



Response to Health Education England's Commission on Education and Training for Patient Safety

September 2015

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At the Institute of Health Visiting (iHV), we strive to promote the best available high quality standards in health visiting practice. We are responding to the request for information to contribute to the Commission on Education and Training for Patient Safety review, undertaken by Imperial College London on behalf of Health Education England (HEE) and the specific questions posed below.

1. What makes effective education and training in quality and safety in healthcare?

Quality and safety should be seen as essential to all elements of education and training as otherwise they can be seen as separate to the reality of practice. Therefore, all effective education and training should be underpinned by an understanding of what is meant by quality and safety relevant to the context. This will allow all training and education to be applied appropriately as core concepts of all aspects of patient/client healthcare. This is particularly pertinent when promoting patient safety in a community environment and within primary care in a team context. Therefore, effective education and training in safety needs to be cognisant of the environmental setting, for example hospital versus community, and not presume that education only relates to hospital patients, but rather taking account of and tailored for different working environments.

Training and education in quality and safety has to incorporate multi professional working. Due to the nature of the complexity of healthcare no professional acts independent of others. With this in mind specific outcomes and impact need to be clear in education and training from the beginning, to ensure best use of resources, and that there are opportunities to deliver in a multi-disciplinary team setting as well as to individual professional groups.

As an organisation the iHV has embedded client safety into all the training programmes developed so that it is contextualised in practice. Consideration has been given when developing our Continuous Professional Development (CPD) standards to ensure safety is recognised as part of the wider quality assurance of all education products. In the future we intend to make this element of the training more explicit, focusing in more depth on impact. Further articulation of safety elements within the training, i.e. by linking training outcomes to aims and learning outcomes and incorporating the specific themes of the Nursing and Midwifery Council (NMC) Code: Professional Standards of Practice and Behaviour for Nurses and Midwives (2015) for example prioritise people and preserve safety; has the potential to support practitioners to really understand the breadth of patient safety training and link it to their revalidation applications. We are currently developing products to assist health visitors to achieve the NMC requirements for revalidation for example guidance on CPD opportunities and reflections on practice that incorporate quality and safety.

All education and training should consider patient safety from individual, team and organisational perspectives to ensure a systems approach to learning applicable to the context of practice; along with recognition of how such learning is implemented, at what level/ standard and how it is assured at an organisational level. As such, safety training

should not occur as a separate entity or be seen purely as an individual activity. To support such activities being undertaken as part of the model of practice sufficient resources/management structures need to be in place within employing organisations.

2. What are the priorities for patient safety education and training in the future?

Further discussion is required about the terminology used when delivering training as patient safety discourse is often based on an illness model of health, and assumes that patients are sick and in clinical settings usually centered on hospitalised care although not exclusively. Health visitors work with healthy children, families and communities to promote and prevent ill health. This is undertaken in a community setting, not a hospital environment, and health visitors do not work with patients *per se*. Restricting the terminology to “patient” may have the effect of reducing the wider understanding of what constitutes patient safety education and training as this applies to health visitors.

Raising awareness of what constitutes patient safety is a priority for all health professionals. Some of the patient safety education that health visitors do receive may not be recognised as such for example risk assessment training as part of their organisation’s mandatory training programme. Many health visitors may not see that this relates to them as it is not contextualised and applied to practice although many community clinic environments are a risk to patient safety, along with non-clinical settings for example the home and community.

Patient safety training in the future should take account of the context in which the care is given. For example the increasing awareness of exploitation and slavery amongst vulnerable communities, so that priorities for “service user safety” training for health visitors and others working in the community should be to see mental capacity training and adult safeguarding/ exploitation education as mandatory.

Health visitors have a key role in public health education, are the leaders of the Healthy Child Programme and work in partnership with local authorities including social workers on high level child protection cases requiring specialised knowledge. Additionally health visitors are the only universal service in the lives of very young children, who consistently have a key role in detection, early intervention and support of perinatal mental health, infant mental health problems, domestic violence, relationship difficulties and emotional distress in families including the essential parent-infant relationship. These highly complex issues often coexist and future training should endeavour to ensure that all practitioners have a sound understanding of the impact that these issues can have on the safety of all members of a family/community. Furthermore we advocate strengthening a life-course approach to address the intergenerational transmission of these complex issues.

The promotion of home safety and the prevention of unintentional injury are key aspects of the health visiting role. Health visitors are specialists in public health and are motivational change agents, skilled in empowering families through early intervention to prevent hospital admissions. However, a major study led by Professor Dame Sarah Cowley found amongst many salient points that “There needs to be more investment in education programmes for health visitors, including continuing professional development.” One of the key areas

identified as requiring further training was better preparation for health visitors to promote home safety and prevent unintentional injury (Cowley et al 2013). In response to this the iHV has developed a safety training programme; it is important going forward that funding is available to further train health visitors in the promotion of home safety and the prevention of unintentional injury.

The iHV is committed to improving the availability of evidence for practice, and works to achieve this in three main ways. First, the iHV has commissioned experts in the field to prepare readily accessible resources focusing on the research underpinning key aspects of practice, such as child safety and safeguarding. The iHV has established a robust quality assurance process to ensure the accuracy of these documents. Second, supported by a grant from Health Education England, the iHV has published (40) peer-reviewed but accessible 'Good Practice Points' focused on improving practice in areas such as safety prevention and safeguarding which includes unintentional injury. These complement a series of information sheets for parents (35), which can be downloaded by parents and printed as resources for health visitors to offer parents. As well as these direct approaches to learning, the iHV hosts an online Community of Practice, which enables practitioners to contact peers with queries and to discuss issues relating to promoting safety within the home.

The iHV promotes the use of the SAFER tool, which are guidelines for communications between health and local authority children's social care teams using the SAFER process when a child may be suffering or is likely to suffer significant harm. In addition the iHV have provided training in 'Contemporary issues in Safeguarding' which was rolled out to over 200 health visitors with the remit to cascade the training. There is e-learning to support this and a training pack.

All safety education and training priorities should be informed by service providers training needs analysis combined with local intelligence from such data as patient/client complaints and the Care Quality Commission. This will utilise available information to understand what the key issues are and enable a systems approach to development of future education and training that is systematically developed, delivered in various media and evaluated. It should be flexible enough to be tailored to different settings where patients/clients are seen.

An understanding of what health professionals currently access, what it means to them and how they see the future vision should be undertaken. At the core of all developments should be making education/training effective and easy to access.

Central to all developments should be utilising evidence-based methodology on patient safety, for example human factors training and findings from the Institute for Healthcare Improvement. Most importantly all education and training should be developed with input from patients, carers and service users.