NHS
Health Education England

Delivering Patient Safety Through Education, Training and Development

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

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Executive summary

The Commission on Education and Training for Patient Safety published its report Improving Safety Through Education and Training in 2016. Since that time Health Education England (HEE) has been delivering against the recommendations within the report nationally, regionally and in collaboration with system partners. This has set a firm grounding for the next phase of educational development required to deliver the Patient Safety Strategy identified within the Long Term Plan for the NHS.

Patient safety is a key part of the quality of healthcare services; patient safety, patient experience, and service efficacy. As such there are many development activities that overlay these domains. Delivering educational activities to improve patient safety often overlaps with other initiatives such as quality improvement, human factors, and simulation based education. This paper outlines some of the many initiatives which HEE has commissioned, sponsored and promoted in support of patient safety within healthcare practice.

Introduction

Patient safety is everyone's responsibility. It is the responsibility of every member of staff and every part of the system. Within that system HEE has a duty to ensure that:

1. learners on HEE commissioned programmes are learning safe practices,
2. learners understand the importance of safety and how to deliver safe healthcare, and
3. that the learning we commission is effective at enhancing patient safety.

In March 2016 the Commission on Education and Training for Patient Safety published its report 'Improving Safety Through Education and Training'[1]. This report established a vision for how educational resources and the levers available to Health Education England can be applied to deliver a long-term plan for change. Since the publication of the Report, HEE has been working through its regional and local structures to enhance patient care through education, training and development activities throughout the NHS. This paper demonstrates some of the work HEE has undertaken to embed the recommendations of the Commission into educational practice and outlines the next steps to delivering ever safer healthcare practice.

Health Education England has worked in collaboration with system partners and providers to deliver the work of the Commission in the context of a dynamic and changing health and social care environment. NHS service providers, in partnership with HEE local offices, are implementing many education, training and development initiatives to promote safe clinical practice across health and care services and work is taking place across the strategic bodies to ensure an awareness of patient safety issues is developed throughout the workforce.

The publication of this report coincides with the publication of several strategic policy documents which talk to patient safety in the NHS:

- The Care Quality Commission report into 'Never events', Opening the Door to Change[2],
- NHS Improvement (NHSI) consultation to develop a Patient Safety Strategy for the NHS[3],
- NHS England (NHSE) 'Long Term Plan' for the NHS[4].

The safety of patients is paramount and cannot be compromised, and Health Education England has a Patient Safety Programme Board which oversees the strategic delivery of education to promote safe healthcare practice throughout the NHS. It is the responsibility of HEE to ensure sufficient high-quality educational resources are available and to ensure staff are sufficiently knowledgeable and skilled to practise safely.

Patient safety is a complex issue; by the very nature of healthcare, a degree of hazard is inherent in a significant proportion of NHS activities. This makes healthcare comparable with other 'high

[1] https://www.hee.nhs.uk/sites/default/files/documents/Improving%20safety%20through%20education%20and%20training.pdf
[2] https://www.cqc.org.uk/publications/themed-work/opening-door-change
[3] https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/
[4] https://www.longtermplan.nhs.uk/

> ***The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning***
>
> A Promise to Learn, A Commitment to Act

risk industries' such as nuclear and aviation (Ted Baker, CQC[5]). As with those industries, patients and the public rightly expect NHS care to be safe[6]. Learning, both in respect of the learning for individuals and in developing the NHS to become a learning organisation, are key to ensuing patient safety[7].

Safe practice is an integral element of high quality care; it is the fundamental expectation that our patients, the public, and our staff have of the NHS. Services which are not in the first instance safe, fail all other criteria for quality.

Context

The NHS has, throughout its history, striven to address patient safety issues and has, during that time, continued to become safer and safer.

In recent years there has been an increasing focus on patient safety within the NHS. There is greater awareness of patient safety issues within healthcare, as well as an increasing awareness of quality improvement methodologies to improve patient safety. Notwithstanding that, the NHS still faces significant challenges in developing and embedding a consistent culture of patient safety[8].

Don Berwick supported the long-standing idiom that 'culture trumps strategy', stating "A safer NHS will depend far more on major cultural change than on a new regulatory regime"[9]. Education, training and development play an important part in culture change and, whilst culture change within clinical services cannot be implemented by national bodies, it is possible to facilitate the development of a learning culture with patient safety at its heart through the provision of the necessary educational support and infrastructure to inform and motivate staff. Recent publications by the Care Quality Commission[10] and NHS Improvement[11] refer to the importance of culture for patient safety.

The importance of patient safety, and the complex nature of the NHS, means that safety cannot be the responsibility of any one organisation. Important as education and training is, many other bodies also have a part to play in ensuring safety in the NHS. Organisations such as the Care Quality Commission[12] and Healthcare Safety Investigation Branch[13] play an important part in monitoring the safety of services and recommending improvement. Service and professional regulators such as NHS Improvement[14], General Medical Council[15] and Nursing & Midwifery

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[5] https://www.cqc.org.uk/sites/default/files/20181224_openingthedoor_report.pd
[6] https://www.gov.uk/government/speeches/patient-safety-no-room-for-complacency
[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
[8] https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/user_uploads/developing-a-patient-safety-strategy-for-the-nhs-14-dec-2018-v2.pdf
[9] Don Berwick presentation to Kings Fund 06.09.2013
[10] https://www.cqc.org.uk/sites/default/files/20181224_openingthedoor_report.pdf
[11] https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/user_uploads/developing-a-patient-safety-strategy-for-the-nhs-14-dec-2018-v2.pdf
[12] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment
[13] https://www.hsib.org.uk/about-us/
[14] https://improvement.nhs.uk/improvement-hub/patient-safety/
[15] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-2----safety-and-quality

Council[16] have a role in setting the standards for safety in learning and in practice. National and regional commissioning agents, NHS England[17] and Sustainability and Transformation Partnerships/ Integrated Care Systems[18] have a responsibility to understand the factors that affect patient safety and to commissioning services with patient safety at the heart. Universities, Royal Colleges and practice learning providers are key to teaching safety and setting a supportive culture for patient safety[19]. Patient safety requires a system wide approach with knowledge, skills and culture at the heart.

Rising to the challenge

Improving Safety Through Education and Training[20] clearly identified the important part learning and development plays in changing culture and enhancing practice. This created a fantastic opportunity for educational policy and delivery leads to focus on patient safety as a priority for provision, based on the vision created by the Commission. Since the publication of the report, much work has taken place across the English healthcare system, in partnership with university providers, clinical leads, Academic Health Science Networks, Royal Colleges, and many other parties. The report also identified the variety of intelligence available (academic and clinical) to promote safety in practice.

Improving Safety Through Education and Training recommendations:

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 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.

[16] https://www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/
[17] https://www.england.nhs.uk/five-year-forward-view/next-steps-on-the-nhs-five-year-forward-view/patient-safety/
[18] https://www.england.nhs.uk/integratedcare/stps/faqs/#one
[19] https://www.nhsemployers.org/search-results?q=safety
[20] https://www.hee.nhs.uk/sites/default/files/documents/Improving%20safety%20through%20education%20and%20training.pdf

Collaborating for impact

Health Education England cannot deliver the learning and the culture change necessary to improve patient safety alone. Every patient expects safe care[21], and each of the strategic bodies of the NHS have their part to play, and so too do the professional and system regulators, education and service providers, and other parts of the NHS system. HEE has taken an approach of working in partnership with other agencies and providers to deliver change. This has strengthened the system-wide ability to deliver improved patient care:

- building on the networks of others to increase reach,
- using expertise and capability where it exists to maximise productivity,
- getting closer to frontline services in respect to educational need,
- developing a culture that promotes the importance of patient safety through the levers of education, training & development.

> *"Every patient – whether in hospital, at home, in a GP surgery – expects compassionate, effective and safe care."*
>
> **Matt Hancock, Secretary of State, 2018**

Health Education England is an active member of the Joint Strategic Oversight Group, collaborating with other strategic bodies to oversee the quality and safety of patient care across the NHS. We have also developed a memorandum of understanding with the Healthcare Safety Investigation Branch[22] to share non-confidential intelligence to improve patient safety. We are working in collaboration with NHS Improvement to bring forward an implementation plan for the necessary training and development to deliver the emerging NHS strategy for patient safety. HEE has strong collaborative relationships with service providers, the professional regulators and professional royal colleges to enhance the quality and safety of education provision.

Supports delivery of recommendation 1

Technology enhanced learning

e-Learning has, in recent years, become a significant source of learning for the health and care workforce; providing a cost-effective means of delivering a variety of training to large numbers of staff in a readily accessible format.

The primary source of e-learning for health and care staff is the HEE e-Learning for Healthcare (e-LfH) portal[23]. e-LfH has over 200 e-learning programmes, more than 24,000 e-learning sessions and more than 900,000 registered users.

Patient safety is an integral part of the working lives of all health and care staff; this is reflected by patient safety training being implicit within many of the learning resources

[21] http://www.nationalhealthexecutive.com/Health-Care-News/humility-openness-and-learning-hancock-asks-nhsi-director-to-draft-10-year-patient-safety-plan

[22] https://www.hsib.org.uk/

[23] https://portal.e-lfh.org.uk/

available on the e-LfH platform. Furthermore, 'patient safety' is a specific and identifiable aspect of many e-LfH programmes, ranging from individual learning sessions through to complete programmes.

In 2018 there were over 147,000 session launches of e-learning programmes on the e-LfH Hub that included a patient safety element. In the same year there were more than 81,000 registered users for these programmes, and over the past five years, there were cumulatively more than 180,000 registered users.

The learning available via the e-LfH Hub[24] also varies in focus from learning that is relevant and appropriate for all staff such as the Freedom To Speak Up and Statutory and Mandatory programmes, to learning aimed at particular professional groups such as Sepsis in Paediatrics, and training on safety in specific procedures such as the MRI Safety programme.

As well as the existing e-ELfH portfolio, patient safety training is being developed further through new modules and up-dating existing ones in light of changing need. This is set to continue with patient safety taking advantage of more innovative and intuitive learning mechanism, and development of a comprehensive learning solution; creating an educational one stop shop for safety learning.

This approach is aligns with the outcomes of the Topol Review*,* exploring how to prepare the healthcare workforce, through education and training, to deliver the digital future[25].

Supports delivery of recommendation 3, 5, 6, 7, 1

Human Factors

Human error, poor process and system design are widely recognised as contributory factors in patient harm incidents[26]. Developing an understanding of human factors in staff is therefore a primary mechanism for quality improvement and safety in healthcare[27]. The language of human factors is comparatively new to the NHS, although it is well established in other safety critical industries (such as defence, nuclear, aviation sectors). A common language is emerging across the fields of quality improvement and human factors aided by the Clinical Human Factors Group (CHFG) nomenclature guide[28].

[24] www.e-lfh.org.uk

[25] https://www.hee.nhs.uk/our-work/topol-review

[26] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

[27] https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-hum-fact-concord.pdf

[28] https://chfg.org/learning-resources/human-factors-common-terms/

> ***"Enhancing 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."***
>
> **Human Factors in Healthcare; A Concordat from the National Quality Board**

A passion for quality improvement and human factors training is developing amongst NHS staff, resulting in a multitude of training opportunities within academic health science networks (AHSNs), universities, and practice settings, to enhance skills and knowledge in quality improvement and human factors. The breadth of these opportunities ranges from introductory workshops to masters qualifications, delivered as direct training or embedded within existing training provision.

HEE is working in partnership with representatives from the Chartered Institute for Ergonomics and Human Factors[29] and the Clinical Human Factors Group[30] to inform our strategic approach to the development of human factors capability within the health and care workforce.

Supports delivery of recommendation 2, 3, 6, 8, 9, 10, 11

Making connections, developing networks

The enormity of the NHS, the diverse nature of patient safety issues, and the plethora of learning interventions available has led to a variety of education and development opportunities evolving across the healthcare sector. Many good practice examples are set out below.

The diverse nature of patient safety learning, being commissioned and delivered locally in response to local need, allows for learning to be tested locally in response to service need before being translated and implemented at scale across the system. Recognising the opportunity created by the diverse nature of professional healthcare learning HEE has established a 'Patient Safety Network' for education, training and development in the NHS. This Network includes academics and clinicians coming together from across the HEE local offices seeking to understand and share best practice in patient safety learning and development.

This network has identified a huge range of learning and development activities across the HEE regions. Whilst some of these activities are explicitly identifiable as patient safety learning, most of safety learning is integrated within clinical programmes and broader developmental activities such as; quality improvement initiatives, incident investigation training, human factors training, and simulation-based training.

[29] https://www.ergonomics.org.uk/
[30] https://chfg.org/

Undergraduate and postgraduate training

The preparation of the NHS workforce, at pre- and post-registration level, is a key opportunity to develop a culture of safe clinical practice. Safety and quality improvement is integral within the professional standards for education of healthcare professional learners, by example; GMC educational framework[31] and the NMC standards[32]. These standards are delivered by educational providers; universities and royal colleges, in collaboration with service providers providing practice learning opportunities. Patient safety is integrated as part of their respective curricula and assured by the professional regulator.

All agencies involved in the commissioning, delivery and assurance of professional healthcare education echo the importance of patient safety training, which is embedded throughout curricula, implicit in every episode of learning.

Supports delivery of recommendation 3, 5, 6, 10

Simulation based education

Simulation is a recognised tool for learning that can have powerful application to safety for patients and staff as well as at an organisational level. The term 'simulation' represents a broad spectrum of educational technologies and techniques for experiential learning that can be used remotely and within a variety of different environments; in classrooms, simulation facilities, or in-situ in the workplace itself.

HEE has developed a simulation framework[33] to promote simulation-based educational interventions, either within profession specific groups, or supporting interprofessional learning and team development. Simulation based education (SBE) can also be applied at all levels of learner (undergraduate, postgraduate, and support workers), promoting learning from customer care skills, through communication skills and team working, to advanced technical procedures. It offers a safe space to develop team working skills and other behaviours that underpin effective and safe healthcare practice.

Supports delivery of recommendation 3, 4, 8, 9, 10, 11

Quality Framework

Patient safety is an integral part of educational quality[34] as identified within the Quality Framework and the reviews undertaken across the regions to assure the quality of learning in practice. It is essential that learners understand the importance of patient safety, and that they are taught safe healthcare practices. There are many examples across the regions of learners using patient safety systems (e.g. Datix) and where they have an educational element being raised within the quality review mechanism. Learners can be great advocates for patient safety, their experience across a wide variety of settings can be a valuable source of learning and learner feedback is a key test of quality and patient safety.

Supports delivery of recommendation 1, 3, 4, 5, 6, 10

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[31] https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework

[32] https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf

[33] https://www.hee.nhs.uk/our-work/technology-enhanced-learning/simulation-immersive-technologies

[34] HEE Quality Framework

Educational quality survey

HEE has worked collaboratively for many years with the General Medical Council to ensure the effectiveness of the National Training Survey for postgraduate medical trainees and the National Trainers Survey for educational staff[35]. This has proved an invaluable tool in the assurance and development of educational quality. HEE also works in collaboration with the Office for Students to support the placement questions within the National Student Survey[36].

In 2018/19 HEE launched the first ever National Education and Training Survey (NETS) to include a variety of professional healthcare learners in different clinical environments[37]. Conducted twice a year, NETS will gather a huge quantity of prevalence and trend data on the quality of clinical practice learning and learner feedback will be indicative intelligence of the patient safety within a learning environment. This will provide a unique insight into learner perceptions of the training environment, a vital element in the quality and patient safety management process.

Many of the questions indicate issues relating to patient safety, including; communication, opportunities to improve the quality of care, clinical supervision, learners' confidence in raising concerns, etc.

NETS will provide the first multi-professional source of evidence about the quality and safety of learning environments that will enable national comparison and benchmarking across all professional groups to provide assurance about the quality of clinical learning environments. This will help HEE to enable staff to develop the right skills, values and behaviours to deliver high quality, safe patient care.

Recommendation 1, 3, 6, 12

Patients as part of the patient safety domain

Health Education England recognise that the NHS is here for patients and the public and to that goal seek to engage patients and the public in contributing to the development of policy as appropriate. There are many examples of patients/ lay representatives being involved across the regions for quality reviews, patient forum and curricula development, not only for patient safety specific issues but for all aspects of training policy, delivery, and monitoring. Centrally HEE has a national Patient Advisory Forum to ensure the patient/ public voice is heard within the development of national initiatives as well as regional and local initiatives.

Supports delivery of recommendation 4

Promoting transparency and a culture to speak up

There are numerous activities taking place locally and nationally to support Duty of Candour and Freedom to Speak Up[38], training that is both stand alone and incorporated

[35] https://www.gmc-uk.org/education/how-we-quality-assure/national-training-surveys
[36] https://www.thestudentsurvey.com/
[37] https://www.hee.nhs.uk/our-work/quality/national-education-training-survey

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

in other professional training initiatives. Working in partnership with the Academic Health Science Network (AHSN) Patient Safety Collaboratives, HEE is looking to do further work on evaluating 'Freedom to Speak Up' and Duty of Candour in practice to address the concerns identified within the Gosport Report[39], particularly in respect of the culture of openness and transparency.

HEE has supported the training and development of the first cadre of Freedom to Speak Up (FTSU) Guardians within NHS trusts in partnership with the National Guardians Office and Protect and sponsored the first Freedom to Speak Up Guardians Day in March 2017. We commissioned the film "Making Speaking Up Business as Usual"[40] as a means of communicating the powerful stories of some of those Freedom To Speak Up Guardians with experience of speaking up themselves. We have also worked in partnership with the National Guardians Office to develop a suite of Freedom to Speak Up training packages on ELfH website[41].

Supports delivery of recommendation 5, 6

Quality Improvement Fellows

Quality improvement plays an important role in enhancing patient experience and improving patient safety. There is therefore increasing emphasis on enhancing quality improvement capability within healthcare and a move to encourage all healthcare professionals to drive quality improvement. Training is an important aspect of quality improvement and is already on the curriculum for most training schemes, for example the "Learning to Make a Difference" programme in Core Medical Training.

HEE is working throughout its regional structures to support the development of Quality Improvement (QI) Fellows. By example, HEE is working collaboratively with the Royal College of Physician on the Flexible Portfolio Training (FPT) scheme with separate pathways developing skills in; clinical informatics, medical education, research, and quality improvement. This work is to be boosted by the recruitment of Quality Improvement Fellows. We are also working with the AHSN Patient Safety Collaboratives to support two Patient Safety Fellows to explore and share good practice in patient safety training, education and development.

Supports delivery of recommendation 8

Emerging Concerns Protocol

Early identification of patient safety risk is a priority for health and care services; identifying risk early and therefore being able to put into place measures to mitigate that risk. To be able to deliver this proactive approach to identification of risk, eight health and social care regulators and other bodies, including HEE, have signed an agreement to help them share concerns with each other more effectively; the Emerging Concerns Protocol[42]. This protocol provides a mechanism for organisations to share information and intelligence that may indicate risks, making it easier to notice that a problem is emerging.

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[39] https://www.gosportpanel.independent.gov.uk/media/documents/070618_CCS207_CCS03183220761_Gosport_Inquiry_Whole_Document.pdf

[40] https://www.youtube.com/watch?v=YDrJOMbHxUQ

[41] https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/

[42] https://www.cqc.org.uk/news/stories/joint-statement-emerging-concerns-protocol

Supports delivery of recommendation 1

Promoting a learning culture

There is extensive evaluation of training throughout the portfolio of training commissioned by HEE (of which patient safety is an element). Notwithstanding this, the direct correlation between training and patient safety is difficult to quantify. Patient safety training is very often incorporated as an integral element within other training courses (e.g. procedural safety within care pathway training) and as such evaluation of patient safety training per se is limited.

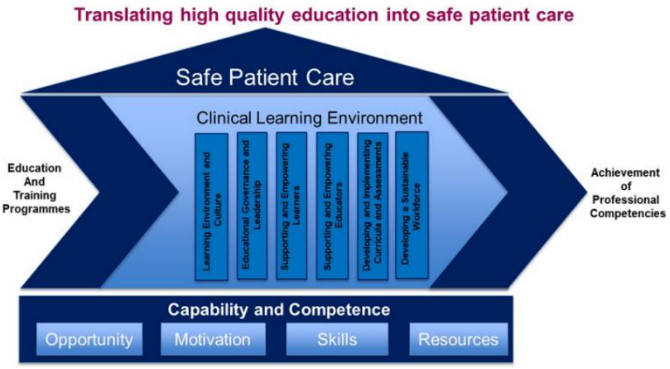

Image from Commission on Education and Training for Patient Safety Progress Report [43]

Work commissioned by the Department of Health from the University of York, Newcastle University, and Durham University[44] has clearly identified a structured approach to delivering education and training is needed to maximise impact in practice. This understanding contributes to our knowledge of the importance of support in practice for the implementation of learning – an understanding that can now be incorporated into our commissioning and evaluation processes.

Supports delivery of recommendation 3

Mandatory training

The UK Core Skills Training Framework (CSTF), developed by Skills for Health and endorsed by HEE, sets out standards for statutory and mandatory training for healthcare staff across 11 core topics. Most trusts have declared that the training they provide is aligned to these standards and to assist delivery, HEE makes CSTF-aligned e-learning freely available via the E-Learning for Healthcare (e-LfH) and Electronic Staff Record (ESR) platforms. Patient safety issues are addressed within the statutory and mandatory training.

Supports delivery of recommendation 7

Interprofessional and cross-organisational learning

There are many examples of multi-professional learning, interprofessional learning and other collaborative initiatives that span health and social care at local and regional level. HEE recognise the Centre for Advancement of Interprofessional Education[45] (CAIPE) as experts in IPE to explore how the link between team-working and leadership across boundaries could help to improve patient safety.

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[43] https://www.hee.nhs.uk/sites/default/files/documents/Commission%20on%20Education%20and%20Training%20for%20Patient%20Safety%20-%20progress%20report.pdf

[44] How does the education and training of health and social care staff transfer to practice and benefit patients? A realist approach – Prof. Jan Illing

[45] https://www.caipe.org/

Supports delivery of recommendation 10

Patient Safety Syllabus

The embedded nature of safety training within existing programmes means that patient safety training is not explicitly visible. Responding to the need for a defined, high quality, national syllabus for patient safety, HEE has commissioned the development of such a syllabus to promote safe healthcare practice. This programme aims to develop a new approach to patient safety applicable to all NHS staff. The focus of the initial piece of work is to design and develop a patient safety syllabus using a systems thinking, proactive approach to safe healthcare practice.

The Academy of Medical Royal Colleges, commissioned and funded by HEE, has now completed the design of the syllabus. Coinciding with the call for a national curriculum for patient safety in publications by CQC, NHSI and NHSE, we are now working to implement this syllabus throughout the NHS.

Supports delivery of recommendation 6, 8, 11, 12

Leading the way

Improving Safety Through Education and Training created a vision for educational policy and delivery leads to focus on patient safety as a priority. Since that time HEE has developed, commissioned and supported many initiatives to enhance the knowledge, skills and culture of patient safety in the NHS. HEE clearly has a leading part to play in ensuring sufficient, high quality education and training is available for learners and staff in the NHS. Notwithstanding this, ensuring safe clinical practice is the responsibility of all and important as learning and development is, it is only a part of the story. Ensuring patient safety requires everyone in the NHS to recognise their responsibility for patient safety. It also requires all parts of the system; regulators, commissioners, providers and policy makers, to work together to the same goal.

Delivering for the future

Health Education England has a key part to play within the NHS system to promote safe working practices, for staff and particularly for patients. To deliver safer healthcare practice across the NHS, in support of the emerging NHS Patient Safety Strategy, HEE will continue its current efforts to improve safety through everything we do, with a particular emphasis on further developing the following programmes of work:

Developing a national patient safety syllabus for the NHS

Building on the existing Patient Safety Syllabus commissioned by HEE from the Academy of Medical Royal Colleges, we propose to further develop and refine this syllabus to provide a truly national safety science syllabus for the NHS. This syllabus will be based upon the principles of safety science, based on extensive consultation, to ensure consistent learning throughout the workforce. This syllabus will then be stratified to address the needs of different levels of healthcare staff and delivered through a variety of channels.

The safety science syllabus will;

- offer a framework for curriculum development,

- set standards for competence levels and assessment criteria for each level of training,
- offer a national e-learning ‘Foundations in Safety Science’ programme available to all.

Promote a culture of safety through education, training and development

Notwithstanding the patient safety syllabus, HEE will continue to commission, promote and use networks to link other training initiatives to promote safe healthcare practice including (but not restricted to); human factors training, increased opportunities for interprofessional learning, and continued development of training to promote transparency and freedom to speak. This will include the increased use of technology enhanced solutions to promote access and utilisation of training opportunities and increased use of simulation to enhance learning.

Sharing what works well

We will develop a mechanism for sharing safe healthcare practice across the NHS through networks, benchmarking, website, conferences, etc. We will develop a repository of intelligence, good practice examples, and links to resources for safe clinical practice including; video, animation, good practice examples, networking opportunities, collaborations, and positive safe practice reporting.

Conclusion

The safety of patients, staff and the public who come into contact with the NHS are not the concern of any one individual. Patient safety is the responsibility of everyone, in every role in the NHS, and it is the responsibility of every part of the system. HEE’s role is to facilitate continuous improvement at system, regional and local level through the careful application of educational levers.

This paper has outlined, some of the many initiatives taking place across the NHS and partner organisations to educate, promote, and enhance patient safety in the NHS. The nature of these developments means that they rarely relate to only one of the commission recommendations; rather they weave lattice like through workforce capacity and capability, developing quality improvement skills, patient safety knowledge, and human factors understanding, and cultural change capability. The examples in this paper have developed knowledge, skills, understanding and improved the attitude of the NHS workforce to enhance patient safety.

There is much work taking place across the system to improve patient safety in the NHS. HEE is playing a crucial role in supporting quality improvement and patient safety by supporting workforce transformation and by providing education, training and development to ensure learners have access to training that incorporates patient safety as an integral aspect of high quality education provision.

There is much more still to do. The emerging NHS Improvement Strategy for Patient Safety in the NHS will set out the next stage of patient safety improvement with an ambitious plan for change. HEE will support this approach and is committed to working in partnership with NHS Improvement and other system partners to continue to develop patient safety capacity and capability throughout the NHS.

Annex I
Examples of patient safety learning & development in practice:

Health Education England has sponsored, commissioned and delivered many initiatives to promote patient safety in practice. This Annex I identifies a range of examples of good practice which have been delivered through its regional and local structures to enhance patient care.

1. Wessex Patient Safety First Programme

This is a training programme delivered to all Wessex CT1 (3rd year) junior doctors and selected nursing preceptees, more recently pharmacists and palliative care nurses have also been included in the programme.

This programme has been run annually since 2009 and includes training in human factors, risk and error, role modelling, leadership skills and quality improvement (QI) methodology. A patient safety project is carried out in the work place over a three to eight-month period and this includes mentoring from speciality and trust patient safety champions, work is then presented at the annual conference.

To date there have been 2463 junior doctors and nurses trained with good feedback being gathered on the effectiveness of the programme. 1193 patient safety projects have been carried out with the themes and risks being able to be fed back to the workplace.
http://www.wessexdeanery.nhs.uk/quality_improvement/wessex_school_of_qi/qi_fellowship_programmes/patient_safety_first_programme.aspx

2. Cinematic Storytelling of Human Factors Research - Dilemmas in Suicide Prevention

This short film is based on human factors research by Loughborough University, in collaboration with Leicestershire Partnership NHS Trust and Cambridgeshire and Peterborough NHS Foundation Trust. It is inspired by two true events.
It aims to illustrate complexity and dilemmas faced by clinicians and managers and challenge us to think about design of mental health care delivery differently.
https://youtu.be/pqQZ4dAbDLs

3. Human Factors & Ergonomics Taster Workshops

Greenstreet Berman were commissioned to deliver Human Factors and Ergonomics (HFE) Taster Workshops across the Midlands and East region. Over 100 staff attended the workshops with all delegates being able to demonstrate an introductory knowledge of HFE principles and practices. 84% of delegates reported that they would be looking for further HFE education for themselves, 71% for their team and 52% for their organisation.

4. Working to support physical and psychiatric comorbidities

Work has been done to tackle physical and psychiatric comorbidities. The Mind and Body Programme brought together four London Trusts in a partnership to challenge the barriers to integrating mental and physical healthcare across the health and social care system to improve patient experience and outcomes. This learning and development programme is supported by underpinning learning resources.

https://www.kingshealthpartners.org/assets/000/001/702/Mind_and_Body_Learning_and_Development_Strategy_3.1.18_original.pdf?1515058622

Simulation training was also proposed as a tool to improve clinicians' management of physical and psychiatric comorbidities. This resulted in the Simulation Workshop at the Mental-Physical Interface (SWAMPI) being developed as a one-day interprofessional mental health simulation course consisting of six scenarios developed to meet clinicians' needs for working with physical and psychiatric comorbidities.
https://www.sciencedirect.com/science/article/pii/S1876139916301116

5. Human factors and ergonomics and quality improvement science: integrating approaches for safety in healthcare
A HEE funded project to explore how quality improvement science (QIS) and human factors and ergonomics (HFE) can work together to produce safer solutions for healthcare.
https://qualitysafety.bmj.com/content/24/4/250

6. North West Human Factors and Ergonomics Activity
Health Education England (HEE) North West have developed five e-learning resources to help in simulation faculty development and CPD. These are also used in the North West as pre-learning prior to a face to face session by the North West Simulation Education Network's (NWSEN) faculty development course. The course has been running since 2010 and has trained over 650 staff. Elements of the course include An Introduction to Simulation Based Learning and An Introduction to Human Factors and Patient Safety.
https://learning.wm.hee.nhs.uk/node/877

7. Safe Clinical Systems Syllabus
The multi-professional syllabus has been created by the Academy of Medical Royal Colleges to provide a framework curriculum for training all NHS staff in patient safety. This syllabus is being used as the framework for the NHS Improvement draft national patient safety curriculum.
http://www.aomrc.org.uk/patient-safety/

8. Team situational awareness: practitioner-centred design of a safety huddles
This project explored practitioner-centred design of a safety huddles toolkit. The toolkit is designed to be continuously adapted to allow practitioner-led improvement for different clinical specialties to adopt safety huddles and to improve team communication and patient safety awareness. The tool is being spread further six months following project completion.

The final project report 'Mobilising Human Factors Knowledge to Maximise Safety Huddle Impact: Protecting Patients & Optimising Organisations' further examines this project and explores in detail the impact of the toolkit to improve patient safety and the learning identified after implementation.
https://lra.le.ac.uk/bitstream/2381/40210/2/Huddles_GreenEtAl.pdf

9. Final Project Report - Transforming Root cause analysis Using The lens of Human Factors to better Understand and Underpin Lessons for Learning (TRUTHFUL)

Using Human Factors theory to inform and improve Root Cause Analysis (RCA) in a clinical context The TRUTHFUL project takes the approach of identifying potential contributory markers of errors prior to serious untoward incidents. Through the analysis of footage of previous patient-doctor encounters, taken from a simulation with real patients, patient-doctor interactions will be identified as markers in relation to the resulting clinical decision and compared to the encounter outcome (diagnosis and actions). This project sought to provide an incremental improvement to RCA by identifying contributing factors to adverse clinical decisions. These factors can then be used as factors that may be identified when conducting RCAs, and proactively to design them out.

10. Evaluation Report - Effective Performance Insight for the Future (EPIFFANY)
The EPIFFANY (Effective Performance Insight for the Future) Training Programme is an innovative approach to improving the training of healthcare professionals. Through the creation of a safe learning environment and simulations, supported with the principles of human factors training and educational theory, EPIFFANY has been shown to be effective at improving behaviours, confidence, wellbeing and patient safety.
http://emahsn.org.uk/impact-reports-new/epiffany-training-programme/

11. Quality and Safety: Achieving Better Care
This annual multidisciplinary quality improvement (QI) and patient safety event is a joint venture with Health Education England (HEE) South West and the South West Academic Health Science Networks (AHSNs). Working collaboratively to cover a large and varied geography, they attracted more than 200 healthcare professionals to this free conference in 2018 to promote Quality Improvement (QI) in health care, to celebrate QIP learning and share good practice on patient safety.
https://www.weahsn.net/event/quality-safety-achieving-better-care/

12. Freedom to Speak Up (FTSU)
In response to concerns about culture in the NHS, the Secretary of State for Health and Social Care commissioned Sir Robert Francis to carry out an independent review. The review recommended that every NHS organisation should provide training on the value of speaking up which meets national standards. To meet this recommendation, HEE designed and launched e-learning sessions on 'Speaking Up in Primary Care' and 'Speaking Up in Secondary Care'. These are a resource for current and future healthcare staff and promote relevant policies, procedures, good practice and the support available in relation to speaking up.
https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/

13. National Guardian: Freedom to Speak Up (Guardian Education and Training Guide)
The National Guardian's Office (NGO) is an independent, non-statutory body with the remit to lead culture change in the NHS. They are sponsored by the Care Quality Commission (CQC), NHS England and NHS Improvement. They support the National Guardian for the NHS, Dr Henrietta Hughes, in providing leadership, training and advice for Freedom to Speak Up Guardians based in all NHS trusts. In collaboration, the NGO and Health Education England (HEE) commissioned a training guide to be produced by the NHS Leadership Academy that will be a central resource for the development of all Freedom to Speak Up Guardians.
https://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

14. Evidencing the Impact of Human Factors Training within the NHS and the Ability to Change Culture

This report was commissioned by the Health Education England (HEE) national Patient Safety programme team. The Chartered Institute of Ergonomics and Human Factors (CIEHF) utilised the HEE Patient Safety Network Group and their own networks to estimate the scale of human factors training within the NHS, collect the available evidence in case studies and assess to what degree human factors training affected a change in culture. The primary focus was on evidencing human factors within healthcare with a secondary focus to share examples of learning from other high-risk industries.

15. National Framework for Simulation Based Education (SBE)

The Health Education England (HEE) SBE National Framework has been developed with leading experts in simulation to deliver quality improvement in practice, improvements in patient safety, and a positive learner experience.
https://www.hee.nhs.uk/sites/default/files/documents/National%20framework%20for%20simulation%20based%20education.pdf

Annex II

Table 1

Exemplar of the educational interventions taking place across and throughout HEE.

Educational intervention	Ensure learning from patient safety data and good practice	Develop and use a common language	Ensure robust evaluation of education and training	Engage patients, family members, carers	Supporting the duty of candour	Support all learners and staff to raise concerns	Mandatory training for patient safety	NHS leaders need patient safety training	Education and training must support integrated	Interprofessional learning	Principles of human factors	Skills to identify and manage potential risks
Wessex Patient Safety First Programme	✓	✓							✓	✓	✓	
Cinematic Storytelling of Human Factors Research - Dilemmas in Suicide Prevention	✓											
Human Factors & Ergonomics Taster Workshops		✓								✓		
Working to support physical and psychiatric comorbidities	✓	✓						✓	✓		✓	
Human factors and ergonomics and quality improvement science: integrating approaches for safety in healthcare	✓	✓						✓	✓	✓		
North West Human Factors and Ergonomics Activity	✓	✓					✓		✓	✓	✓	
Safe Clinical Systems Syllabus	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Team situational awareness: practitioner-centred design of a safety huddles	✓				✓	✓			✓	✓		✓
Final Project Report - Transforming Root cause analysis Using The lens of Human Factors to better Understand and Underpin Lessons for Learning (TRUTHFUL)	✓		✓									
Evaluation Report - Effective Performance Insight for the Future (EPIFFANY)	✓		✓	✓		✓			✓	✓	✓	✓
Quality and Safety: Achieving Better Care	✓								✓			
Freedom to Speak Up (FTSU)					✓	✓	✓	✓				✓
National Guardian: Freedom to Speak Up (Guardian Education and Training Guide)					✓	✓	✓	✓				✓
Evidencing the Impact of Human Factors Training within the NHS and the Ability to Change Culture	✓										✓	
National Framework for Simulation Based Education (SBE)			✓				✓		✓	✓		

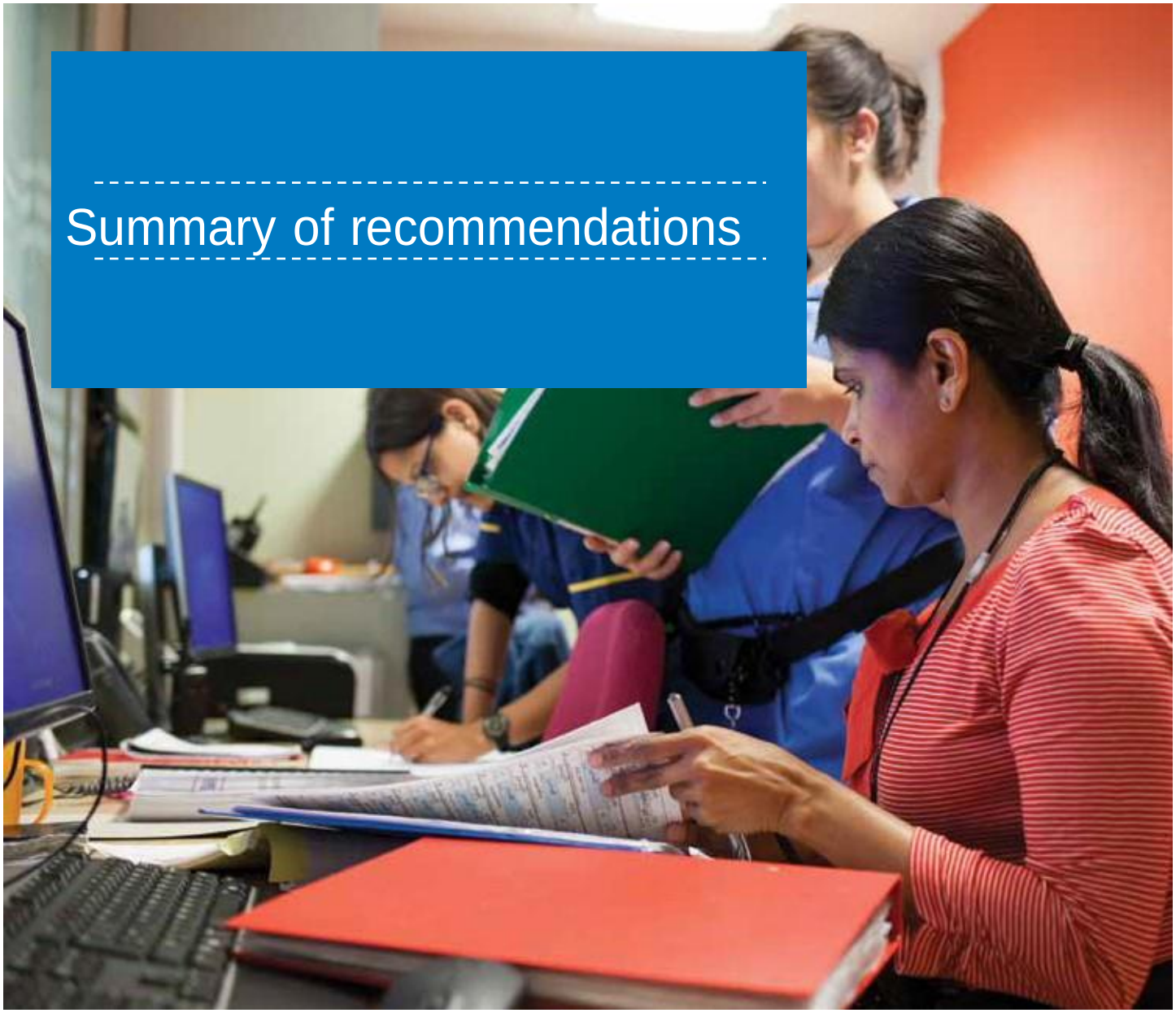
Table 2

Educational interventions being undertaken to address the recommendations of Improving Safety Through Education & Training.

Educational intervention	Ensure learning from patient safety data and good practice	Develop and use a common language	Ensure robust evaluation of education and training	Engage patients, family members, carers	Supporting the duty of candour	Support all learners and staff to raise concerns	Mandatory training for patient safety	NHS leaders need patient safety training	Education and training must support integrated	Interprofessional learning	Principles of human factors	Skills to identify and manage potential risks
Collaborating for impact	✓											
Technology enhanced learning			✓		✓	✓	✓					✓
Human Factors		✓	✓			✓		✓	✓	✓	✓	
Undergraduate and postgraduate training			✓		✓	✓				✓		
Simulation based education			✓	✓				✓	✓	✓	✓	
Quality Framework	✓		✓	✓	✓	✓				✓		
Educational quality survey	✓		✓			✓						✓
Patients as part of the patient safety domain				✓								
Promoting transparency and a culture to speak up					✓	✓						
Quality Improvement Fellows								✓				
Emerging Concerns Protocol	✓											
Promoting a learning culture			✓									
Mandatory training							✓					
Interprofessional and cross-organisational learning									✓			
Patient Safety Syllabus						✓		✓		✓	✓	

Annex III
Improving Safety Through Education & Training

Summary of recommendations



Improving Safety Through Education and Training

Report by the Commission on Education and Training for Patient Safety

www.hee.nhs.uk/the-commission-on-education-and-training-for-patient-safety

Executive summary

The report by the Commission on Education and Training for Patient Safety is different from the many reports on patient safety published both for the NHS and internationally over the last decade. For the first time, the focus is on how education and training interventions can actively improve patient safety. There is a real need for a systematic approach that uses learning tools effectively, both for short term reduction in risk to patients and also to build a long-term, sustainable learning environment within healthcare that is centred on patients and on the need for the safest care possible.

The report sets out the Commission's ambition to improve patient safety through education and training and makes a number of recommendations to Health Education England (HEE) and the wider system.

Background

The energy and pace of change in the NHS is greater than ever before. There is a real and palpable commitment to improving patient safety and widespread recognition that education and training is vital in reducing patient harm. Organisations are pioneering initiatives and healthcare staff at every level recognise how they contribute to keeping patients safe. Patients and staff are demanding improvement, pushing for deeper, broader, faster change and the government have made patient safety a priority area.

Despite this, an estimated one in 10[i] patients admitted to NHS hospitals will still experience some kind of patient safety incident and around half of all incidents are thought to be avoidable.[ii]

Patient safety should be a golden thread of learning that connects all staff working in the NHS, across all disciplines, from apprentice and undergraduate right through to retirement. 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. Changing behaviours and outcomes will be impossible if there continues to be a blame culture where individuals are vilified when things go wrong rather than supported to learn from errors and to look at the system as a whole. The NHS has to change.

The Commission

The Commission, supported by Imperial College London, gathered evidence through focus groups, interviews, regional visits and online surveys; 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 were told what works, and what does not work when it comes to improving patient safety through education and training. We saw evidence of good educational practice, heard what supports people to make improvements and what gets in the way. We asked people for their ideas on how to improve patient safety through education and training. This report is the culmination of these months of work.

This report aims to shape the future of education and training for patient safety in the NHS over the next 10 years. 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. This underpins all of our recommendations.

"The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning."

Professor Don Berwick

i NHS England website. Available at: https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-5/ [Accessed 17 February 2016]

ii Carruthers & Philip (2006) Safety First – a report for patients, clinicians and healthcare managers. Department of Health. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_064159.pdf [Accessed 12 February 2016]

Our recommendations

Education and training can break down barriers to providing safe care, creating an environment where all staff learn from error, patients are at the centre of care, treated with openness and honesty and where staff are trained to focus on patient needs. However, the right workplace conditions, motivation and opportunity must also exist in order to ensure sustained behaviour change.

Set out under four broad themes, the report makes a series of recommendations that we believe will make the greatest difference to patient safety both now and in the future.

Creating a culture of shared learning

Recommendation 1

Ensure learning from patient safety data and good practice

Patient safety data, including learning from incidents and good practice case studies, must be made more readily available to those responsible for developing education and training. The Commission recommends:

- HEE engages with national partner organisations, employers and those responsible for curricula to ensure patient safety data is being shared beyond traditional professional and institutional boundaries and is being used as an educational resource
- HEE works with partner organisations to scale up and replicate good practice training and education for patient safety. We suggest sharing good practice examples through the forthcoming Technology Enhanced Learning (TEL) platform
- HEE works with NHS Improvement and local partners to overcome existing barriers and facilitate access to locally relevant incident reports for use in development of education and training
- clinical commissioning groups, NHS England, HEE and other system partners particularly NHS Improvement, to work together to explore the potential for development of 'lessons learned' alerts following a patient safety incident or near miss.

Recommendation 2

Develop and use a common language to describe all elements of quality improvement science and human factors with respect to patient safety

The Commission recommends the development of a common language, to increase understanding about the relationship between human factors and quality improvement science and the importance of integrating these approaches.

Recommendation 3

Ensure robust evaluation of education and training for patient safety

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

The patient at the centre of education and training

Recommendation 4

Engage patients, family members, carers and the public in the design and delivery of education and training for patient safety

HEE and the relevant regulators of education to ensure that future education and training emphasises the important role of patients, family members and carers in preventing patient safety incidents and improving patient safety. Specifically, the Commission recommends:

- HEE uses its levers to ensure that patients and service users are involved in the co-design and co-delivery of education and training for patient safety
- HEE works with provider organisations to ensure that work-based clinical placements encourage learning to facilitate meaningful patient involvement and to enable shared-decision making
- HEE explores the need for education and training for patients and carers through its work on self-care with the Patient Advisory Forum.

Recommendation 5

Supporting the duty of candour is vital and there must be high quality educational training packages available

The Commission recommends that HEE helps create a culture of openness and transparency by reviewing existing training packages to ensure they support the duty of candour regulations. They should commission relevant educational tools where needed and work with professional regulators to reflect the inclusion of a duty of candour in professional codes, extending beyond the legal duty for organisations and building on existing work in this area.

Lifelong learning – focussing on safety from start to finish

Recommendation 6

The learning environment must support all learners and staff to raise and respond to concerns about patient safety

The Commission recommends that HEE works with national partner organisations and employers to ensure that the learning environment encourages and supports staff, including those learning and those teaching, to raise and respond to patient safety concerns.

Recommendation 7

The content of mandatory training for patient safety needs to be coherent across the NHS

The Commission recommends HEE reviews both mandatory training requirements and the delivery of Continuing Professional Development (CPD) related to patient safety. It should work with stakeholders to ensure that employer-led appraisals assess understanding of human factors and patient safety. HEE should use its contracts with providers to ensure protected time for training on patient safety is part of the mandatory training programme in each organisation.

Recommendation 8

All NHS leaders need patient safety training so they have the knowledge and tools to drive change and improvement

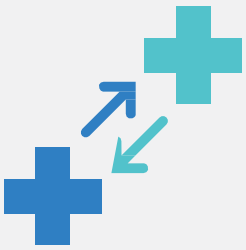
The Commission recommends HEE works with partner organisations to ensure that leadership on patient safety is a key component of the leadership education agenda. This will foster greater understanding of patient safety among leaders and therefore greater commitment on their part.

Delivering education and training for patient safety

Recommendation 9

Education and training must support the delivery of more integrated 'joined up' care

There are particular patient safety challenges during transition between health and social care, primary and secondary care. The Commission recommends HEE works with partner organisations to ensure education and training supports delivery of safer joined up care. It should spread learning from the early adopters of integrated care such as Academic Health Science Networks' (AHSNs), Patient Safety Collaboratives, and the Q Initiative, to all those designing and delivering education and training.



Recommendation 10

Ensure increased opportunities for inter-professional learning

There is enthusiasm and a real need for more inter-professional, practical and team-based learning at every level, from first year undergraduates and apprentices through to the existing workforce. The Commission recommends HEE uses its levers to facilitate increased opportunities for inter-professional learning.

Recommendation 11

Principles of human factors and professionalism must be embedded across education and training

The Commission recommends HEE works with national partner organisations to ensure the basic principles of human factors and professionalism are embedded across all education and training. Multi-professional human factors training should form part of the induction process for every new employee. It also needs to be offered as part of regular refresher training for all staff so they understand the importance of human factors and professionalism and how this can influence patient outcomes.

Recommendation 12

Ensure staff have the skills to identify and manage potential risks

The Commission recommends HEE works with national partner organisations to ensure staff have the skills to be able to identify and manage potential risks, to come up with possible solutions and to be able to implement these solutions. All staff should also have an understanding of how the system and human behaviour impacts their own practice and how this relates to patient safety.

The Commission's academic partner Imperial College London explored the most effective education and training interventions, the barriers to access and the challenges in embedding learning outcomes and implementing change.

Their full report is available on HEE's website along with the full Commission report. Visit: **www.hee.nhs.uk/the-commission-on-education-and-training-for-patient-safety**

This report was commissioned by Health Education England

March 2016

www.hee.nhs.uk