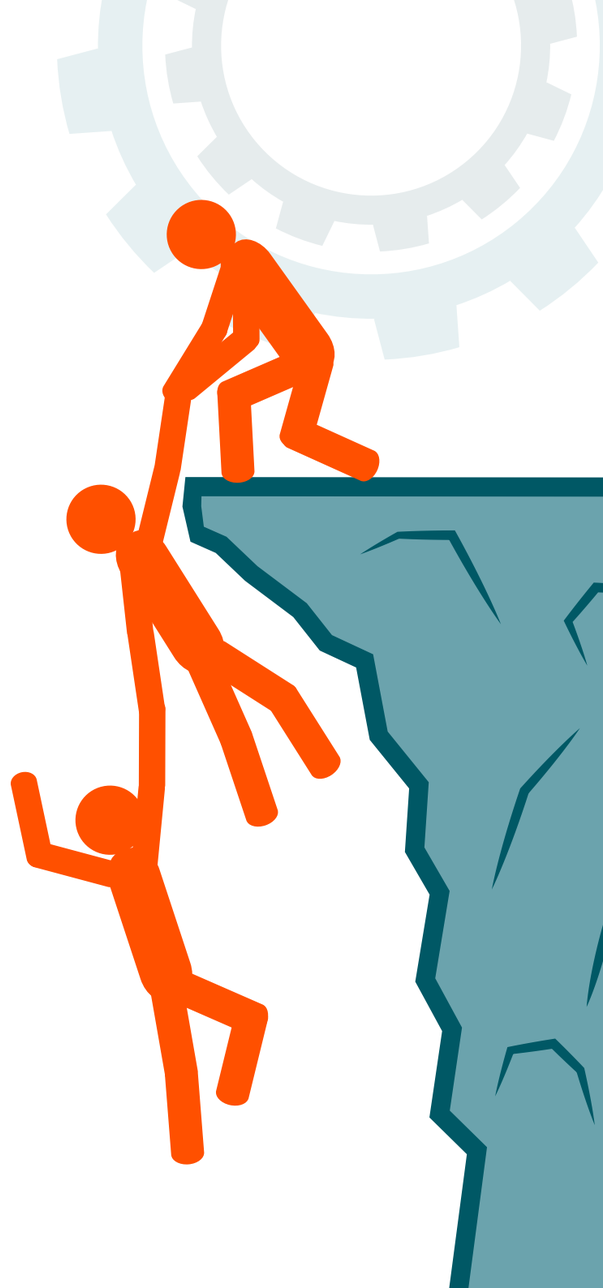
In addition to working with providers we are working with commissioning organisations to encourage and co-ordinate the creation of commissioning strategies to assist providers with their safety improvement goals across pathways of care.

We feel it is vital that any improvement in the safety and quality of care is measured with a range of indicators. These need to be both valid and accurate, as well as meaningful to those who both receive and deliver care. Promoting a culture which keeps patients and their carers at the heart of everything we do encourages colleagues across health and social care to share their experiences and expertise. This will be key to delivering safer services.

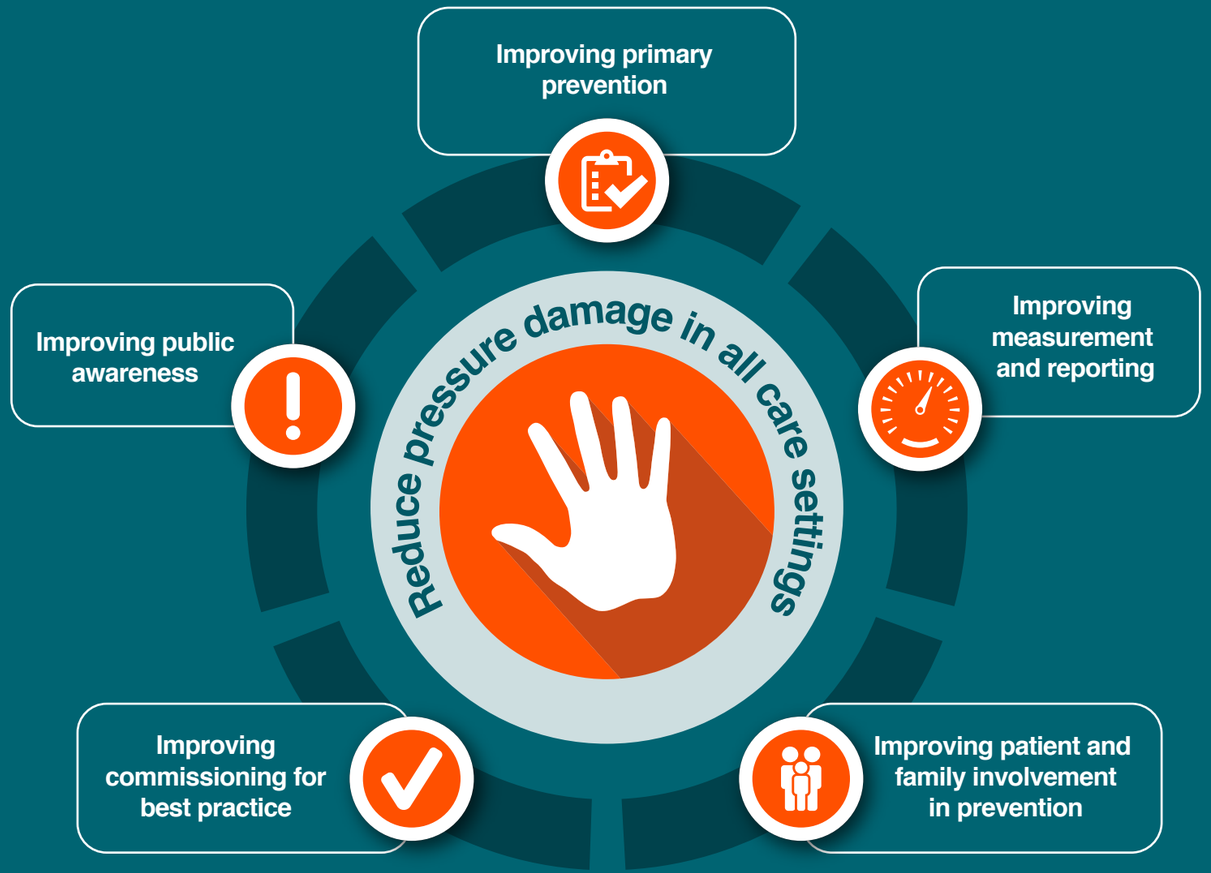
We look forward to working with you.

Tony Kelly

Director, Kent Surrey Sussex Patient Safety Collaborative



Pressure damage



Why are we focussing on pressure damage?

Pressure damage is caused when an area of skin is placed under prolonged pressure which can lead to pressure ulcers, also known as bed sores or pressure sores. These are a type of injury that breaks down the skin and the underlying tissue. Wheelchair users and people who are bed bound or less mobile are particularly at risk.

The risks are further increased by acute illness, poor nutrition and hydration, cognitive impairment such as Dementia, reduced healing due to lack of blood supply or oxygen to the tissues, and some types of medication.

If not identified quickly and treated appropriately, as well as causing serious pain pressure ulcers can put patients at high risk of developing life-threatening infections.

How big is the problem?

Last year, one in every 20 patients surveyed across acute and community services in Kent, Surrey and Sussex had a pressure ulcer. One in every 100 patients surveyed had acquired a pressure ulcer whilst under the care of health services.

Treating a superficial pressure ulcer costs the NHS just over £1,000, whilst treating the deeper more severe forms costs more than £24,000.

How are we going to reduce pressure damage and improve care over the next two years?

We are working with service providers to improve pressure damage measurement and reporting to develop a robust comparable and transparent baseline, common definitions and reporting methodology that enables tracking of care across the whole system. This will help identify best practice and areas with higher than expected pressure damage rates. We aim to expand this to care home providers.

We are working with academia and industry to spread latest research and innovation to front line teams.

We are working with patients to develop improvement plans for their involvement and information in pressure damage prevention and treatment.

We are working with service providers and commissioners to support collaborative development of effective pressure damage commissioning.

How will we know if we are having an impact?

Our ultimate aim is to see a reduction in the rate of the incidence of category 2, 3 and 4 pressure ulcers in all care settings.

Who is leading the work?

- Joint Clinical Lead - Clare Stone, Chief Nurse, North West Surrey CCG
- Joint Clinical Lead - Sherrie Ryder, Clinical Improvement Project Manager, Service Lead for Tissue Viability, Kent Community Health NHS Trust
- Director - Tony Kelly, KSS PSC
- Senior Improvement Manager – Pauline Smith, KSS PSC

The project team is supported by a reference group made up of staff and patient representatives from across Kent, Surrey and Sussex. Contact the project team at **psc@kssahsn.net**

Find out more

For more detail about our plans to reduce pressure damage visit the pressure damage pages on our website **www.kssahsn.net/pressure**

Acute Kidney Injury

Why are we focussing on Acute Kidney Injury?

Acute Kidney Injury (AKI) is a sudden loss of kidney function. AKI may be mild, moderate or severe, but even the mildest cases are associated with an increased risk of death and prolonged hospital admission. AKI is a common complication affecting up to 20% of patients admitted to hospital as an emergency. AKI may be seen in patients with severe infection, low blood pressure, poor blood flow to the kidneys, medication or other toxicity and bladder diseases. In the majority of cases AKI is not primarily a kidney problem and reflects the severity of a patient's other underlying problems. In some patients the development or progression of AKI may be predictable or avoidable.

It is estimated that there may be more than 40,000 deaths every year in England associated with AKI.

We are working to improve recognition and early steps in the management of AKI. We believe that the number of cases of AKI acquired in hospital length of stay and number of patients dying can be improved.

How are we going to improve care for patients with Acute Kidney Injury over the next two years?

We are enabling providers to share best practice in recognising and treating AKI, auditing all the most severe cases against the best practice standards and providing benchmarking information to identify best practice and areas for improvement.

We are supporting providers to achieve the national target of giving clear information and instructions for on-going treatment of AKI to GPs on patients discharged from hospital.

We are going to provide increased educational opportunities for staff from care providers in all healthcare sectors.

We are working with primary care to raise the profile of AKI and to ensure awareness and preparedness for automated identification of cases of AKI.

How will we know if we are having an impact?

We expect that our work will lead to more widespread delivery of best practice and reduction in rates of progression of AKI in hospital and the mortality rate for AKI patients.

We will also see an increase in the percentage of patients with AKI whose discharge information is of high quality.

Who is leading the work?

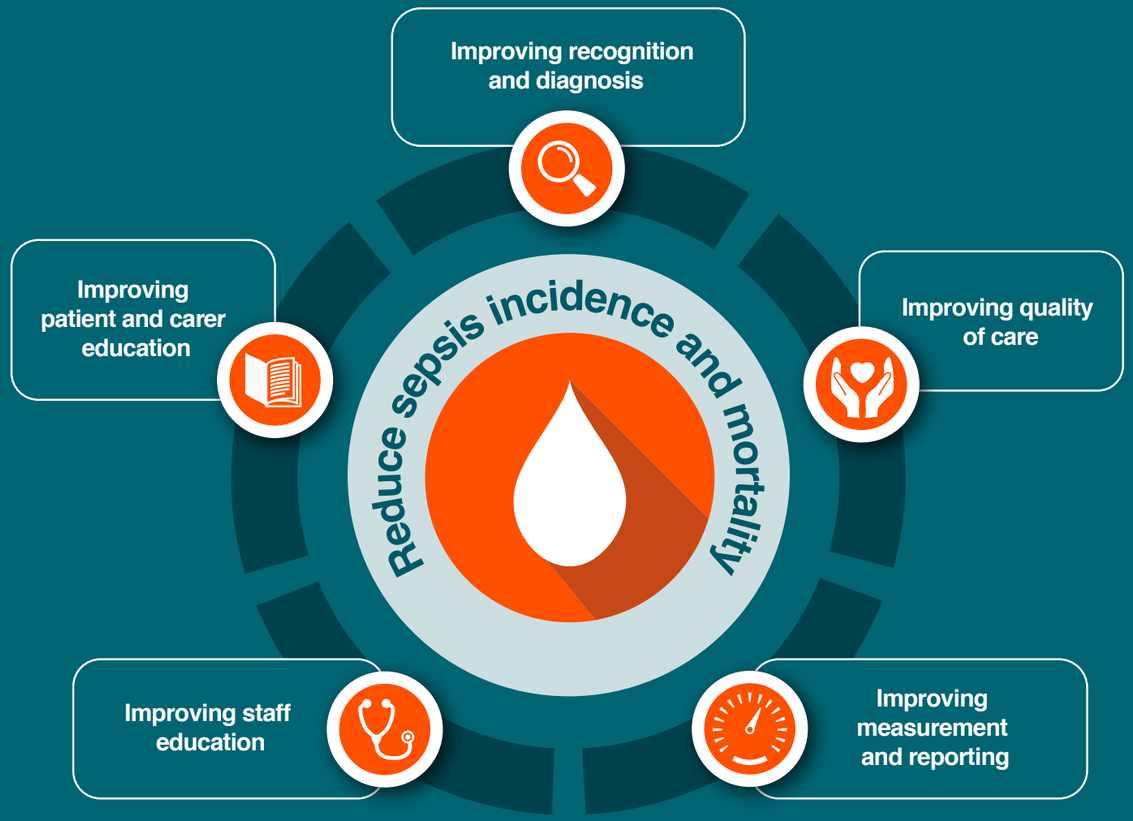
- Clinical Lead – Ed Kingdon, Renal Consultant, Brighton and Sussex University Hospitals NHS Trust
- Director - Tony Kelly, KSS PSC
- Improvement Manager - Jo Wookey, KSS PSC

The project team is supported by a reference group made up of staff and patient representatives from across Kent, Surrey and Sussex. Contact the project team at **psc@kssahsn.net**

Find out more

For more detail about our plans to improve care for patients with AKI visit the sepsis pages on our website **www.kssahsn.net/aki**

Sepsis



Why are we focussing on sepsis?

Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognised early and treated promptly. Because sepsis can look like flu, gastroenteritis or a chest infection, sepsis is often misdiagnosed until the condition escalates and becomes more serious.

How big is the problem?

Last year 3,496 patients were admitted to hospital in Kent, Surrey and Sussex with sepsis. Almost one in five patients died. Nationally, the UK Sepsis Trust estimates that sepsis kills about 37,000 people every year, and costs the NHS £2.5 billion a year to treat.

How are we going to improve care for patients with sepsis over the next year?

We are enabling hospital providers to collaborate on achieving national targets to improve screening for and recognition of sepsis, and rapid delivery of the Sepsis Six, a set of basic interventions that can double a patients chances of survival if delivered within an hour of diagnosis.

Work is ongoing with NHS trusts to improve coding of sepsis from medical records. This will give us a truer picture of the incidence and outcomes of sepsis regionally, helping raise awareness amongst staff of the scale of the issue and helping trusts to measure the impact of their improvement work.

We are working with patients and carers to improve the information given on diagnosis, treatment and ongoing recovery.

We are working with all care providers and organisations in Kent Surrey and Sussex to raise public awareness about the signs and symptoms of sepsis and how to seek help.

We are working with out of hospital providers, such as NHS 111, out-of-hours services and GP practices to improve early recognition and treatment of sepsis using tools tested by South East Coast Ambulance.

How will we know if we are having an impact?

For patients with sepsis we will see an improvement in them receiving the Sepsis Six within one hour and a reduction in mortality, with the initial focus being in-hospital mortality.

Who is leading the work?

- Joint Clinical Lead – Michelle Webb, Consultant Nephrologist, East Kent Hospitals University NHS Foundation Trust
- Joint Clinical Lead – Nial Quiney, Consultant Anaesthetist, Royal Surrey County Hospital NHS Foundation Trust
- Director - Tony Kelly, KSS PSC
- Improvement Manager - Sadie Leack, KSS PSC

The project team is supported by a reference group made up of staff and patient representatives from across Kent, Surrey and Sussex. Contact the project team at **psc@kssahsn.net**

Find out more

For more detail about our plans to improve care for patients with sepsis visit the sepsis pages on our website **www.kssahsn.net/sepsis**

Safe discharge and transfer

Why are we focussing on safe discharge and transfer?

The patients and carers we consulted as part of the mobilisation of the PSC told us that for too many patients, discharged from hospital did not feel safe for them. They felt poorly informed about what was happening, they did not feel that communication between sending and receiving service providers was adequate and arrangements for being safe at home were haphazard. We also know that safety incidents, including medication errors and relapse, happen after discharge often resulting in a readmission.

How big is the problem?

In the 2014 national Inpatient Survey 1 in 5 people did not feel involved in the decisions about their discharge from hospital.

Data is limited but qualitative information from patients, carers and providers clearly demonstrates the need for improvement. The national inpatient survey is our current data source for patient perspectives but there are other measures of quality that we are exploring with providers that will give us good benchmarking and baselines for improvement.

What are we doing to make discharge and transfers safer over the next year?

We are working with providers from all sectors to improve the planning, co-ordination and communication of transfers between hospital and patients' usual place of residence. This will involve working with acute trusts, care home providers, transport services, local authorities, social care providers and the third sector.

We are developing a common reporting structure and set of metrics to improve the measurement of quality of transfer and discharge between providers.

We are working with patients, carers and their families and commissioners and service providers to develop a core set of standards for safe transfer with a view to embedding these standards in contracts to ensure best practice.

How will we know if we are having an impact?

Improvements in the number of discharges occurring earlier in the day and a reduction in variation between the rate of early discharges between weekdays and weekends, as well as a reduction in the number of failed or abandoned discharges from acute trusts. We will also see an improvement in patient experience of their discharge.

Who is leading the work?

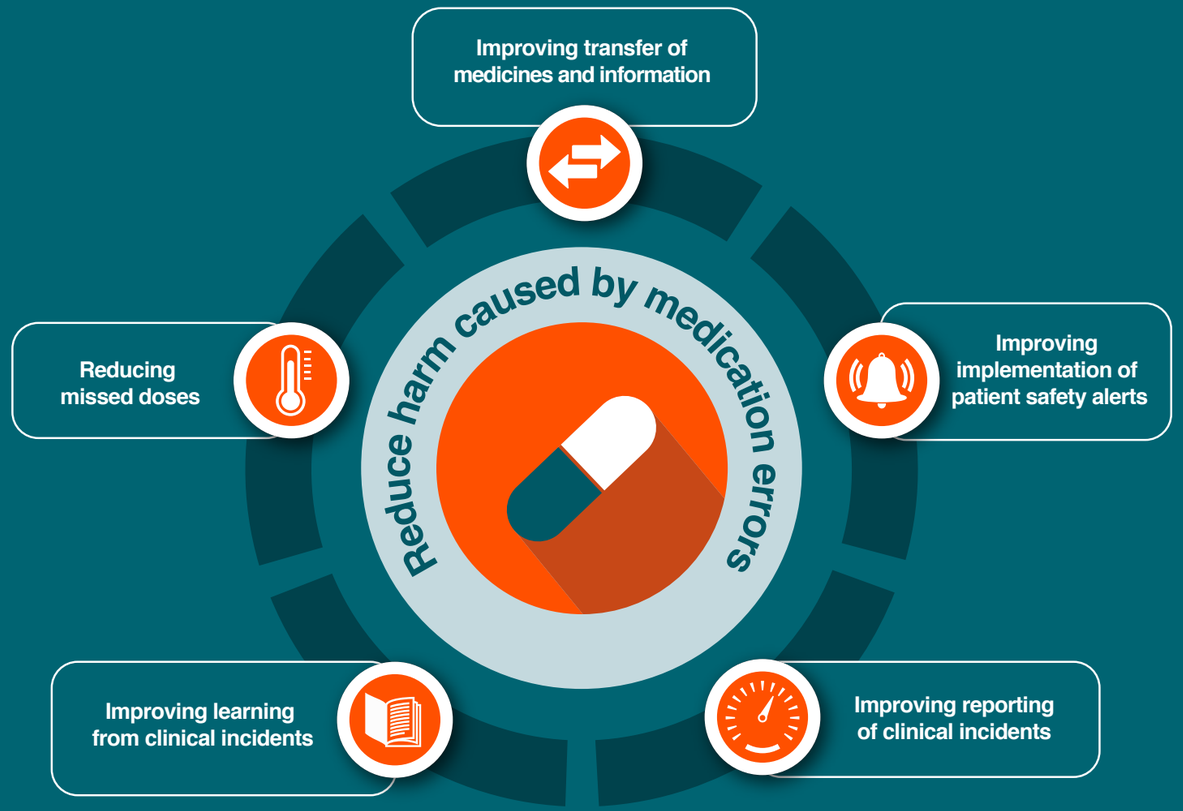
- Clinical Lead – Emma Sherriff, Head of Nursing for Discharge and Partnerships, Brighton and Sussex University Hospitals NHS Trust
- Director – Tony Kelly, KSS PSC
- Senior Improvement Manager – Sue Wales, KSS PSC

The project team is supported by a reference group made up of staff and patient representatives from across Kent, Surrey and Sussex. Contact the project team at **psc@kssahsn.net**

Find out more

For more detail about our plans to make discharge and transfers between care settings safer visit the safe discharge and transfer pages on our website **www.kssahsn.net/transfer**

Medication errors



Why are we focussing on medication errors?

Reducing medication errors would have a positive effect on every health and care service in Kent, Surrey and Sussex. At any one time, more than two thirds of the population are taking some form of medicine, however, up to 50% of medicines are not taken as prescribed, putting patients at risk of major harm.

How big is the problem?

Last year one in 20 hospital admissions was due to the potentially preventable effects of medicines. The NHS spends about £9 billion on medicines every year. This is about 10% of the overall NHS budget, and the second largest cost to the NHS after staff. Recent major UK studies have also identified high levels of avoidable prescribing and medication errors in hospitals, care homes and primary care but routine incident reporting of these is variable.

How are we going to reduce medication errors over the next two years?

We are starting our work with improving medicines reconciliation. This is the process obtaining an up to date and accurate list of a patient's medicines, comparing the list with current records, then identifying and communicating any discrepancies.

Initially we will focus our medicines reconciliation work on admission and discharge of patients between hospitals and care homes. We have made a CQUIN available to all CCGs and providers in Kent Surrey and Sussex which can be used to support the implementation of the national Medication Safety Thermometer. This will have a range of benefits and will allow us to develop a wider picture of a range of issues connected with medication errors.

We are developing a platform to aid the spread of best practice in line with recommendations from national patient safety alerts which relate to medications, covering old and new alerts, which will support organisations to implement solutions more quickly.

We are also developing a supportive process to improve incident reporting and support and spread learning from these reports across Kent, Surrey and Sussex.

How will we know if we are having an impact?

We will see an increase in the number and range of medication incidents as reported offering more opportunity for shared learning. We will see improvements in the Medications Safety Thermometer results.

We also hope to see a reduction in the number of never events linked to patient safety alerts as implementation of the recommendations from these alerts is improved.

Who is leading the work?

- Joint Clinical Lead – Louise Maunick, Associate Chief Pharmacist: Quality Governance and Training Medway Foundation Trust
- Joint Clinical Lead – David Heller, Chief Pharmacist, Surrey and Sussex Healthcare NHS Trust
- Director – Tony Kelly, KSS PSC
- Subject Matter Expert – Carina Livingstone, NHS Specialist Pharmacy Services
- Improvement Manager - Lisa Radway, KSS PSC

The project team is supported by a reference group made up of staff and patient representatives from across Kent, Surrey and Sussex. Contact the project team at **psc@kssahsn.net**

Find out more

For more detail about our plans to reduce medication errors visit the medication errors pages on our website **www.kssahsn.net/medication**

Leadership, culture and capability

Why are we focussing on leadership, culture and capability?

Culture is “the way we do things around here”, it’s what you do when nobody’s watching. All evidence shows that to improve patient safety you need to focus on a range of issues, and that to make a lasting impact, improving the culture in teams and organisations has to be a priority. Good safety culture is where staff have positive perceptions of teamwork and leadership, where staff feel comfortable discussing errors, where leaders and frontline staff take shared responsibility for delivering safer care.

How big is the problem?

The Francis Inquiry into patient deaths at Mid Staffordshire NHS Foundation Trust made 290 recommendations for change. The running theme throughout these recommendations was that the culture in health services needed to change so that individuals can make a stand for good patient safety practice knowing that they will supported by their organisation. These recommendations have been further endorsed by the recommendations of the Berwick review into patient safety.

How are we going to improve leadership, culture and capability over the next year?

We coordinated the Health Foundation’s founding cohort of Q Initiative Fellows (originally known as the 5,000 Safety Fellows) from Kent, Surrey and Sussex to help patient safety leadership skills to be embedded in all disciplines across the region. We are also working with providers to develop capability for the delivery and support of patient safety work by appropriately skilled and trained patients and carers, through the support of our workstreams.

We are working with the Yorkshire & Humber Improvement Academy to implement their successful programme for assessing and improving safety culture in front line teams in four acute trusts initially before spreading into other organisations and sectors.

We are working collaboratively with our local colleagues in Health Education KSS and the KSS Leadership Collaborative to focus our resources for workforce and leadership development and align our programmes to meet the national and local priorities.

Through the combination of these processes, we aim to create a ‘faculty for safety and improvement’ for Kent Surrey and Sussex which the AHSN will support and facilitate.

How will we know if we are having an impact?

We will measure the spread of the work on safety culture through the number of staff who have engaged in the process and the number of facilitators we have developed through the work.

A region wide assessment of quality improvement and patient safety capability will allow us to map current and desired capability in the region. In the long term we will support organisations to improve capability, in part by increasing the number of staff who take part in future Q Initiative cohorts.

Who is leading the work?

- Director – Tony Kelly, KSS PSC
- Associate – Kay Mackay KSS PSC

The project team is supported by a reference group made up of staff and patient representatives from across Kent, Surrey and Sussex. Contact the project team at **psc@kssahsn.net**

Find out more

For more detail about our plans to improve leadership, culture and capability visit the leadership, culture and capability pages on our website **www.kssahsn.net/lcc**

Measurements of patient safety

Why are we focussing on measurements of patient safety?

Measurement helps us prove we have made a difference, and identify where change or intervention is needed. Without it, we run the risk of good work being lost under the burden of poor evidence.

The Kent Surrey Sussex Patient Safety Collaborative offers a unique opportunity to support local organisations in measuring and evidencing their improvement work in high priority areas. We will also look towards the development of measurement approaches that look beyond the measurement of retrospective harm and looks toward predicting where harm may occur in the future.

How big is the problem?

Currently there are significant differences in how data is recorded across the region. This can make it more difficult to get a true picture of how prevalent some conditions are, which makes it more difficult to plan services and identify where good practice is taking place and where improvement is needed.

How are we going to improve measurement and reporting over the next year?

One of the key elements of our approach to measurement is to share data and encourage health and care providers in Kent, Surrey and Sussex to utilise the wealth of existing data sets already available. To facilitate this, we have published our Atlas of Variation as a first step towards sharing some of this high level data using simple visualisations to help answer key questions, support quality improvement, accountability, organisational insight and preparedness.

Who is leading the work?

- Workstream Lead – Kate Cheema, Head of Service, Quality Observatory
- Director - Tony Kelly, KSS PSC

Kate is supported by a reference group made up of staff and patient representatives from across Kent, Surrey and Sussex. Contact the project team at **psc@kssahsn.net**

Find out more

For more detail about our plans to improve measurement and reporting visit the measurements of patient safety pages on our website **www.kssahsn.net/measure**

As well as supporting local improvement work for the priority areas in Kent, Surrey and Sussex, we are also the channel for the local dissemination of nationwide patient safety schemes and projects, including…

National patient safety clusters

All 15 Patient Safety Collaboratives in England working on similar priorities have been grouped into cluster groups. These clusters will directly develop local improvement metrics, share learning, develop expertise, build on the evidence base and share the outputs of the work with the wider NHS.

Kent Surrey Sussex Patient Safety Collaborative is leading the work in the Acute Kidney Injury national cluster. Read more about the national clusters at **www.kssahsn.net/safety**

The Q Initiative

The Q Initiative, led by the Health Foundation and supported and co-funded by NHS England, is connecting people skilled in improvement across the UK.

Q is bringing together a diverse range of people to form a community working to improve health and care. These people range from frontline staff, managers and researchers to policymakers and 'patient leaders'.

KSS PSC is developing a new Safety and Quality Improvement Network which will work alongside the Q Initiative. Future Q members will be selected from this network. If you are interested, experienced or trained in safety or quality improvement work, we want you to join. Find out more and sign up at **www.kssahsn.net/Q**

Mental health

We are part of the South of England Mental Health Patient Safety Collaborative. Our main priorities are improving the physical health of people with poor mental health and collaborating with mental health providers to reduce avoidable harm.

Find out more at **www.kssahsn.net/mentalhealth**

Sign up to Safety

Sign up to Safety (Su2S) is an NHS England campaign designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. The core message of the campaign is simple – by listening to patients, carers and staff, learning from what they say when things go wrong and taking action we can improve patient safety

We have analysed local Su2S pledges and action plans, cross referenced to AHSN priorities and mapping where we can create links for priorities that KSS PSC is not focussing on.

Discover more about the Sign up to Safety pledges of organisations in Kent, Surrey and Sussex on the interactive Sign up to Safety map on our website at **www.kssahsn.net/su2s**

Get involved

Patient safety is everybody's responsibility. Find out more about our work, sign up for updates and events and get involved at…

Find out more **www.kssahsn.net/safety**

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Youtube.com/kssahsn

Kent Surrey Sussex Patient Safety Collaborative

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