Pledges, commitments and progress

What are our key areas of patient safety improvement we will be focusing on through Sign up to Safety?

We have identified the following areas:

- Pressure ulcers and falls
- Managing long term conditions (particularly diabetes) for people with severe and enduring mental health conditions
- Medication errors
- Safewards programme
- Supporting open and honest reporting

What do we hope to achieve by being part of Sign up to Safety?

- Continuous improvement in patient safety
- Continuous promotion of the safety message to patients and staff to remind and help protect them from avoidable harm with the added support and profile of a national campaign
- Communicate and demonstrate our open and transparent culture, reminding patients and staff that it’s OK to raise concerns
- Raise awareness and increase opportunities for patients and staff to provide feedback and create open lines of communication at all times
- Learn from peers and share best practice throughout the life of the campaign and beyond
- Build on existing partnerships with GPs; local authorities; voluntary sector and others

What do we see as the main challenges to improving patient safety?

- Striking a balance between campaigning without raising public concern
- Similar, past campaigns; initiative/campaign overload
- Potential perception of ‘more things to measure’
- Embedding the message that recognising and raising improvements where they could be made is encouraged; 'It’s OK to ask, raise concerns and challenge senior colleagues
- Skills and confidence of clinicians in Mental Health to tackle physical problems

**Why do we think it is important to be part of Sign up to Safety?**
- Protecting the safety of our patients and staff is a priority and one of our key values
- We welcome the opportunity to participate in a nationally supported campaign to further embed the ‘safety first’ message
- To create additional opportunities to further engage with patients around what keeps them safe

**What have we done to date to improve patient safety?**

**Improved and increased training:**
- Launched RCA master classes for staff who are investigating serious incidents
- Introduced e-learning for mental health staff on common physical health problems
- Physical health well-being training for mental health nurses

**Pressure Ulcer Prevention Campaign:**
- Provided staff with prevention knowledge by raising awareness through activities and discussion
- Utilised the PUPs Strategy to unify communication and learning

**Enhanced communication and reporting:**
- Quarterly Embedded Learning Events
- Introduced regular patient safety newsletter
- Significantly increased reporting of patient safety incidents
- Improved communication through regular Pharmacy newsletter
- Openly published carer, patient and public engagement feedback

**Medication Safety:**
- Introduced arm bands and staff tabards in intermediate care to signify patient allergies and reduce interruptions; achieving Gold award for innovation

**Safewards programme:**
- We are delivering the Safewards programme on seven wards
- We provide every ward with an introductory ‘calm down’ resource pack
Additional comments to Sign up to Safety?

- We see this campaign as an opportunity to build on existing work.
- We welcome the opportunity to lead the way in patient and staff safety, transparency and openness

The five pledges underpinning the campaign:

**Put safety first** - commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally

We will:

- Resource and support a community campaign to raise the profile and highlight the importance of patient safety
- Deliver internal campaign that keeps quality, patient safety, transparency and open lines of communication at the top of our agenda
- Publish goals and plans (patient safety improvement and implementation plan) through public facing channels
- Build practice improvements in mental health services with the long term conditions team
- continue to implement the remaining nine interventions and expand the Safewards programme across remaining wards
- Embed best practice to reduce restrictive intervention
- Utilise the Institute of Integrated Care to support research and best practice

**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

- Join the South London Patient Safety Collaborative
- Embed learning from incidents reporting and complaints through learning events and working groups
- Further develop checks and measures, to include trends and analysis of incidents
- Disseminate and promote best practice, learning from each of our key areas of focus
- All teams will utilise Reflective Practice
- Openly publish patient feedback and responses

**Share** - 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

- Promote and build on our open and honest culture, further develop staff training and safety communications
• Broaden the availability of ‘Being Open’ training
• Service directors will telephone complainants within 3 days of receiving a response to their complaint to check satisfaction levels
• We will publish lessons learnt from serious incidents
• Maximise patient engagement through research net
• Share outcomes and lessons learned from complaints with the Council of Governors

Collaborate - take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services patients use

• Participate in SE London Patient Safety Collaborative
• Nominate champions within service areas to regularly disseminate safety information across their service areas
• Develop our online resources for patient safety
• Link annual trust recognition awards to Annual Nursing Excellence Awards
• Continue to share learning and best practice with GPs, local authorities and other partners, maximising existing channels and relationships to embed and share learning

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

• Openly share examples of improvement experience; encourage the sharing and discussion of these cases at patient engagement groups and team meetings
• Share and embed the learning of the Clinical Patient Safety Lead
• Embed the use of Reflective Practice and publish examples
• Continue to promote and encourage the use of the dedicated staff support phone line Care first
• Ensure people receive supportive supervision and are able to access Continued Professional Development