Healthcare Organization Commitment

Contact Details

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Position
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Organization Name
Sign Up To Safety

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Commitment Details

How many hospitals are represented in this commitment?

<table>
<thead>
<tr>
<th>Last Report</th>
<th>Current</th>
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<tbody>
<tr>
<td>419</td>
<td>419</td>
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Action Plan
Enage - aim of over 160 participant organisations and over 300 individual staff members (already over reached) Action - aim of over 100 safety improvement plans across the NHS in England (already over reached) Learn - aim to hold learning events to identify what works
and what doesn’t and share the learning in real time over the next year

**Commitment Update**
We have aligned our work with a number of our national programmes to learn from deaths and current harms that occur while in the care of the NHS and our strategy builds upon three elements: We seek to increase our understanding of what goes wrong in healthcare, We will enhance the capability and capacity of the NHS to improve safety, We will tackle the major underlying barriers to widespread safety improvement.

**Other**
Challenge 1 - Creating a Foundation for Safe and Reliable Care

Please describe any best practices your organization has learned through your commitment and share valuable lessons or challenges that were overcome.

We have continued to develop our National Reporting and Learning System which collects 1.8 million reports per year and have further enhanced the National Patient Safety Alerting System that has produced 43 national learning alerts in the last three years. We have developed a nationwide learning system by the establishment of 15 Regional Patient Safety Collaboratives covering our whole population of nearly 60 million people, based upon Academic Health Science Network footprints. We have established a programme to support and develop 5000 Patient Safety Improvement Fellows through the Q initiative working with The Health Foundation. We have developed and supported change programmes to reduce harm from VTE, Sepsis, Acute Kidney Injury, Falls and Pressure Ulcers. We launch in February a countrywide Maternal and Neonatal Health Improvement programme to reduce stillbirths and neonatal injury by 50%. We have started an Infection Improvement programme to reduce gram negative bloodstream infections by 50% by 2020, to improve Infection Prevention and Control implementation as well as improving Antimicrobial Stewardship in every setting including community and primary care. This year we are asking all hospitals to introduce a standardised method of structured mortality case record review in their institutions to identify deaths that may have been avoided. We are also asking all hospitals to publish their findings and discuss their improvement strategies. We have learnt that simply telling people what the problem is and disseminating a set of interventions does not lead to sustained change. Engagement, motivation and implementation are key areas that need continued focus. It is essential to align the values of all those trying to provide quality care in order to develop a sustained successful system. This is particularly the case between Boards of Hospitals, Operational Managers, all Clinical Staff and most importantly our patients and their families. Our style, our tone, our whole way of working and the commitment of Government and the public to support healthcare staff and the management of provider settings to sustain efforts to improve while this may often be seen to be slow in practice.

We have developed a respected expertise with our patients and their families and a reputation for reducing harm and improving outcomes particularly in VTE, Sepsis and Acute Kidney Injury. We have enabled and supported improvement strategies to be tested and put into place across all our Patient Safety Collaboratives and we will continue to increase our cohort of Patient Safety Improvement Fellows as we work to
our first goal of 5000.

Impact Details

<table>
<thead>
<tr>
<th>Initial Commitment</th>
<th>Commitment Update</th>
<th>Project Next Year</th>
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<tbody>
<tr>
<td>Lives Lost 0</td>
<td>Lives Lost 0</td>
<td>Lives Lost</td>
</tr>
<tr>
<td>Lives Spared Harm Target 0</td>
<td>Actual Lives Spared Harm in last 12 months 0</td>
<td>Lives Spared Harm Target for following calendar year 0</td>
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<tr>
<td>Lives Saved Target 0</td>
<td>Actual Lives Saved in last 12 months (might differ from initial target) 0</td>
<td>Projected Target of Lives Saved for following calendar to try to finish commitment 0</td>
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Acknowledgement
Yes, I acknowledge that this commitment may be used for external communication and publicly announced at the World Patient Safety, Science & Technology Summit. Furthermore, I agree that this commitment may appear on the website of The Patient Safety Movement Foundation or the Masimo Foundation. I also give permission for my commitment to be used in support of the promotion of the World Patient Safety, Science & Technology Summit as well as The Patient Safety Movement initiative.