Royal National Orthopaedic Hospital NHS Trust

Patient Safety

Sign Up to Safety Campaign

The vision is for the whole of the NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. Sign up to safety has an ambition of halving avoidable harm in the NHS over the next three years with the aim of saving 6,000 lives as a result. This ambition is bigger than any individual or organisation and making it work requires us all to unite behind the common purpose.

What is Sign up to Safety?

Sign up to Safety is a new national patient safety campaign creating a system devoted to continuous learning and improvement.

Sign up to Safety requires NHS organisations to:

- Listen to patients, carers and staff
- Learn from what they say when things go wrong
- Take action to improve patient safety

What happens next?

We are invited to set out what our organisation will do to strengthen patient safety by:

Setting out the actions we will undertake in response to the five key pledges and agree to publish this on our website for staff, patients and the public to see.

Committing to turn our proposed actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.

Within our safety improvement plan we will be asked to identify the patient safety improvement areas we will focus on. We will be supported to identify two or more areas from a national menu of high priority issues and two or more from our own local priorities.

One of the first steps is for the Trust to develop a plan that describes what we will do to reduce harm and save lives.

The Trust's five core pledges are:

1. **Put safety first** - Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally. We will:

   Continue work to drive down:

   - Hospital acquired infections – C-difficle infections and avoidable MRSA cases
   - Reducing Surgical Site Infections
   - Avoidable falls resulting in moderate or severe harm
   - Avoidable hospital acquired pressure ulcers – continue to undertake Root Cause Analysis investigation into Grade 2,3 and 4 hospital acquired pressure ulcers

   Eliminate Never Events with improvements that:

   - Focus on 'human factors' such as listening, team briefings, checklists and techniques to communicate and escalate concerns
   - Share learning from incidents
   - Standardise practices with new systems and processes
   - Improve the team effectiveness and safety culture in the operating theatre by embedding the WHO Surgical Checklist
2. **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. We will:
   - Achieve a high level of reporting of errors, accidents and near misses as a measure of a good safety culture willing to learn and improve
   - Develop mechanisms and databases that provide assurance that learning has been embedded from actions derived from improvement plans
3. **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. We will:
   - Continue to implement the principle of ''Duty of Candour'' and work with staff to develop their communication skills. We will increase our achievement of openness and transparency by discussing incidents with the patient/patient family where moderate harm or higher has occurred
   - Introduce the use of Patient Stories at Trust Board and throughout the organisation
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:

- Improve engagement internally and externally with the public, patients and staff
- Improve communications and collaborative working between the Trust and local commissioning groups specially in relation to achieving CQUIN goals and collaboration in the handling of serious incidents

5. **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 will:
    - The development and evaluation of Schwartz rounds could be considered as well as exploring better ways of using debriefing and support through the SIRI process.
    - To implement quality improvement training programme for junior doctors, with awards for best safety improvement project led by junior doctors
    - Continue with service improvements that will allow staff to deliver quality, safe care. The organisation has already demonstrated this by investing in the nursing workforce in response to Francis2, making ward managers/senior sisters supervisory and re-establishing the link nurse roles.