Sign up to SAFETY

Bringing learning to life

Useful resources we recommend

Share your favourite links & we will acknowledge you here!

- **Current thinking**

National Advisory Group on the Safety of Patients in England - A promise to learn - a commitment to act, Improving the Safety of Patients in England

Hollnagel, Wears, Braithwaite - From Safety I to Safety II: A White Paper

Carl Macrae - The problem with…incident reporting

- **Learning about better alternatives for learning from incident reporting and investigations**

You are the Doctor video session from a Behavioural Exchange conference held earlier in 2015, which brought together leading academics, policy-makers and practitioners from around the world to discuss how behavioural insights can help us create better policy and a better society. This session shows a hospital through a doctor's eyes to help the audience look at better ways to set up health systems to help reduce avoidable adverse events.

Huddles

Leeds Teaching Hospital NHS Trust, Dr Alison Cracknell, Scaling up patient safety huddles to enhance patient safety and safety culture in hospital wards

Yorkshire and the Humber Leadership Academy, Dr Alison Cracknell, Leading Quality Improvement Part Three

Western Sussex Hospitals, Safety Huddle

Nottingham University Hospital, Medicines Safety Huddle

Great Ormond Street Hospital, Using the huddle technique to improve patient safety

Agency for Healthcare Research and Quality. About TeamSTEPPS.

Institute for Healthcare Improvement. Use regular huddles and staff meetings to plan production and to optimize team communication.

Briefing and debriefing

Health Quality & Safety Commission's teamwork and communication workshop in Auckland – 18 June 2015

Agency for Healthcare Research and Quality, Team working tools

Human personality theories; Extraversion and introversion

Openness

National Reporting and Learning System Being Open framework

Boston's Brigham and Women's Hospital publicly posted case studies on patients who were injured when members of the hospital staff made medical errors. Example of a case study

Australian Commission on Safety and Quality in Health Care Open Disclosure Framework

You can find out more about the first safety pledge Put Safety First at www.signuptosafety.nhs.uk/latest-thinking

Sign up to Safety is fostering a movement across the NHS in England to make care safer.

***Be part of it ***

www.signuptosafety.nhs.uk