National Patient Safety Syllabus v1.0

Key points

January / 2020

Training for every member of staff across the NHS

Making Safety Active

- Preventing harm before it occurs
- Seeing risks and making them safe
- It's time to change what we do

Background

The past two decades have seen many positive examples of change in caring for patients safely and sustained efforts to reduce patient harm. However, many health systems across the world have not achieved the level of reduction that might have been anticipated. In part this is because the prevailing approach is almost entirely reactive.

This retrospective 'find and fix' approach is an admission that we are not safe – it is a search for a breakdown in safety, not an assurance of safety. The time between harms may be long, but we do not know whether the next harm will happen tomorrow or next month – in other words, we do not know whether we are 'safe' today by luck or by design.

It is time for a different approach – to identify risks proactively and prevent errors happening in the first place, by acknowledging that it is generally the system that is creating risk, not individual staff. This will achieve many objectives – better patient care, reduced harm to patients, reduced professional and personal damage to clinicians who, almost always inadvertently, are involved in errors, and, of course, reduced litigation and reduced costs. It will also reduce the blame culture, which engenders fear of reporting risk and harm that is 'toxic to both safety and improvement'. [1]

The Strategy and the Syllabus

The NHS published its first Patient Safety Strategy in July 2019. As part of this, it was announced that the first NHS-wide Patient Safety Syllabus would be developed to support a transformation in patient safety education and training in the NHS. The Patient Safety Strategy included ambitions to develop training in the fundamentals of patient safety that would be relevant to all NHS staff – clinical and non-clinical – as well as more detailed training and education that could be incorporated into clinical and non-clinical undergraduate and postgraduate healthcare education and continuing professional development. There will also be training provided within teams in NHS trusts for those who are not covered by such programmes.

This Patient Safety Syllabus is the first stage in delivering that ambition. We are publishing this now so that the NHS and its stakeholders can provide views on the proposed content, highlight potential gaps or areas that need further work. We know there are areas that need more work, such as content on safety improvement approaches, and we will continue to iterate the syllabus on a twice-yearly basis and based on your feedback. This syllabus will be the basis for work to develop the curricula and education content that will support continuing improvements in patient safety for the next decade.

1. The Berwick Report: A promise to learn – a commitment to act. Improving the Safety of Patients in England (2013) National Advisory Group on the Safety of Patients in England, HMSO

The development of a syllabus for patient safety education, a process which began in the context of a national programme for patient safety (Safer Clinical Systems, The Health Foundation), aimed to capture existing good practice in the areas of systems thinking, learning from incidents and national safety priorities. Central to the syllabus, and the approach that makes this work unique, is the inclusion of best practice from other safety-critical industries, which have become safer during a period when the rate of adverse incidents suffered by patients has not significantly changed.

The syllabus for patient safety is a synthesis of current practice in healthcare and best practices from safer industries. Put simply, these two approaches can be seen as reactive (where healthcare organisations pay close attention to what has already gone wrong for patients) and proactive (where, in addition to the foregoing, safe organisations focus on reducing risk before harm occurs).

Patient Safety Education

Training in patient safety forms an integral part of medical education and other clinical training and will now be provided for all staff who contribute to the system of patient care. Patient safety education generally focuses on the safety of the direct care relationship between the clinician and the patient, which is central to good practice. However, it is widely recognised that most adverse events involve more than the immediate care provided to the patient and are the result of failures in the systems within which clinicians work.

The Academy of Medical Royal Colleges, supported by funding from Health Education England, initiated a programme of work to develop a syllabus for patient safety, based on a systems perspective, and designed as a framework suitable to be developed into curricula for all NHS staff.

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Syllabus content

The syllabus is designed for all NHS staff and is structured to provide both a technical understanding of safety in complex systems and a suite of tools and approaches that will:

- Build safety for patients
- Reduce the risks created by systems and practices
- Develop a genuine culture of patient safety.

Although there are a number of well-known safety procedures in healthcare – including the intention to learn from incidents and national safety regulations – this syllabus is distinct in three ways. First, it draws explicitly from widely-used safety methodologies applied routinely in other safety-critical industries such as aviation and process engineering. These are industries where the use of a systems-based approach and the recognition of human performance variability have brought safety to high-risk areas. These industries have long been upheld as learning opportunities for healthcare. Second, in line with best practices from safer sectors, the syllabus adopts an approach that brings a systems perspective to reactive safety methods and – perhaps most importantly – uses a systems approach to enhance patient safety proactively. Third, this is the first NHS-wide patient safety syllabus.

The syllabus has five domains that are presented below as a linear sequence, though there are inevitable dependencies and synergies between them.

Figure 1 – Key Domains in the Patient Safety Syllabus

What is the difference between a syllabus and a curriculum?

The syllabus represents a very high-level description of material that could be covered on a topic. Subsequent curricula developed from that syllabus contain the educational content reflecting the syllabus items tailored to particular categories and levels of audience. Curricula will address the range of potential educational methods that might be used. An example is given below.

Illustration of mapping of syllabus content to curriculum content

Syllabus statement:
Applies strategies to improve non- technical skills (from Domain 3).

Curriculum developed from that syllabus description:
Educational modules which encourage good communication about risk and safety at all levels. This will include listening skills, dealing with steep hierarchy gradients and skills in patient handover. Training will include case studies and examples.

Where can I find the syllabus?

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.

Academy of Medical Royal Colleges

Relevant Publications

The following publications relate directly to the work outlined in this document, with a comprehensive description of the work and its practical application presented in *Building Safer Healthcare systems*.

1. Peter Spurgeon, Mark-Alexander Sujan, Stephen Cross, Hugh Flanagan (2019) *Building Safer Healthcare Systems – a proactive, risk-based approach to improving patient safety.* Springer, London.
2. Matthew Cooke, Stephen Cross, Peter Spurgeon (2012) *'A Safer Clinical Systems Approach'* in Peter Spurgeon, Ronald Burke, Cary Cooper *The Innovation Imperative in Healthcare Organisations*. Edwin Elgar. pp 246-262.
3. Safer Clinical Systems, a reference guide for clinicians and managers (2013). http://patientsafety.health.org.uk/sites/default/files/resources/hf_safer_clinical_systems_reference_guide_final_1.pdf [accessed 1 December 2019]
4. Spurgeon P, Flanagan H, Cooke M. et al. (2017). Creating safer health systems: lessons from other sectors and an account of an application in the Safer Clinical Systems programme. *Health Services Management Research*, 0(0) 1-9.
5. Sujan M, Spurgeon P, Cooke M. et al. (2015) The development of safety cases for healthcare services: Practical experiences, opportunities and challenges. *Reliability Engineering and System Safety* 140, 200-207.
6. The systems approach at the sharp end (2018) Stephen Cross. *Future Healthcare Journal* Vol 5, No 3: 176–80.

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