Appendix 2

Sign up to SAFETY
LISTEN LEARN ACT

Our "Sign up to Safety" pledges

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:**

   - Work towards our stated Vision which is for Bristol, and our hospitals, to be among the best and safest places in the country to receive care;
   - Achieve the successful transition of the work of our existing patient safety improvement programmes into the work streams of the emerging national Patient Safety Collaborative programme;
   - Achieve year on year improvement in our NHS Safety Thermometer benchmarked position for the percentage of patients who are "harm free" and have no "new harms";
   - Review and improve our patient safety executive walk rounds to support the development of our safety culture and to act on safety concerns raised by staff, patients and visitors;
   - Work in partnership with patients in developing the Trust's safety agenda, for example in the design of information and processes to reduce harm, and also within the proactive patient safety improvement work of the West of England Patient Safety Collaborative.

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:**

   - Systematically review our arrangements for preventing never events and identify and implement any further risk reduction measures. We will prioritise our highest risk areas which will include surgical never events;
   - Review and strengthen our arrangements for learning from all serious incidents;
   - Continue to focus on encouraging incident reporting and systematic incident analysis and implementation of risk reduction actions;
   - Spread the breadth of our Safety Bulletins and review and strengthen our systems for sharing organisation wide learning;

- Complete our “Southwest STAR” project to test two innovations designed to improve patient safety in emergency care systems as part of Shine programme supported by The Health Foundation.

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:**

- Continually develop an open and transparent culture when things go wrong and a mind-set of seeking continuous improvement;

- Build on initial pilots of patient safety culture/climate assessments tools and implement a programme of patient safety culture/climate assessments across the organisation. Learning from these assessments will be used by local teams to develop their patient safety culture;

- Review our processes for working with patients and their families when things go wrong, i.e. ensure that patient safety incidents, complaints, mortality and morbidity reviews are joined up from the patient/family perspective and they have a key and clear point of contact.

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:**

- Initially continue to focus on existing patient safety improvement measures until such time as the strategic direction and the resources to support the work of the collaborative are established. These are aligned with the proposed national patient safety collaborative programme framework and our quality objectives;

- Work with our colleagues in the West of England Patient Safety Collaborative to engage and involve patients in the patient safety agenda and develop cross system working;

- As new safety thermometers are developed e.g. for medication, maternity and paediatrics, we will review how they can best be used within our Trust.

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:**

- Develop our culture so that staff, patients and their families feel able to raise concerns and report incidents about the safety of care being provided without fear of repercussions and in the knowledge that these will be investigated and acted on;

- Ensure support is there when staff need it if something goes wrong;

- Develop a human factors approach to patient safety updates over the next three years;

- Celebrate the successes of staff who have achieved patient safety improvements through our internal Patient Safety Champion annual staff award and beyond.