Health Education England

Supporting Patient Safety Through Education and Training

"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

A brief chronology

Patient safety in the NHS has been evolving for as long as healthcare has been a science. However, throughout that chronology, efforts to improve patient safety have been hampered by resistance to change, attitudes towards professional identify, and organisational culture. Notwithstanding marked hand hygiene[1] and public health episodes[2] in the 19th & 20th centuries, in more recent times patient safety issues have become more widely recognised and more widely publicised.

In 1990 James Reason described the 'swiss cheese model'[3] of incidence management in the aerospace industry which has been widely transferred into healthcare safety models. In 1999 the Institute of Medicine released a report called To Err is Human: Building a Safer Health System[4] which reviewed patient safety in the USA and UK. Sir Liam Donaldson published An Organisation with a Memory[5] in 2000. In 2004 the National Patient Safety Agency identified seven non-technical skills as key elements in patient safety[6] (e.g. incident reporting, culture, communication). In 2008 the World Health Organisation published the WHO Surgery Safety Checklist[7] then in 2009 we have the first Never Events report[8].

Until this point, patient safety remained, to a greater or lesser degree, a professional issue. This was all to change with the publication of the Francis Enquiry into the quality of care in a hospital in the Midlands in 2013[9] coming after many years of internal and independent investigations. In the same year Don Berwick published A Promise to Learn, A Commitment to Act[10]. From this point, patients and the public have become much more conscious of, and much more engaged with, patient safety in the NHS.

In March 2016 the Commission on Education and Training for Patient Safety published its report 'Improving Safety Through Education and Training'[11]. 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 that

[1] 1847 Dr Semmelweis suggests hand hygiene for obstetricians
[2] 1854 Dr Snow removes the handle from a water-pump in Broad Street, London
[3] http://aerossurance.com/helicopters/james-reasons-12-principles-error-management/
[4] http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/1999/To-Err-is-Human/To%20Err%20is%20Human%201999%20%20report%20brief.pdf
[5] https://webarchive.nationalarchives.gov.uk/20130105105027/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4065083
[6] file:///C:/Users/User/AppData/Local/Temp/NRLS-0034A-seven-steps-pa~-overview-2004-07-v1.pdf
[7] https://www.who.int/patientsafety/safesurgery/checklist/en/
[8] https://improvement.nhs.uk/documents/2265/Revised_Never_Events_policy_and_framework_FINAL.pdf
[9] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf
[11] https://www.hee.nhs.uk/sites/default/files/documents/Improving%20safety%20through%20education%20and%20training.pdf

report HEE has been working to enhance patient safety through education, training and development[12].

The publication of HEE response to Improving Safety Through Education & Training coincided with the publication of several strategic policy documents which talk to patient safety in the NHS, such as the Care Quality Commission report into 'Never events', Opening the Door to Change[13], and the Long Term Plan for the NHS[14]. NHS Improvement (NHSI) subsequently published the Patient Safety Strategy for the NHS[15] in July this year, in which HEE have committed to developing a patient safety syllabus for the NHS in collaboration with the Academy of Medical Royal Colleges.

A global context to patient safety

This year will see the first ever World Patient Safety Day recognised by the World Health Organisation on 17th September. This is an important move for patient safety in England and across the world. World Patient Safety Day[16] will ensure the focus of patient safety has not only an individual and organisational level focus to increasing the national and international profile.

World Patient Safety Day provides a focal point for healthcare and patient safety bodies, all over the world, to recognise the work they are doing to improve patient safety and to share intelligence and resources with other bodies to create a momentum for patient safety system-wide. HEE are part of the WHO patient safety (virtual) network and we will also taking this opportunity to reflect on what we are doing to promote patient safety; patient safety is being discussed at HEE Board and at HEE Deans meetings on this day and our Communications Team will be engaging in a social media campaign throughout the day.

A system wide approach

HEE has an important part to play in ensuring staff are well trained and that the quality of the learning environment is good, both important contributors to a safe healthcare environment. However, 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.

[12] https://www.hee.nhs.uk/sites/default/files/documents/Strategic%20Response%20to%20Improving%20Safety%20Through%20Education%20Training%20-%20HEE%20-%20July19.pdf
[13] https://www.cqc.org.uk/publications/themed-work/opening-door-change
[14] https://www.longtermplan.nhs.uk/
[15] https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf
[16] https://www.who.int/campaigns/world-patient-safety-day/2019

Organisations such as the Care Quality Commission[17] and Healthcare Safety Investigation Branch[18] play an important part in monitoring the safety of services and recommending improvement. Service and professional regulators such as NHS Improvement[19], General Medical Council[20] and Nursing & Midwifery Council[21] have a role in setting the standards for safety in learning and in practice whilst the universities and royal colleges are key to teaching safety and setting a supportive culture for patient safety[22]. And throughout the system, patient safety requires the patient and public perspective to be paramount in our thinking and planning.

HEE role in supporting patient safety

Safe clinical practice and professionalism is inherent within all healthcare professional training. The professional regulatory bodies set the standards (for education and for professional practice) and oversee that these are met by training institutions. HEE in turn plays its part in overseeing the quality of clinical professional education through its Quality Framework[23], our national and regional quality monitoring mechanism, and our work with professional regulators.

Despite clinical safety being weaved throughout the learner' journey, patient harm remains an aspect of todays' complex healthcare system. Important as clinical safety training is, it is often focused on specific aspects of care (e.g. safety in the anaesthetic room or safety for the diabetic patient) rather than developing a transferable knowledge of safety that can be applied in any situation.

It is important to recognise that up until this point patient safety training has almost solely been contained within professional training, and this only captures a proportion of the NHS workforce. Whilst clearly professional staff are an essential aspect of the workforce, training to date has not been inclusive and generic. There is a value in porters understanding patient safety as they transfer patients, GP receptions staff as they are a first point of contact, or procurement staff purchasing surgical equipment.

HEE has been instrumental (along with system partners) in raising awareness that multiple factors play a part in any patient safety incident – the 'Swiss cheese model'. This has

[17] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-12-safe-care-treatment
[18] https://www.hsib.org.uk/about-us/
[19] https://improvement.nhs.uk/improvement-hub/patient-safety/
[20] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice/domain-2----safety-and-quality
[21] https://www.nmc.org.uk/about-us/consultations/past-consultations/2018-consultations/ensuring-patient-safety-enabling-professionalism/
[22] https://www.nhsemployers.org/search-results?q=safety
[23] https://healtheducationengland.sharepoint.com/Comms/Digital/Shared%20Documents/Forms/AllItems.aspx?id=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality%2FHEE%20Quality%20Framework%2Epdf&parent=%2FComms%2FDigital%2FShared%20Documents%2Fhee%2Enhs%2Euk%20documents%2FWebsite%20files%2FQuality&p=true

led to a shift away from a 'blame culture', where the individual is held to account, to a more 'just culture'[24] recognising that no professional (notwithstanding malicious individuals) set out to do harm and that incidents are in fact a convergence of many factors.

HEE has, particularly at regional level, supported a considerable amount of training in those factors that contribute to more efficient, effective and safer services, collectively referred to as 'human factors' (annex I offer exemplar of that work).

Delivering patient safety through education, training & development

Health Education England has supported and delivered improvement training for patient safety across the NHS through our regional structures and national collaborations. The patient safety programme is overseen by the Patient Safety Programme Board which has promoted such initiatives as:

- Sharing good practice and building regional consensus via our Patient Safety Network – this network devised the 'response to improving safety through education and training' and is now developing the 'patient safety repository of good practice',
- Commissioning of two Patient Safety Fellows working across HEE & the AHSN Patient Safety Collaboratives (1yr secondments) to explore learning and development opportunities arising from the Gosport Review,
- Worked with the Chartered Institute of Ergonomics and Human Factors to develop a report on the contribution of human factors to safe practice[25],
- Enhancing 'Freedom To Speak Up' training jointly developed with HEE and the National Guardians Office,
- The Academy of Medical Royal Colleges has developed a syllabus, initially for postgraduate medical education, which is being used as the basis to develop a national patient safety syllabus for the NHS,
- Working with the Technology Enhanced Learning team - learning available via the e-LfH Hub[26] varies in focus from learning that is relevant and appropriate for all staff such as mandatory training to learning aimed at specific groups such as Sepsis in Paediatrics training,
- Working with Healthcare Safety Investigation Branch we have developed a memorandum of understanding for sharing non-confidential patient safety intelligence,
- Patient safety is an integral part of educational quality[27] as identified within the Quality Framework and the reviews undertaken across the regions to assure

[24] https://improvement.nhs.uk/documents/2490/NHS_0690_IC_A5_web_version.pdf
[25] https://www.hee.nhs.uk/sites/default/files/documents/Health%20Education%20England%20and%20CIEHF%20-%20Human%20Factors%20and%20Healthcare%20Report.pdf
[26] www.e-lfh.org.uk

the quality of learning in practice – last year HEE launched the first ever National Education and Training Survey (NETS)[28], conducted twice a year NETS will gather data on the quality of clinical practice learning.

Delivering for the future

NHSI launched the Patient Safety Strategy for the NHS in July this year. The strategy focuses on three key elements;

Insight

- Adopt and promote key safety measurement principles,
- Use new digital technologies to support learning by replacing the National Reporting and Learning System,
- Introduce the Patient Safety Incident Response Framework,
- Implement a new National Patient Safety Alerts Committee,
- Share insight.

Involvement

- Establish principles for the involvement of patients, families, carers,
- Create the first system-wide and consistent patient safety syllabus,
- Establish patient safety specialists to lead safety,
- Ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong.

Improvement

- Deliver the National Patient Safety Improvement Programme,
- Deliver the Maternity and Neonatal Safety Improvement Programme,
- Develop the Medicines Safety Improvement Programme,
- Deliver a Mental Health Safety Improvement Programme,
- Work with partners across the NHS to support safety improvement,
- Work to ensure research and innovation support safety improvement.

Within the Strategy we have committed to:

1. Develop a robust, achievable and aspirational plan for patient safety training for the NHS
2. Make safety training within professional educational programmes explicit and mapped to the competencies in a national syllabus
3. Ensure every member of the NHS has access to patient safety training; from ward to board and from commissioner to provider.

[27] https://www.hee.nhs.uk/our-work/quality
[28] https://www.hee.nhs.uk/our-work/quality/national-education-training-survey

Implementing the patient safety syllabus
Working in partnership with NHS Improvement and with the Academy of Medical Royal Colleges, we will develop a consistent national patient safety syllabus appropriate for all staff in in the NHS. A syllabus is the overarching framework for education from which education providers will build their curricula to address the specific needs of their learner group. Having a single syllabus means that everyone will learn the same things, just at a level and in a manner, that suits their role and learning needs. The Academy of Medical Royal Colleges, commissioned and funded by HEE, has now completed the outline of the syllabus and we are now working with system partners to ensure this syllabus is inclusive of the whole workforce and to implement this syllabus throughout the NHS.

Further development and implementation of the syllabus will need the support of universities and royal colleges, patients, providers, regulators and others. We have an engagement event for professional and service regulators planned for 2nd October at which we wish to begin our engagement in earnest.

Foundation level training for patient safety
The aspiration of the NHS Patient Safety Strategy to make patient safety training available for all staff within the NHS is a significant undertaking. Over the next 18 months we will scope, design and deliver a foundation programme for patient safety, applicable to all staff, in all roles within the NHS, that is aligned to the patient safety syllabus.

Promoting a patient safety culture
Creating a patient safety culture is not the responsibility of HEE. However, education, training and development can play an important part in creating the knowledge, skills and confidence that facilitates culture change.

HEE, nationally and regionally, will continue to commission (and where appropriate fund), promote and use networks to link other training initiatives to enhance safe healthcare practice including (but not restricted to); human factors training, interprofessional learning, and training to promote transparency and freedom to speak up. We will also use the financial, educational and influential levers available to us to promote a safer culture in the NHS.

Collaboration
Patient safety in the NHS requires a collaborative approach. HEE will continue to work across the system to promote patient safety through sharing safe healthcare practice across the NHS through networks, collaborations, and positive safe practice reporting.

Patient/ public voice
We recognise the importance of patient and public engagement in everything we do. We regularly report our quality transformation and patient safety activities to the HEE Patient Advisory Forum (PAF). From 2019 we have invited a representative of HEE

PAF to engage directly with the Patient Safety Programme to ensure greater transparency and accountability.

Conclusion

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

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 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 and human factors and ergonomics 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 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 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. 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

8. 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 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. 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.

9. Effective Performance Insight for the Future

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/

10. Quality and Safety: Achieving Better Care

This annual multidisciplinary quality improvement and patient safety event is a joint venture with Health Education England South West and the South West Academic Health Science Networks. 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 in health care, to celebrate QIP learning and share good practice on patient safety.

https://www.weahsn.net/event/quality-safety-achieving-better-care/

11. National Guardian: Freedom to Speak Up (Guardian Education and Training Guide)

The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS. They are sponsored by the Care Quality Commission, 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 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