Sign up to SAFETY
LISTEN LEARN ACT

SIGN UP PACK

Welcome to Sign up to Safety

Listen, Learn, Act

Listening to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

Our vision is for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that each of our organisations undertake and aligning them with this single common purpose. Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years and saving 6,000 lives as a result

As Chief Executive or leader of your organisation, we invite you sign up to the campaign by setting out what your organisation will do to strengthen patient safety by

- Describing the actions your organisation will undertake in response to the five Sign up to Safety pledges (see page 3 and 4) and agree to publish this on your organisation's website for staff, patients and the public to see. You may like to share and compare your ideas before you publish – this support will be available to you.
- Committing to turn your proposed actions into a safety improvement plan which will show how your organisation intends to save lives and reduce harm for patients over the next 3 years. Again, support will be available, if you wish to access it, to assist in the description of these plans.
- Within your safety improvement plan you will be asked to identify the patient safety improvement areas you will focus on. You will be supported to identify 2 or more areas from a national menu of high priority issues and 2 or more from your own local priorities.

To officially sign up your organisation to the campaign, please complete the following sign up form and return via email to england.signuptosafety@nhs.net or post to Sign up to Safety, Skipton House, Area 2B, 80 London Road, London SE1 6LH

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Organisation name:

Whittington Health

- Describing the actions (on the following pages) we will undertake in response to the five campaign pledges
- Committing to turn these actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.
- Identify the patient safety improvement areas we will focus on within the safety plans.
- Engage our local community, patients and staff to ensure that the focus of our plan reflects what is important to our community
- Make public our plan and update regularly on our progress against it.

Chief Executive Sponsor:

Simon Pleydell		04-03-2015
Name	Signature	Date

Please tell who will be the key contact in your organisation for Sign up to Safety:

Title:	Dr	First name:	Richard	Last name:	Jennings
Email:	richard.jennings@nhs.net			Job title:	Medical Director

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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

Building on improvements we have already made, we will work with our patients and partners to develop a quality improvement programme that prioritises reducing avoidable harm in key areas.

We will focus our efforts on the most vulnerable patients in our community and link our safety initiatives with related strategies such as our deteriorating patient's strategy.

Pressure Care

We will aim to eliminate avoidable grade 3 and 4 pressure ulcers within our integrated care organisation. With an increasing number of elderly patients with complex care needs this is an important area of improvement for us. If we can eliminate the most severe pressure ulcers we can reduce the level of medical interventions our patients need, and we can work with our community teams to extend independent living for our patients.

Falls

We will aim to reduce the number of in-patient falls that result in serious harm. We will ensure that every patient is assessed for risk of falling and that this risk is re-assessed in line with the patients' clinical needs. This will be supported by the development of a 'falls care bundle' for use in all acute clinical areas. This falls care bundle will be applied to all high risk patients, with the aim of eliminating falls which result in serious avoidable harm

Sepsis and Acute Kidney Injury

We will aim for all cases of severe sepsis to be recognised and treated according to the "sepsis six" care bundle early interventions within the first hour. We will aim for all cases of Acute Kidney Injury to be promptly recognised and appropriately treated.

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Reducing Suboptimal care in people with Learning Disability

We will aim to reduce avoidable harm and avoidable poor patient experience in patients with Learning Disability by putting in place recognised improvement initiatives to make our care more responsive to the individual needs of each patient.

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

Continue to develop our use of internal and external information including from our key performance indicators, incidents and serious incidents, complaints, safety thermometer, our own clinical audit programme and national audits to ensure that we are aware of and develop appropriate action plans and quality improvement projects targeted to our concerns. We will disseminate the outcomes through our staff briefings, walkabouts, and website and present them at divisional and Trust wide quality meetings.

We will develop our quality improvement projects with patients and share the improvement outcome with them through our stakeholder initiatives.

We will ensure there is team and personal learning from adverse events, through the sharing of RCA investigation reports and delivery of the subsequent post incident action plans.

We will ensure that there is organisational wide learning from incidents, SIs and complaints through existing communications methodology to improve patient safety and experience, as well as drive down the number of claims.

We will ensure that we continually learn from all claims and Coroners' inquests, using this intelligence to identify further quality improvement projects.

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

Implement the Duty of Candour and work with staff to build our skills in disclosure. We will aim to increase our levels of reporting incidents and ensure that the Duty of Candour process is applied within the required timescales for any incidents which result in moderate harm or above.

We will ensure that we continually develop our culture of open and honest conversations with patients and families when things do go wrong and when care has fallen below expected standards, and we will support staff to do this.

We will seek out patient and carer involvement in our investigative processes and discuss the findings of our investigation and actions with them once complete.

We will publish progress with our quality improvement initiatives and the impact of these on patient safety.

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

Whittington Health will be an active participator in our regional Patient Safety Collaborative and will also actively engage with safety initiatives across the local health and social care system. We will work with our university colleagues on developing quality improvement expertise. We will continue to work closely with the Academic Health Science Network and UCLP Quality Forums including the

MD's Forum, Community Education Provider Network to develop education in patient safety, leadership development in improvement methodology and trainee education in improvement methodology.

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.

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We will

Implement a process of written reflection as part of our Serious Incident process for all staff involved in incidents and also develop our debriefing process following adverse events ensuring that appropriate feedback is given to staff where ever appropriate when harm or incidents have occurred. We will develop processes that enable our patients and partners to understand our systems and how they can help be involved to help us improve. We will celebrate our success by holding events to share them with our staff and others but also to champion individuals and teams who have done great work. We will use our excellence awards schemes to celebrate achievements. We will ensure that staff can quickly and easily access our Employee Assistance Programme where additional emotional support may be required following involvement in an incident or complaint. We will ensure that professional supervision structure is used effectively to help staff develop and improve individually and celebrate successes.

FREQUENTLY ASKED QUESTIONS

1. **What is Sign up to Safety?**

   Sign up to Safety is a campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. By signing up to the campaign organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient's safety helping to ensure patients get harm free care every time, everywhere.

2. **What does Sign up to Safety mean?**

   This campaign and its mission are bigger and much more important than any individual's or organisations' programmes or activities. We want to establish and deliver a single vision for the whole NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. This means taking all the activities and programmes that organisations currently own and aligning them with this single common purpose.

3. **What is different about Sign up to Safety from previous campaigns?**

   What is unique and fundamentally different is that this campaign is for everyone. It transcends organisational boundaries and will align the whole system to achieving our shared ambition. There will be no targets or 'performance management' from the centre – the energy, ideas and expertise will be found deep inside the NHS and within your organisation. The Chief Executives of NHS England, the Care Quality Commission (CQC), the NHS Trust Development Authority, Monitor, NHS Improving Quality (NHS IQ) and the NHS Litigation Authority (NHS LA) have all signed up to align their work with this campaign.

   The idea is to harness the talent and enthusiasm within organisations and connect this to others in our National Health Service.

4. **Who can sign up to the campaign?**

   Sign up to Safety is for everyone, everywhere. Whether you work in primary, secondary, or tertiary care; whether you work in acute, mental health, learning disabilities, ambulance, or community care settings; whether you work in a national body or a general practice, Sign up to Safety applies to you.

5. **How is the campaign being organised and supported?**

A National Co-ordinating and Support Group has been established, chaired by **Sir David Dalton** who is supported by **Dr Suzette Woodward** as Campaign Director.

The following national organisations have committed to system wide support of Sign up to Safety:

- NHS England will provide expert clinical patient safety input to the development of improvement plans and framework for plan assessment. They will also play a key leadership role in the campaign and will ensure all their programmes of work described above are actively working to support the campaign.
- Monitor and the NHS Trust Development Authority will offer leadership and advice to trusts and foundation trusts who participate in Sign up to Safety and who will develop and own locally their improvement plans. They will also sign post to partner organisations for specific expertise where required.
- NHS Litigation Authority which indemnifies NHS organisations against the cost of claims, will review trusts' plans and if the plans are robust and will reduce claims, they will receive a financial incentive to support implementation of the plan. Any savings made in this way will be redirected into frontline care. This is just one way that we can tackle some of the financial costs of poor care. Any savings made in this way will be redirected into frontline care.
- The Care Quality Commission will support trusts signed up by reviewing their improvement plans for safety as part of its inspection programme. CQC will not offer a judgment on the plans themselves but consider them as a key source of evidence for Trusts to demonstrate how they are meeting the expectations of the five domains of safety and quality.
- The Department of Health will provide Government-level support to the campaign and work with the Sign up to Safety partners to ensure that the policy framework does all it can to support the campaign and the development of a culture of safer care.

6. **What support is available to organisations who sign up to the campaign?**

The National partners will work together with improvement experts to establish what a good improvement plan looks like and to support organisations to learn from each other in drawing up and delivering theirs. It is crucial that the leadership of the campaign is exercised locally but equally that this work is completely aligned with and mutually supportive of the work that is already underway or planned in relation to patient safety improvement. In this first phase, an 'Alliance of Improvement Experts' will be asked to come together and offer provider organisations who sign up the opportunity to have improvement support and advice. The Improvement Alliance will also combine their sign up coaching with supporting the local patient safety collaborative to help enhance and align the activities of both. The level of advice and support will depend on what local organisations ask for, but the Improvement Alliance will act to bolster the development of these linked initiatives where they can, transferring skills to collaboratives and provider organisations, as well as supporting the development of the Patient Safety Fellows Programme.

Over time we expect that the Campaign will be self-supporting as capacity is created locally to harness enthusiasm and develop capability, not least through the developing patient safety collaboratives.

At the outset of the campaign a National Co-ordinating and Support Group will be established chaired by Sir David Dalton, with NHS England leadership provided by Dr Mike Durkin. The CQC, Monitor, the NHS LA and TDA will be part of the Group alongside representation from professional bodies, patient groups and improvement experts. The Group will encourage organisations to commit to the campaign and will listen to what they need for support. The Group will also work to ensure the alignment with and support the establishment of related system activities including the patient safety collaborative programme, the Patient Safety Fellows Programme and the core development and support activity of the Trust development Authority and Monitor already in place. It is crucial that this campaign is seen as bringing the activity of the whole system together with a common and urgent single purpose.

7. **How should organisations get patients, families and carers involved in Sign up to Safety**

We strongly encourage organisations that sign up to be actively engaging with patients in a meaningful and productive way. Patients, their families and carers have a vital role in patient safety and their perception of safety and opinions on where improvement can be made should form part of the development of the improvement plans. Their opinions are one of the most powerful influencers of other people and their choices and their voice a powerful force for change if listened to and learned from. This could be through a patient suggestion scheme, inviting patient representatives to be part of committees or forums to develop the plans, holding consultation events etc. More suggestions on including patients in the campaign are available on the website and case studies will be added as more and more organisations sign up to the campaign.

8. **How does Sign up to Safety align with other patient safety programmes and initiatives?**

The following linked initiatives to improve patient safety will be aligned with the campaign so that the whole system supports involvement. *Patient Safety collaboratives* – These are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods. They will begin their work later in the year. Organisations that sign up to safety can commit to join their local collaborative as part of their plan (although they are open to all organisations).

Patient safety Fellows – work is underway to create a group of 5,000 respected, enthusiastic and effective safety improvers who will become the backbone of patient safety improvement over the coming decade, making an active contribution to improving safety. The group will launch later this year and organisations who participate in Sign up to Safety are involved in the collaboratives will benefit from the expertise of the fellows and can also support their own staff to become fellows.

New National Reporting and Learning System (NRLS) – work is underway to review and re-commission the NRLS. We already have the world's most comprehensive incident reporting system and this will be developed further to make incident reporting as easy, effective and rewarding as possible, so that learning and improvement continue to grow across the system.

SAFE team – A new Safety Action for England team will be developed to provide short-term support to individual trusts in the area of patient safety. SAFE will provide trusts with a clinical and managerial resource to help to develop organisational and staff capabilities to help improve the delivery of safe treatment and care. SAFE will be piloted later this year and could help support signed up organisations, and others, who require additional help.

Safety website – A new set of hospital patient safety data is now available on NHS Choices enabling trusts to be compared against each indicator. Putting key safety information into the public domain supporting transparency and helping patients to make informed choices about their care and exercise their right to challenge their local healthcare providers on safety issues. Organisations that have signed

up to safety can use this public data to inform their plans and conversations with their local communities.