Sign up to Safety

Fostering a movement for safety across the whole of the NHS in England

Contents

I want … to create a profound change in culture in the NHS. For too long we have assumed that the only way to tackle problems is a combination of money and targets. Both have their roles - but both, too, have unintended consequences. Our focus should be different: not top-down targets but transparency and peer review; learning and self-directed improvement that tap into the basic desire of every doctor, nurse and manager to do a better job for their patients; empowered leaders with the permission and the space to excel.

Secretary of State for Health
16 July 2015

Executive Summary

Sign up to Safety is a campaign launched in June 2014. This document builds on the initial strategy document '*sign up to Safety - 3 year strategy'* and shifts the thinking further as a result of learning from the first year. It describes our achievements in year one, and the lessons we have learned and our plans for year two.

Sign up to Safety has a vision to build a safer NHS in England to reduce avoidable harm by half and save 6000 lives. The mission is to create the conditions for a safer NHS to support locally led self-directed safety improvement. It is not about developing new improvement activity. Our five key objectives focus on the campaign pledges; put safety first, continually learn, be honest, collaborate and be supportive.

To date 90% of acute care, 95% of community providers, 80% of ambulance trusts and 64% of mental health organisations have joined the campaign. Towards the end of the first year participation from clinical commissioning groups (22%) has started to rise but this remains an area we want to increase further. The majority of provider organisations (95%) have written a safety improvement plan which sets out what they will do to reduce avoidable harm and save lives over the next 3-5 years.

The campaign team comprises 5 WTE individuals including a regional presence. This team has engaged across all healthcare settings through; 21 webinars, 37 keynote presentations, 1,700 newsletter subscribers, 3,000 twitter followers, opinion pieces and blogs, videos and podcasts and 83 pieces of press coverage. We have continued to raise awareness about a safety culture and what that actually means in practice and challenged the way patient safety has been done to date in a way that helps people think differently. We have worked closely with the NHS Litigation Authority (NHS LA) to design and implement a unique incentive scheme for members of the NHS LA in which they are given funding to improve safety which reduces the avoidable harm that leads to clinical claims.

In our second year we will bring the five pledges to life through a systematic programme of activity together with shifting the focus away from one harm at a time to a more holistic approach of addressing the five system and human factors related to; communication, design of equipment, individuals, observation and information. We will encourage the use of a wide range of guiding theories; improvement science, implementation science, social movements, campaign and evidence based practice.

"*I want today to mark the start of a new movement within the NHS in which each and every part of our remarkable healthcare system signs up to safety, heart and soul, board to ward".*

Secretary of State for Health
26 March 2014 as part of a speech in Virginia Mason Hospital, Seattle

1 Introduction and background

1.0 Across the globe and in the NHS we have seen a multitude of improvement programmes and projects for healthcare. However the full potential of these efforts and especially those that seek to address an entire system has not yet been reached. Most of the current approaches are top down, programmatic and target driven. In terms of changing behaviour and practice as well as processes and systems different thinking is needed.

1.2 On 26 March 2014 The Secretary of State for Health presented a speech[i] at the Virginia Mason Hospital in Seattle (US), which announced the start of a new movement within the NHS (in England) to make the NHS the safest healthcare system in the world. This signposted the formal launch of a campaign titled 'Sign up to Safety' which was subsequently launched on 24 June 2014.

1.3 The vision then, and which continues, was that a combination of three initiatives (Sign up to Safety, a network of patient safety collaboratives, and the now Q initiative) would create a new movement to share, learn and improve ideas for creating a safety and learning culture, to reduce avoidable harm and save lives.

2 Role of Sign up to Safety

2.0 It's easy to glance at Sign up to Safety and see 'just another top down initiative or national campaign' and ask 'why do we need this?' It could be argued that organisations are already working on improving safety and reducing harm. Yet we also know that despite all the previous efforts we have not made the kind of impact we had hoped; patients still fall, we continue to administer the wrong drugs and operate on the wrong leg, and a patient deteriorating can still be missed.

2.1 Sign up to Safety is the campaign component of the national patient safety strategy for the NHS in England. It uses campaign and social movement methodology to motivate individuals within organisations across all care settings of the NHS. The scale of potential reach and influence includes over 260 hospital trusts, thousands of GPs, over 200 clinical commissioning groups, thousands of care homes and over 1.3 million staff across the system.

2.2 The campaign was launched with a group of 12 'trailblazer' organisations already joined. Every Chief Executive was invited invited to join them and sign up to safety. They were asked to complete the five Sign up to Safety pledges and turn them into a three year safety improvement plan which will show how the organisation intends to reduce avoidable harm and save lives:

- Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally
- Continually learn. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are
- 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
- Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
- 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 have focused unprecedented attention on improving patient safety in the NHS, but there's always more to do and these collaboratives will help drive standards even higher. The collaboratives also support our Sign up to Safety campaign, which sets out our ambition to halve avoidable harm over the next three years and save up to 6,000 lives"

Secretary of State for Health
October 2014, Launch of the Patient Safety Collaboratives

3 Sign up to Safety and the overall patient safety strategy

3.0 Sign up to Safety is one part of a whole safety system that should be 'wired together' to support the conditions for safety.

3.1 The unique bit about Sign up to Safety is that it is a campaign – and as such is not about developing new improvement activity. As a campaign its part in the system is to help learning, sharing and implementation to help make care safer. It raises awareness about the problems, the solutions and where we should think differently. As a campaign it uses social movements and campaigning methods which are developing locally led actions and mobilising self-directed safety improvement. We are also able to work at a national level across the while system to create a coherent approach e.g. working with the national leads for harm based areas such as falls and sepsis to ensure they are helping the frontline cope with the competing interests and 'wiring up' the system through strong partnerships, including all the key partners (above) and in particular the patient safety collaboratives and Q initiative; as well as working closely with the NHS LA and supporting their new incentive scheme.

3.2 Sign up to Safety therefore adds value and compliments the additional components of the national patient safety strategy which includes the following:

National leadership through the national patient safety team (moving to NHS Improvement under the leadership of Mike Durkin)

Learning from incidents and improved incident investigation via the National Reporting and Learning System and the new Independent patient safety investigation service under the leadership of Mike Durkin

Collaboration through the fifteen patient safety collaboratives sited in each Academic Health Science Network; teams of people who tackle intractable problems and find out how they can be solved and develop the right solutions or safer practices e.g. medication safety, pressure ulcers, and falls. The programme will run over five years

Building individual capability and a network of quality improvers via the Q initiative – a partnership with The Health Foundation to create 5000 quality improvers over the next five years

Buddying through the five organisations that will be supported by staff from the Virginia Mason Institute (US) who will spend time in the five trusts over the course of the next five years helping the doctors, nurses and leaders figure out how they can improve using the tools developed in Seattle. The programme will run over five years and set five NHS trusts on the road to becoming leading healthcare institutions, at the same time sharing learning and benefitting the NHS as a whole

Patient safety education via Health Education England and the Patient Safety Commission

Patient safety standards and regulation via the professional and organisational regulators and inspections

Financial incentives to reduce harm associated with claims through the NHS Litigation Authority in partnership with Sign up to Safety

3.3 All this variety of activity can have the potential to create confusion at the frontline. Participants frequently look to Sign up to Safety for clarity around the national system for patient safety. Therefore one other aspect of the campaign is its ability to help make sense of the current system and to explain any changes in the patient safety system for the frontline.

"We have tended to focus on problems in isolation, one harm at a time, and our efforts have been simplistic and myopic. If we are to save more lives and significantly reduce patient harm, we need to adopt a holistic, systematic approach that extends across cultural, technological and procedural boundaries – one that is based on the evidence of what works".

Ara Darzi
February 2015, HSJ

4 Our approach

4.0 The ideas, methods and approach for Sign up to Safety represents fifteen years of work by the campaign team, in particular from a previous campaign *patient safety first* and lessons we have learnt since about large scale change from across the globe including patient safety campaigns in other countries.

4.1 Year one was all about participation (see section 5 for detail).

4.2 Year two in summary (see section 9 for detail and our strategy on a page in annex A) is about ongoing participation, spread and reach into areas of low participation together with bringing to life our five pledges. We will continue to energise and galvanise the NHS in England to deliver locally led, self-directed safety improvement and use new approaches to capture what is going on locally and share what people are doing at scale under the overarching brand of Sign up to Safety.

Sign up to SAFETY
LISTEN LEARN ACT:

4.3 We will help explore and address the implementation gap under our beneath the surface sub-brand below:

And help revise patient safety thinking under our re(**think**) sub-brand of Sign up to Safety to shift the focus from one harm at a time towards a more systematic approach to safety which focuses on addressing system and human factors.

"The NHS needs a profound transformation in its culture"

Secretary of State for Health
16 July 2015

5 Sign up to Safety – First Year

5.0 The campaign is providing a niche role not provided anywhere else in the system and aims to be different by:

- Engaging, energising and mobilising individuals and organisations across the whole of the NHS in England to create the conditions for a safety culture, a just culture, a learning culture
- Using a consistent approach to help locally led, self-directed improvement and providing tools and resources to help over 280 organisations 'own' the campaign locally; making it meaningful for their staff, patients and community while at the same time being part of something bigger which unites them around a shared cause across the whole of the NHS in England
- Creating an innovative way of sharing *how* change is achieved and not just *what* is achieved
- Helping people on the frontline re(**think**) patient safety and to shift the focus away from single areas of harm and moving the efforts to address 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 impacts on safety and apply across the NHS from secondary to primary, acute to community, hospital to GP practice, board to ward
- Helping people on the frontline re(**think**) the way they learn from mistakes and incidents
- Getting *beneath the surface* of implementation of known safer practices and the recognised gap between this evidence and every day practice

5.1 Sign up to Safety has supported the Secretary of State for Health's vision for a *'profound transformation'* of the safety culture of the NHS (ii) by:

- Increasing awareness about patient safety with people on the frontline and informing them about the components of a safety culture, patient safety concepts and improvement methods via opinion pieces, blogs and videos
- Encouraging key partners to support the conditions for a safety culture e.g. medical and nursing schools so that the future generation of doctors, nurses and other healthcare professionals learn about safety as part of their training; Health Education England in respect of their commission for patient safety and so on
- Using different motivational factors (intrinsic and extrinsic) including reward and recognition
- Developing trust with participants in both the campaign brand and the team through our behaviours, role modelling and operational actions
- Involving CEOs, boards and senior leaders to ensure they sign off their safety improvement plans and lead by example at their launch events and team events to visibly demonstrate that safety is a priority
- Setting up a Patient Engagement group to inform our approach
- Working in tandem with a number of the patient safety collaboratives, in particular; Imperial, Wessex, West Midlands, Oxford, North West Coast. This helps show a more cohesive patient safety system ('wired up') to the frontline, reduces duplication of effort, helps connect networks and valuable intelligence is shared
- Living and breathing the importance of workforce safety, wellbeing, joy and pride that Don Berwick so eloquently described in his review of patient safety
- Constantly encouraging people and organisations across the NHS in England to share and learn from each other

5.2 **A prime objective** was to engage organisations and individuals and increase membership from all care settings across the whole NHS in England. We have achieved a significant level of participation in many areas. The campaign was set an aim of 160 organisations participating by the summer of 2015. At the time of reporting, the campaign has over 280 organisations signed up.

Table 1: Total number and percentage of signed up organisations per type (as at time of report)

Type of organisation	Number	Percentage of total in England
Acute	139 (out of 155)	90%
Community Provider	29 (out of 34)	85%
Ambulance	8 (out of 10)	80%
Mental health	36 (out of 56)	64%
CCG	47 (out of 209)	22%
GPs	4 (out of 8k)	0.05%

5.3 The vast majority of acute care organisations are signed up (where most of the focus over the last fifteen years in patient safety has been to date) and we have had an excellent response across community, ambulance and mental health. However, we are disappointed with the level of sign up by CCGs and GPs (a crucial gap which needs addressing in year 2 and beyond). In order to identify momentum over the first year we tracked the sign up per month:

Table 2: Numbers signed up per month

	2014-2015 All orgs	CCGs and GPs	Individuals
June	14	0	41
July	40	5	43
Aug	26	5	53
Sep	37	5	37
Oct	22	1	24
Nov	24	2	16
Dec	43	5	13
Jan	24	4	6
Feb	8	1	11
Mar	10	5	15
Apr	12	3 (+3 GPs)	20
May	8	3	15
June	8	4	29
July	8	3 (+1 GP)	41

5.4 We have had a steady sign up of all organisations over the calendar year from June 2014, with less over time from February 2015 onwards. However, as some organisations continue to sign up, for example 78 since January 2015, their campaigns' first year started in 2015. CCGs have been mainly at a flat line in terms of sign up and a tiny handful of GPs only just came on board from April 2015 onwards.

5.5 Signing up (completing the pledges and engaging the organisations senior leader or CEO to agree and sign the joining form) can take time with some organisations needing sign off from their Board. So the process starts some months before they send in their sign up pack. Then once signed up they take on average between 3 and 6 months to develop their safety improvement plan as we ask them to review their last 3-5 years of data and seek feedback from their staff and patients in choosing what to work on for the next 3-5 years. Therefore signing up in July 2015 could have meant planning started in January 2015 and their 3 year plan will not start until January 2016.

5.6 Engaging has been easy with so many enthusiastic participants. Many organisations have held Sign up to Safety events to celebrate joining, or their launch or the first birthday of the campaign. The events aimed to raise awareness of Sign up to Safety and the improvement work that the particular organisation is taking forward, but also to engage with patients, the public and staff on the patient safety agenda and how they can be involved. For example one organisation engaged their local community by attending their County Show and having a Sign up to Safety stand. A number of organisations provided ongoing listening events to give staff an opportunity to contribute suggestions, concerns and comments at a local level about what should be in their safety improvement plan.

5.7 **Our next objective** was to encourage action and not just sign up. All provider organisations that had joined to campaign were invited to commit to turn their pledges into a three year safety improvement plan to show how they intended to reduce avoidable harm and save lives. Non provider organisations and individuals were asked to commit their pledges but were not required to complete a safety improvement plan.

5.8 Out of 203 provider organisations, 192 (95%) safety improvement plans have been completed and shared with the campaign allowing us to see what is happening across the NHS in England. A total of 673 individual projects were set out in their plans to reduce avoidable harm divided between:

- Harm specific (419)
- Cross cutting themes (155)
- Specialty specific (99)

Table 3: Harm specific themes – number of organisations focusing on each area

Harm	Number
Falls	73
Pressure ulcers	68
Medication Safety incl diabetes	61
Sepsis	61
Deterioration	56
Infections incl CAUTI	32
VTE	25
Acute kidney injury	23
Failure or delayed diagnosis	14
Assault, violence	2
Patient restraint	4

Table 4: Cross cutting themes – number of organisations focusing on each area

Topic	Number
Communication	30
Safety culture	21
Mortality reviews	18
Patient engagement	17
Leadership	15
Increasing QI and safety skills	13
Nutrition and hydration	11
Incident analysis	10
Tests and screening	10
Safe staffing	7
Team work	3

5.9 The total number of individuals joined nationally is over 365. Although we know that there are over 600 pledged locally. The focus on individual membership culminated in the campaigns first birthday on 24 June which focused on *Sign up to Safety and me* a targeted campaign aimed at individual practitioners.

5.10 Campaign in numbers:

- Over 280 participant organisations
- 90% of acute care signed up

- Delivered 21 webinars; a variety of topic specific (e.g. falls, sepsis, pressure ulcers) and strategic issues (e.g. improvement methods, measurement, implementation, thinking differently, patient engagement)
- Director delivered 37 key note presentations at conferences and events across the country between June 2014 and June 2015
- Average of 5000 visits to the campaign website
- Five trusts in the North West have taken to the initiative to create their own Sign up to Safety network to share best practice across their organisations, led by an Assistant Director of Nursing from Blackpool Teaching Hospitals NHS FT
- The majority of the 280 organisations have appointed dedicated staff to be their Sign up to Safety Lead – some of these are new posts or realigned posts thereby committing resources to take this work forward
- Between 60 to 100 downloads of the 'sign up packs' per month
- A range of 200 to 900 downloads of campaign resources each month
- Over 1700 subscribers to the weekly e-newsletter SignUPdate
- Over 3,000 followers on campaign twitter supported by an additional 4,867 followers for the campaign director twitter feed with an average of 500k 'impressions' (potential reach in terms of people) per month
- Steady increase of twitter followers of 200 people following each month
- Press coverage via trade, regionals, and specialist media (monitored since February 2015); 83 pieces of coverage, £129,263.98 average worth, 11,279,064 circulation

"People often say that they need to be given permission to be radical so they can do the right thing for patients'. 'Our focus should be different: not top-down targets but transparency and peer review; learning and self-directed improvement that tap into the basic desire of every doctor, nurse and manager to do a better job for their patients; empowered leaders with the permission and the space to excel".

Secretary of State for Health
16 July 2015

6 Working Differently

6.0 We have purposely developed a different way of working in order to be light, nimble and cost effective. We are a virtual, people light, cloud-based, on-line, social media focused team which enables us to be immediate, flexible and highly responsive so that we can adapt and evolve as the intelligence about what people are doing and what is working grows.

Feedback: *participants over the life of the campaign compliment us about how responsive we are to enquiries; they feel it's not what they would expect from a national campaign. They are surprised that we are so small and not a large office of campaigners. Our aim is to 'wow them' and show them we are different.*

6.1 Maintaining a level of independence from oversight bodies and regulators has been a key factor in why people have wanted to join and helped the campaign to reach into other sectors such as GP practices, social care, private healthcare, local authorities, and prisons.

6.2 We have role modelled innovative ways to engage using highly cost effective methods (periscope for live videos, smart phone apps for podcasts and twitter for engaging people and sharing ideas) and encouraged our members to think about the use of social media tools and webinars as a way of engaging their staff. Organisations at the frontline have funded and created their own resources and events rather than relying on us to fund or run.

6.3 Using a campaign approach is vastly different from a top down initiative or a programme; we build energy and motivation by supporting people to see the need to change. We make a point of not telling organisations what they must work on; they tailor their safety improvement plans to their organisational need and what their local data is telling them and has therefore not created any additional burden of reporting 'up' to the campaign. We have recommended a 90 day planning approach to change which simplifies what can be overwhelming and focusing people on what is working and what is not

7 Lessons learned from the campaign so far

7.0 Throughout the first year we have been learning from the participants and working with individuals in a number of different ways including; a Sounding Board of frontline safety leads, a communication group of key communication leads across the system, webinar discussions and surveys. These have provided an insight into the challenges faced in the NHS in trying to achieve a safety culture and safety improvement across the system. This has also helped share our second year.

7.1 Challenges include:

- Challenges with metrics; there is no standardised way of recording or measuring harm and there is an over reliance on incident data
- Confusion about the role of the patient safety collaboratives
- A desire by some to be simply told what to do (particularly by CCGs) while at the same time a wish to move away from regulation, performance metrics and CQUINs
- Some organisations are still really early in their journey and are even now only about to start developing their plans and some organisations were dependent on getting the money from the NHS Litigation Authority and had to change their plans when unsuccessful – this caused some anxiety locally
- A few organisations launched the campaign but workload increased and staff were not released to deliver the programme so have struggled since
- Organisations have valued the ability to link all work streams together under the 'heading' of Sign up to Safety but not all have understood this and have unnecessarily created additional plans which duplicate or cross over existing plans
- 'Sign up' has been on a steady increase each month since launch with some only just starting. Some organisations continue to sign up, for example 78 since January 2015, their campaigns' first year started in 2015. *Organisations that continue to join (which means that for over 78 organisations their first year starts in 2015) will require the same level of support as those that started earlier*
- Preparation takes time - Signing up (completing the pledges and engaging the organisations senior leader or CEO to agree and sign the joining form) can take time with some organisations needing sign off from their Board. So the process starts some months before they send in their sign up pack. Then once signed up they take on

average between 3 and 6 months to develop their safety improvement plan as we ask them to review their last 3-5 years of data and seek feedback from their staff and patients in choosing what to work on for the next 3-5 years. Therefore signing up in July 2015 could have meant planning started in January 2015 and their 3 year plan will not start until January 2016.

7.2 Positive aspects include:

- **Locally led** - Delight that the campaign is trusting participants to develop locally led and locally driven safety improvement plans and relief that once written they could evolve. Also being asked to develop a 3 to five year plan, instead of an annual plan which is the norm, it has given people the permission and opportunity to think more longer term
- **Niche role** - The campaign is filling a gap by focusing on cultural and behaviour change, helping implementation of locally led, self-directed safety improvement and in creating the coherent narrative for the front line.
- **Timing** – There is a timely opportunity of the current changes at a national level of patient safety policy, strategy and infrastructure for the NHS in England with the campaign being a key method for shifting the emphasis away from focusing on one harm at a time.
- **Alignment** – There is a strong desire for alignment, to create a more coherent approach and the campaign helps frontline organisations and staff to understand the different initiatives (patient safety collaboratives, the Q initiative and the buddying programme with Virginia Mason).
- **Adaptability** – The campaign team are kept purposefully small and nimble in order to support changes over time from raising awareness and engagement activity to energising and motivating activity (to keep people going) and to advancing knowledge and learning activity (to share what is working and progress).
- **Continuing to build the community** - We have a strong community wand the channels and reach of the campaign is already considerable
- **Extending reach across primary care** - CCGs have been mainly at a flat line in terms of sign up and a tiny handful of GPs only just came on board from April 2015 onwards. Over the next year we have a fantastic opportunity to further engage primary care, care homes, GPs and other areas providing out of hospital care.
- **Implementation gap -** It is as important to learn about implementation as it is to learn about improvement – i.e. learn about *how* as much as *what* they are doing – the campaign could

continue with its unique approach to exploring the implementation gap between theory and practice.

- **Spread -** the campaign has an opportunity to share emerging lessons across the NHS at scale
- **Profile and trust -** The campaign has built a trusted brand that is connected in a different way to participants than any of the other national organisations.
- **Skills and expertise -** the campaigning, movement and communications skills and experience required for this are quite unique and niche – the current patient safety function does not have individuals with these
- **Evaluating impact –** the campaign is exploring different ways to measure the difference we are making
- **Affordability** – the campaign team is a people light, virtual team working from home or hot desking where we can in. We have a small budget and provide a cost effective approach to change using free platforms to engage, free social media tools to provide information and free video tools.

8 Participant feedback

7.0 The campaign is giving people permission to do what matters to them and what matters to their patients and permission to take their time to get it right. Sign up to Safety is helping people and organisations take the lead on patient safety without being told to do so.

7.1 **Ten** examples of what people are saying about being involved:

- *Our social media campaign has also been key to getting the message out there, both internally and externally. We have used Twitter to share our messages and also to keep people updated on where we were and what's going on. It even caused some healthy competition between our localities to have the best pictures on Twitter!*

- *We joined up to Sign up to Safety (SU2S) as a health community in Lincolnshire in July 2014 and outlined our ambitions alongside the Clinical Commissioning Groups, St Barnabas Hospice, Lincolnshire Partnership NHS Foundation Trust and Lincolnshire Community Health Services NHS Trust.*

- *To maximise engagement from staff but also other stakeholders such as governors, service users and carers we created 'Pledge Sheets' and asked all people to pledge an action, which is something that they could do as part of their role to contribute to reducing harm.*

- *It's been crucial to engage a wide range of people and ensure that the Sign Up to Safety message spread throughout this organisation. We achieved this through some quite innovative approaches including the Sign Up to Safety logo as a 'watermark' on agendas of key groups to serve as a reminder to people during these meetings that we had 'Signed Up to Safety' and to ensure discussions considered this.*

- *The Trust offered goodie bags to everyone making pledges as a little incentive to take time out of their already busy days to make a pledge. The pledges were also entered into a competition to win one of five £50 vouchers for the 'top 5' pledges.*

- *We had a bit of a 'eureka moment' during one of our planning meetings and decided to utilise the Trust's Health bus and take 'Sign Up to Safety On Tour'! We are a geographically diverse trust operating out of over 200 sites so our bus was a great way of reaching staff from across the organisation to share our message. We also found that as it was out of the*

ordinary, people's curiosity got the better of them and they would come over to see what was going on (parking right outside the canteen helped too!).

- *Seeing and feeling the enthusiasm that people have for our patients and to do a good job has been fantastic. Staff have been really engaged and genuinely want to contribute to our goal…together!*
- *I enjoyed taking part, [in the birthday] and it was lovely to see our photos up with other Trusts who were taking part at exactly the same time. It felt like we had virtual colleagues all working towards giving out the same message!*
- *Staff were consulted in November and December 2014 with regard to key objectives in patient safety through a formal survey. These results were matched with more qualitative outputs from the Trust locality fora in order to finalise key objectives and areas of interest. Our Patient Safety Committee signed off our local Safety Improvement Plan in December 2014.*
- *Our campaign is fully supported by our communications department who have been instrumental in publicising events, promoting banners and literature, both internally and externally across social media. We have a strong Twitter community within the Trust and have proactively used this resource to advertise our work under SU2S.*
- *What has been a real surprise as we have worked on this is the range of staff groups wanting to get involved and make a pledge. It has been really interesting; so we have pledges from catering staff, human resources staff, nurses, directors, occupational therapists, doctors, students, corporate affairs staff…quite literally every staff group possible!*

"*We can turn the NHS into the world's largest learning organisation - a big ambition for which there is a long way to go, but one really worth aiming for"*

"… we need to foster an inquisitive, curious and hungry learning culture. The world's fifth largest organisation needs to become the world's largest learning organisation"

Secretary of State for Health
16 July 2015

9 Sign up to Safety Second Year

9.0 Professor Berwick[iii] said the heart of safe care is a culture of learning. The campaign is deploying a number of different mechanisms including; learning events, webdives and webinars, focus groups and local networks to accelerate learning across the system.

9.2 In this second year of the campaign we will help organisations revisit and bring to life the five campaign pledges; put safety first, continually learn, be honest, collaborate and be supportive. Our programme to bring the pledges to life:

October; Put safety first – Committing to reduce avoidable harm in the NHS by half through taking a systematic approach to safety and making public locally developed goals, plans and progress. Instil a preoccupation with failure so that systems are designed to prevent error and avoidable harm

December; Continually learn – Reviewing incident reporting and investigation processes to make sure they are truly learning from them and using these lessons to make organisations more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe services are

February; Be honest – Being open and transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

April; Collaborate – Stepping up and actively collaborating with other organisations and teams; sharing work, ideas and learning to create a truly national approach to safety. Working together with others, to join forces and create partnerships that ensure a sustained approach to sharing and learning across the system

June; Be supportive – Be kind to 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 staff, reward and recognise their efforts and celebrate progress towards safer care

9.3 To help the NHS in England adopt a more systematic approach; over the course of the year we will persuade organisations and individuals to focus on the cross cutting contributory system and human factors that impact safety every day. This may mean that they end up stopping things that are simply not working. We will help people re(**think**) patient safety.

9.4 We will focus on creating a continuous learning culture which addresses our current failure to learn from incidents and investigations but also encourages organisations and individuals to share what they are learning from implementing change. We will do so through a number of different activities and events:

- We will be getting *beneath the surface* of why there is an implementation gap.

9.5 We will encourage people to keep sharing their work and stories in our e-newsletter, SignUPdate, so they reach frontline staff who are not actively engaged with the campaign directly.

9.6 We will share lessons and best practice via videos, frontline videos, webinars which focus on the pledges as well as the cross cutting themes and we will share a variety of blogs, podcasts, and polls so staff can get directly involved in our shared cause.

10 Evaluation

10.0 In terms of measurement and evaluation, the campaign is exploring the different mechanisms in which we may identify what difference is being made and progress without participants feel that they are being performance managed, inspected or in fact creating an additional and new reporting mechanism over and above existing reporting mechanisms.

10.1 With 95% of safety improvement plans completed we already have a baseline of activity and can use this to work with participants to identify progress and local activity related to reducing avoidable harm and saving lives.

10.2 The campaign will interrogate frontline board reports and quality accounts to track progress and work with a sample of sites that will provide us with data in which we can measure aspects of impact and outcome.

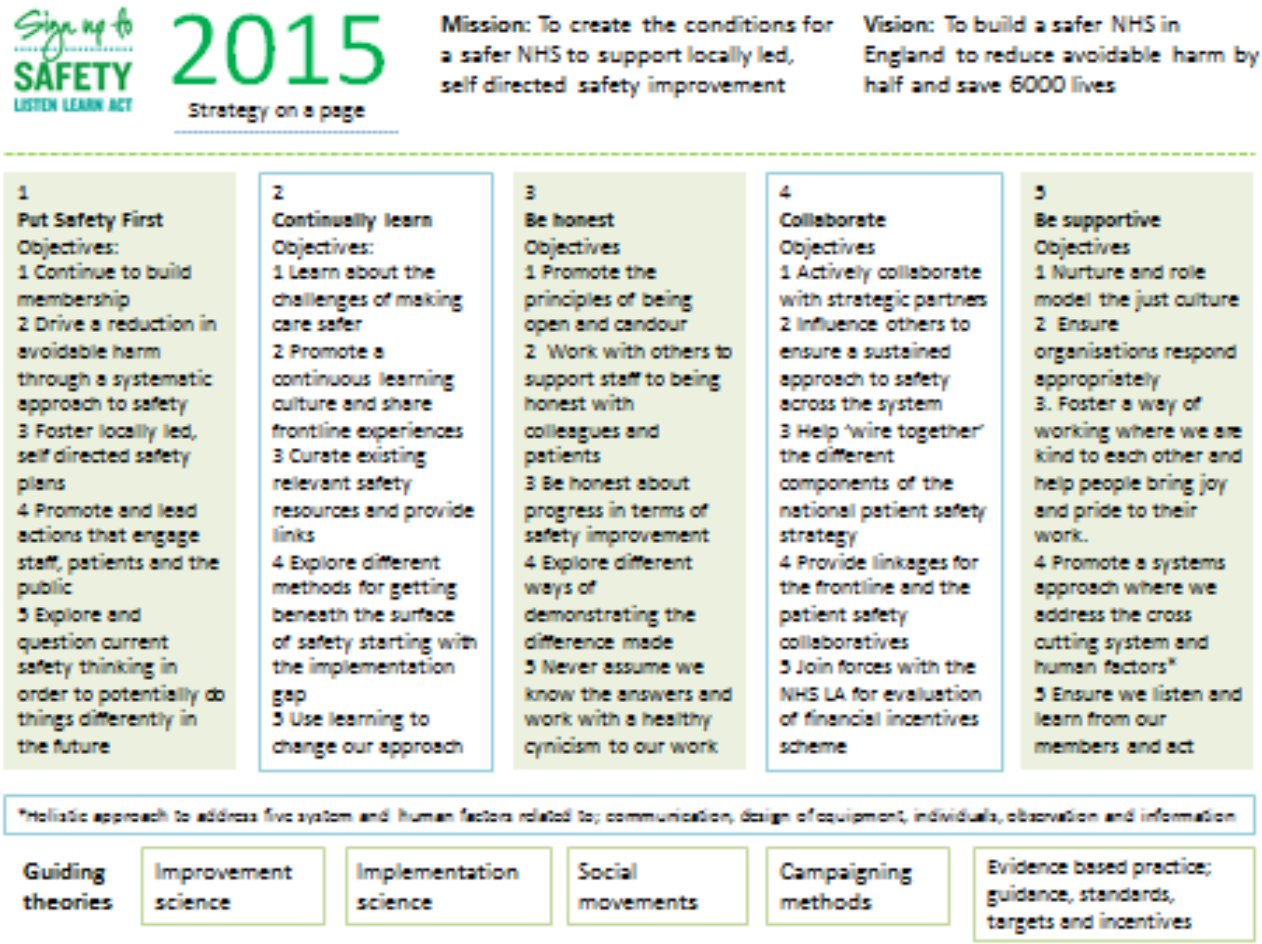
10.3 The campaign will commission the (new) measurement unit to identify data associated with a reduction in harm, lives saved and an increase in a safety culture.

10.4 We will identify ways in which we can detect qualitative results and any other changes but changes on this scale and in patient safety can take between 10 and 17 years (evidence by cultural research) – so any measurement or evaluation after just 3 years will be too early to identify impact on harm in the long term.

10.5 The campaign team will work with any new data systems currently at the design stage for measuring mortality and case note review and the King's Fund ratings on the overall quality of care provided to different patient groups in every local health economy.

10.6 The campaign will also work in partnership with the NHS LA which is undertaking a review of the sign up to safety incentive scheme

Annex A 2nd year strategy on a page



Annex B Staffing

Total campaign team = 5 WTE

Type of employment	Role title	Notes
Secondment	Campaign Director	indefinitely from NHS LA [not expected back by NHS LA – potential redundancy underwritten by DH] [NHSLA already filled role with permanent employee]
Secondment	Regional support	Seconded on a year by year basis from Nottingham University Hospitals NHS Trust – 7.5 hours
Independent contractor	Campaign Manager	– 5 days a week
Independent contractor	Communication Manager	– 4 days a week
Independent contractor	Executive Assistant	– 5 days a week
Independent contractor	Regional Lead	– 10 hours a week
Specialist support	2 posts	– providing hours as required (no more than 10 hours a week)

Employment Notes:

- No staff permanently employed by the campaign – either secondment or independent contractor
- All staff employed on a year by year basis – flexible contracts
- All work virtually, hot desking or working from home
- Hosting costs paid to NHS LA for finance, IT, HR and admin support as required
- Default option virtual meetings (webinar or teleconference) to keep travel costs and impact on environment down

Annex C Funding

Note: We were unable to use our first year monies effectively as they came in November 2014

Year	£k – total	Pay	Non-Pay
14/15 (4 mths)	879**	248	632
15/16	798	504	294
16/17	712	511	201
17/18 (3 mths)	358	169	189
Total	2,747		

** not all used – 548 actually used

References

[i] https://www.gov.uk/government/speeches/sign-up-to-safety-the-path-to-saving-6000-lives

[ii] https://www.gov.uk/government/speeches/making-healthcare-more-human-centred-and-not-system-centred

[iii] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf