NHS
Health Education England

Education and Training Interventions to Improve Patient Safety

Health Education England Implementation Plan 2016 – 2018

Developing people for health and healthcare

www.hee.nhs.uk

THE NHS CONSTITUTION
the NHS belongs to us all

Foreword

Health Education England (HEE) established the Commission on Education and Training for Patient Safety in February 2015 to make evidence based recommendations for improving education and training of health professionals to deliver safe, dignified, compassionate, person centred care.

The independent report addresses one of the most important issues the National Health Service is confronting: delivering safe, dignified, compassionate and person-centred care. It is the first of its kind to focus on how education and training interventions for all healthcare staff can actively improve the safety of patients in the NHS.

The report is informed by a wealth of evidence gathered through focus groups, site visits, surveys and interviews; from patients and their families, carers, students and trainees, frontline staff at every level across all settings, healthcare managers, executives, as well as international experts and national organisations. We wanted to obtain the views of these varied constituencies and create a better approach to the adoption of innovation in patient safety.

The Commission's work has been a cornerstone of HEE's patient safety strategy and therefore this implementation plan. So much so, that the Mandate from Government to HEE asks that HEE **"continue its strategic leadership role to the organisations which have been working together to embed patient safety knowledge and skills at all stages and levels of education, training and professional development."**

There are important steps that need to be taken to assure the success of this report. HEE and wider partners, need to continue to lead and engage and work together at the highest level in this agenda; although early signs are positive, a sustained focus on taking forward this report's recommendations will be essential to realising the vision we set out. In response to the Commission's report, HEE:

- supports its findings and accepts all 12 recommendations
- will provide a leadership role in taking forward all 12 recommendations working in partnership with key organisations across all levels in the system
- publishes this implementation plan to set out progress to date and the next stages
- recognises that in the longer-term implementing the recommendations will deliver significant benefits to patients through improvements to education and training of the healthcare workforce to deliver high quality, safe and compassionate care.

We are grateful to the many participants involved in the original Commission who gave up their time to inform and advise us on this journey. Ultimately now, responsibility for success will lie with the leadership from across the NHS – at national and local level. With this in place we see no reason for the benefits of improved patient safety not to flow rapidly and widely, delivering high quality education and training for patient-centred care and better outcomes for our patients.

Professor Wendy Reid
Executive Director of Education and Quality & National Medical Director

Ged Byrne
Director of Education and Quality – North

Purpose of the Implementation Plan

1. The purpose of this document is to set out the plan for the implementation of the recommendations of the Commission on Education and Training for Patient Safety report, published in March 2016. It describes substantive progress on delivery since the publication of the report, including the alignment to HEE's wider levers and activities, whilst recognising that there is a need for on-going discussions and collaboration with key partner organisations to ensure high quality patient safety.

2. The delivery of the implementation plan is on three key levels; through identifying local best practice and working across local offices to spread and adopt this; the strategic alignment at national level across our system partners, such as Arms Length Bodies and Professional Regulators, and; using national levers to enable delivery, such as the HEE Quality Framework.

3. This plan also describes the governance arrangements and wider system partner and stakeholder engagement required to ensure successful delivery.

Background

4. The report makes 12 recommendations (Annex A) across four themes to Health Education England and the wider healthcare system. The Commission emphasised that strategic leadership and collaboration across the NHS is vital to ensure all staff have the right skills, knowledge, values and behaviours to ensure patient safety.

5. The report aims to shape the future of education and training for patient safety in the NHS over the next 10 years and argues for education and training to be utilised to break down barriers to providing safe care, creating an environment where all staff are trained to focus on patient needs coupled with the right workplace conditions, motivation and opportunity to ensure sustained behaviour change.

HEE's Mandate for 2016-17

6. The Depart of Health mandate to HEE for 2016-17 sets out 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, not only in its response to the Commission, but also:

   - supporting the work of the National Quality Board
   - contributing to continual improvements in the provision of safe and compassionate care in line with the NHS Constitution
   - supporting the Government's aspiration for the NHS in England to become the world's largest learning organisation, particularly in learning from patient safety incidents.

Progress to Date

Strategic Alignments

7. The Commission's report and the progress since publication has broadened HEE's understanding of education and training interventions which can break down barriers to providing safe care, create an environment where all staff learn from error, where patients are at the centre of care, treated with openness and honesty and where staff are trained to focus on patient needs. As stated in the Commission's report:

> "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"

8. The correlation between education and training, patient safety and quality of care is not new. Many reports on NHS care have highlighted the importance of good quality training for all professions across their career to secure patient safety. The Francis Inquiry into the failings at the Mid Staffordshire Foundation Trust found that a poor system, inadequate coordination and provision of training for NHS staff (particularly clinical professions) inevitably resulted in poor care and increased the risk of harm to patients. Similarly, the Berwick Report into NHS patient safety made a number of recommendations for improving the training and capacity of the NHS workforce to deliver safe care to patients:

> "The entire NHS should commit to lifelong learning about patient safety and quality of care through customised training for the entire workforce on such topics as safety science, quality improvement methods, approaches to compassionate care and teamwork."

9. This is the context in which HEE developed and published in April 2016, its Quality Strategy and Quality Framework for education and training, which will enable HEE to consistently identify, benchmark and improve the quality of the training environment. Patient safety and quality of care is a core thread through the framework and at the heart of HEE's statutory duties. The Quality Framework provides a broad, multi-professional and England wide lever through which many of the Commission's recommendations are already being delivered. Quality and Patient Safety are inextricably linked and this strategic alignment is a major and positive development for implementation.

10. The HEE Quality Framework also enables HEE to work consistently with system partners across patient safety, including the Care Quality Commission (CQC), NHS England (NHSE) and NHS Improvement (NHSI) on system support and patient safety through, for example, Quality Surveillance Groups (QSGs). HEE provides insight and soft intelligence across a multi-professional view to QSGs and the CQC for quality summits and inspections and works increasingly with NHSE and NHSI to support providers improve training.

Partnership Working and Stakeholder Engagement

11. The Commission recognises that education alone will not be enough to improve patient safety and a system wide approach is needed to collectively create the right environments for work and learning to equip staff with patient safety skills.

12. On 1 April 2016 the statutory patient safety functions previously delivered by NHS England transferred to NHS Improvement. As such, NHS Improvement lead nationally on NHS patient safety policy in relation to all providers of NHS-funded care, including NHS trusts and NHS foundation trusts, primary care providers and social enterprises, among others. However the universality of patient safety requires HEE to work with key NHS Arm's Length Bodies to implement the Commission's recommendations to embed and sustain improvements in education and training across the system. NHS Improvement will therefore be a crucial partner in the application of HEE's implementation plan.

13. HEE has also recently worked in partnership with NHS Arm's Length Bodies in the National Quality Board to develop a soon to be published 'Shared commitment to Quality' which aims to signal the system's need for a joined up approach to quality and a common language across the system. As an example of this, HEE is a signatory to the 'Human Factors in Healthcare: a Concordat from the National Quality Board' published in August 2013. Whilst the Commission on Education and Training for Patient Safety identified best practice in embedding human factor principles and practice across the NHS, the Concordat formalised the commitment of NHS Arms-Length Bodies, regulators and other healthcare representative bodies to develop programmes of work to enable the NHS to embed Human Factors principles and practices in its culture, systems and processes.

Implementation of the Recommendations

14. On the 14th July 2016 a Stakeholder Workshop took place to discuss the draft implementation plan and to identify how HEE can best work with and across the healthcare system to implement the detail of the Commission's recommendations.

15. The workshop was an integral step in scoping out the next steps of the programme and was focussed around core objectives to:

i) identify what is happening already across HEE and other key organisations and therefore what can be scaled up as best practice

ii) suggest a number of implementation activities to deliver the recommendations which contribute to the plan at Annex B

iii) understand the barriers and enablers to delivery

iv) secure commitment from partners to support delivery of the implementation plan.

16. To enable effective delivery, the recommendations have been grouped into four key workstreams:

- Workstream 1: Learning and Training Environments (Recs 1, 4, 6, 10)
- Workstream 2: Human Factors and Culture (Recs 2, 5, 11, 12)
- Workstream 3: Embedding Existing Training Initiatives (Recs 7,8)
- Workstream 4: Supporting Joined Up Care (Rec 9).

17. Recommendation 3: Evaluation of Education and Training for Patient Safety will be embedded into each workstream for discussion and consideration. In addition, the work of the Commissioning for Quality team will also be a vehicle to take this forward as well as wider discussions with our key stakeholder partners.

18. In order to ensure effective leadership of each of these workstreams and promote working as one organisation, each workstream is led by one region, involving each local office. Each nominated lead across the region sits as a member of the Programme Board. In addition, a member of the original Commission will be aligned to each workstream to act as an expert to support the implementation of that particular series of recommendations.

19. Working in this way re-engages the original Commission and the 13 plus members from the previous Local Education Training Board (LETB) Delivery Group and promotes engagement and alignment across the local offices. It will also ensure we have involvement from experts in patient safety who can advise on those initiatives that can be scaled up as best practice and engage in other work to deliver on the recommendations within each workstream.

Roundtable – Arms Length Bodies and System Partners

20. On the 9th November, HEE brought together senior leaders from system partners including Arms Length Bodies (ALBs), Professional Regulators and Royal Colleges, to ensure alignment in delivery and approach.

21. The meeting identified much consensus with regards to ongoing alignment and joined up working in the implementation of the recommendations as well as identifying the appropriate levers in the system. It also highlighted what else should be considered in light of a changing health and political landscape.

22. There was clear recognition amongst attendees that there is an enormity of evidence demonstrating improvements in patient safety at local level with great momentum in best practice, spread and adoption. Whilst we expect this to evolve as work continues, there was agreement that strategic alignment across the ALBs and system partners is imperative to achieve the desired impact for quality and patient safety.

23. We sought feedback on five questions, a summary of which is below and will feature as part of the wider strategic delivery of the Commission's recommendations:

i. **Do we need to revisit any of the recommendations?**
The general consensus was that the recommendations were appropriate and still relevant. However, it was recognised that the political landscape had changed since the Commission, an example being Brexit, and we therefore need to be mindful of continual change and ensure that we focus on a few meaningful deliverables as opposed to trying to tackle everything at once. In addition, it was suggested that we revisit Lord Carter's report, 'Operational productivity and performance in English NHS acute hospitals: Unwarranted variations' as it reinforces some of the key messages in the Commission.

ii. **What else do we need to consider?**
There was agreement that more could be done in relation to patient engagement in the design and development of education and training. It was acknowledged that this had not been done systematically to date. However, there were opportunities to gain traction to do this through strategic levers such as the HEE Quality Framework. Linked to this there was consensus that consideration needed to be given to how improvements in patient safety are measured; not everything is reported and there needs to be a marked improvement in the transition from translating what goes wrong into meaningful and impactful learning, and therefore a shift in behaviour and culture. There was also a constructive discussion around the use of multi-professional team based competency frameworks for patient safety. There is an example of this in the North West which the team will explore further and whilst there were some concerns, most agreed that developed and used in the right way, it could help harmonise a number of the recommendations and be a step change towards measured improvements in patient safety.

iii. **What would we like to report back to the Commission and Secretary of State in March 2017?**
There was clear consensus that the report back to the Commission and Secretary of State in March was an opportunity to showcase some of the local best practice already in place across the country. As part of the implementation plan leads from across the system are being identified. The report will also describe progress from national initiatives such as the Quality Framework as the metrics developing for quality assurance reporting will reflect patient safety. Specifically, handover in patient care was sighted as an area that the Quality Framework could be used to drive systematic improvements, coordinated nationally and delivered locally through HEE's quality management arrangements.

iv. **Are there any other national areas of work we need to align with?**
The roundtable agreed that there was a significant opportunity through the National Quality Board to set out clear organisational roles and responsibilities across the Arms Length Bodies in relation to the quality and patient safety agenda and establish a common narrative through this vehicle.

v. **Is the membership of the roundtable the appropriate membership for the Stakeholder Oversight Group?**
There was positive agreement that this group would be able to provide strategic oversight of the delivery of the implementation plan, ensuring that there is consideration of and alignment with other important national areas of work. It was agreed that this group will meet twice a year and membership may evolve.

24. To round up the meeting, the group were asked 'what do we want to deliver in the next 100 days.' This led to in depth discussion and a number of key and immediate actions which HEE will now take forward with key partner organisations to deliver the vision of high quality education and training and patient safety:

- It was proposed that the National Quality Board should set out the specific roles and responsibilities of national and local organisations in respect of patient safety to ensure clarity and agreement across the whole system e.g. ALBs, employers, regulators.
- HEE to work with partners to consider multi-professional, team and role based competencies along with exploring how we can bring Quality Improvement into curricula. There is much good practice around this to draw upon.
- HEE, Professional Regulators, Royal Colleges and others to work together in identifying the collective levers for the delivery of behaviour and cultural change at provider level. Patient safety should be a driver to improve culture in all organisations but the issue needs to be address with more work on how to measure patient safety outcomes. The Advanced Quality Alliance programme in the North West has already done some significant work on this to build on and cascade nationally. In addition, work is taking place regarding patient safety metrics in the Quality Framework dashboard.
- Acceleration in the work taking place across multi-professional education and training is needed, particularly around measuring outcomes.

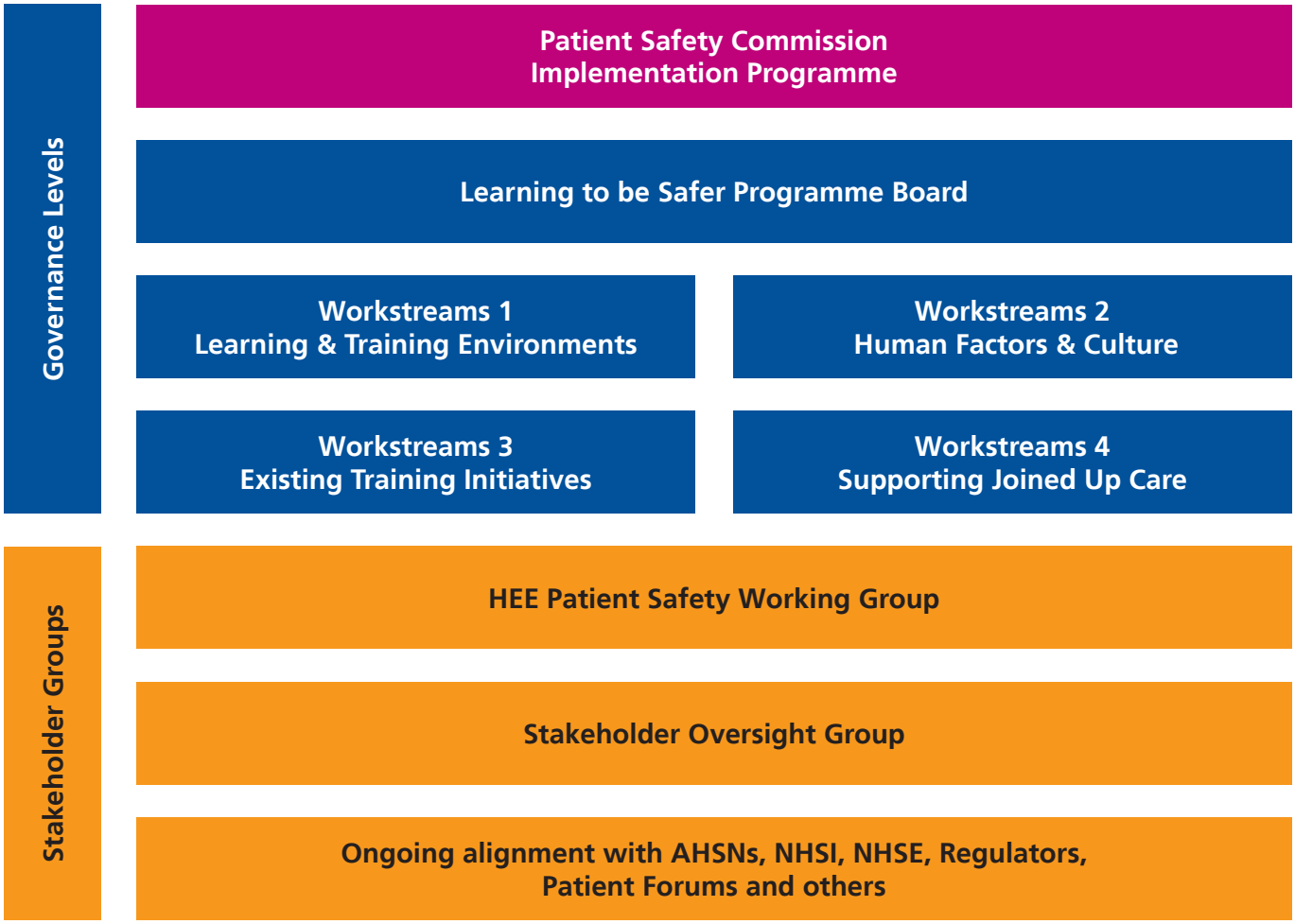
25. HEE will translate these proposals into actions within the patient safety programme and report on progress to the Commission and the Secretary of State in March 2017.

Transforming Education and Quality – National Conference

26. In February 2017 HEE will be bringing together the patient safety and quality agendas by hosting a national conference on 'Transforming Education and Training.' This will provide HEE with an integral opportunity to showcase and promote best practice in education and training interventions for quality and patient safety and amongst others, hear from experts in the system on how we can together shape a system based on world class quality and patient care.

Governance

27. To enable the programme to deliver on its objectives, it is essential to ensure robust governance exists with clear processes for decision making. The diagram below describes the programme governance arrangements:



Programme Board

28. To ensure there is internal oversight of the programme, a Learning to be Safer Programme Board was established in October 2016. This group, chaired by Ged Byrne, Director of Education and Quality (North) meets every two months and is responsible for the day-to-day delivery and oversight of the programme. The Board will provide an ongoing steer on the implementation plan (Annex B).

HEE Patient Safety Working Group

29. This group has evolved from the LETB Delivery Group, which was central to the work of the Commission. It has been reconvened to drive forward the recommendations across the four key worksteams.

30. It is crucial that the recommendations are delivered and owned locally with the involvement of system partners and threaded through local Sustainability and Transformation Plans (STPs). This group is therefore integral to help shape this in more detail and to take the lead on the delivery, with national input and support where needed. Representatives of this group will take on the leadership of the workstreams.

31. This group also made up a large number of the attendees at the Stakeholder Workshop on the 14th July and provided an invaluable contribution to the next steps underpinning the implementation plan.

Stakeholder Oversight Group

32. The July 2016 HEE workshop with stakeholders revealed programmes which would complement implementation to make connections, share learning, foster synergy and, where appropriate, deliver shared outcomes.

33. To ensure cohesive leadership across the system and alignment with HEE's key partnership organisations, a Stakeholder Oversight Group was established in November 2016. Whilst this group will not have any formal accountability, it is essential the work has input and challenge from system leaders to ensure wider strategic issues are considered and that there is consistency across the organisations in approach and ultimate objectives.

34. HEE's membership of the National Quality Board will also be a key forum to communicate, bring together, contribute or rationalise activity on education and training interventions which are driven by quality techniques and approaches.

Next Steps

35. This implementation plan sets out the high volume of activity that is already taking place to deliver on the Commission recommendations and lays the foundation for embedding the work, discussion and collaboration required across HEE and its key partners to ensure that quality and patient safety are at the top of the agenda in delivery of education and training.

36. In March 2017, a progress report will be submitted to both the Commission members and the Secretary of State to highlight key progress to date including local best practice embedded across the NHS to ensure the highest quality education and training interventions for world class patient safety and the impact that is being made at national level across HEE and our system partners.

ANNEX A

The Commission's 12 Recommendations within the Four Themes

No	Commission on Education and Training for Patient Safety: Report Recommendations
	THEME 1: Creating a Culture of Shared Learning
1.	**Ensure learning from patient safety data and good practice** Patient safety data and learning from incidents to be made available to those developing education and training. HEE to: • 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.	**Develop and use a common language to describe all elements of quality improvement science and human factors with respect to patient safety.** • incorporate work of Human Factors group into way all staff are trained
3.	**Ensure robust evaluation of education and training for patient safety** • 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

THEME 2: The Patient at the Centre of Education and Training	
4.	**Engage patients, family members, carers and the public in the design and delivery of education and training for patient safety** • 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.	**Supporting the duty of candour is vital and there must be high quality educational training packages available** • 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
THEME 3: Lifelong Learning – Focussing on Safety from Start to Finish	
6.	**The learning environment must support all learners and staff to raise and respond to concerns about patient safety** • 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.	**The content of mandatory training for patient safety needs to be coherent across the NHS** • 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.	**All NHS Leaders need patient safety training so they have the knowledge and tools to drive and change improvement** • HEE to work with partner organisations to ensure that leadership on patient safety training is incorporated into leadership programmes

THEME 4: Delivering Education and Training for Patient Safety	
9.	**Education and training must support the delivery of more integrated 'joined up' care** • HEE to work with partner organisations to ensure education and training supports 'joined up' care
10.	**Ensure increased opportunities for inter-professional learning** • HEE to use levers to facilitate increased opportunities for inter-professional learning
11.	**Principles of Human Factors and professionalism must be embedded across education and training** • 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.	**Ensure staff have the skills to identify and manage the potential risks** • HEE to work with national partner organisations to ensure that staff have the skills to identify and manage risks

ANNEX B

HEE Implementation Plan

The HEE Implementation Plan is underpinned by key activities, detailed below, that will provide a systematic approach to implementation and ensure that we build both a repository of best practice across the system and a detailed plan of how to address any essential gaps in delivery of the recommendations, as follows:

Leadership and delivery the overall programme

Each HEE region is leading one of the workstreams to ensure collaboration and alignment in the delivery of the programme. Each workstream lead will sit on the Programme Board and will be supported by member of the original Commission who will provide 'expert' support to each workstream.

Highlighting best practice across HEE

A mapping exercise has been undertaken across HEE and work is now underway with the HEE Patient Safety Working Group to identify the best practice and where there might be important gaps in delivery. A detailed write up of this evidence is underway including the impact and outcomes of these interventions.

Building a repository of best practice to be accessible across the NHS

To support the spread and adoption of good practice and to continually capture this as the programme develops, the Technology Enhanced Learning team are working on embedding patient safety case studies and best practice into the pilot of the 'learning solution'.

Establish robust governance

A robust governance structure is in place to ensure essential and continuous collaboration and engagement across HEE, Arms Lengths Bodies (ALBs)and key system partners.

Stakeholder Engagement

On the 9th November 2016 HEE chaired a Roundtable, attended by senior leaders from a cross section of HEE local offices, Arms Length Bodies and key system partners, such as Royal Colleges and Professional Regulators. This meeting ignited important discussion around patient safety and quality and continual engagement will be taking place amongst these organisations on the patient safety agenda.

On the 2nd February 2017, HEE will be hosting a joint patient safety and quality conference - 'Transforming Education and Training' with 300 invitees representing the patient safety and quality arenas.

Learning to be Safer Workstream Implementation Plan		
Workstream One: Learning and Training Environments		
Implementation through embedding good practice across HEE		**Implementation through the HEE Quality Framework**
Recommendation 1. Ensuring learning from patient safety data and good practice	Many of the local offices have excellent quality surveillance, data analysis and response mechanisms in place and national reporting metrics are in development. There is also a wide array of specialty specific, small-scale bespoke initiatives which demonstrate vast improvements to patient safety.	HEE is working with an Academic Partner (Newcastle University) to test metrics against the Quality Framework so we can ensure that the metrics for Domain 1 – Learning Environment and Culture (Standards 1.1 and 1.4) encompass patient safety data. The learning, from an organisational perspective will be demonstrated with case studies.
Recommendation 4. Engaging patients and public in design and delivery of patient safety training	Best practice includes Kent, Surrey and Sussex's Leadership Collaborative funded programme to develop patient and clinical leaders in tandem. North West London's has excellent patient engagement through their "Partnerships in Innovative Education" (PIEs); and patient participation in simulation training in the East Midlands.	HEE's Patient Advisory Forum support work across England to support the intent of this recommendation. This is also a standard within the HEE Quality Framework.
Recommendation 6. The learning environment supporting response to concerns	Best practice includes designated forums and appointed individuals for reporting concerns, e.g. Safety Huddles in Kent, Surrey and Sussex and Student Quality Ambassadors in the North West. Induction has been highlighted by a number of local offices as an opportunity for delivering specific information about reporting concerns and work is under way to deliver this.	An element of the HEE Quality Framework is to ensure a clear and accessible route for raising concerns and issues. This is one of the elements currently being tested by some of the local offices. The team are mindful that even with a clear and accessible channel to raise concerns does not necessarily mean that learners feel supported to raise concerns. This is one of the key questions within the National Education and Training Survey (NETS) that is being tested by the Academic Partner. There is also work ongoing around how we listen and feedback to learner voice.

Workstream One: Learning and Training Environments		
	Implementation through embedding good practice across HEE	**Implementation through the HEE Quality Framework**
Recommendation 10. Increased opportunities for inter-professional learning	There is a vast amount of work across HEE which promotes high quality inter-professional training. HEE's Children and Young People, Mental Health and Learning Disabilities, and Maternity Programmes all emphasise inter-professional learning. GP Practice Training Hubs, in particular, have been highlighted as promoting and enabling inter-professionalism. The Better Training, Better Care pilots provide a wealth of good practice in inter-professional learning and is published in a tool-kit for all to access.	The outcomes from above will help to provide the evidence base/case study that we can build on. HEE are also collecting early case studies for applications of the Quality Framework from across the local offices via the Quality Leads Network.

Workstream Two: Human factors and Culture		
Implementation through embedding good practice across HEE		**Implementation through the HEE Quality Framework**
Recommendation 2. Developing a common language	The Care Certificate provides an existing standard education framework for delivering safe, quality, compassionate care, as part of a healthcare team	The Quality Framework will introduce a consistent and common definition of quality, quality management processes and an associated reporting process across England.
Recommendation 5. Duty of Candour	Duty of candour is covered at induction in many places. The national Freedom to Speak Up programme, and appointment of Guardians should make significant progress towards delivering this recommendation.	Duty of Candour is included within the standards of the HEE Quality Framework.
Recommendation 11. Principles of Human Factors & Professionalism embedded into training	There is some excellent work taking place within Human Factors across all of HEE which is supported by the work within the Patient Safety Collaboratives. Simulation stands out in particular, as a recognised and widely utilised means for delivering and embedding Human Factors awareness. In East of England, the Human Factors exchange works in partnership with universities, providers and frontline staff to embed Human Factors into training.	Domain 3, 'Supporting and Empowering Learners' of the Quality Framework will ensure that learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards. This domain will also encourage learners to be practitioners who are collaborative in their approach and who will work in partnership with patients and service users in order to deliver effective patient and used-centred care.
Recommendation 12. Management of risks	There is some excellent good practice to build upon here. Simulation is a widely used tool for delivering risk management training. Kent, Surrey and Sussex are in the process of developing a number of initiatives around Human Factors, reflective practice and the identification and reduction of risk.	In development.

Workstream Three: Embedding Existing Training Initiatives		
Implementation through embedding good practice across HEE		**Implementation through the HEE Quality Framework**
Recommendation 7. Mandatory training	In South London and North, Central and East London, the training needs analysis process ensures that patient safety issues are considered and incorporated into mandatory training requirements. In most local offices, mechanisms are in place to ensure that all students and trainees undergo a thorough induction process. Plans in place to incorporate this work into the Statutory and Mandatory Training Group.	The quality team are heavily involved in this work and provide an intrinsic link to delivering this recommendation.
Recommendation 8. Patient Safety Training for Leaders	There are national and bespoke leadership fellowship programmes across England. In Wessex, the School of Quality Improvement manages leadership fellowships and learner-led improvement programmes. The national Mental Health and Learning Disabilities Programme is developing training for expert leaders for dementia-care, and the Maternity Programme is developing multi-professional leadership training.	Domain 1, 'Learning Environment and Culture', of the Quality Framework recognises that a learning environment must deliver safe and effective care for patients in order to provide a supportive environment for learners and educators. The Framework also recognises that educational, clinical and corporate governance arrangements must be fully integrated, allowing organisations to address concerns about patient and service user safety.

Workstream Four: Supporting Joined up Care		
	Implementation through embedding good practice across HEE	**Implementation through the HEE Quality Framework**
Recommendation 9. Supporting joined up care	The Learning to be Safer Programme team have established links with the Strategy Directorate to track the progress of the STPs, and understand how HEE is supporting this through our Workforce Action Board's progress. The Stakeholder Oversight Group was established in November 2017 and will provide continual input and advice on the implementation of the recommendations.	HEE are implementing the Quality Framework across a Training Hub. Domain 2 Educational Governance and Leadership – Standard 2.5 "The educational governance processes embrace a multi-professional approach, supported through appropriate multi-professional educational leadership" supports this recommendation. Good practice in 'hub and spoke' models of clinical placements that excel in multi-professional learning will be identified and cascaded. In addition, there are notable examples of good multi-professional simulation training that will be shared as case studies.

Got more questions?

www.hee.nhs.uk

hee.patientsafety@nhs.net

@NHS_HealthEdEng

Health Education England NHS