NHS
Health Education England

In Safe Hands

Prioritising patient safety across the NHS

Introduction

Welcome to the 'In Safe Hands' interactive guide, produced by Health Education England (HEE) who is responsible for delivering education and training that supports safer clinical practice across the NHS. This guide has been produced in response to the recommendations made in the 2016 report 'Improving Safety Through Education & Training'.

Over the past three years, HEE has worked with its clinical leads, providers and more to address the report's 12 recommendations (see next page). This has led to the implementation of many education, training and development schemes that promote safe clinical practice across all health and care services.

This guide highlights many of the key areas where progress has been made, while offering a roadmap to what still needs to be achieved. Most importantly, it illustrates how all NHS stakeholders – including you – can get involved to help adopt and promote a safety-first culture whichever care sector you work within.

Click on the links at the bottom of this page to navigate to the sections that are relevant to your area (you can click the introduction button at the bottom of the page to return here). Alternatively, browse the entire guide to learn about the four strategic elements that make up HEE's 'In Safe Hands' initiative.

These are:

1. Focusing on Human Factors

Uncover what human factors is and how it is able to transform clinical excellence and safety through out the NHS.

GO TO SECTION ›

2. Embedding Simulation Training

Learn why simulation training is a powerful method for improving patient safety whether delivered within a simulation suite or in the practice environment.

GO TO SECTION ›

3. Delivering the Education

Discover the many safety-focused learning and development opportunities available within the NHS

GO TO SECTION ›

4. Speaking Up

Learn why raising concerns is critical to maximising patient and workforce safety across the NHS.

GO TO SECTION ›

It is the responsibility of all health and social care staff, in whatever role and whatever department, to ensure patient safety is their greatest priority. To achieve this, staff need the necessary training, support and encouragement to make safe clinical practise their primary concern."

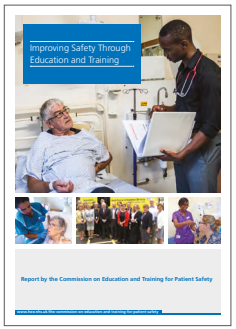
– Health Education England

Why 'in Safe Hands'?

In March 2016, the Commission on Education and Training for Patient Safety published its report 'Improving Safety Through Education & Training', which offered 12 recommendations for actively improving the safety of patients:

1. Ensure learning from patient safety data and good practice
2. Develop and use a common language to describe all elements of quality improvement science and human factors with respect to patient safety
3. Ensure robust evaluation of education and training for patient safety
4. Engage patients, family members, carers and the public in the design and delivery of education and training for patient safety
5. Supporting the duty of candour is vital and there must be high quality educational training packages available
6. The learning environment must support all learners and staff to raise and respond to concerns about patient safety
7. The content of mandatory training for patient safety needs to be coherent across the NHS
8. All NHS leaders need patient safety training so they can have the knowledge and tools to drive change and improvement
9. Education and training must support the delivery of more integrated 'joined-up' care
10. Ensure increased opportunities for inter-professional learning
11. Principles of human factors and professionalism must be embedded across education and training
12. Ensure staff have the skills to identify and manage potential risks.

Since the report's publication, HEE has been tirelessly working to enhance patient care through education, training and development activities across the NHS. Three years later and this work has laid strong foundations on which to build a national patient safety syllabus accessible to all.



The 'Improving Safety Through Education & Training' report can be accessed here.

DOWNLOAD NOW ›

The 'Delivering Patient Safety Through Education, Training and Development' can be accessed here.

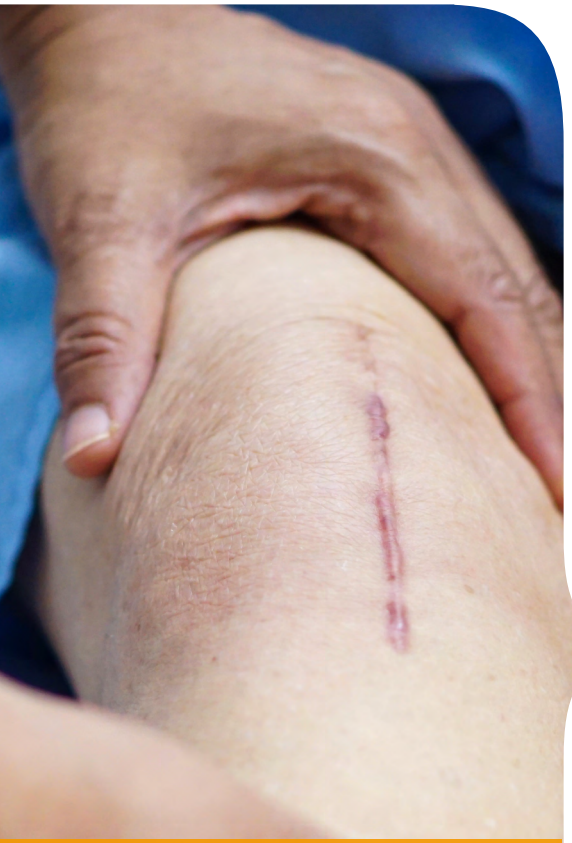
DOWNLOAD NOW ›

> *Patient safety should be the golden thread of learning that connects all staff working in the NHS, across all disciplines"*
>
> **– Commission on Education and Training for Patient Safety**

Focusing on Human Factors

Uncover what human factors is and how it is able to transform clinical excellence and safety throughout the NHS.

Focusing on Human Factors



Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety

https://www.hse.gov.uk/humanfactors/introduction.htm

UP TO 80% of healthcare errors are caused by human factors associated with poor team communication and understanding

But what is 'human factors' – and how does it enhance patient safety?

This case study taken from the **'Human Factors in Healthcare' report** illustrates a scenario where a serious error could have been avoided using human factors techniques:

A patient was given an unnecessary knee operation

- Two patients with the same name associate with one set of medical notes and hence the same hospital number
- They had different medical conditions that required hospital appointments in different departments; however, they both just happened to have knee pain at the same time
- The wrong patient arrived and had the procedure intended for the other.

How did this mistake occur?

- Four different hospital numbers were recorded in the patient's medical notes, along with more than one GP and several different addresses
- The hospital used patient identifier labels which allowed one mistaken patient detail to be replicated many times
- An independent translator wasn't always available when either patient turned up for the treatment of their different conditions
- Neither the consent form nor the pre-operation assessment form were properly completed.

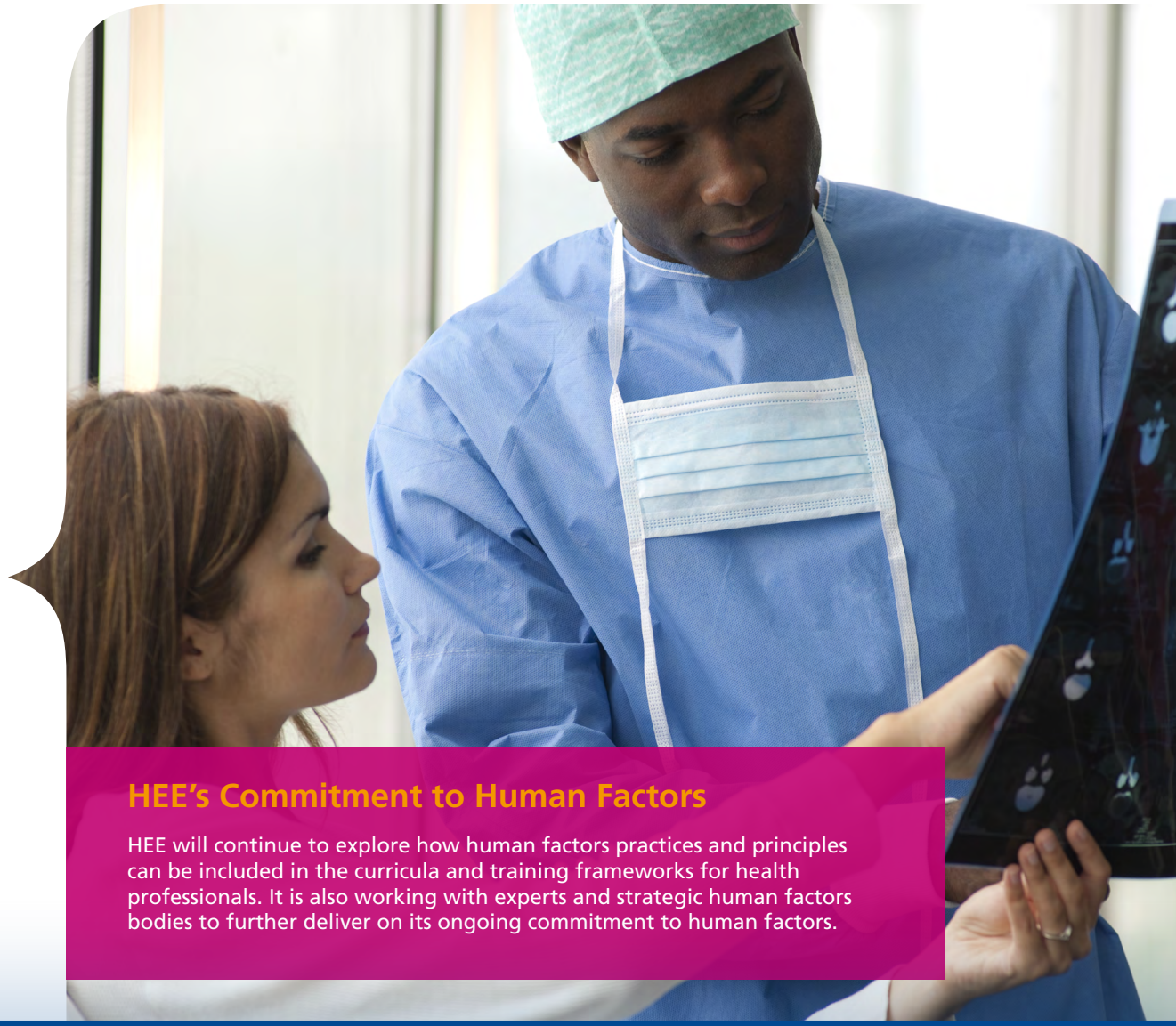
These kinds of error, poor processes and system designs that impact human decision making are widely recognised as contributory factors in patient harm incidents – but what is the solution?

Focusing on Human Factors

Enhance clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings."

States Dr Ken Catchpole in his report, 'Human Factors in Critical Care'. It's a statement that HEE agrees with – and its why human factors education, training and the development of staff combined with HF implementation across all NHS systems has become a primary focus for us as we strive to drive up quality and safety standards within healthcare.

This commitment has seen the rollout of educational opportunities across many clinical settings and fields of practice, and it's an approach that has been endorsed by staff across the NHS.



HEE's Commitment to Human Factors

HEE will continue to explore how human factors practices and principles can be included in the curricula and training frameworks for health professionals. It is also working with experts and strategic human factors bodies to further deliver on its ongoing commitment to human factors.

Focusing on Human Factors

Video Introduction to Human Factors

Learn about the potential of human factors – and the harm that can be caused if it is not considered in everyday practice:

Human Factors Defined

Produced by NHS Scotland, this animation defines what human factors actually is by outlining the seven key areas it can impact on within healthcare:

Cognition and mental workload • Distractions • Physical environment • Physical demands • Device/product design • Teamwork • Process design.

Watch video

'The Human Factor: Learning from Gina's Story'

This hard-hitting film by Doncaster and Bassetlaw Hospitals NHS Foundation Trust reveals how a simple mistake resulted in a tragic incident at the Trust in February 2013 – one that could have been avoided if human factors processes had been in place.

Watch video

Focusing on Human Factors

Enabling Human Factors Training

To increase understanding, several initiatives have been created that offer a vision of how human factors awareness can be raised across the NHS.

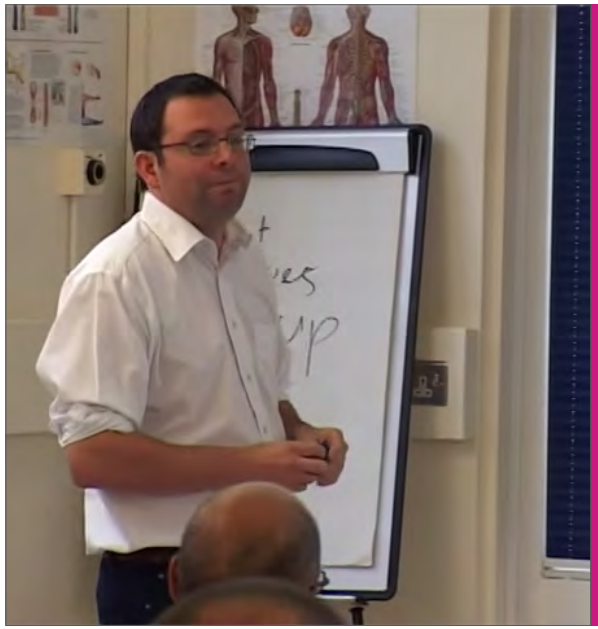
For instance, twelve two-hour taster workshops were delivered in 2018 to introduce Human Factors and Ergonomics (HFE) principles and practices in healthcare. Lead by HEE (Midlands and East), these workshops were:

- delivered in six locations across the East of England, East Midlands and West Midlands
- attended by 105 delegates involved in direct patient care, management of clinical support services, leadership, organisational development and workforce development
- delivered by representatives from tertiary education and private consultancy, including a chartered member of the CIEHF
- taught using featured videos, applied theoretical models and exercises, designed to engage and enable the delegates to consider the application of HFE within their own role and work environment.

Post-training feedback from delegates revealed:

- 99% felt the workshop had been directly relevant to their work
- Many delegates expressed an interest in learning more, either for themselves, their team, and/or their organisation.

Better still, the multidisciplinary nature of the workshops saw the sharing of good practice and experiences, which in turn led to deeper discussions between different disciplines about human factors.



Meet the Human Factors Expert

Dr Rob Galloway

A consultant in Emergency Medicine at Brighton and Sussex University Hospital NHS Trust, Dr Galloway offers extensive training in human factors for the trust's workforce. The following is a presentation given by Dr Galloway, which was recorded live at the Queen Victoria Hospital in East Grinstead.

Watch video

Evolving Systems

The NHS Patient Safety Strategy highlights the importance of safer systems being embedded in all patient safety activities, and not simply focusing on individual employees and their human factors awareness. This push for deeper system thinking will be delivered by patient safety specialists who will work closely key stakeholders to underline that safety is the responsibility of everyone working within the NHS – including those who design system processes.

View the full report here ›

Focusing on Human Factors

Human Factors Case Study – Ambulance Design

The Challenge

Prior to 2006, many NHS Ambulance Trusts produced unique vehicle specifications for their ambulances, resulting in over 40 different designs. Such variants posed a significant risk to patient safety as operator confusion over equipment location and interior layout could lead to delayed care delivery.

The Setting

Secondary NHS Provider, Ambulance Service staff, designers and manufacturers within the East Midlands, East, West and North East England and Yorkshire regions.

The Response

Human factors professionals worked with paramedics, 'riding along' for hundreds of hours during days, nights and weekends. This helped them gain a full understanding of the challenges faced by paramedics to deliver emergency care before arrival at hospital.

The resulting report outlined the challenges and issues created by disparate, often conflicting, ambulance designs while offering constructive solutions developed in partnership with vehicle and ambulance equipment manufacturers.

The Outcome

Based on the report's recommendations, prototypes were built and tested before being used to deploy a coherent, joined-up national specification for all emergency ambulances. Topline benefits included:

- Adoption of a standardised interior and exterior design
- Improved patient safety due to design standardisation
- Improved working conditions for healthcare workers
- Financial savings of £2.5 million over three years.

Focusing on Human Factors

Human Factors Case Study – Dilemmas in Suicide Prevention

Inspired by true events, this short film illustrates the many complexities and dilemmas faced by clinicians and managers every day – and how the NHS must challenge itself to deliver mental healthcare more efficiently and with greater awareness and sensitivity.

Watch video

The very first requirement in a hospital, that it should do the sick no harm."

Florence Nightingale, 1859.

Embedding Simulation Training

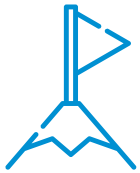
Learn why simulation training is a powerful method for improving patient safety.

Embedding Simulation Training

Used throughout all safety-critical industries, the NHS is no exception with Simulation-Based Education (SBE) providing a safe environment for practising skills and learning about teamwork. Just as you wouldn't expect a pilot to practice flying a plane in real life without first honing their skills in a simulator, the same approach must be applied to any safety-critical job in the NHS.

SBE can be used at every level of learning, improving the safety of patient care through the design of medical devices, information technologies, working environments, and the procedures that underpin everyday practice.

The NHS is a global leader in the field of SBE.



The UK has the highest number of advanced simulation centres in Europe.

SBE in core curricula is increasing for most medical specialties and nursing.

Simulation is a technique – not a technology – to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner."

Professor David Gaba, Sim Healthcare

[SOURCE: http://aspih.org.uk/wp-content/uploads/2017/07/national-scoping-project-summary-report.pdf]

Embedding Simulation Training

Access the SBE Framework Video Playlist

Produced by HEE, view a set of six videos that explores the SBE Framework and its wider implications for the future of the NHS.

Watch video

The HEE SBE Framework

The Simulation Based Education (SBE) Framework lays out a roadmap for a national approach to the continued delivery of SBE across England.

The framework is designed to support the development, delivery and commissioning of SBE moving forward. Developed with simulation experts, the circular process offers an over-arching strategic vision for ensuring SBE's ongoing success:

1. Quality Outcomes

- SBE investment is aligned with the delivery and continuing improvement of high quality, safe and effective care as well as enhancing the learner experience.

2. Leadership and Governance

- Simulation-based education and its leadership are clearly defined, and the appropriate governance model and processes are explicitly stated.

3. Strategic Approach and Resource Allocation

- Each local area's strategic approach is aligned with the SBE national approach – connecting to Local Workforce and Action Boards (LWABs) – meaning there is consistency across regions.

4. Multi-Professional Faculty Development

- There is a clear and consistent approach to multi-professional faculty development across all local areas.
- There are clear mechanisms in place within multi-professional faculty development for sharing best practice and learning across the region.

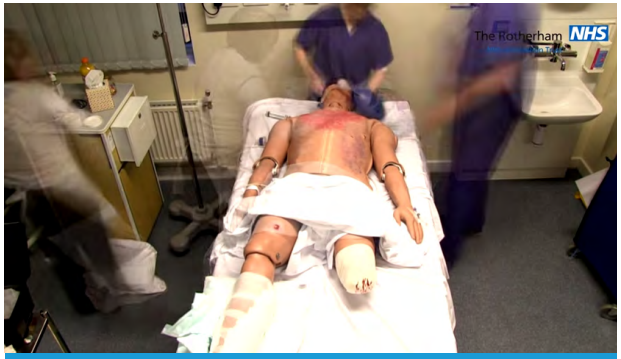
5. Quality Assurance

- There is a well-defined method for quality assuring the content and delivery of SBE, using the HEE Quality Framework for education and training alongside other appropriate national standards.

Embedding Simulation Training

Video Introduction to Simulation Training

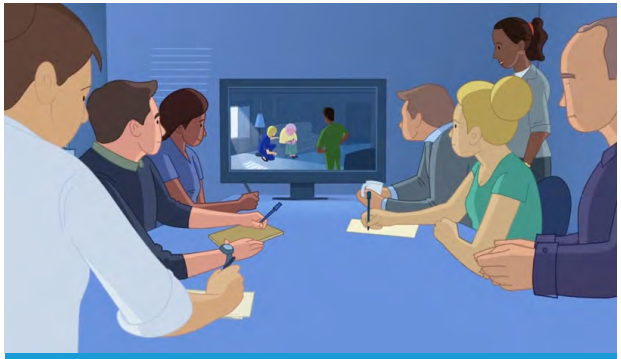
Learn about the potential of Simulation-Based Education – and how it can transform patient safety in everyday practice:



Go Behind the Scenes

Discover how simulation training is implemented at the Rotherham NHS Foundation Trust (including obstetrics and A&E scenarios).

Watch video



Mental Health Simulation

An animated video explaining how mental health simulation training works and its impact. Click here for a case study.

Watch video

Introducing the Simbulance

Trainee paramedics use HEE's Simbulance to learn about their role within a monitored and safe environment. Video produced by Brighton's Latest TV team.

Watch video

Embedding Simulation Training

Simulation Case Study – Safely Relocating a Hospital

The Challenge

Moving from one hospital site to another is a huge undertaking, requiring meticulous planning to avoid compromised patient care/safety.

The Setting

A regional paediatric NHS Trust hospital in the North West of England with 270,000 patients was soon to move to a new site. However, the trust recognised the importance of considering the logistics behind moving staff, patients and equipment before changing location.

The Response

An orientation and system testing process was created featuring simulations that would enable a group of NHS staff to move into the new hospital site before patients arrived. This would allow them to orientate themselves, test systems and offer critical feedback on safety.

The Simulations

Phase One

Because the new hospital contained 14 operating theatres over two floors, three simulations were devised to test the location of emergency equipment and processes:

- Responding to an unexpected airway emergency during the introduction of anaesthesia
- Responding to a major blood loss event during surgery
- Evacuating the theatre suite due to a fire emergency.

Following the simulations, a debriefing highlighted any process changes required. Further development and testing were then carried out alongside the analysis of other procedures including the movement of patients from one area to another.

Phase Two

Simulations were used to test the clinical areas; a multi-professional team was assembled for each theatre area with a simulated case conducted to ensure all equipment was available and working. Only after successfully completing these simulations were areas then opened up for patient use.

The Outcome

The simulations highlighted numerous processes that required modification due to the new build's layout. These included:

- Siting of emergency equipment
- Flow of patients through departments
- Optimal configuration and layout of rooms and areas.

These findings led to:

- Errors in organisational systems and processes being identified and redeveloped prior to patient arrival
- Frontline staff helping develop these processes, leading to an increase in their own confidence working in the new areas
- The NHS staff involved understanding the benefits of simulation application in areas such as the physical environment and the use of equipment, processes and systems
- This in turn enabled the staff to apply the benefits and insights to other aspects of their clinical work.

Embedding Simulation Training

Simulation Case Study – Mental Health Training

The Challenge

According to the 2014 'The Interface of Physical and Mental Health' report, patients with mental health conditions are at increased risk of physical ill-heath due to delayed diagnoses and in turn suffer from higher mortality rates. This makes their assessment by police and ambulance service staff critical to their effective treatment.

The Setting

An innovative full-day course was run on 14 occasions at the Maudsley Simulation centre at Lambeth Hospital.

The Simulation

Police and ambulance service staff took part in a series of simulated scenarios using actors playing people experiencing a mental health condition, often in crisis. Each scenario involved two participants acting in their professional capacity to deal with the presented challenge while other course attendees watched the simulation via video-link.

Example scenario

Danny Acheampong, a 25 year old male, has begun to act oddly at home, becoming increasingly agitated. His mother is concerned about his behaviour and is worried he is unwell. She calls the ambulance service.

Participant One

…is a paramedic who on arrival is told by the mother her son has potentially taken a knife. The police are called.

Participant Two

…is a police officer who arrives at the scene and, together with Participant One, will continue the assessment.

Throughout Danny is scared and at times agitated. However, he is not holding the knife but instead has stored it in his bedroom. His mother also represents a challenge as she is antagonistic towards both her son and the participants – in particular, the police officer.

The aim for the two participants is to contain the situation, provide a brief assessment and consider a management plan.

Their learning objectives are:

- Improved knowledge and confidence in assessing people presenting with psychotic symptoms
- Improved knowledge managing people presenting with psychotic symptoms.

[SOURCE: BMA 2104; Doherty & Gaughran 2014 Doherty AM, Gaughran F. The interface of physical and mental health. Social Psychiatry & Psychiatric Epidemiology 2014;49:673-682]

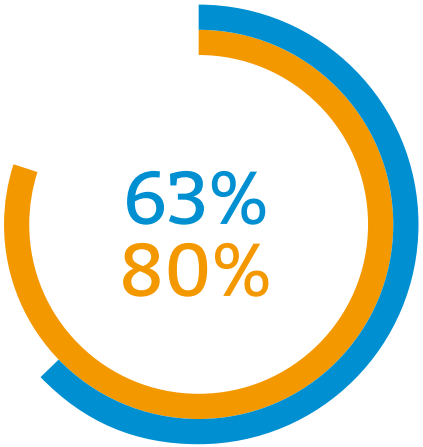
Embedding Simulation Training

Simulation Case Study – Mental Health Training (cont.)

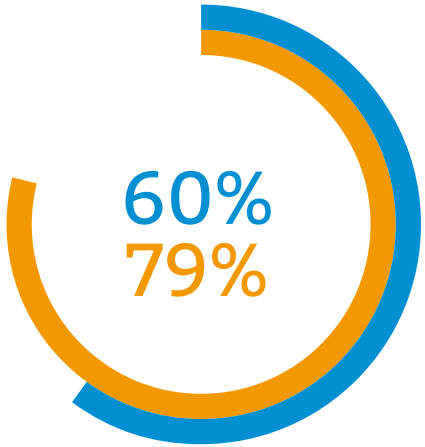
The Outcome

Responses to the open questions and individual interviews were analysed by the course leads and research team. Their findings revealed that participants experienced an increase in confidence, knowledge and more. For example:

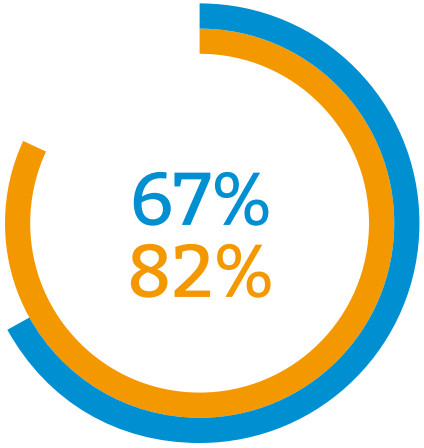
Confidence (conditions)



Knowledge (conditions)



Collaboration with colleagues



■ before the course in human factors and healthcare skills ■ after the course in human factors and healthcare skills

[SOURCE: Police & Ambulance (PASHMA) Course Report JULY 2017.pdf, SIMHS evaluation paper JMHTEP-06-2018-0037.pdf]

The Feedback

It was useful to interact and learn from colleagues, both in the ambulance and police services"

"It increased my confidence in managing patients experiencing mental ill-health"

"The course helped me develop a greater understanding of the issues involved, allowing me to communicate more empathy and options"

"It made me more aware of what more I could possibly do – and what other emergency services do"

Embedding Simulation Training

"Simulation is about building skillsets up in a safe environment and being able to think and reflect on what you're doing, and what you could change. Simulation is not always about technical skills necessarily either, it's about situational and relational awareness, team working, collaboration, and providing an environment where people are working together to problem solve and provide the best care for patients."

Sarah Wright, global simulation training expert who recently collaborated with Great Ormond Street Hospital

[SOURCE: https://www.gosh.nhs.uk/art-facilitating-clinical-simulation]

Delivering the Education

Discover the many safety-focused learning and training opportunities available within the NHS.

Delivering the Education

200+ e-learning programmes

24,000+ e-learning sessions

900,000+ registered users.

From undergraduates to the existing workforce, there are already a host of e-learning and training opportunities available, all delivered via the HEE 'e-Learning for Healthcare' (e-LfH) portal.

Safety First

While safety is implicit within a majority of the portal's learning resources, 'patient safety' is a specific aspect of many programmes:

- 187 learning sessions
- 36 courses
- 10 programmes
- 1 learning pathway.

In 2018, there were:

147,000+ session launches of programmes including a patient safety element

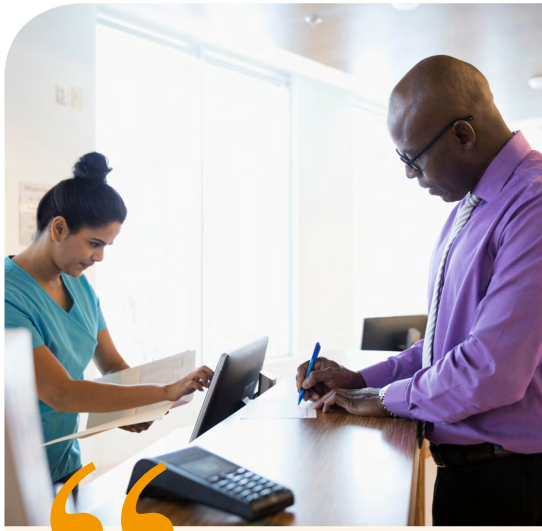
81,000+ registered users for these programmes

180,000+ registered users in the past 5 years.

The learning available covers all areas of NHS care:

From the general
Learning journeys relevant to all staff including the 'Freedom To Speak Up' and 'Statutory' and 'Mandatory' programmes.

To the specialist
Learning journeys aimed at specific professional groups including 'Sepsis in Paediatrics', and training on safety in procedures such as MRI.



"Patient safety is mandated by the professional regulators and is integral within all healthcare professional training. There is already a significant amount of patient safety training taking place throughout the NHS, within training programmes and as stand-alone packages."

– Health Education England

Delivering the Education

Introduction to E-Learning

Learn how HEE's e-learning syllabus can help NHS staff master the elements that make up their roles:

TRY THE DEMO ›

E-Learning Demo

Benefit from an overview of the many types of content featured within a typical e-learning training session.

VIEW HERE ›

Planned Programmes

Take a look at our planned programmes

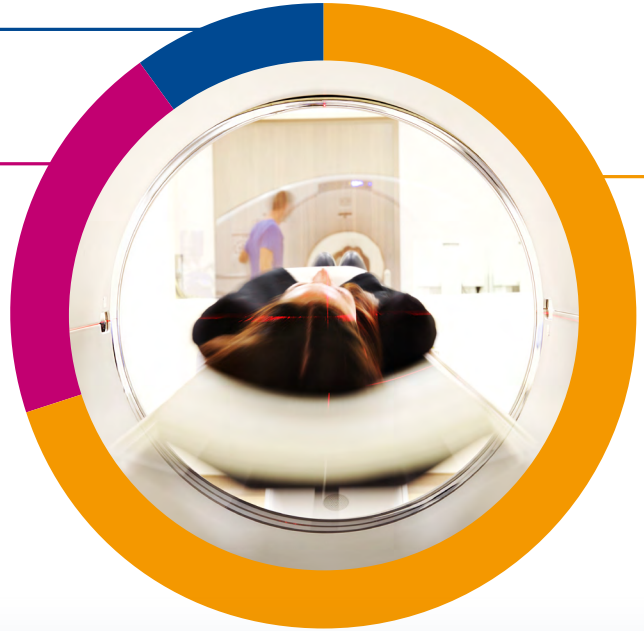
Delivering the Education

Safety in MRI as an exemplar

E-learning Example – MRI Safety Programme

10% of injuries caused by MRI units are due to the 'missile effect', where a ferromagnetic object can kill/severely injure as it 'flies' towards the magnet.

20% are due to implant disturbance, quench, fire, acoustic concerns or internal heating effects.



70% of injuries are due to burns.

Such life-threatening issues has seen the introduction of a web-based learning resource for MRI staff. It ensures all relevant personnel are made aware of preventable risks and hazards by offering an essential guide to safety knowledge including:

- Safety hazards and risk management
- Safety guidelines/legislation
- Adverse incident management and reporting.

Delivering the Education

Case Study – Primary Care Workstream

The Challenge

To overcome patient safety issues within GP surgeries caused by systemic problems with surgery communications and operations.

The Objectives

To analyse areas of risk to patient safety and to initiate and support practice-led changes, using human factors. For example:

- Getting the most urgent patients seen as rapidly as possible
- Reducing failures in prescription issuance and dispensing
- Handling of the large volumes of incoming clinical information within the GP surgery – without overloading doctors or missing important items.

The Methods

Trialing of a staff-led pilot intervention programme to improve patient safety. This was supported by quantitative and qualitative data collection to assess the impact of the trial. This involved:

- Applying human factors methods of task analysis
- Conducting a solution workshop
- Developing decision-aid materials/graphics
- Collecting and analysing critical data
- Presenting results back to the practice staff.

The Outcome

- More patients were seen in an appropriate appointment type (i.e., from urgent patients to same day appointments)
- A new Advanced Clinical Practitioner (ACP) role was trialed to take on part of the duty call-back appointments and Docman documents; this saw the GP freed up to take on urgent consultations
- A significant reduction in the number of missing prescriptions combined with an increased uptake of electronic prescribing
- A reorganisation of the system for screening low-risk document types and training of staff so that administration staff could safely process some of the Docman correspondence.

[SOURCE: Patient Safety Academy Annual Report 2017-18 FV.pdf]

[As part of the patient safety training in our GP practice], the hands-on activities with the other members of the team was quite an eye-opener because it really highlighted what seems like a very simple process is actually not very simple."

– Feedback from course attendee

Delivering the Education

Positive Progress

There are many provider of human factors and safety across the NHS, delivered by clinical staff and trainers internally and commissioned from external trainers.

Nurses and Midwives

Therapists

Assistants/ Technicians/ Practitioners

Admin and Managers

Doctors

[SOURCE: Patient Safety Academy Annual Report 2017-18 FV.pdf]

The following is participant feedback from the multiple courses run by the PSA:

"It was very well presented and created a good atmosphere where everyone felt able to contribute. I will now be able to effect change in everyday routine."

"All clinical staff should be doing human factors courses to have an awareness of the implications"

"It reveals how human factors affects everyday working and how it can improve safety, bridge gaps and reduce risks in simple ways"

"Can human factors be incorporated into mandatory training?"

Delivering the Education

E-learning can be cost effective, time efficient and a flexible way to access training. In a sector like the health sector where people can be quickly pulled away, it is something you can dip out of and go back to – you aren't locked into a classroom."

Emily Newlands, Development and Support Manager, National Skills Academy for Health

[SOURCE: https://www.theguardian.com/healthcare-network/2015/may/11/e-learning-in-healthcare-benefits-challenges-and-limitations]

Speaking up

Learn why raising concerns is critical to maximising patient and workforce safety across the NHS.

Speaking up

Creating a Speaking Up Culture

After the inquiry into Mid Staffordshire NHS Foundation Trust in 2013, the NHS committed to ensuring all employees were able to report concerns and receive the right advice and support via a Freedom to Speak Up (FtSU) Guardian.

Now a mandatory requirement for every trust, the Guardian works with staff to make trusts more open and transparent – as well as ensure that employees who do raise concerns are protected. Critically, the aim is to promote a culture where speaking up is the rule, not the exception.

According to the National Guardian's Office Annual Report 2018, significant progress is being made:

800 Guardians and champions-in-trusts, independent sector organisations and some arm's-length bodies

7,000+ cases raised through Freedom to Speak Up Guardians in trusts

32% of cases raised had an element of patient safety

45% of cases had an element of bullying and harassment, a latent patient safety issue

87% of those who gave feedback would speak up again.

Speaking up should be something that everyone does and is encouraged to do. There needs to be a shared belief at all levels of the organisation that raising concerns is a positive, not a troublesome activity, and a shared commitment to support and encourage all those who raise honestly held concerns about safety."

– Sir Robert Francis, Freedom to Speak Up report, February 2015

Speaking up

Uncovering the Truth

The work of the Guardians has revealed a number of extremely serious cases. According to the National Guardian's Office, these include:

- gaps in junior doctor rotas, which left a single doctor responsible for hundreds of acutely unwell patients overnight
- a lack of social worker's curiosity that led to the uncovering of a modern slavery and human trafficking ring following a multiagency investigation
- understaffing on a ward that led to a fundamental review of recruitment practices
- a concern raised by a housekeeper that led to the review of infection control policies and training at a trust.

Despite unearthing such cases, the National Guardian's Office Annual Report 2018 report shows that there is still much work to be done:

5% of workers believed they were prejudiced against after speaking up.

Far from suggesting reassurance, where no cases have been raised, or where no data returns have been submitted, trust boards should be robustly challenging themselves about the effectiveness of their FTSU arrangements…

[SOURCE: Speaking up in the NHS in England – Data Report https://www.cqc.org.uk/sites/default/files/20180919%20-%20Speaking%20up%20data%20report%202017%20-18.pdf]

> *"Leaders need to attend to the culture of their organisations without delay, ensuring that workers are thanked, listened to, that their confidentiality is protected, that the right investigations are carried out and the right actions taken as a result. Feedback to the worker that has spoken up, with a guarantee that they will not be victimised as a result, are key to ensuring that some of the barriers to speaking up are removed for good."*
>
> **– Dr Henrietta Hughes, National Guardian for the NHS, National Guardian's Office Annual Report 2018**

Speaking up

Video Introduction to Speaking Up

Learn more about how to speak up – and why it is so critical to the future of the NHS and its duty of care to both patients and staff.

Raising Concerns

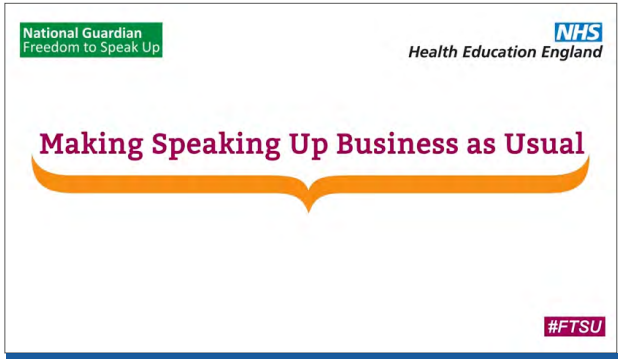
A video highlighting how everyone working within the NHS has a responsibility to raise concerns if they see something that threatens patient safety. Includes three scenarios – hygiene, communication and near miss surgery.

Watch video

Responding to Concerns

A video detailing how to manage the concerns that were raised by the NHS staff featured in 'Raising Concerns' film, offering practical examples of effective management and successful outcomes.

Watch video



Making Speaking Up Business as Usual

A video calling for all NHS staff to make reporting concerns the rule, not the exception. It details the brave actions of three 'Speaking Up' pioneers whose whistleblowing not only saved lives and/or improved care within their Trusts – but also acted as a catalyst for bringing about transformative change within the NHS itself (including the creation of the Freedom to Speak Up Guardian scheme).

Watch video

Speaking up

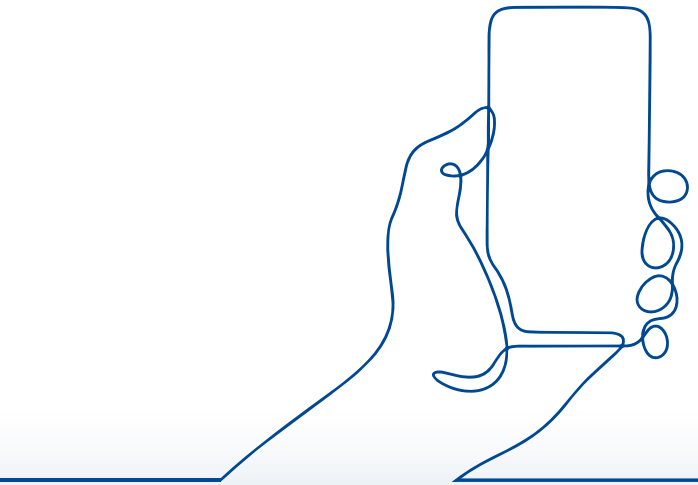
Case Study – 999 Callbacks

The Location

The Emergency Operations Centre (EOC) at the North West Ambulance Service NHS Trust handles approximately 1.5 million 999 calls every year. During periods of high demand, unanswered 999 calls can stack up, leading to an increase in abandoned calls.

The Concern

Staff raised concerns that during one very busy night shift in 2017, 420 calls between the hours of 00:00 and 07:30 had been abandoned. Standard procedures dictate that every caller who has abandoned their call must be re-contacted to check if an ambulance is needed. This puts a huge time-consuming strain on all staff involved in the callback process.



The Response

Staff approached the centre's Guardian who in turn contacted the director of operations to discuss the issue. Immediate action was taken with the resulting investigation highlighting how complicated and time-consuming the callback procedure was. Critically, it also revealed that the executive management team weren't even aware of the callback issue.

The Outcome

Just six weeks after staff had spoken up about the issue to their Guardian, procedures were changed; calls that had been abandoned before connection were no longer routinely re-contacted. This gave staff additional time to answer waiting 999 calls, making their workload more manageable.

[SOURCE: https://www.england.nhs.uk/wp-content/uploads/2017/11/07-pb-30-11-2017-national-guardian-annual-report.pdf]

Speaking up

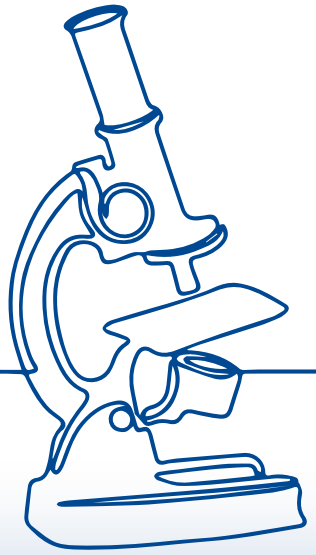
Case Study – Lab Safety

The Location

The Salford Royal NHS Foundation Trust.

The Concern

A worker in a surgical laboratory raised concerns about recurring leaks of sewerage water within the department. While the immediate effects such as unblocking pipes were always dealt with, the actual cause of the problem had never been addressed. This led to recurring problems including patient appointments being delayed, equipment made in the lab requiring decommissioning, and evacuating the lab while the area was decontaminated.



The Response

The worker's concern was escalated by the Guardian to senior management who immediately created a group to draw up an action plan to tackle the ongoing issue.

The Outcome

A full risk assessment was carried out as well as surveys of the building undertaken with contractors conducting camera investigations and installing new pipework. During this period, any delays in patient care were monitored with service continuity plans put in place to help ensure delays were not experienced. The surgical laboratory is now a cleaner, safer place for both staff and patients.

[SOURCE: https://www.cqc.org.uk/sites/default/files/CCS119_CCS0718215408-001_NGO%20Annual%20Report%202018_WEB_Accessible-2.pdf]

Speaking up

From the Frontline: 'Freedom to Speak Up' Feedback

The Positive

"From the very beginning I was assured my concern would be dealt with in the upmost confidence and a higher level of Trust management would be involved and not 'swept under the carpet' as I believe would have been the outcome if lower level management had been involved"

"Definitely a great service, advice and support, I feel you empowered me with the knowledge I needed to action and raise my concerns further"

"Historically escalating the issue I raised would not have been an option for fear of repercussions, I would have no concerns in the future contacting you again for help"

"This is a great service and I feel staff need to be reminded frequently this is a confidential route and no names or blame attributed to the reporting party ... Extend my heartfelt thanks for not only a well-handled situation but a really positive learning experience too. It was very humbling and empowering."

The Negative

"This has been very stressful and I'm honestly not sure if I would do it again"

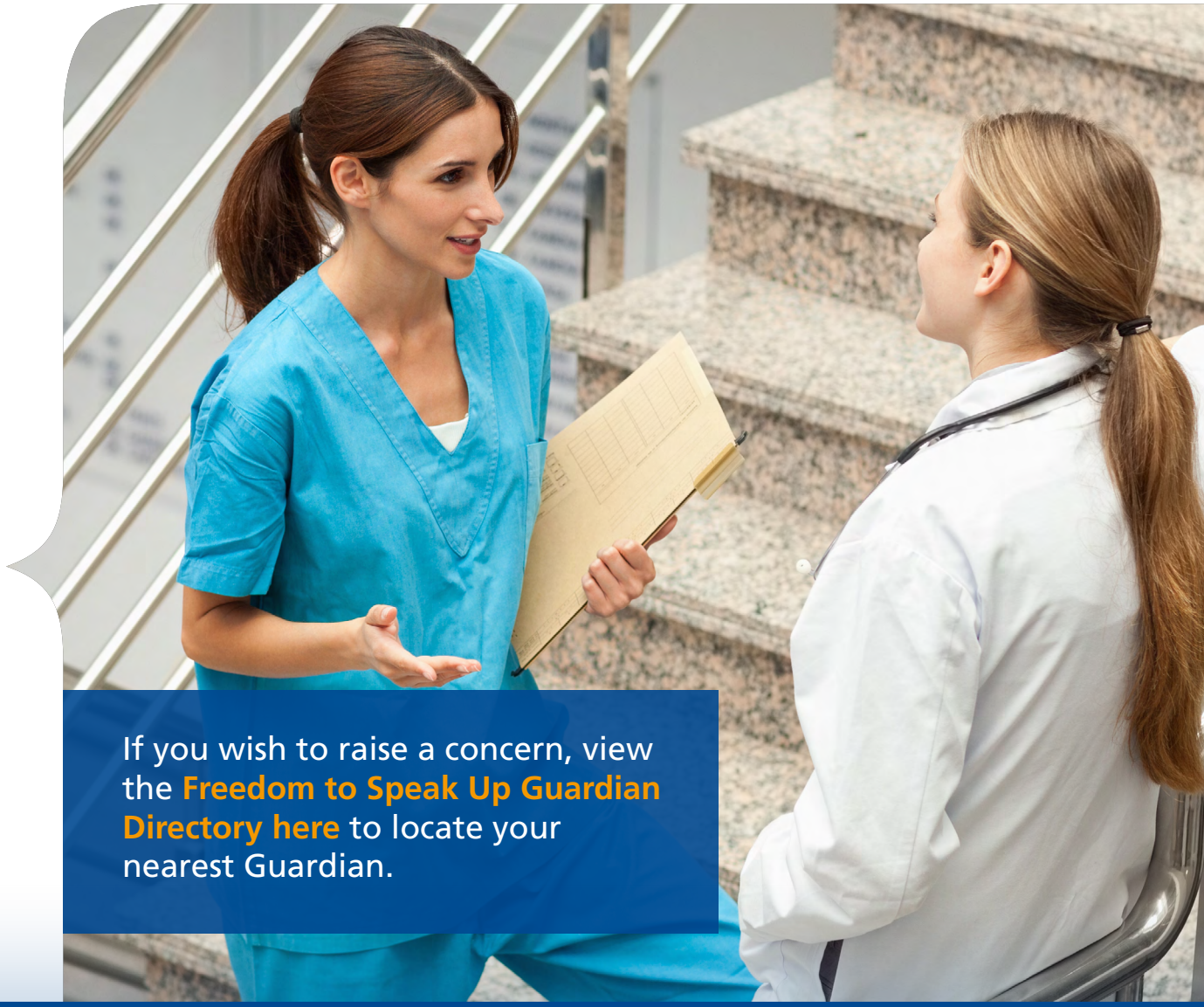
"Things haven't completely got better, but I'm glad I spoke up"

[SOURCE: https://www.cqc.org.uk/sites/default/files/20180919%20-%20Speaking%20up%20data%20report%202017%20-18.pdf]

Speaking up

I remember when I was giving evidence at the [Mid-Staffs] public inquiry. [I was asked] why did I speak up? Was it because of my awareness of my professional duty? And I said of course I was aware that I had a professional duty to speak up as a registered nurse – but it was much more than that. It was my moral code that told me you can't let patients suffer, that you can't see colleagues suffer – and simply walk by and do nothing."

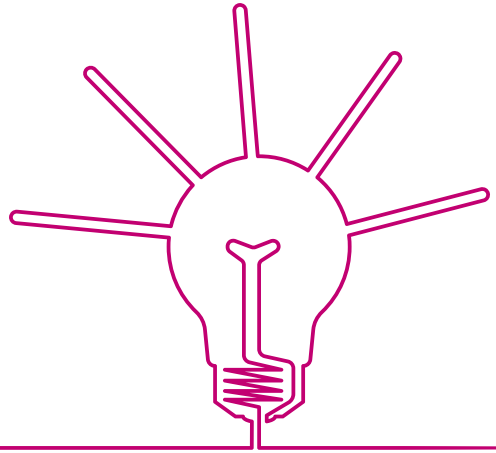
Helene Donnelly OBE, Ambassador for Cultural Change/ Freedom to Speak Up Guardian, Staffordshire & Stoke on Trent Partnership NHS Trust. **Read her story here ›**



If you wish to raise a concern, view the **Freedom to Speak Up Guardian Directory here** to locate your nearest Guardian.

Creating a Safer Future

The NHS has 1.2 million staff and offers 350 different careers; such numbers means developing a consistent national patient safety syllabus for the whole of the NHS is an enormous challenge. But it's one we're already undertaking and building on – and we can go even further with your help and commitment.



Creating a safer future

Patient Safety First

To make patient safety a priority for the NHS over the next decade, HEE will work in partnership with NHS Improvement to produce the most informed and safety-focused workforce in the world by:

- Implementing the patient safety syllabus; Working in partnership with NHS Improvement and with the Academy of Medical Royal Colleges, we will develop a consistent national patient safety syllabus appropriate for all staff in in the NHS.
- Foundation level training for patient safety; The aspiration of the NHS Patient Safety Strategy to make patient safety training available for all staff within the NHS.
- Promoting a patient safety culture; HEE, nationally and regionally, will continue to promote training initiatives to enhance safe healthcare practice.
- Collaboration; HEE will continue to work across the system to promote patient safety through sharing safe healthcare practice across the NHS through networks, collaborations, and positive safe practice reporting.
- Patient/ public voice; We recognise the importance of patient and public engagement to ensure greater transparency and enhance accountability.

In order to ensure the necessary knowledge, skills, capability and culture to promote patient safety throughout the NHS, staff need the best possible education, training and development opportunities."

– Health Education England