Commission on Education and Training for Patient Safety

Professor Ged Byrne
Director of Education and Quality, North
“The desire for safety stands against every great and noble enterprise”
– improving patient safety through education and training
European data, consistently show that medical errors and health-care related adverse events occur in 8% to 12% of hospitalisations (10% in the UK)

Infections associated with health care affect an estimated 1 in 20 hospital patients on average every year (estimated at 4.1 million patients)

18% of European Union Citizens claim to have experienced a serious medical error in a hospital and 11% to have been prescribed wrong medication

Evidence on medical errors shows that 50% to 70% of such harm can be prevented through comprehensive systematic approaches to patient safety.
Patient safety in England (Aug 2012 - Dec 2016)

Source NHS Safety Thermometer
Demonstrating improvements in patient safety – Wessex

HEE Wessex supports individuals & teams in a number of ways, including:

• Wessex School of Quality Improvement, includes QI Fellowships
• Patient Safety First Programme for all junior doctors
• Quality Improvement Master classes
• Paediatric Innovation, Education and Research Network (PIER)
• Human Factors – 2 day course
• Evening seminars
Reminder of the Commission

In November 2014 HEE established the independent Commission on Education and Training for Patient Safety to review the current provision of training and ensure that we embed safety at the heart of all future education and training.

We brought together experts, patients, those responsible for and those receiving training in healthcare.

The Commission on Education and Training for Patient Safety published a full report in March 2016 of their findings. The report – *Improving Safety through Education and Training* – outlines 12 recommendations to HEE and the wider system.
What the Commission heard

“Training at the moment on patient safety is not sufficient…there is no awareness of safety at the systems level.”

- Education and training is fragmented and needs to change in order to address the wide ranging patient safety issues that exist
- The lack of robust evidence on which interventions are most effective is a major drawback
- Good practice needs to be disseminated. It is out there but is not being replicated and learning from incidents is rarely shared beyond traditional boundaries
The 12 Recommendations

1. Ensuring learning from patient safety data and good practice
2. Developing a common language
3. Ensure robust evaluation of education and training for patient safety
4. Engaging patients and public in design and delivery of patient safety training
5. Duty of Candour
6. The learning environment supporting response to concerns
7. Mandatory training
8. Patient safety training for leaders
9. Supporting joined up care
10. Increased opportunities for inter-professional learning
11. Principles of Human Factors & Professionalism embedded into training
12. Management of risks
What we have done since the Commission

**HEE’s approach to implementation:**

- **Extensive stakeholder engagement** across the system since the launch of the Commission report
- **Promoting synergy** across HEE, each Region is leading one of four workstream
- **Regional Leads through the HEE Patient Safety Working Group** taking the local lead on delivery
- ‘**Professional expert**’ from the Commission to support each workstream

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

• Commission is our opportunity to affect change and really embrace the need to put education and training at the heart of quality and patient safety

• Regional implementation across HEE is integral to success

• Can’t be done without engagement with other key elements of the system – Academic Health Science Networks, Patient Safety Collaboratives, other ALBs – this is on-going

• Spread and adoption of the local/regional education and training projects – ‘Communities of Practice’

• Evidence base to support the spread of local initiatives

• HEE has a responsibility to ensure that local good practice is scaled and spread – as part of the workstream delivery, we are using local innovation to populate the ‘STAR' and include patient safety metrics in the quality programme
The relationship between the quality of education and training and patient safety

Clinical Learning Environment

High Quality Education and Training

- Motivation
- Opportunity

Patient safety
Translating high quality education into safe patient care
….and when elements are missing

Safe Patient Care

Clinical Learning Environment

Education and Training Programmes

Achievement of Professional Competencies

Capability and Competence

Opportunity

Motivation

Skills

Resources

- Learning Environment and Culture
- Educational Governance and Leadership
- Supporting and Empowering Educators
- Developing and Implementing Curricula and Assessments
- Developing a Sustainable Workforce

- Opportunity
- Motivation
....patient safety may be compromised
Alignment across the system

- A successful implementation plan requires **on-going alignment** with and across HEE’s key partners
- It is essential to **share learning and foster synergy** in delivery of the recommendations
- Where we can, we need to deliver **shared outcomes** and **rationalise education and training** interventions
- The patient safety agenda needs to be underpinned by the **quality framework** and vice versa.