National Patient Safety Syllabus

About this syllabus — what you need to know. Key FAQs

Training for every member of staff across the NHS

— Preventing harm before it occurs

— Seeing risks and making them safe

— It's time to change what we do

Who is it for?

— This is a multi-professional syllabus. It is intended to cover all the patient safety training and educational needs of people currently working in the NHS or in training to work in the NHS. This includes both clinical and non-clinical staff and covers the voluntary sector and social care.

How is it different?

— This is the first NHS-wide patient safety syllabus. It is applicable to all staff

— The syllabus includes the incident reporting and investigation that takes place after incidents (including near-misses), but also adds critical proactive systems to prevent harm occurring in the first place. This reflects best practice in building safe systems within other safety-critical industries

— The syllabus encompasses all national safety initiatives including national alerts, key safety regulations and safety campaigns.

How will it make a difference to NHS staff, including clinicians and managers?

— The syllabus provides a common language and framework for patient safety

— It provides content to support all patient safety activities carried out by NHS staff. This includes incident investigation, creating a safety culture, using human factors, proactive risk management and managing system-induced human failures.

Does the syllabus include Human Factors?

— The syllabus is based on a systems approach to human factors. It is holistic in its use of human factors, both system- and person-based

— Human factors is the study of the system within which staff work, including their environment, equipment and people. In other industries, the application of human factors adds a proactive approach to safety that goes beyond the reactive approach that currently dominates in healthcare

— The syllabus therefore explicitly emphasises a systems-based human factors approach to safety, where working systems and their interaction with staff are paramount in creating safety for patients and supportive working conditions for staff

— The aim of all the tools and techniques is always to minimise risk and consequent harm to patients. These tools and techniques apply to all aspects of work within the NHS, including the safe design of plant, equipment, environment and working conditions

— The syllabus also includes popular 'human factors' approaches based on non-technical skills such as communication, stress management and situational awareness, commonly referred to as Team- or Crew-Resource Management.

What are some of the tools and techniques described in the syllabus?

— Because the syllabus is based on a systems approach, system mapping and risk evaluation are critically important

— Tools to understand the system and the risks to patients include process mapping, Hierarchical Task Analysis, Failure Mode and Effect Analysis (FMEA) and human error management

— Incident Investigation tools are based on best practice in identifying care and service delivery problems and emphasise system interventions in preventing future harm. These include the use of the Hierarchy of Control in designing the most effective interventions, report writing and sharing lessons learned

— Safety Culture, one of the four key themes on which the syllabus is based, is addressed through several tools including the Manchester Patient Safety Framework and the Safety Culture Index. The use of these instruments in creating a reflective, risk-aware culture and in accurately measuring it is an essential part of the syllabus

— The syllabus emphasises throughout, the importance of avoiding corrosive blame culture and the correct use of an Incident Decision Tree or Just Culture Guide in evaluating human performance and variability

— Measurement and monitoring of patient safety and the models that underpin thinking on safety, are included in Safety Culture education

— The syllabus also describes the use of formal tools in risk management, including reporting and learning from adverse events (including near-misses), risk evaluation and ranking, risk registers and escalation of risk

— The syllabus addresses improvement methodology as it affects patient safety, with an emphasis on the reliability of safety-critical processes. The development of essential process reliability metrics and their correct application in building safe clinical systems is key to the syllabus.

Where does this work come from?

— The work builds on previous work in the NHS on patient safety, academic courses in patient safety, the national programme Safer Clinical Systems and direct experience in managing safety in NHS trusts

— The development of the syllabus has been guided by an expert advisory group including representatives from patients, NHS staff, academia, medical Royal Colleges, NHS Improvement and NHS England. The work was funded by Health Education England and other jurisdictions have been consulted.

What impact will this work have?

— This syllabus will be relevant to patient safety education at all levels and in all professions

— The syllabus is expected to create a step-change in thinking about safety, providing the understanding, tools and techniques that NHS staff at all levels need to build safety for patients

— The syllabus is also intended to begin moving the emphasis from reactive to proactive methods, managing risk before it creates harm for patients

— The syllabus takes the systems approach to safety that has been continually advocated across the world and sets it out clearly for professional education

— Throughout the syllabus, the emphasis is pragmatic and focuses clearly on how to build safe clinical systems in all areas and departments of the NHS.

The syllabus is on the Academy of Medical Royal Colleges website. We would welcome further questions and/or feedback on the syllabus via the survey on the website or by emailing Rose Jarvis at the Academy directly.