Reporting to:	**Trust Board – March 2015**
Title	Organisational Sign up to Safety
Sponsoring Director	Sarah Bloomfield – Director of Nursing & Quality
Author(s)	Jo Banks – Associate Director of Patient Safety Samantha Carling – Patient Safety Team Manager
Previously considered by	Executive Directors, Quality & Safety Committee
Executive Summary	The purpose of this report is to inform the Board and seek agreement that the Trust signs up to the national initiative, Sign up to Safety. The initiative follows the Berwick review during 2013 of patient safety in the NHS and is part of a number of national programmes of work aimed at making the NHS safer. The 'Sign up to Safety' campaign is aimed at individuals and NHS organisations to sign up and pledge to deliver local initiatives to reduce harm that contribute to national safety objectives. It ambitiously aims to deliver harm free care for every patient, every time, everywhere and champions openness and honesty whilst supporting all Trusts to improve the safety of patients. The three year objective for the campaign is to reduce avoidable harm by 50% and save 6,000 lives across England. The Trust has made considerable progress on improving the safety of our patients and improving the openness culture across the organisation. The sign up to safety campaign will endorse the improvements to deliver the safest care for our patients within the Trust and local safety programmes will form part of a delivery plan that builds on the Trusts safety priorities. This report recommends to the Board that the Trust pledges and signs up to the safety campaign.
Strategic Priorities ☒ Quality and Safety ☐ Healthcare Standards ☐ People and Innovation ☐ Community and Partnership ☐ Financial Strength	**Operational Objectives** Reduce avoidable deaths by learning form Mortality reviews Improve clinical outcomes Reduce the level of harm Reduce HCAI
Board Assurance Framework (BAF) Risks	☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience ☒ If we do not implement our **falls** prevention strategy then patients may suffer serious injury ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☐ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve

	☐ If we are unable to resolve our (historic) shortfall in **liquidity** and the structural imbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	☒ Safe ☐ Effective ☐ Caring ☐ Responsive ☐ Well led
☐ **Receive** ☐ **Review** ☐ **Note** ☒ **Approve**	**Recommendation** The Board is asked to approve the organisation wide pledge to sign up to the national safety campaign.

1. Introduction

Sign up to Safety is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation and achieving it requires the Trust to pledge its support to a nationally recognised common purpose in order to give patients confidence that we take safety seriously; are doing all we can to ensure that the care they receive will be safe and effective at all times. Sign up to safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients with a 3 year objective to reduce avoidable harm by 50% and save 6,000 lives.

2. How do organisations sign up to safety?

2.1 Core Pledges:

Trusts and individuals who sign up to the campaign commit to setting out priorities that they will undertake in response to the following five pledges:

***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 their 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 progress.

2.2 Determining our priorities

Trusts are asked to develop a plan that describes what they will do to reduce harm and save lives, by working to reduce the causes of harm and take a preventative approach. They will be asked to identify two or more national patient safety priorities (Table 1 below) and two or more local priorities to focus on in their planning. As part of this work; engagement with local communities, patients and staff will ensure that the focus of plans reflect what is important to the population we serve. The Trust will be required to make the priorities public and routinely update on the progress against our plans. It is proposed that the priorities for the campaign align to the 5 pledges and will form part of the work being undertaken to develop our priorities for the Quality Account and revising the 5 year quality improvement strategy.

Table 1: National Patient Safety Priorities

Topic Area	Patient Safety Topic								
The 'Essentials'	Leadership				Measurement/Outcomes				
NHS Outcomes Framework improvement areas	Venous thrombo-embolism	Healthcare Associated Infections	Pressure Ulcers		Maternity	Medication Errors	Deterioration in Children		
Other major sources of severe harm	Falls	Handover and discharge	Nutrition and Hydration	Acute Kidney Injury	Missed and Delayed Diagnosis	Deteriorating patients	Medical Device Errors	Sepsis	
Vulnerable groups needing improved patient safety	People with Mental Health Needs	People with Learning Disabilities	Children		Offenders	Acutely ill older people	Transition between paediatric and adult care		

3. SaTH Safety plan

The Trust has been working on delivering improvements to patient safety which have been driven by a number of national and local factors. These include:

- Pressure ulcer prevention
- Reducing falls / severe harm from falls
- Reducing Medication errors
- Improving early recognition and survival of Sepsis
- Improving early recognition and survival of AKI
- Improve the interpretation of CTG monitoring in labour
- Reducing Harm from VTE
- Improving the management of acute abdomen pathway
- Standardising care
- Improving our safety culture through openness

There are a number of specific programmes of safety improvement plans that have been and continue to be developed which will become part of our safety improvement plan and sign up to safety campaign. Appendix 1 provides our strategic commitment to the 5 pledges aligned to the campaign that relate to the Trust priorities. This will be used as our pledge and will be made available on our Trust website.

4. Next Steps

Following agreement to the sign up to the safety pledge; it is proposed that the campaign priorities and objectives are developed and agreed to enable a launch across the organisation. The Board will be asked to approve the safety priorities and plan and receive quarterly updates on progress.

Appendix 1

	Sign up to Safety Pledge	Supporting Statements
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 measure accurately, report and publish our progress against key national and local quality and safety metrics; showing clear and measurable actions taken to address shortfalls in order to improve outcomes for our patients. We will support our staff across all our services to recognise that safety is a priority and to be vigilant to opportunities of improving safety through learning and improvement. We will report and publish data from the NHS Safety Thermometer as a contributory measure of avoidable harm to our patients within the Trust and as part of the local health economy wide harm prevention programmes. Where able, we will benchmark our harm data with other Trusts and organisations in order to understand and analyse thoroughly; any trends or themes that need restorative action. We will report to the Board; assurances and progress of how we are making our services safer and reducing harm within the Trust.
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 listen to and learn from patients, relatives and carers by responding proactively to their feedback and comments; changing our culture, practice and process where needed. We will monitor feedback to make sure that changes we have made have improved the safety of the services and enhanced patient outcomes as a result. In order to learn and improve, we will act promptly on patient feedback from multiple sources such as ward to board audits, patient experience surveys, external visits, peer reviews and complaints where safety issues have been raised. We will use feedback from external visits and inspections to learn and make changes in our practices. We will work with our patients, relatives, carers, patient experience and involvement panel members to ensure that we empower our patients to be involved in their own care.
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 adhere to expectations under the Duty of Candour Regulations when serious or moderate incidents occur and be open and transparent with patients and their families about how we will put things right where safety has been compromised. We will be open and honest with our patients, relatives and carers, our commissioners and regulating organisations about our progress in improving patient safety; including progress against internal and external safety performance indicators. We will support and encourage our staff to adopt the Trust values and engage in open and honest discussions about patient safety incidents through forums such as governance and senior clinical groups. Through our "Root Cause" processes we will be open with patients and relatives and share Trust wide and local learning following incidents where harm has been caused; thereby preventing future harm. We will utilise our annual Quality Account and be clear in our priorities for reducing harm and improving safety to provide the safest possible care to our patients.

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 work closely with other local health or care providers and commissioning organisations to share best practice and improvements in patient safety and harm reduction. We will contribute to local harm reduction local health economy forums and actively participate in any operational sub groups of the Project Board. We will proactively contribute to the West Midlands Quality Review Services where services are being reviewed to improve the quality of care in the patient's pathway.
5	Support - 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 use systematic and evidence based analysis to review our services in order to improve safety and create an environment that is supportive and constructive through learning and improvements. We will share best practice through governance and senior clinical forums and celebrate improvements through our Trust board and Chairman's awards processes. In order to ensure that harm is a priority and focus from the ward to the Board, we will put in place a regular programme of senior management, Board visits and walks to all services within the Trust; to exercise open and honest conversations directly with staff and the Board.