East Kent Hospitals University NHS Foundation Trust is one of the largest hospital trusts in England, with five hospitals (three acute and two community) serving a local population of around 759,000 people. We provide many health services from other NHS facilities across East Kent including renal services in Medway and Maidstone.

Underpinning our Patient Safety Strategy and pledges to improve is our Quality Strategy. This sets out our four quality objectives, which form the basis of everything we do. These are: to provide person-centred care and improve patient experience, to deliver safe care, to provide effective care and develop a workplace culture that enables and sustains quality improvement. We have achieved national recognition for our high standards as Dr Foster NHS Foundation Trust of the Year 2010, with two HSJ/NT Patient Safety Awards for Board Leadership and Best Use of Information in 2013, and a further award for Patient Safety in Hospital Care in 2014 for partnering with a local NHS Trust to develop a screening tool for people attending our hospitals with mental health symptoms.

What are we doing in East Kent Hospitals University Foundation NHS Trust (EKHUFT) to keep our patients safe?

At East Kent Hospitals University Foundation Trust, safety is one of our core values so that:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel that we are making a difference

Our Patient Safety Strategy is designed to reduce unnecessary deaths and “harm events” year on year as measured by our mortality rate and audit of case notes (UK Trigger Tool). We have set out the following actions in response to the national Sign up to Safety Five pledges which forms the basis of NHS England’s patient safety improvement quest to half avoidable harm by 50% in 3 years.

The five Sign up to Safety pledges

1. **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally. ***We will:***

1.1 Recognise and treat sepsis early, to prevent shock, multiple organ failure, and death. Three collaborative work-streams will develop:

- An educational programme on our unique 'Sepsis Seven', a set of actions that can be taken when a patient is diagnosed with sepsis;
- Establishing an emergency laparotomy bundle which ensures a streamlined pathway delivering a timely surgical review and intervention;
- Measures that will help us monitor our improvement in managing sepsis and our compliance against the College of Emergency Medicine standards for septicaemia

1.2 Implement a nurse-led HOUDINI protocol to make sure urinary catheters are only used where appropriate to reduce the infection risk.

H aematuria
O bstruction (urinary)
U rology surgery
D ecubitis ulcer - sacral or perineal ulcer in an incontinent patient
I nput/output monitoring
N ot for resus /comfort care
I mmobility due to physical constraints, i.e. unstable fracture

1.3 Continue work to drive down:

- Hospital acquired infections - C-difficile infections and avoidable MRSA cases:
- Avoidable falls resulting in moderate or severe harm;
- Avoidable hospital acquired pressure ulcers;
- Medication errors, especially with high risk medicines.

1.4 Spread good practices from Theatres to other areas to prevent procedural errors by developing and implementing safety checklists that include consent, site checks, equipment safety and team involvement.

1.5 Eliminate Never Events with improvements that:

- Focus on 'human factors' such as listening, team briefings, checklists and techniques to communicate and escalate concerns;
- Share learning from incidents;
- Standardise practices with new systems and processes

2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are. ***We will*:**

2.1 Achieve a high level of reporting of errors, accidents and near misses as a measure of a good safety culture willing to learn and improve.

2.2 Monitor, publish and respond to safety indicators derived from; patient and staff experiences (PROMS, Friends and Family Test, complaints, national surveys), risk assessments, incident trends, audit results and consultant level outcome data covering mortality and quality for surgical and medical specialities.

2.3 Develop mechanisms and databases that provide assurance that learning has been embedded from actions derived from improvement plans.

3. **Honesty**. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. **We will:**

3.1 Continue to implement the principle of "Duty of Candour" and work with staff to develop their communication skills. We will increase our achievement of openness and transparency by discussing incidents with the patient / patient family where moderate harm or higher has occurred.

3.2 Support senior nurses, clinicians and allied health professional to improve their skills in communicating with patients and their families when something goes wrong.

3.3 Increase transparency of information on the number of staff on duty on all wards by sharing this with patients and families.

3.4 Improve our website such that our patient safety record and current initiatives are clearly visible.

4. **Collaborate**. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. ***We will:***

4.1 Engage users alongside clinical teams in both local and regional collaborative ventures to take forward patient safety improvements.

4.2 Improve engagement internally and externally with public, patients and staff

4.3 Improve communications and collaborative working between the Trust and local commissioning groups specifically in relation to achieving CQUIN goals and collaboration in the handling of serious incidents

4.4 Drive the Trust's overarching Patient Safety Strategy through corporate and divisional safety work plans to enable improvement.

5. **Support**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress. ***We will:***

5.1 Provide clinical leadership development based on our shared purpose framework competencies to all relevant staff to enable person-centred, safe and effective care in a learning organisation.

5.2 Enable our Trust values to become part of the way we do things at East Kent Hospitals. 'We Care' champions – a nurse, doctor, manager, administrator, porter or radiologist – will be identified in every department across the Trust, to help make this happen. Our values are what make us distinctive and are used in appraisals, in communications and as a basis for quality improvement.

5.3 Assist our staff to develop and refine their skills in improvement and development approaches, by offering a variety of work based programmes and opportunities, using supported active learning, master classes, creative spaces, supported activities and, reflection. A new Quality Improvement and Innovation Hub offers staff the opportunity to access an improvement mentor, and enable staff to learn about safety, improvement, development and enquiry in tandem. It will also serve as a repository of resources; events, project templates, tools, publications, shared competencies, Lean methods, small cycles of change and patient/staff stories, to help staff – Improve, Develop, Enquire and ACT (IDEA).

QII QUALITY IMPROVEMENT & INNOVATION HUB