

Sign up to safety is harnessing the commitment of staff to make care safer.

A patient safety campaign, it is one of a set of national initiatives to help the NHS in England improve the safety of patient care. Collectively and cumulatively these initiatives aim to reduce avoidable harm by 50% and support the ambition to save 6,000 lives.

Healthcare is high risk and mistakes can happen. Only safe healthcare services are truly efficient, effective and able to offer the best experience - patient safety is the organising principle of the high quality healthcare we all want to provide.

Sign up to Safety is helping the NHS to make improvements and create a supportive, open and transparent environment for patients and staff. Alongside the hundreds of organisations taking part, we are creating the conditions for a safety culture, a just culture, and a learning culture. Together, we're building a safer care movement which is committed to locally led, self-directed safety improvement.

Sign up to Safety is for everybody, in every part of the NHS 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. We are united by our common goal; to continually strive to make the care we give our patients as safe as possible.

All those who sign up are committing to not just believe in, but to embed and be an example of the values and beliefs that make us all proud to work in the NHS.

The **five safety pledges** are more than words on paper. They mean something. By making a commitment to bringing them to life, and by helping others to understand their role in this, we are working together to create the right conditions for safer care.

Those taking part gain the opportunity to share their passion, knowledge and experience in patient safety with others, to help create broad-based learning that's shared throughout the NHS.

The five safety pledges:

1. **Put safety first.** Committing to reduce avoidable harm in the NHS by half through taking a systematic approach to safety and making public your locally developed goals, plans and progress. Instil a preoccupation with failure so that systems are designed to prevent error and avoidable harm.
2. **Continually learn.** Reviewing your incident reporting and investigation processes to make sure that you are truly learning from them and using these lessons to make your organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe your services are
3. **Be honest.** Being open and transparent with people about your progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

4. **Collaborate.** Stepping up and actively collaborating with other organisations and teams; share your work, your ideas and your learning to create a truly national approach to safety. Work together with others, join forces and create partnerships that ensure a sustained approach to sharing and learning across the system
5. **Be supportive.** Be kind to your staff, help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right. Give staff the time, resources and support to work safely and to work on improvements. Thank your staff, reward and recognise their efforts and celebrate your progress towards safer care.

In the second year of Sign up to Safety we are on a mission to help the NHS in England to improve patient safety by:

- Advancing patient safety knowledge and in particular the science of implementation
- Fostering consistent exchange and use of best practices
- Working with and through others to address common interests related to patient safety
- Advocating on behalf of the campaign participants and others
- Interacting with key stakeholder groups on specific issues
- Reinforcing the essential role of improving patient safety as a distinct part of the wider quality improvement activity

Our key messages for this year:

1. For the next 15 years we need to review our approach and potentially re(think) Patient Safety, to do something differently for long term success
2. We urgently need to shift our thinking and concentrate our efforts on solutions that address the cross cutting causal factors and learn more about how to implement these solutions in a way that leads to lasting change
3. Patient Safety is the responsibility of everyone and is built upon the actions of individuals. Sign up to Safety is building a community of individuals and supporting them to action their pledges and more.