

Commission on Education and Training for Patient Safety

Progress report



Developing people
for health and
healthcare

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Executive summary

Since the publication of the Commission on Education and Training for Patient Safety report in March 2016, Health Education England (HEE) has worked in collaboration with system partners and providers to introduce and embed the work of the Commission and suite of evidence-based recommendations for improving the education and training of health professionals to deliver safe, dignified, compassionate, person centred care.



This progress report sets out the substantive achievements in delivering the work and recommendations of the Commission, in line with the Education and Training Interventions to Improve Patient Safety Implementation Plan 2016 – 2018.

The milestones achieved include:

- Continuing the integral partnership working with our Arms-Length Bodies (ALBs) and system partners to ensure national alignment in the objective to ensure high quality patient safety training and safer patient care.
- The inaugural **HEE Transforming Education and Training Conference** demonstrating the impact of high quality education and training on the delivery of patient-centred care and better outcomes for patients.
- Work across the HEE regions to embed good practice in education and training with some of the most impactful projects

covering human factors and culture, out of hospital care, the quality of the learning environment and simulation.

- Publication of the multi-professional **HEE Quality Framework** recognising the significant impact that excellent educational leadership and the culture within an organisation has on the experience and outcomes of learners, and the experience and empowerment of patients as partners in their care

The Department of Health's mandate to HEE for 2016-17 describes HEE's continued system leadership role across the NHS to embed patient safety, knowledge and skills at all stages and levels of education, training and professional development.

“The NHS cannot expect to achieve improvements in patient safety if it is not embedded within education and training and if we cannot safely allow staff the time away from the workplace to undergo training”

Over the coming year, we will continue to work in collaboration with system partners and providers to implement the Commission recommendations to deliver significant benefits to patients through improvements to education and training of the healthcare workforce to deliver high quality, safe and compassionate care.

Introduction

1. The Commission on Education and Training for Patient Safety report¹ was the first of its kind to focus on the impact of education and training interventions for healthcare staff and how these can actively improve the safety of patients in the NHS. As a result, Health Education England (HEE) has and will continue to change the way education and training are delivered for our workforce. These changes will not only ensure the highest quality clinical learning environments but also address the need to improve behaviour and culture.
2. In January 2017, HEE published the implementation plan² which sets out the strategy to deliver on the Commission's 12 recommendations (Annex A). This plan, 'Education and Training Interventions for Patient Safety' has laid the foundation for delivery over the next two years and enables HEE to highlight what has been achieved so far in the 12 months since publication and shapes the next steps for the implementation period.
3. This Progress Report follows the implementation plan by providing a snapshot of activity and delivery in the one year since the Commission report was published in March 2016. The report focuses on the following areas of progress:
 - Implementation plan development and delivery
 - Case studies demonstrating the wealth and impact of good practice across the country
 - Strategic alignment with Arms-Length Bodies and system partners
 - Internal change
 - External influence
 - The integration of patient safety and quality

Methodology

4. Since the Commission report was published in March 2016, HEE has continued system-wide stakeholder engagement to test out and frame the implementation plan in the following ways:
 - **Mapping exercise** across HEE to capture examples of good practice in education and training that are already delivering the context of the recommendations, to establish where these can and should be spread and adopted across England.
 - **Stakeholder Workshop** in July 2016 to review the mapping, discuss the implementation approach and how HEE should work across the healthcare system to implement the recommendations.
 - **Arms Length Bodies (ALBs) and system partners Roundtable** in November 2016 to bring key system leaders together to share the thinking of the implementation plan and ensure ongoing engagement and alignment. The core outcomes of this meeting were as follows:
 - i) Consensus to ongoing alignment and joined up working in the implementation of the recommendations as well as identifying the appropriate levers in the system.
 - ii) Recognition that there is a significant body of evidence, which demonstrates improvements in patient safety at local level through educational interventions.

¹ <https://hee.nhs.uk/sites/default/files/documents/FULL%20report%20medium%20res%20for%20web.pdf>

² https://www.hee.nhs.uk/sites/default/files/documents/Education%20and%20Training%20Interventions%20to%20improve%20Patient%20Safety_v3_0.pdf

Commission on Education and Training for Patient Safety: One year on progress report

- iii) Agreement that strategic alignment across the ALBs and system partners is imperative to achieve the desired impact for quality and patient safety. The current review of the Quality Surveillance Groups (QSGs), which HEE is involved in, will support this work.
5. HEE will continue to work with its partners in the delivery of the recommendations and in addressing emerging needs and issues relating to the quality and patient safety agendas. This, combined with HEE's regional leadership of the implementation plan will enable high quality education and training, improvements in behaviour and culture and ultimately the best safety outcomes for patients.

Governance

6. The patient safety programme of work reports to its Programme Board, which was set up following the publication of the Commission. It is an essential forum to ensure accountabilities are in place and to help guarantee integration and interface with other key programmes of work. The membership of this group has now grown to include senior leads from the HEE regions who have a leadership role in taking the implementation forward.

Regional leadership for implementation

7. In HEE's response to the Commission's report, one of our commitments is to *'state from the outset that HEE will provide a leadership role in taking forward all 12 recommendations working in partnership with key organisations across all levels in the system.'*
8. To do this we have identified senior leadership through the regions who will work across HEE, supported by the national team, to lead and oversee the continued delivery of the recommendations. The recommendations have been grouped together into four workstreams with regional leadership assigned as shown in the table below:

Workstream (and recommendations)	Lead Region	Regional Lead
Workstream 1: Learning and Training Environments (Recommendations 1, 4, 6, 10)	North	David Wilkinson, Postgraduate Dean, HEE working across Yorkshire and Humber
Workstream 2: Human Factors and Culture (Recommendations 2, 5, 11, 12)	Midlands and East	Dr Chetna Modi, Head of Research, HEE working across the East Midlands
	London and South East	Tracey Jenkins, Head of Office, HEE working across London and the South East
Workstream 3:	South	Pauline Brown, Local Director, HEE working across Thames Valley

Embedding Existing Training Initiatives (Recommendations 7,8)		
Workstream 4: Supporting Joined Up Care (Recommendation 9)	South	Pauline Brown, Local Director, HEE working across Thames Valley

- The regional leads will ensure consistency of approach where this makes sense, but enable local solutions where bespoke approaches are needed in line with emerging models of care. This engagement will also enable HEE to provide the leadership close to where training for patient safety needs to be enabled – with providers and students within the service and training environment.
- The leads will create a ‘Community of Practice’ across HEE, bringing in the expertise of wider partners such as Academic Health Science Networks and their Patient Safety Collaboratives, NHS Improvement, HEIs and Providers, where this adds value, to identify, spread and adopt innovation and evidence based training interventions for patient safety. Some of the best practice initiatives identified through the mapping exercise and through the implementation period will then be positioned across HEE as good practice for national spread and adoption.
- To support the leadership and delivery at regional level, we have also approached Commission members with the objective to identify four people to act as ‘experts’ for each workstream and to provide integral advice on the initiatives that should be put forward for national spread and adoption.

HEE’s transformation offer - the STAR

- One of the vehicles HEE will use to help inform the knowledge of good practice and to help the regional leads create a ‘community of practice’ is ‘HEE’s Transformation Offer’ – the STAR (Fig.1).
- This is essentially a menu of products to support workforce transformation, mapped to the triple aims of the Five Year Forward View (FYFV). It includes material of common interest relevant to workforce transformation and system leadership activities across HEE, and so acts as a knowledge repository for the benefit of all staff.
- The content of the STAR is curated by the leads for each of its domains through a process which is dependent on HEE and the NHS Leadership Academy colleagues sharing material of relevance.

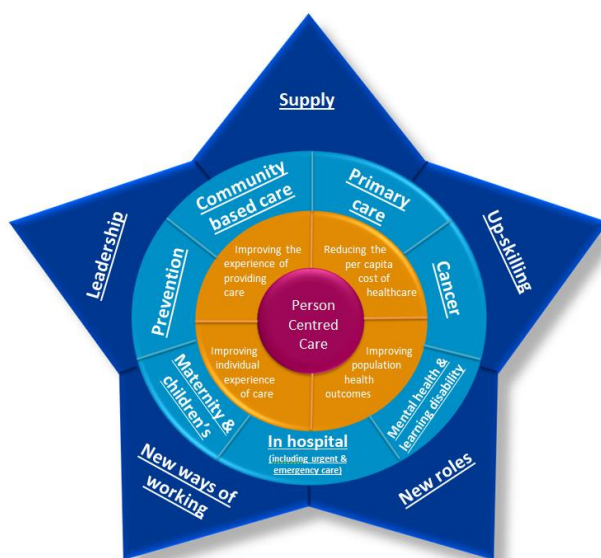


Figure 1: Health Education England’s Transformation Offer

15. The STAR is managed by Transformation Delivery Group (TDG), which includes representatives from across HEE. A number of the TDG's core aims is to facilitate the delivery of transformational activity and products to support Sustainability and Transformation Plans (STPs), provide an engagement and support network for staff delivering transformation activity, embed transformational activity into business as usual and build a national picture of transformation from local priorities.
16. This will be an integral resource to enable delivery of the implementation plan and the recommendations, enabling national spread and adoption of interventions identified for roll out across the NHS.

Delivery of the Commission's recommendations

17. Through the case studies from the Commission report and the subsequent mapping exercise of all the education and training activities happening across HEE, it is already evident that significant progress has been made in delivering on the 12 recommendations.
18. The case studies that have been selected for this report from the four HEE regions are just a few of the outstanding examples of education and training projects that are underway and demonstrating, through the outcomes, the major impact on quality and patient safety.
19. Whilst Annex B provides an example of the single interventions meeting the requirements of each recommendation, the case studies below give a cross section of the delivery for each of the workstreams looking specifically at the core issues of out of hospital care, human factors and culture, simulation and the quality of the learning environment.
20. These are examples of the interventions that will be considered for national spread and adoption, reinforcing the need to develop and drive forward a 'community of practice' across HEE and wider.



Case studies

HEE working across the South

Improving the care of frail older patients in colorectal surgery at RBCH, HEE working across the Wessex, Edward Hewertson

The aim of the project

To improve the care of elderly colorectal patients, leading to a reduction in length of stay by 10% without increasing readmissions or mortality, within six months at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.

What we did / The role of education and training

An initial detailed assessment of the current care for the older patients in colorectal surgery demonstrated that improvements were needed with the multidisciplinary team working, input from Older Persons Medicine specialists and delirium management. We tested interventions to ensure these areas were addressed and that the medical and social issues of frail, older patients were recognised and well managed.

Semi-structured interviews were conducted with staff from across the MDT which ensured all staff were aware of the project from the beginning; they were involved in setting the aim and the decision making process. Responses were graded on a Likert scale to identify the areas each staff member thought needed most improvement; **Availability of OPM input, MDT working and delirium management were identified as the main drivers for change.** The MDT members developed strategies with specific actions to improve these areas (captured in a driver diagram). They were tested with iterative PDSA cycles to ensure the changes lead to an improvement.

Impact and outcomes on patient safety

Over a six-month intervention period the project demonstrated a **23% reduction in the length of stay of non-elective colorectal patients over the age of 70 without significant change in readmissions or mortality.**

Outcome Measure - Length of stay - There was a significant reduction in the intervention group, 7.4 days to 5.7 days, a **23% reduction**. The Statistical Process Control (SPC) chart showed 3 runs of 7 below the previous mean level. In the intervention period only 4 patients stayed more than 12 days (7.7%) compared to 19 pre-intervention (15.6%).

Balancing Measures - Readmissions - 7.4% (9 of 122) pre-intervention and 3.8% (2 of 52) post-intervention. Mortality - 5.7% (7 of 122) pre-intervention and 7.7% (4 of 52) post intervention. There are low numbers of deaths in both groups and this is not felt to be a significant change related to the interventions.

The interventions within the system remain in place including the MDT meeting and structure of the therapy team. **From this project a business case has been agreed for a full time OPM specialist registrar. There is also agreement to recruit an OPM nurse practitioner and a consultant in the future.**

Enhancing the quality of placement experiences and patient care through a multi-professional Urgent Concerns Review, HEE working across the South West, Professor V Heath and Dr J Francis

The aim of the project

To work as a multi-professional team in reviewing a placement setting with the aim to take action, report and escalate concerns, as appropriate, to all applicable stakeholders.

What we did / The role of education and training

As part of a routine annual quality assessment of training, foundation doctors raised concerns about the educational environment and the safety of patients on one ward in a psychiatric hospital. Concerns regarding patient safety focused on lack of medical supervision and perceived inadequate staffing levels. This resulted in an urgent meeting with the foundation doctors leading to a multi-professional review.

- A review of the quality of the whole clinical and educational environment.
- Included Lay representation and a ward visit which enabled public and patient involvement.
- Determined *one review* involving all learners with input from Lay Reps and patients was a powerful tool in reviewing the culture of the whole multi-professional environment.
- Received assurance that routine quality processes detect and report multi-professional concerns.
- Amalgamated findings from medical and nursing perspectives and fed back to the Trust. One joint action report was provided.
- Communicated immediately to the Higher Education Institution that placed student nurses in this setting the Trusts ongoing challenges in terms of nursing workforce.
- Shared intelligence for monitoring, progression and enhancement. This included the provision of a report to the next Quality Surveillance Group.
- This resulted in an unannounced visit from the CQC and the application of special measures.
- Learned as a newly designed multidisciplinary team that visits that talk to a range of professions and include clinical based visits have enhanced patient and learner outcomes.

Impact and outcomes on patient safety

Patient Safety is *likely* to have improved as a result of the HEE's Urgent Concerns Review Report highlighting:

- **The inappropriate numbers and skills associated with a lack of permanent nursing workforce.**
- **The need to interrupt student nurse attendance at this placement where less than best practice was on display.**
- **The need for enhanced learning opportunities for Foundation doctors**
- **Poor practice resultant in a CQC unannounced visit and subsequent surveillance placing the spotlight on the area.**
- **The need for ongoing monitoring by all stakeholders.**

We can measure or evidence this improvement through:

- Participation in the Quality Surveillance Group and other stakeholder activity.
- Continued learner experience and student evaluation.

Developing a Regional System for External Review of Serious Safety Incidents, HEE working across Thames Valley, Patient Safety Academy

The aims of the project

1. To provide expert objective external analysis for a selected group of safety incidents, to assist Trusts in fulfilling their clinical governance responsibilities for controversial, complex or sensitive incidents.
2. To model the use of a Human Factors based, system-focused investigation methodology designed to produce useful recommendations on system change rather than focusing on individual responsibility, with the intention that the model will influence the protocols and conduct of internal investigations at the Trusts involved.
3. To provide a standardised approach within the region in order to ensure that the quality of clinical governance is developed to an equivalent high standard in all involved Trusts.

What we did / The role of education and training

In order to ensure that patient safety incidents drive sustainable improvements, we proposed to **develop a system for the exchange of senior investigators with in-depth Human-Factors based training in incident investigation between Trusts in the Thames Valley region.**

The Patient Safety Academy (PSA) proposed an initial communications and engagement initiative to explain the project to Medical Directors and seek to engage them and use their feedback to improve the project. This would be followed, once agreement to participate was obtained from all Trusts, by a training programme for senior staff identified by Trusts, to equip them to undertake the investigation tasks. Once investigators from all Trusts were trained, a low-volume pilot programme would be conducted for a year, investigating two incidents from each Trust. After a thorough evaluation of this pilot, the PSA would consult with Trusts about whether they wished to expand the programme and resource it for sustainability in the long term.

Through informal meetings at national events our programme has come to the attention of the leadership of the new Healthcare Safety Investigations Branch (HSIB), which has been charged with setting up a national system for serious incident investigation. We have had very positive meetings with senior representatives of HSIB and have been asked for assistance in their work to devise a strategy for engagement between their central team and those investigating safety regionally and locally.

Impact and outcomes on patient safety

The process of development has provided some important learning for the PSA around the general principles of developing this kind of co-operation on safety between independent NHS entities:

- **Structural and environmental influences on NHS organisations are not necessarily conducive to the openness and sharing of information and learning which is essential for co-operative improvement of safety standards.**

- Hesitancy about engagement can be overcome by patient discussion and addressing of practical concerns: there is a strong “domino effect” which encourages alignment once two of three organisations have agreed to come together.
- Indemnity and Data Protection issues are potential barriers to this kind of activity but can be overcome by developing appropriate Memoranda of Understanding
- Investigators need to have sufficient seniority and training to command respect in Trusts they visit: Mentoring by Human Factors experts is essential initially. It is not yet clear whether this needs to be continued beyond the first couple of investigations for each individual.
- External investigation from the start is not feasible with the resources and regulatory apparatus currently in place. Initial data collection and preliminary analysis by the internal Trust team is preferable on the grounds of logistics and stress for involved staff.
- Early and frequent interaction with the external team is however desirable. The point at which external Human Factors analysis is best conducted is an important question which needs to be resolved via the pilot programme.
- The costs of the programme are very reasonable in relation to the potential safety benefits, comprising the costs of the training programme, mentoring and logistics, report writing and travel. It is proposed that in future the Trusts should take joint responsibility for these costs if the Pilot programme is accepted as showing the value of continuing with the system.



HEE working across the North

Peripatetic Clinical Skills Training in Care Homes, HEE working across Yorkshire and the Humber, Kay Ford

The aim of the project

Deliver clinical procedures training to care home staff to prevent unnecessary demands on NHS services and enable the care homes staff to provide the right care at the right time by competent care staff.

What we did / The role of education and training

In Yorkshire and the Humber there are approximately 1,654 care homes, with 485 providing care with Nursing and, 1169 providing care that is non nursing. In total they provide 49,473 care beds. In addition there are 654 home care agencies which provide domiciliary care to people in their own homes, 7.9% of domiciliary care is provided by local authority and 92.1% provided by independent providers on behalf of local authorities. It is anticipated that with changing demographics the demand for these services will only increase. It is therefore essential that care home staff are competent to carry out procedures where and when the residents need the care. If the care home staff are not trained or up to date to be able provide an element of care, for example a urinary catheter change, the resident will have to access NHS services, usually the emergency department. By training the care home workforce in these skills it was anticipated that there would be less reliance on some NHS services and improve the care and safety of residents.

The 2 year project covering North Yorkshire, trained over 900 registered and unregistered care home staff in a range of clinical skills including:

- Venepuncture
- Catheterisation
- Catheter care and management
- Baseline clinical observations
- Fundamentals of care / developing care in practice
- Tracheostomy care
- Parental nutritional care
- Pressure area prevention and skin care

Delivering the training within the homes ensured attendance, supported staff release and enabled larger numbers to attend. This could change the culture for learning. The trainer also provided support post training for staff to gain confidence and competence in these skills using a competency assessment tool.

Training packages were developed that was specifically for this care environment and were delivered using simulated methodologies.

Impact and outcomes on patient safety

- **Care home staff had less reliance on NHS services including A&E, District nurses and community matrons**

- Staff used their skills to provide prompt care rather than having to wait for another health professional to carry out the care
- Staff were able to recognise and escalate problems earlier and seek appropriate advice and help
- Confidence and competency, skills and knowledge improved
- Pre and post training competency assessment was carried out
- This work has been evidenced and evaluated through independent researchers at Leeds Beckett University.

As a result of this work we are currently delivering a project to train Registered Nurses working in nursing homes to become clinical skills facilitators. This new work will enable the homes to become more self-sufficient by developing their own trainers.

There are currently 2 pilot sites in Airedale / Bradford and Wakefield. The project is just underway and will run throughout 2017. This has been well received by CCGs, local authorities and the homes.

Recognising and Assessing Medical Problems in Psychiatric Settings, HEE working across Yorkshire and the Humber, Paul Rowlands, Mike Akroyd, Gary Jordan, Zead Said, Paul McCormick and Tracy Latham

The aim of the project

Patients in psychiatry setting have both physical and psychological health needs. This project was developed to create a multi-disciplinary simulation course around real life incidents to encourage teams to consider the ways that a mental health problem can complicate recognition of a physical problem.

What we did / The role of education and training

RAMPPS stands for Recognising and Assessing Medical Problems in psychiatric Settings. It is a simulation course aimed at supporting a multidisciplinary team to engage with patients on a psychological level that also addresses the physical health needs of the patient.

By using realistic scenarios based around real life incidents, we hope to encourage teams to consider the ways that a mental health problem can complicate recognition of a physical problem. We also hope to increase the confidence of individuals and teams in communicating clearly around these issues.

RAMPPS consists of scenarios which can be used flexibly in a range of situations and areas. Most scenarios allow flexibility in the use of manikins or simulated patients, and the flexibility provided allows local needs to be addressed.

All the RAMPPS scenarios are generated with the multi-disciplinary team in mind, typically consisting of a doctor, a nurse and a health care assistant. In reality, many members of a team will work to care for a patient who is unwell in a mental health setting. RAMPPS is explicitly a multi-disciplinary course with emphasis on team working, communication, mutual respect and collaborative integration of care.

RAMPPS also has an e-Learning package, aimed to give delegates attending the chance to review some of the key principles such as AVPU, the ABCDE approach, SBARD (Situation, Background, Assessment, Recommendation and Decision) and the basics of simulation teaching with an introduction to RAMPPS.

Impact and outcomes on patient safety

RAMPPS – The patient safety agenda:

- **Recognising the deteriorating patient**
- **Embedding patient safety tools e.g. ABCDE**
- **Using a standardised communication tool SBARD**
- **Understanding human factors**
- **Multi professional learning and role appreciation**
- **Reflection and formative learning to transfer to practice**
- **Experiential learning from serious incidents**

In total over 350 multi professional staff have been trained. Analysis from pre and post course questionnaires show significant improvement in:

- **Confidence in dealing with medical emergencies**
- **Care and compassion**
- **Organisational aspects of care**
- **Medicine management**
- **Effective team work**

HEE working across the Midlands and East

Adopting a Human Factors approach to the analysis of reported patient safety incidents in the handover and discharge processes, HEE working across the East Midlands, Evi Carmen and Bill Brown

The aim of the project

The project was aimed at adopting a Human Factors approach to the analysis of reported incidents where patient safety is compromised as a result of handover or the discharge process, the main focus of the project was to analyse the discharge process from a Human Factors perspective.

What we did / The role of education and training

HEE working across the East Midlands has funded a Bespoke project to address key safety concerns in Handovers in the Community. Across Nottinghamshire County 419 unsafe discharges were reported in the final quarter of 2014. This included discharges without reference to community services, adequate medicines management information and ensuring appropriate equipment being in situ.

Breakdown of communication involving handovers is one of the leading causes of 'sentinel events' (WHO 'High 5' patient safety initiative). A joint project team Nottingham Community Partnerships Trust and Human Factors expertise from Loughborough University have explored the Human Factors aspects of communication at handover.

Working with both pre-discharge teams in an acute hospital and conducting post discharge analysis with community staff, the team identified key influencing factors that play a role in the delay of discharge process. As well as aspects that can fail, elements that work well and promote safety during the discharge process were captured.

Impact and outcomes on patient safety

The results provide a model for handover of care and the discharge process. **This allows a better understanding of the system regarding transfer of care and patient discharge for both community and a hospital- perspective.**

The next step is to work closely with Stakeholders and frontline staff to develop informed solutions to improve safety, efficacy and efficiency to the care process. The aim is to reduce patient safety incidents and improve the capability to foresee the potential for future harm.

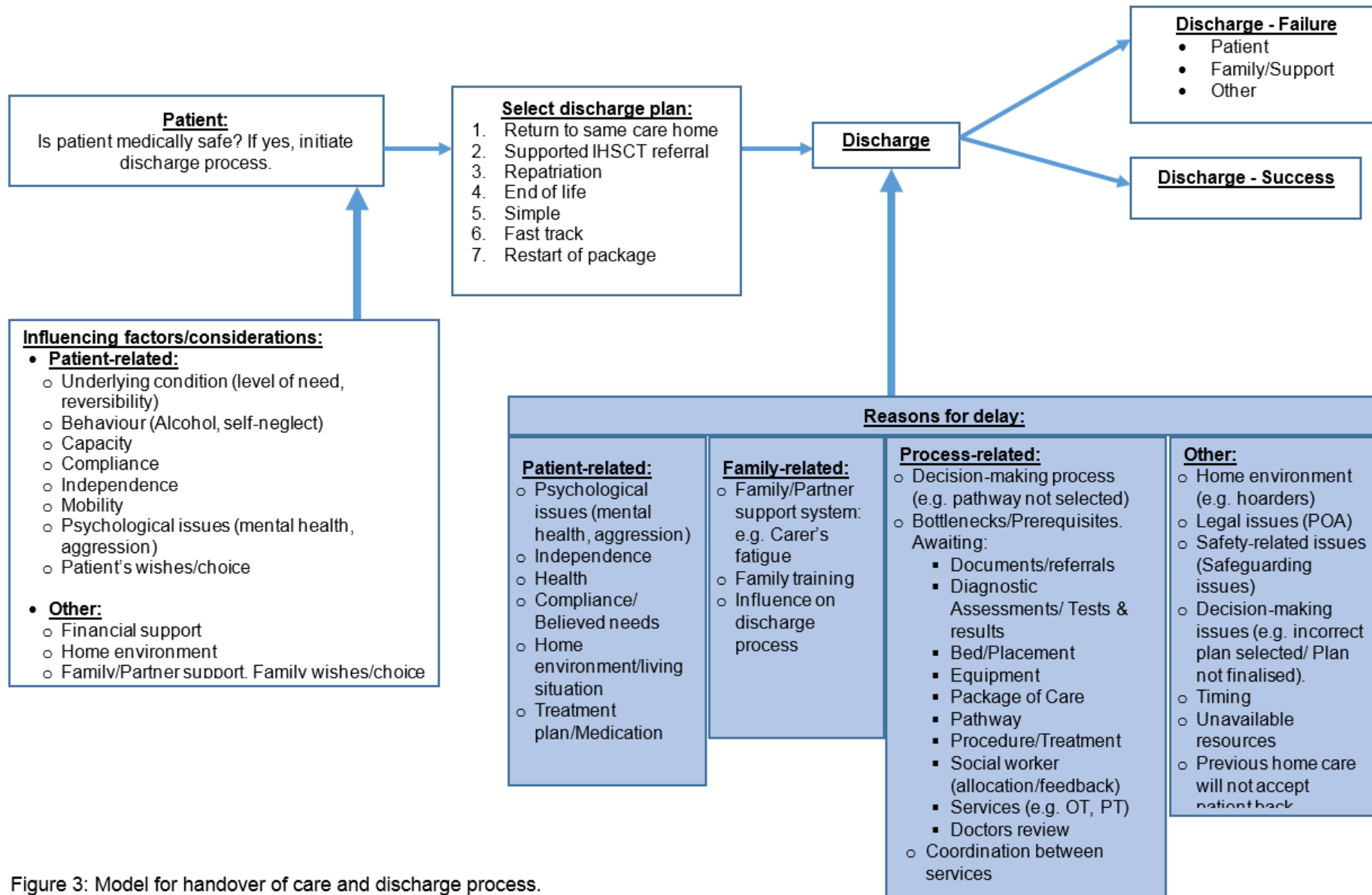


Figure 3: Model for handover of care and discharge process.

**Human Factors Exchange,
HEE working across the East Midlands, Dr Chetna Modi, Oliver Sloman and Waseem Shahzad**

The aims of the project

1. **Creating a knowledge base and raising awareness of Human Factors in Healthcare**
2. **Develop a career pathway for Human Factors Professionals in healthcare**
3. **Create a sustainable pool of expertise capable of implementing Human Factors based solutions to critical patient safety issues, resulting in improved patient outcomes.**

What we did / the role of education and training

HEE working across the East Midlands has been working closely with NHS Trusts, leading Universities, the Patient safety Collaborative at the AHSN, the Health and Safety Laboratory and professional bodies, within the region through the Human Factors Exchange.

We recognise that the route to sustained benefits of Human Factors is to build capability and develop a cadre of NHS staff with Human Factors skills. An Education and Training Pathway approach has been adopted providing opportunities for all NHS staff to develop professional competencies from Awareness – to-Expert in Human Factors.

In 2016, the Human Factors Awareness Roadshows reached some 200 NHS staff across the region. The programme supported an increased understanding and awareness in HF for Healthcare Professionals at all levels. It also brought together staff from multi-disciplines in both acute and community care.

Impact and outcomes on patient safety

A total of 16 workshops were delivered across the East Midlands in collaboration with Loughborough University and University of Nottingham. Below is a breakdown of attendees.

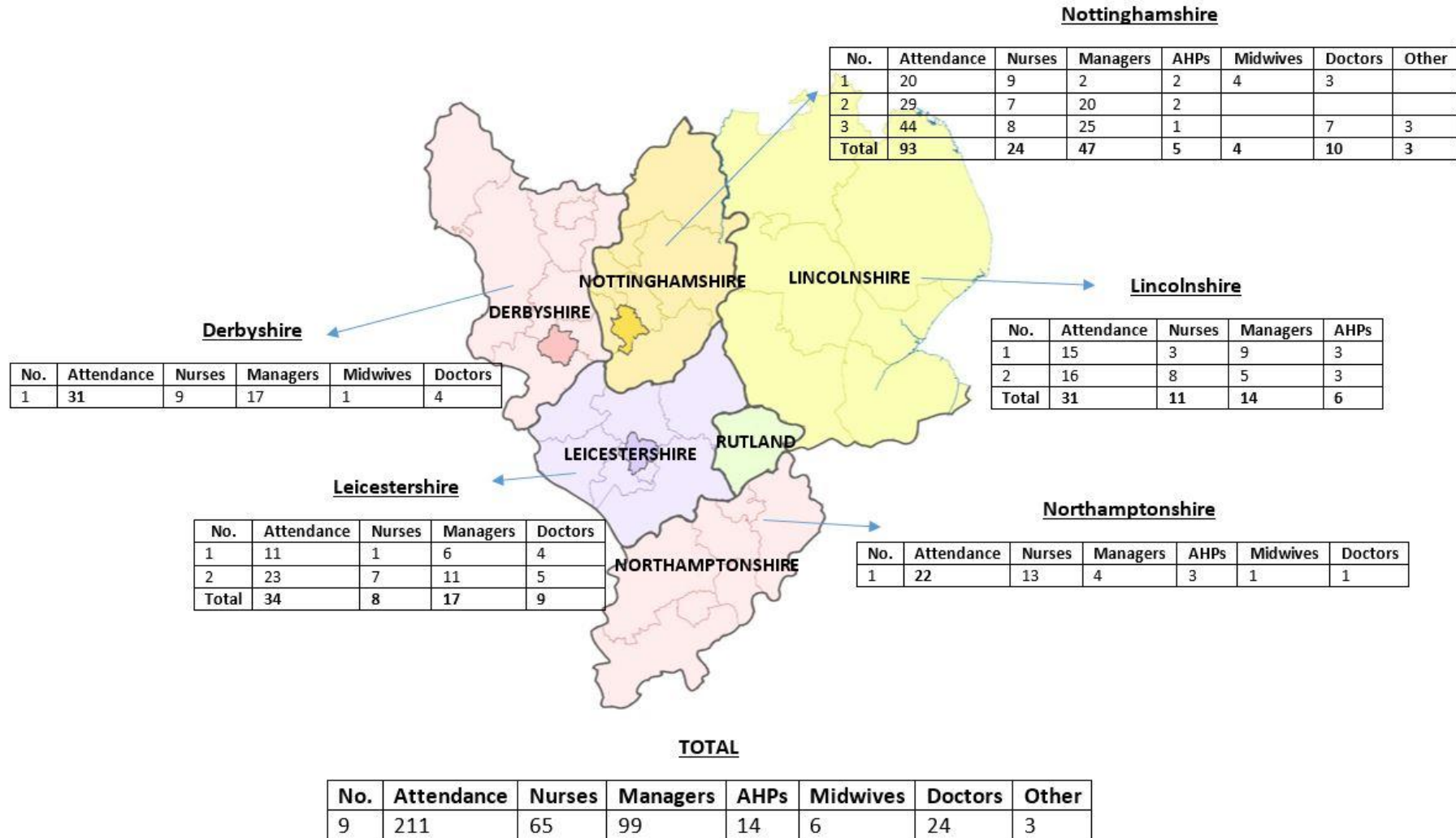
Attendance	Nurses	Managers	AHPs	Midwives	Doctors	Others
211	65	99	14	6	24	3

Ensuring a consistent approach to both education and application of Human Factors is a high priority. The HF Exchange has inputs from the CIEHF professional body and universities renowned for delivering excellence. This has enabled an accredited PG Cert programme with funded placements for 10 PG Certs in Human Factors due to complete in 2017/18. There is also the opportunity to progress to PhD through the regional Clinical Academic Careers programme and the NIHR/HEE Integrated Clinical Academic programme.

With an emphasis on taking education to application in practice, the **newly qualified staff will help further raising awareness in their own trust, whether through improved delivery of the NHS applied projects or high quality clinical skills and simulation training in Trusts.**

□

Roadshow Taster Workshops in Human Factors



Antimicrobial Resistance and Sepsis

21. HEE is also addressing the issue of patient safety through its work on antimicrobial resistance and sepsis and the system's reaction to these as major safety issues. HEE is a key stakeholder in the implementation of the Government's 5 year strategy to tackle AMR (published in 2013) and has lead in the investigation of the education and training resources that are currently available to support the recognition and management of sepsis.
22. This work and the learning resources that have been and continue to be developed support the implementation plan through the case studies of activity for these two major areas that impact patient safety.

Patient safety at the heart of HEE's quality agenda

23. The delivery of excellent education and training programmes for students and learners will help to create a future workforce that can provide high quality care for patients in a safe environment. Focussing HEE's quality strategy on the quality of the clinical training environment, will allow HEE to influence both future healthcare workers and those already within the system.

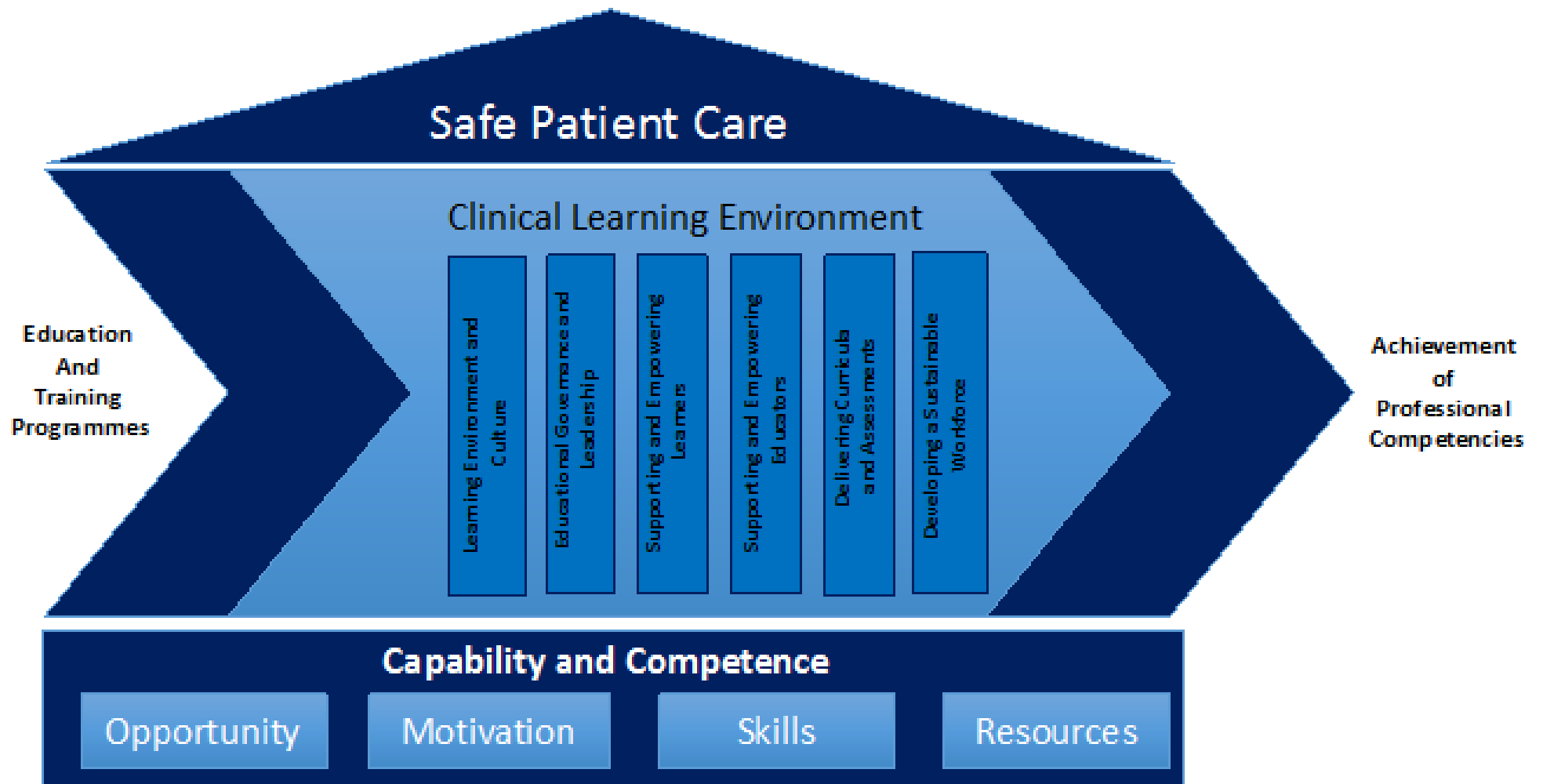


Figure 2: Translating high quality education into safe patient care

24. Education and training can break down some of the barriers to providing safe care, creating an environment where staff learn from error, patients are at the centre of care and treated with openness and honesty, and where healthcare staff, including those in training, work with patients collaboratively to understand how to raise patient safety standards.
25. It is why HEE developed a Quality Framework³ that focusses entirely on the quality of the clinical training environment and enables a broad multi-professional lens through which HEE can evaluate – identify, measure and improve – education and training.
26. The Framework is based on six domains that reflect the key characteristics of quality in clinical placements for all professional groups. Each domain is supported by a set of evidence-based Quality Standards that learning environments will be expected to demonstrate. Each domain has a small set of metrics that will act as proxy measures to evidence the standards. This will be facilitated by triangulation of data and information including insight on patient safety by local teams and where appropriate, wider system partners.
27. As part of building the data sources to support an evidence base for the quality standards, the framework will also introduce a National Education and Training Survey (NETS) to capture student experience during placements, with patient safety being a key central theme within the survey.
28. Under each Quality Domain HEE is building an evidence base of what high quality education and training looks like that will act as guidance for providers, educators and students. This will be underpinned by best practice, innovation and tools to drive quality improvement.
29. The Quality Framework sets out a broad view of the clinical learning environment from the ‘Board to the Ward’, the right culture and values that support and enable training for patient safety through robust educational governance and leadership and with the right infrastructure and resources to support and empower educators and students.
30. We have continued to engage with professional and system regulators as we test and pilot the Quality Framework during this year. Engaging and working in collaboration with regulatory bodies and our wider system partners remains a priority and a key guiding thread for our programme as we progress to full implementation of the Quality Framework from April 2017.
31. This is a crucial vehicle for HEE to lead and demonstrate the delivery of the Commission’s recommendations.

Transforming education and training – national conference

32. In February 2017 HEE hosted a national conference, ‘Transforming Education and Training’, which focussed on quality and patient safety. It was developed with HEE’s patient advisory forum and our regional and local leadership. It provided HEE with an opportunity to showcase and promote best practice in education and training interventions

³ <https://www.hee.nhs.uk/our-work/planning-commissioning/commissioning-quality>

for quality and patient safety and amongst others, heard from experts in the system on how we can together shape a system based on world class quality and patient care.

Ensuring robust evaluation of education and training for patient safety – delivery of recommendation 3

33. The Commission's third recommendation is one of key focus in the implementation. It said:

“The Commission recommends HEE works with partner organisations to facilitate the development of an evaluation framework to ensure all education and training for patient safety commissioned in future is effectively evaluated using robust models. HEE should facilitate a discussion with major research funders and those academically active in health education about this vital and neglected area.”

34. As well as this recommendation underpinning each workstream, HEE's Quality Framework is one vehicle to enable delivery of this recommendation. The Framework is designed to identify measure and improve the quality of the clinical learning environment. It has within it a core set of metrics via which HEE can carry out the measurement and improvement and as part of the work this year in implementation; we will explore the evaluation recommendation as part of the continual evolution of the framework and the metrics.

35. As part of the development of the Quality Framework, HEE worked with an academic partner to test and strengthen the standards and measures that underpin quality in the clinical training environment. Alongside this, HEE is developing a quality dashboard that will enable insight into measuring and evaluating education quality. As part of the next phase of this work, we will explore how HEE can evaluate specific initiatives in education and training for patient safety, to identify the most impactful and evidence based interventions. This will be supported through the myriad of good practice examples already identified across England.

36. Academic Health Science Networks (AHSNs) have an agenda to drive adoption and spread of innovation across all areas of healthcare provision by translating research into practice supported by knowledge exchange networks. A network of 15 Patient Safety Collaboratives (PSCs), led by each AHSN support patients and healthcare staff to work together to identify safety priorities and develop solutions. HEE will continue to explore the opportunities for partnership working with the PSCs to continually improve patient safety through high quality education and training.

Conclusion

37. The next phases of the implementation will put firm stakes in the ground for HEE's continued leadership to transform education and training for high quality care and patient safety, creating a system which puts quality at the heart of everything it does.

38. As well as the regional leadership of the implementation, the on-going engagement with system partners, such as NHS Improvement and Academic Health Science Networks will be integral to achieving the delivery of the recommendations as well as ensuring there are links and interfaces with key programmes of work which will provide levers for delivery.

39. The core implementation will take place until the end of 2018, however, with the right focus, the work will lay the foundation of high quality education and patient safety for the future.

Annex A - The Commission's 12 recommendations within the four themes

No	The Commission on Education and Training for Patient Safety: report recommendations
1.	<p>Ensure learning from patient safety data and good practice</p> <p>Patient safety data and learning from incidents to be made available to those developing education and training. HEE to:</p> <ul style="list-style-type: none"> • engage with national partner organisations and HEIs to ensure data shared as an education resource • work with partner orgs to scale up and replicate good practice – use Technology Enhanced Learning (TEL) platform • work with NHS Improvement to enable access to local Serious Incident (SI) reports for use in education and training • work with CCGs NHS England, NHS Improvement and others to develop lessons learned alerts following incidents / near misses
2.	<p>Develop and use a common language to describe all elements of quality improvement science and human factors with respect to patient safety.</p> <ul style="list-style-type: none"> • incorporate work of Human Factors group into way all staff are trained
3.	<p>Ensure robust evaluation of education and training for patient safety</p> <ul style="list-style-type: none"> • HEE to work with partner organisations to facilitate development of an effective framework for evaluating models of education for patient safety education and training • HEE to facilitate discussion with major research funders and academics to generate research into models of education for patient safety training
4.	<p>Engage patients, family members, carers and the public in the design and delivery of education and training for patient safety</p> <ul style="list-style-type: none"> • HEE to use levers to ensure patients and service users are involved in co-design and co-delivery of education and training for patient safety • HEE to work with provider organisations to ensure placements facilitate meaningful patient involvement and shared decision making • HEE to explore need for education and training for patients and carers in relation to self-care with the Patient Advisory Forum (PAF)
5.	<p>Supporting the duty of candour is vital and there must be high quality educational training packages available</p> <ul style="list-style-type: none"> • HEE to review existing training packages to ensure they support duty of candour regulations • HEE to work with professional regulators to include duty of candour in codes
6.	<p>The learning environment must support all learners and staff to raise and respond to concerns about patient safety</p>

	<ul style="list-style-type: none"> • HEE to work with national partner organisations and employers to ensure the learning environment supports staff (learners and educators) to raise and respond to patient safety concerns
7.	<p>The content of mandatory training for patient safety needs to be coherent across the NHS</p> <ul style="list-style-type: none"> • HEE to review mandatory training requirements related to patient safety • HEE to review CPD related to patient safety • HEE to work with stakeholders to ensure employer-led appraisal assesses understanding of human factors and patient safety • HEE to use contracts to ensure protected learning time on patient safety training as part of mandatory training
8.	<p>All NHS Leaders need patient safety training so they have the knowledge and tools to drive and change improvement</p> <ul style="list-style-type: none"> • HEE to work with partner organisations to ensure that leadership on patient safety training is incorporated into leadership programmes
9.	<p>Education and training must support the delivery of more integrated ‘joined up’ care</p> <ul style="list-style-type: none"> • HEE to work with partner organisations to ensure education and training supports ‘joined up’ care
10.	<p>Ensure increased opportunities for inter-professional learning</p> <ul style="list-style-type: none"> • HEE to use levers to facilitate increased opportunities for inter-professional learning
11.	<p>Principles of Human Factors and professionalism must be embedded across education and training</p> <ul style="list-style-type: none"> • HEE to work with national partner organisations to ensure that basic principles of human factors and professionalism are embedded within all education and training • Multi-professional human factors training to form part of all induction programmes and be offered as periodic refresher training
12.	<p>Ensure staff have the skills to identify and manage the potential risks</p> <ul style="list-style-type: none"> • HEE to work with national partner organisations to ensure that staff have the skills to identify and manage risks

Annex B – HEE education and training interventions

Recommendation	Lead Region	Intervention	Description	Outcomes/ Emerging Outcomes
1	Ensure learning from patient safety data and good practice.	North	Quality Management visits – GMC Enhanced Monitoring Concerns that adversely affect patient safety where very little/no improvement has taken are escalated to the GMC through their Enhanced Monitoring process. Providers are informed and regular progress updates are monitored and reported to the GMC to demonstrate the progress that providers are making in managing these concerns.	Improvement in indicator scores in the GMC National Training Survey and HEE Junior Doctor Survey in specific specialities/areas. Improving from negative outliers to positive. Specific quality conditions for enhanced monitoring lead to very clear staffing/training improvements to fix major risk factors – case studies are published by the GMC eg. Emergency Medicine at Hull Royal Infirmary – the 2015 NTS showed multiple negative outliers for doctors in the second year of the Foundation Programme working in emergency medicine. Concerns were also identified in this area when HEE visited the Trust. The Trust named one senior trainer and gave them dedicated supporting professional activities time to promote training delivery within the department and to supervise the educational programme. The Trust also began to have some success in recruiting additional senior staff. When HEE visited in July 2016, doctors in training reported that, although it remains a very busy department, additional staff appointments and improved working practices have meant that workloads have become more manageable. Average indicator scores in the department’s 2016 NTS results improved significantly – the mean score for handover increased from 40.39% to 70.24%.
2	Develop and use a common	Midlands and East	Human Factors	Human Factors (HF) awareness programme, to develop increased Regional Roadshows

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	language to describe all elements of quality improvement science and human factors with respect to patient safety.		Awareness programme	<p>understanding and awareness in HF for all levels of staff across the region.</p> <p>Ensure that staff understand the integration between human factors, service improvement science and change management principles to enable the identification of risk, a solution and implementation of that solution.</p> <p>A particular requirement of the PGCert funding is to tailor all assignments and coursework as part of the PGCert to the health professional's current work.</p>	PGCert in Human Factors and Ergonomics
3	Ensure robust evaluation of education and training for patient safety.	London and South East	Increasing Psychology and Psychotherapy Involvement in Serious Incident Investigations (SI)	This project has undertaken an extensive examination of the processes behind Serious Incident Investigations. Based on this a number of recommendations have been made to improve the efficiency of this process. The project has also worked to increase the number of Psychologists and Psychotherapists trained to facilitate these investigations as well as providing consultation to the Patient Safety Team.	Increased number of Psychologists and Psychotherapists trained to facilitate Serious Incident Investigations (SI)
4	Engage patients, family members, carers and the public in the design and delivery of education and training for patient safety.	South	Patient leadership of quality improvement	NHS KSS Leadership Collaborative funded programme to develop patient and clinical leaders in tandem. Enabling them to develop an "equal partner" relationship when engaged in the quality improvement of pathways of care. Proof of concept to inform STP patient leadership development model.	STP Patient Leadership Development Model
5	Supporting the duty of candour is vital and there must be high quality	Midlands and East	PRemieRe	A multi-disciplinary team of health workers in the East Midlands review patient safety incidents in a no-blame environment. Mortality and morbidity	Reflective practice in the review of patient safety incidents and the identification of key learning points.

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	educational training packages available.			meetings have been extended to include reflection of patient safety incidents. At these meetings patient safety incidents are discussed to ascertain; what happened, why it happened, whether it could have been prevented or managed better, and what the key learning points are. Trainees are encouraged to reflect on what they learn in their portfolios.	
6	The learning environment must support all learners and staff to raise and respond to concerns about patient safety.	London and South East	Schwartz Rounds (SR)	A 23 month programme funded by the Maudsley Charity to run Schwartz Rounds across South London. This is a type of evidence-based reflective practice for all staff, both clinical and non-clinical, which focusses on the emotional impact of the work we do in healthcare.	Building emotional resilience through evidence-based reflective practice for all staff.
7	The content of mandatory training for patient safety needs to be coherent across the NHS.	London and South East	Improving medical induction - Oxford University Hospitals NHS Foundation Trust (OUH)	OUH proposes a developed and blended approach to monthly induction, whereby half of the content is delivered via an interactive online module, creating the opportunity to make better use of the face to face time.	Improved induction experience process for medical trainees.
8	All NHS leaders need patient safety training so they can have the knowledge and tools to drive change and improvement.	North	Future Leaders Programme	The Future Leaders Programme offers opportunities for trainees to undertake a Clinical Leadership Fellowship to help develop their personal leadership skills. The programme is available in a number of areas including patient safety and quality improvement.	There are currently over 50 Leadership Fellows in Yorkshire and Humber - in a program that has been running for over three years. Particularly those trainees that have performed QI projects, a number of specific outcomes have assisted in improving patient safety. There was a recent publication from the Paediatric Fellow who had used Paediatric and neonatal simulation to improve the identification of latent risks.

9	Education and training must support the delivery of more integrated 'joined up' care.	London and South East	Integration Programme	<p>The Integrated Workforce Project forms part of the wider programmes of: Hospital @ Home, Enhanced Care Home Support, Re-enablement Services Integration and Primary Care Development and the Better Care Fund (BCF) schemes which include the redesign of the workforce around 7 day working across health and social care, care coordination, Joint assessments and care planning.</p> <p>A new Generic Support Worker role has been designed to meet the delivery of Health & Social Care Patients and Users. New strategies have been developed following the new generic role design: A Development of joint recruitment plans and campaigns was established with a training plan; combined with a development of HR Strategy & Plan. A communication and engagement plan was undertaken. A career path for new Generic Support Worker roles has been created.</p>	New Generic Support Worker role and career path has been designed to meet the delivery of Health & Social Care Patients and Users.
10	Ensure increased opportunities for inter-professional learning.	North	Simulation Training Programmes	<p>Paediatric, mental health and midwifery simulation training is multi-professional and includes obstetricians, anaesthetists, healthcare assistants and midwives. Other examples include intraosseous training which includes ambulance staff, medical and nursing staff and End of Care Life which includes GPs, doctors, and nurses and care home nursing and healthcare support workers.</p>	<p>A multi-professional simulation training programme.</p>

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11	Principles of human factors and professionalism must be embedded across education and training.	North	FY2 Human Factors Training	There is a one day specific Human Factors training course for Foundation Year 2 trainees.	There has been an annual evaluation of this training which consistently demonstrated high levels of trainee satisfaction and an increased awareness of human factors in achieving the highest levels of patient safety
12	Ensure staff have the skills to identify and manage potential risks.	London and South East	Clinical Supervision and Teaching Assessment	It addresses teaching in clinical situations, large and small groups, and an introduction to the workplace based assessments. The course will help participants: a) To discuss best practice in supervising trainees in different clinical settings b) To plan a formal teaching session: set aims and objectives, and determine appropriate teaching, learning and assessment methods c) To differentiate between the main workplace-based assessments and consider how to use them effectively d) To undertake a short teaching session and receive constructive feedback	A supportive and evidence-based education and training programme for clinical supervisors and assessors.