Frequently asked questions

What is Sign up to Safety?

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 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.

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.

This is represented by the five safety pledges that every organisation and individual who signs up commits to:

- **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
- **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

- **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
- **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
- **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.

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 are establishing and delivering a single vision for the whole NHS in England to become the safest healthcare system in the world. This means taking all the patient safety activities and programmes that organisations currently own and aligning them with this single common purpose.

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.

After only a year of the campaign, organisations representing CCGs, acute trusts, mental health trusts, ambulance trusts, Royal Colleges and academic institutions are signed up and working proactively on prioritising safe care every day.

Why is Sign up to Safety necessary?

Staff in the NHS care deeply about the care they provide and they all want to provide safe and effective care.

However, we know that human error occurs in healthcare, as it does in all walks of life. Therefore people make mistakes. We are working with hundreds of organisations from across every healthcare setting in England helping galvanise the patient safety field to move forward over the next fifteen years with a unified view of the future of patient safety to create a world where patients and those who care for them are free from avoidable harm

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 their patients and staff.

What can we do to make care safer?

There are numerous interventions that make care safer. Safe care is reliant on successful adoption and implementation of these interventions.

What is the current problem with implementation?

Implementation is complex. When we normally talk about implementation, we often use phrases such as carry out, realise, bring about, launch, etc. Implementation is a specified set of activities designed to put into practice an activity or program or solution. In the NHS we introduce and put new ideas into use and practice all the time.

Implementation is not a one-off event. The implementation process starts with someone having an idea about a new method that can be used to meet a need or solve a problem. The idea may originate in the organisation where the need arose or outside of the organisation where external view has identified a need and a solution.

The idea is presented and a decision is taken, normally on a high level within the relevant organisation. Once decided the next stage is dissemination and adoption which includes the key steps of planning, preparation and application of the solution or activities needed to achieve the sought–after change.

Once the new method has been adopted from both a practical and organisational point of view, it is then evaluated and any necessary local adjustments are made, it is then integrated or assimilated to the local context.

Finally, the method is considered institutionalised, embedded or sustained, if it is taken for granted or is the 'way we do things' regardless of reorganisations, personnel turnover and political changes.

Although there have been huge strides in patient safety made over the last fifteen years, there is still a gap between how safe we all want care to be, and what is achieved in practice each and every time in a highly complex and evolving system.

The issues include:

- Failing to appreciate the complexity of a problem
- Strategies that sound like solutions but still haven't been worked out, so are really unsolved problems e.g. change the culture, sort out team work
- The intervention may commonly be implemented inadequately
- The intervention requires much more effort or expertise than generally recognised
- There are competing priorities

Implementation research has identified the common factors or components that have significant bearing on the success or failure of implementation. These include:

- The recognition that there is an explicit need for change and the solution and that the proposed method is the right one in the context
- There are visible benefits
- The solution is in line with the norms, values and working methods of the individuals, teams or organisation implementing it
- The solution is easy to use and it can be tested on a small scale
- It can be adapted to the needs of the recipient and the context
- Finally, it gives rise to knowledge that can be generalised to other contexts

A dilemma in the patient safety field is that it often takes a long time to see the benefits of a new method. To achieve widespread dissemination, a method for improving the safety of

patient care must therefore be better, preferably much better, than any competing methods and liked by the end users / practitioners so that they influence their colleagues to change.

What is Sign up to Safety actually doing?

Sign up to safety is building capability and enthusiasm for patient safety. Sign up to Safety is harnessing the commitment of staff to make care safer. The campaign is bringing to life the recommendations of the Berwick Advisory Group report and, alongside several other initiatives, aims to make the NHS in England the safest healthcare system in the world.

There are many pockets of individual excellence (individual teams or units or areas) right across the country. We are helping hundreds of participants to share what does and doesn't work when it comes to implementation across our community, while ensuring those at the front-line still own the change and improvement that is key to a safer NHS.

Over the last year, organisations signed up to the campaign have brought their pledges to life in a myriad of exciting ways. From creating learning events for staff and patients through to awarding incident reporting. Our recent birthday celebrations showed many examples of organisations adopting this positive and open approach.

Each participant organisation has created a bespoke and tailored safety improvement plan which sets out what they want to prioritise over the next three to five years to improve safety in their organisation. Their safety improvement plan is based on their own data, what has worked over the last three years and what they want to do differently over the next three to five years. This local ownership is creating a strong connection between frontline staff, delivery and improvement.

We are also advocating an approach to safety which is about 'stopping stuff' and 'thinking differently' about the subject – our aim is to influence across the system to stop doing things that are not working and to rethink how we can do it better – so that we move from Safety I to Safety II – we think there is a transition phase between I and II and again are setting out a think piece on this.

The campaign is also one of the levers for change – we use the extrinsic levers of energising, motivating, rewarding, valuing and supporting to achieve three key things

(1) improved learning and sharing

(2) just culture for safety to enable staff to be supported to speak out

(3) improving the timeliness and effectiveness of implementation of safer practices

Another lever also linked to the campaign is the incentive scheme owned by the NHS LA.

What is a just culture?

A just culture is one where:

- People who make an error (human error) are cared for and supported
- People who don't adhere to policies (risky behaviour) are asked first before being judged
- People who intentionally put their patients or themselves at risk (reckless behaviour) are accountable for their actions

The just culture is also reliant on the use of design – so that we design out the error producing conditions and support humans to get it right.

The just culture is reliant on a preoccupation with failure – to create a resilient system so we are adaptable and prevent the little things getting bigger.

Why is there a need for a just culture?

"The single greatest impediment to error prevention is that we punish people for making mistakes" Dr Lucian Leape, 12 October 1997

Systems need to be designed to take into account that the best people can make the worst mistakes, that systems will never be perfect and humans will never be perfect. If we accept and expect this then we can design our systems to try to make mistakes impossible.

We need a just culture so that staff are able to speak out without fear of retribution and therefore we are able to maximise the ability to learn from when things go wrong.

How is Sign up to Safety helping improve the culture of the NHS?

All organisations which have joined Sign up to Safety so far are united in their common goal; to create the right culture where staff and patients can feel supported and listened to when things go wrong and are able to speak out when they are concerned about safety, so that we can learn about what we can do differently to make care safer.

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

How is Sign up to Safety helping to create a culture of continuous learning?

Over the last fifteen years in the patient safety field there has been a lot of guidance (alerts, solutions, interventions, standards) for those that work in healthcare to help them 'make care safer'.

Many of us have tried to realise ideas and introduce new methods, but after a while we have been forced to admit that things didn't turn out as we had originally intended and planned.

Sign up to Safety is proactively exploring the subject of implementation with our community, topic experts and expert practitioners in delivery of healthcare through webinars and learning events.

Our hope is that we will increase our understanding and knowledge in this area and over the course of the campaign, acquire new knowledge about how we can facilitate learning.

Sign up to safety is developing a learning methodology for implementation of safer practices to help create the 'culture of learning and continuous improvement'.

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

What is unique and fundamentally different is that this campaign is about bottom up, locally owned change and it is for everyone. It transcends organisational boundaries and aims to align the whole system to achieving our shared ambition. There are no mandatory

interventions, targets or 'performance management' from the centre – the energy, ideas and expertise are being found deep inside the NHS and within each organisation.

It is also urging a move forward in how we approach patient safety. Over the last 15 years, there has been a persistent failure to learn from mistakes and incidents and we know that while many of the interventions that can make care safer already exist, there is a known gap between this evidence and every day practice.

The campaign is encouraging participants to move beyond just a focus on single areas of harm and shift efforts to also addressing the myriad of contributory factors that impact on safety every day; communication failures, the availability and the design of the right equipment, inexperience, stress, attitudes and relationships, and the way we observe patients and use information. All of these impact on safety and apply across the NHS from secondary to primary, acute to community, hospital to GP practice, board to ward.

How much is Sign up to Safety costing?

Patient safety is the organising principle of high quality healthcare; only safe healthcare services are truly efficient, effective and able to offer the best experience to patients and carers. A focus on patient safety can offer the best and practical solution to building a healthcare system which is financially sustainable and able to offer the best Patient outcomes and experience. The cost of the campaign is around 900k per year with 5 WTE staff.

How many lives have been saved so far by Sign up to Safety?

Improving safety, reducing avoidable harm and saving lives takes time to demonstrate. Therefore, saved lives will be measured at the end of the campaign using the same methodology as the baseline data study; Hogan et al (insert reference).

Sign up to Safety is one of a set of initiatives to help the NHS improve the safety of patient care including; the fifteen Patient Safety Collaboratives, the Q initiative, Sign up to Safety campaign and the work of the patient safety leadership team. This total programme has a shared cause of saving lives and reducing avoidable harm. The measurement approach will

need to measure the impact across the system of the collection of interventions; as measuring each in isolation would not be possible.

None of these initiatives and commitments by themselves will be the difference between success and failure over the coming years. They are pieces of the jigsaw that will make up a safer NHS in England. Collectively and cumulatively they will help improve the safety of patient care. Sign up to Safety will be evaluated as part of this wider set of initiatives by a specialist measurement team currently being procured.

Is our healthcare system not already safe?

Over a million patients are cared for in the NHS each day and the vast majority of care experienced by patients is high quality and safe. Patient Safety is a worldwide issue with research studies demonstrating that on average one in ten patients are subjected to avoidable harm.

Patient safety issues are the avoidable errors in healthcare that can cause harm to patients. Not all harm is avoidable. Some treatments or drugs are even expected to cause harm, such as chemotherapies or certain drug therapies.

Those working with patients are human and so mistakes can happen. Sign up to Safety is helping organisations tackle the causes of errors in care that can come from badly designed systems or as a result of the lack of awareness of what can make a difference amongst those delivering care – these errors are avoidable and steps can be taken to reduce them.

A critical step is to ensure our healthcare system is safe for staff as well as patients, by creating an open environment where all feel safe to discuss errors, confident that lessons will be learned.

It is important to remember that making care safer is a challenge shared by all advanced healthcare systems across the world. With the NHS, a unified system, we have a unique opportunity to spread continuous learning.

Resources include the extrinsic motivational factors (professional regulation and organisational regulation, alerts, guidance, standards, policy and legislation, financial

incentives such as that of the NHS LA, constitution, embracing the just culture by leaders and HR teams), intrinsic motivational factors (values, behaviours, reward, recognition, knowledge, learning, sharing).