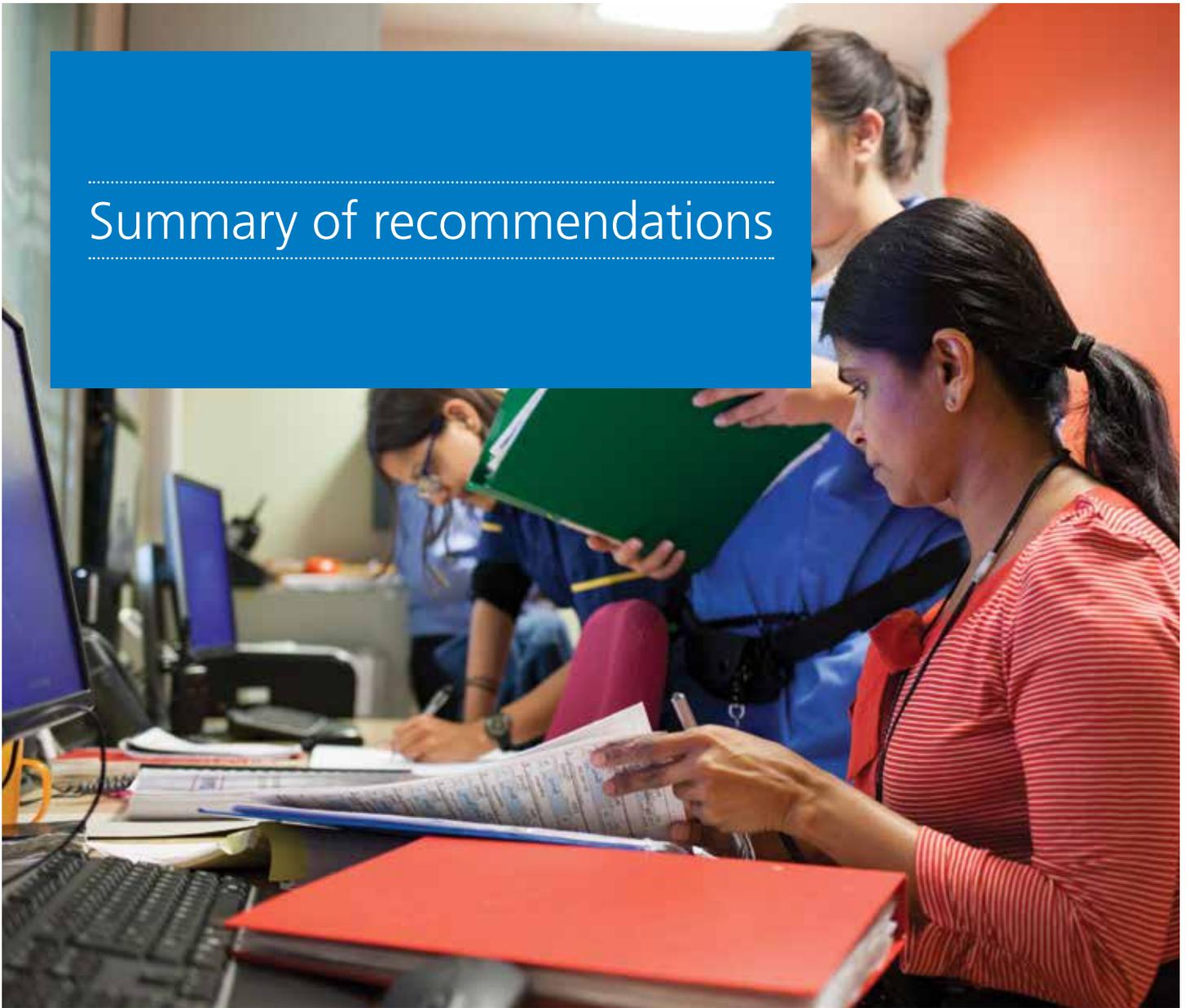


Summary of recommendations



Improving Safety Through Education and Training
Report by 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 10ⁱ 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

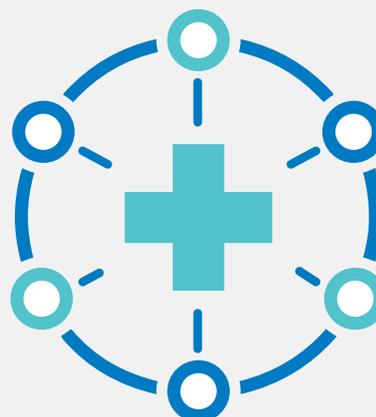
The Commission recommends that HEE works with national partner organisations and employers to ensure that the learning environment encourages and supports staff, including those learning and those teaching, to raise and respond to patient safety concerns.



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.

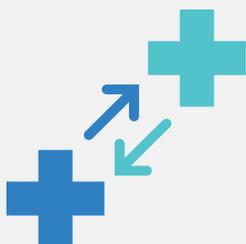


Delivering education and training for patient safety

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 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 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 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**

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www.hee.nhs.uk