NHS
Health Education England

Expert and Advisory Group Recommendations

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Recommendations of the Learning to be Safer Expert and Advisory Group for the Commission on Education and Training for Patient Safety

1. Purpose

This paper details the recommendations of the Learning to be Safer Expert and Advisory Group. The group was established by Health Education England (HEE) in September 2014, to assure necessary advice and expertise to support HEE deliver on its mandate and commitment to the National Quality Board (NQB) Concordat for Human Factors. The group was co-chaired by Professor Jane Reid (Independent Expert Advisor) and Professor Lisa Bayliss-Pratt (Director of Nursing HEE) and has run parallel to the Commission on Education and Training for Patient Safety. Membership of the Expert and Advisory Group can be found in the appendix.

2. Background

Over the last 25 years there have been numerous reports[1] that have made recommendations about patient safety and in the more recent eight years, robust appeals that the NHS should learn from other safety critical industries and integrate human factors and ergonomics. Avoidable harm and related deaths in western healthcare economies and in the UK in particular, have not improved since patient safety emerged as an issue of national and international importance in 2001[2,3]. Patient safety continues to be an issue of concern, with calls to amend approaches and take a system wide view to improvement. It is widely recognised that providing human factors and ergonomics education and training to raise awareness and understanding in the NHS workforce, is only one aspect and that many other inter-dependent factors/interventions are required.

HEE has a unique role to play with regards to developing the current and future workforce to improve patient safety, but it is only one part of the system. For the safety of patients, HEE, Arm's Length Bodies, regulators, signatories of the NQB Human Factors Concordat, providers and commissioners, need to work collectively to create the right conditions so that the healthcare workforce can work in the best environment and be flexible and resilient enough to cope with complexity and change in service need. Human factors and ergonomic awareness and understanding across the workforce and the application of this science has an important role to play in safety improvement and will support the national aim from the Secretary of State to save 6,000 lives and reduce avoidable harm by 50% by 2020.[4 5]

3. Expectations and recommendations

In order to improve safety and integrate human factors and ergonomics into healthcare, it is hoped the Commission's report will help HEE deliver on its mandate to the National Quality Board Concordat for Human Factors in Healthcare[6], while reinforcing the role to be played by other system leaders and organisations in implementing the Concordat recommendations.

Recommendations have been summarised into six key themes.

Raise awareness

- Embed the basic principles of human factors and ergonomics across all education and training, from board to frontline.
    - NHS Improvement, NHS Confederation, NHS Employers, NHS Providers and CQC have a role to play to ensure that executives and non-executives have an

understanding of the basic principles of human factors and ergonomics to discharge their statutory and legal responsibilities for patient safety.

- Develop learning packages that support teaching and learning regarding the core principles of human factors and ergonomics.
    - HEE has a role to play in ensuring a standard framework is developed to support commissioning, scale and sustainability.
- Promote a shared language related to human factors and ergonomics developed by the Clinical Human Factors Group (CHFG) and the Health Foundation, to ensure human factors and ergonomics is contextualised and relates to everyday practice.
- Develop a graduated approach to human factors education that helps organisations and individuals assess what is required to support service delivery.
- 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.

Learning environments

- Human factors and ergonomics needs to be part of the induction process for all staff when they start in an organisation; irrespective of sector or grade.
- Commission training (Team STEPPS or equivalent that takes account of UK health system) for teams working in emergency and high-risk environments, to enable them to better understand the factors that impact on their human performance, capabilities and capacity to deliver care safely.
    - Develop the current workforce through CPD and quality assure learning environments in a standardised way.
- Regulators should support safety by detailing the requirements for revalidation and appraisals and by stating how staff should demonstrate human factors and ergonomic education and practice experience.
- All staff need to have the necessary skills to understand and manage risk. This needs to be assessed and supported by Employers through appraisals and revalidation.
- Organisations engaged in care delivery should model other safety critical industries and include a senior accountable officer for patient safety at Board level (this should be a discrete and separate role, not included as an element of a role).
    - To deliver on the ambitions for safety improvement, there should be a statutory requirement for boards/senior accountable officers to ensure that staff will have the time and opportunity to learn and make improvements for patient safety.

Promote the map of current provision

- Promote and publicise current provision for human factors and patient safety education and training; including key resources and the value that these training packages add.
    - Build on what already exists through the Department of Health's (DH) reference subgroup NHS Innovation for Improvement, and the evidence collected through the Commission's 'listening events', responses from local HEE teams, Academic Health Science Networks, Patient Safety Collaboratives and stakeholders.
    - Develop a strategic commissioning plan to inform HEE's activity locally ensuring a commitment to human factors education and training that supports scale and sustainability.
    - Obtain commitment from professional bodies, colleges and providers to support this and standardise education and training for human factors.

Develop experts

- HEE should identify and develop a faculty of health professionals with human factors and ergonomics expertise that they can draw upon to support and deliver the Commission's recommendations.
    - With NHS Improvement and the Health Foundation, explore development of a faculty of human factors experts modelled on the learning from the Q initiative.
- HEE should work closely with the leadership academy to gather feedback from the last graduate management trainee cohort on the practical implementation and adaptation of human factors skills in middle and senior management roles, in order to identify impact and transferable lessons.

Turn data into learning for impact

- Ensure human factors expertise informs the work of NHS Improvement's central measurement unit, and the, to be established, Healthcare Safety Investigation Branch (April 2016), whose primary responsibility is to review and analyse patient safety data (including near misses) and turn that information into learning for improvement.
- Link learning objectives to patient outcomes.
- HEE should work with the CQC to map the safety element that are measured on CQC visits and identify top high-risk safety issues where shared learning is required.

Whole systems approach

- HEE should work with NHS England, NHS Improvement, NHS Providers and professional regulators to ensure that human factors are embedded across procurement, commissioning and system design.
- Ensure that the activity of the Sign up to Safety campaign, Q initiative, Academic Health Science Networks and Patient Safety Collaboratives are aligned to ensure optimal delivery on the national aim for patient safety of reducing avoidable harm by 50% - saving 6000 lives. Further ensuring that learning is distilled and disseminated for scale and sustainability.

4. Summary

This paper provides the recommendations of the Expert and Advisory Group to inform the Commission's report and facilitate the ambition for the NHS to model other safety critical industries by embedding human factors and ergonomics.

Appendix

- Addendum
- Expert and Advisory Group membership list
- End notes

Addendum - additional feedback

Expert group members also commented on what's working well and what could be improved with regard to the current Expert and Advisory Group.

Feedback included:

What could be improved/changes needed when the Commission reports

- Small task and finish groups of expertise to support HEE in taking forward specific recommendations
- Workstream on leadership and culture to discuss what senior leaders need to focus on in order to reinforce and sustain change
- A long-term implementation plan in order to ensure that change is sustained.
- Learning from the aviation and oil industry suggests that we need to assure a 10 year strategy to support the improvement that is required

Expert and Advisory Group membership list

Professor Jane Reid, Co-chair, National Quality Board Advisor

Lisa Bayliss-Pratt, Co-chair, Deputy Director of Education and Quality & Director of Nursing, Health Education England

Janet Anderson, Senior Lecturer, Florence Nightingale Faculty of Nursing and Midwifery, Kings College London

Sue Bailey, Senior National Clinical Lead, Health Education England

Bryn Baxendale, Simulation Expert, Association for Simulated Practice in Healthcare

Chris Bell, Standards Development Manager, Nursing and Midwifery Council

Cassandra Cameron, Policy Advisor, NHS Providers

Jane Carthey, Independent expert

Kate Cuthbert, Academic Lead, Higher Education Academy

Nicola Davey, Quality Improvement Expert, Quality Improvement Clinic

Mark Dexter, Head of Policy, General Medical Council

Steven Dykes, Deputy Medical Director, Yorkshire Ambulance Service NHS Trust

Jamie Emery, Head of patient services and engagement, Heart of England NHS Foundation Trust

Beatrice Fraenkel, Chairman, Mersey Care NHS Trust

Michael Guthrie, Regulator, Health and Care Professions Council

Richard Hatchett, Head of Department, Education and Standards, Nursing and Midwifery Council

Gretchen Haskins, Safety Expert, Civil Aviation Authority

Sue Hignett, human factors Expert, Loughborough University & Chartered Institute of Ergonomics and Human Factors

Matthew Inada-Kim, Harkness Fellow, Hampshire Hospitals NHS Foundation Trust

Peter Jaye, Clinician, Guys and St Thomas' NHS Foundation Trust

Ceri Jones, Academic, University Hospitals of Leicester NHS Trust

Janine Lucking, Senior Improvement Manager/Patient Safety - Capability Lead, NHS Institute of Quality

Kirk Lower, National Lead for HEE Widening Participation strategy and 'Talent for Care', Health Education England

Ralph Mackinnon, Surgeon, Royal Manchester Children's Hospital

Sally Malin, Patient representative, Patient Advisory Forum member

Jacqueline McKenna, Deputy Director of Nursing, NHS Trust Development Authority

Sue Mellor, Nurse, Independent Consultant

Peter McCulloch, Surgeon / Head of safety improvement collaborative, Oxford University

Alan Nobbs, Senior Programme Lead, NHS Leadership Academy

Jon Stewart, Hollier Simulation Centre

Suzanne Shale, Independent ethicist

Phoebe Smith, Expert Health and Safety Laboratory

James Titcombe, National Advisor on Patient Safety, Culture & Quality, Care Quality Commission

David Wood, Associate Director Safer Services, Cheshire and Wirral Partnership NHS Foundation Trust

End Notes

[1] Berwick, Francis, Winterbourne, Keogh, NQB Human Factors in Healthcare Concordat, DH reference sub-group
[2] Darzi, Ara. 'The NHS record needs to be as good as the airline and motor industries', Health Service Journal, February 2015
[3] Vincent, Charles et al. ‘Averse Events in British Hospitals: preliminary retrospective record review ‘. British Medical Journal, 322 517-519, 2001
[4] Hunt, Jeremy MP, Sign Up To Safety Campaign, ‘The path to saving 6,000 lives’ Speech, Department of Health, March 2014
[5] Department of Health, Gov.uk. ‘Learning not blaming Report’ [ONLINE] Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445640/Learning_not_blaming_acc.pdf [Accessed 29 February 2016]
[6] National Quality Board Human Factors in Healthcare. A concordat from the National Quality Board. (2013) Available at: https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf [Accessed 7 March 2016]