Improving Safety through Education & Training: What is missing from training?

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Improving Safety through Education and Training:

What is missing from training?

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Objectives:

- Share next steps for HEE in taking forward the Commission recommendations and supporting the NHSI Patient Safety Strategy
- Outline a proactive, systems approach to providing safe patient care, working collaboratively with Academy of Medical Royal Colleges
- Highlight the practical challenges of creating a multi-disciplinary syllabus
In March 2016, the Commission on Education and Training for Patient Safety published its report ‘Improving Safety Through Education & 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
3. Ensure robust evaluation of education and training
4. Engage patients, family members, carers and the public in the design and delivery of education and training
5. Supporting the duty of candour with high quality educational training packages
6. Learning environment must support learners and staff to raise and respond to concerns
7. 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
Delivering the Education

200+ e-learning programmes  24,000+ e-learning sessions  900,000+ registered users.

From undergraduates to the existing workforce, there are already a host of e-learning and training opportunities available, all delivered via the HEE ‘e-Learning for Healthcare’ (e-LFH) portal.

Safety First

While safety is implicit within a majority of the portal's learning resources, ‘patient safety’ is a specific aspect of many programmes:

187 learning sessions
36 courses
10 programmes
1 learning pathway.

In 2018, there were:

147,000+ session launches of programmes including a patient safety element
81,000+ registered users for these programmes
180,000+ registered users in the past 5 years.

The learning available covers all areas of NHS care:

From the general
Learning journeys relevant to all staff including the ‘Freedom To Speak Up’ and ‘Statutory’ and ‘Mandatory’ programmes.

To the specialist
Learning journeys aimed at specific professional groups including ‘Sepsis in Paediatrics’, and training on safety in procedures such as MRI.

Patient safety is mandated by the professional regulators and is integral within all healthcare professional training. There is already a significant amount of patient safety training taking place throughout the NHS, within training programmes and as stand-alone packages.”

– Health Education England
Collaborative Effort

- Wessex PSC and HEE Wessex deliver an annual joint event on Patient Safety and Quality Improvement with over **200 attendees** each year.
- Wessex PSC and HEE Wessex created and launched the Wessex Community of Safety and Improvement Practice (CSIP) which now has **over 700 members**.
- Learning from Deaths fellows (funded by HEE, hosted by AHSN Network).
- Numerous examples of partnership working with HEE representation on PSC Boards.
The HEE Patient Safety Interactive Resource –

• Created following collaborative work with the HEE Patient Safety Network

• Showcases examples of good practice in patient safety training across HEE both regionally and nationally

• Hosted on the HEE website and available to anyone

• Links people with the work done on the safety subjects they are interested in

• Connects people wanting to know more with key contacts

• This is a constantly evolving resource where the content will be updated and added to as work in patient safety is progressed
The NHS Patient Strategy

- Safer culture, safer systems, safer patients
- To continuously improve patient safety
- “Golden thread running through healthcare”
We have been asked to:

• develop a robust, achievable and aspirational plan for patient safety training for the NHS

• make safety training within professional educational programmes explicit and mapped to the competencies in a national syllabus

• ensure every member of the NHS has access to patient safety training; from ward to board and from commissioner to provider.
The HEE Mandate

Develop and deliver a national patient safety syllabus, with associated educational resources and infrastructure, aligned to the NHS Patient Safety Strategy (with NHS England/NHS Improvement, Royal Colleges, and professional regulators), including:

- creating the first national syllabus by the end of March 2020;

- conducting an evaluation of current education and training packages to inform plans (to be established by the end of March 2020) for implementing patient safety training in all relevant training and education.
Syllabus or Curriculum?

Syllabus:
Descriptive summary or outline of what will be covered in a course of study.

Curriculum:
Prescriptive, Specified content for a group.

Outcome:
Demonstrate a clear understanding of both reactive and proactive methods of approaching patient safety, including personal clinical safety and the wider factors that impact system safety.
Our Learning Systems are Poor

• Persistent blame culture suppresses reporting
• Reporting systems are cumbersome and time-consuming
• Quality of investigations is variable, rarely thorough, and have become administrative exercises
• The issue of future risk is virtually never addressed
• The primary recommendations are training – the least sustainable intervention
Healthcare approach to safety is essentially reactive:

- The first thing that has to happen to trigger the system is that we harm a patient
- We don’t know whether we are safe until we aren’t

Other safety-critical industries have become safer
- what do they do that we don’t?

- They focus on risk not harm
- They are proactive rather than reactive
- They underpin their approach to safety with broad-based human factors expertise

What is Needed?
Opening the Door to Change – CQC, 2018

• Other industries have become safer: “The same type of change needs to take place in the NHS, driven by clear leadership in education and a coherent patient safety curriculum.”
• There is also an urgent need to prioritise the importance of patient safety in curriculums and training courses.
• Unlike other industries, and healthcare organisations in other countries, competing demands and pressures on trusts means that they do not always prioritise safety and are sometimes reluctant or unable to release staff to give them the time and space to do training.
Patient safety is implicit in all we do for patients

But is it explicit anywhere?

Echoes a conclusion of the Berwick report (2013)

“When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is.”

Focussed on the individual’s responsibility for a patient rather than the role and impact of the system

Moving to a systems focus on safety will help reduce the toxic blame culture within the NHS
The National Patient Safety Syllabus

- Multi-professional
- Includes proactive management of risk as well as dealing better with incidents of harm
- Takes a systems approach to safety
- Includes comprehensive human factors approach
Key Domains and Underpinning Knowledge

- Syllabus consists of five domains
- Diagram shows a linear sequence, but there are dependencies and synergies between them
- Syllabus also includes key outcomes, underpinning knowledge and expertise required at each stage.
Ingredients:

- Education, training and workforce development
- Clear policies
- Leadership capacity
- Data insight to drive safety improvement
- Skilled healthcare professionals
- Effective involvement of patients system wide
- Improvement programmes
- A patient safety culture
- Strong operational and strategic relationships
- A paradigm shift
What’s missing?

A proactive, systems-based approach to safety preventing harm before it occurs