Patient Safety Learning's response to the National patient safety syllabus 1.0

The NHS Patient Safety Strategy, published in June 2019, sets out three strategic aims around Insight, Involvement and Improvement which will enable it to achieve its safety vision. It defines the Involvement aim as 'equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system'.[1]

A key action associated with this aim is the creation of a system-wide patient safety syllabus which is capable of 'producing the best informed and safety-focused workforce in the world'.[2] The Academy of Medical Royal Colleges has been commissioned by Health Education England to develop a new National patient safety syllabus. The Academy has now published its first version of this for review and feedback.

In Patient Safety Learning's report *A Blueprint for Action* we identified the need to professionalise patient safety as one of the six core foundations of safer care.[3] We believe that there are several components required to professionalise patient safety:

- Clear standards for safe care
- Accreditation processes for safe care
- Leadership and governance for safe care
- An agreed competency framework as the basis for education and training
- Evidence-based training for all staff, with continual professional development
- Specialist patient safety and human factors experts

We welcome the development of a National patient safety syllabus as a positive development that can help contribute to this foundation. We have been meeting with Health Education England and the Academy and have shared with them our reflections including areas in which the draft syllabus should be strengthened. We are now sharing these more publicly and invite others to contribute their feedback.

Positive reflections

At Patient Safety Learning we welcome a number of elements of the proposed new syllabus, one being that its approach applies to all staff. The syllabus makes clear that these principles apply to 'clinical and non-clinical staff and covers the voluntary sector and social care'.[4] This supports the concept of patient safety being part of the purpose of healthcare, rather than simply an add-on in particular specialist roles.

The syllabus also sets out the importance of taking a systems approach to patient safety, seeking to ensure that staff are able to demonstrate 'a knowledge of how culture and working systems leads to risks to patients'.[5] Patient safety is a systems issue, with avoidable unsafe care ultimately having complex causes. We are encouraged by this approach and its emphasis on considering safety approaches used in other safety critical industries and the importance of understanding that patient safety goes beyond individual practice.

We also commend the inclusion in the syllabus of detail around taking a proactive approach to safety management. In talking about creating safe systems, it underlines the role of using 'proactive safety techniques to prevent harm to patients', such as the use of process

---

[1] NHS England and NHS Improvement, The NHS Patient Safety Strategy: Safer culture, safe systems, safer patients, July 2019.
https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf
[2] Ibid.
[3] Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409
[4] Academy of Medical Royal Colleges, National patient safety syllabus 1.0, January 2020.
https://www.aomrc.org.uk/wp-content/uploads/2020/01/National_Patient_safety_syllabus_v1.0_0120.pdf
[5] Ibid.

mapping to understand systems and identify high-level risks.[6] To improve patient safety in the NHS it is important that not only we respond to errors in a timely and effective way when they occur, but that we utilise existing information to improve patient safety performance and initiative proactive preventative measures.

While the creation of the National patient safety syllabus is a positive step, we have identified several areas where there are significant gaps in the initial draft that need to be addressed. We also comment on the development process of the syllabus and invite a more inclusive and transparent process that enables a wide range of stakeholder to engage and contribute to the curriculum.

Overall strategy for patient safety and the role of the syllabus

The syllabus builds on and reinforces what we already have in place within the NHS rather than setting out a step change.

The syllabus, we think, struggles to outline how it supports an overall vision for patient safety in health and social care. It takes at its framing ambition, the NHS England and NHS Improvement Patient Safety Strategy. But this strategy doesn't encompass the changing wider health and social care landscape that includes:

- Systems and professional regulators and their role in setting standards and acceptable behaviours for patient safety
- Transformational ambitions of the Long-Term Plan and context of new cross organisational pathways and structures, performance management
- The emerging People Plan and development of new workforce roles and ways of working
- Challenge of setting and delivering safe staffing
- For those working at the 'clinical front line,' the necessity of addressing the 'work as imagined' vs the 'work as done challenge'
- How to create and support a culture that encourages and welcomes staff highlighting patient safety concerns without the need to put their professional lives on the line as 'whistle-blowers'
- Active patient and public engagement
- Leadership for patient safety including setting organisational standards for safer care and role modelling the behaviour needed for safe cultures

These contexts matter as they set and inform cultures, behaviours and how the health and social care system needs to change for harm reductions and staff psychological safety.

The syllabus needs to consider these issues and define its role in addressing them. The syllabus should be more that outlining content that staff need to know about but how they should apply such knowledge – the skills and behaviours that they need and as defined by role.

Gaps in the syllabus

Below we outline some of the specific matters, taking this context into account, that we think the syllabus and curriculum needs to consider and respond to:

---

[6] Ibid.

1) Patient engagement

We describe in *A Blueprint for Action* and *on the hub* how vital it is that patients are effectively engaged for patient safety during the care process, if things go wrong and in the redesign of health and social care using the insight and wisdom from patients. There is clear research evidence that active patient engagement reduces unsafe care. We strongly believe that the new syllabus needs to reflect this. While it mentions the word patient 134 times it distinctly lacks references to the knowledge, skills and attitudes required from healthcare professionals to understand why and how patients can be actively involved in patient safety. This is a serious omission.

Patients tell us that they are often not engaged properly in their care, instead treated as passive participants in the process. To address this issue, we need staff and leaders equipped with the right skills to engage with them. The current draft syllabus does not account for this.

We believe that the syllabus should reflect the significant research and resources available in this area including the World Health Organization (WHO) Patient Safety Curriculum Guide. This guide includes a full why engaging with patients and carers and outlines why this is important:

> *'Modern health care claims to be patient-centred, but the reality for many patients is a long way from this vision. Entrenched views about the level of involvement patients should have in their own care, is a major obstacle to patients and consumers. The tide is turning and, in many countries around the world, the consumer's voice in health care is not only being heard but is being recognized by governments and health-care providers.'* [7]

The WHO Guide includes full details of the Learning objective:

> *'for students to know and understand the ways in which patients and carers can work as partners in health care, both in preventing harm and in learning from adverse events.'* [8]

We think this is a strong starting point and recommend that patients are at the heart the syllabus and its supporting curriculum.

2) Leadership

Good leadership is key to patient safety, and 'maintaining a safety culture requires leaders to consistently and visibly support and promote everyday safety measures'.[9] While the draft syllabus applies to staff at all levels in the NHS, we consider that it has too few references to

---

[7] World Health Organization, Patient Safety Curriculum Guide, 2011.
https://apps.who.int/iris/bitstream/handle/10665/44641/9789241501958_eng.pdf;jsessionid=7819865E90A45E2288606F9BF1F5C4F9?sequence=1

[8] Ibid.

[9] The Joint Commission, The Essential Role of Leadership in Development a Safety Culture, March 2017.
https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/sea_57_safety_culture_leadership_0317pdf.pdf?db=web&hash=10CEAE0FD05B6C3A4A1F040F7B69EBE9

the role of leadership in delivering this and leadership's role in creating and nourishing a just and learning culture.

We believe there should be high standards and behaviours set for our leaders, supported by specialist patient safety experts in defined and resourced executive and non-executive Board roles. Organisations need clear and published goals for patient safety with Board focus and effective oversight on reducing patient harm. These standards and goals will inform the education and training needs for all staff, including leaders throughout the organisation and wider health and social care system.

3) Human Factors

The ambition to include Human factors science is excellent.

However, we think that knowledge base and understanding of how Human factors can be effectively applied in healthcare is still emerging. We need to recognise that taking tools and approaches and directly applying these from other industries might just not work. For instance, Failure Mode and Effect Analysis (FMEA) is a great tool but one that is usually used based on a system design document; this doesn't seem to be how the health sector operates.

The syllabus needs to explain why and how Human factors is an underpinning thread and that in providing the knowledge, skills and behaviours needed, how and when such tools could be used, for example the understanding of when to require Safety Cases taking into account the effort required to produce them.

4) Learning from harm and learning from good practice

Healthcare is systematically poor at learning from harm and this draft syllabus rightly places a strong emphasis on learning from incidents of unsafe care. We need to ensure that all investigations are undertaken for learning:

- By people independent of the incident, properly equipped with Human factors investigation training
- With the resources necessary to undertake an open and just investigation, engaging with and involving patient, families and staff
- Make conclusions and recommendations that will prevent the incident re-occurring
- With action taken to prevent future harm
- With shared learned learning for wider system benefit

The syllabus needs to reflect all these stages in ensuring that we have staff and leaders equipped to lead and participate in investigations for learning.

We also consider that much more emphasis is needed on the importance of learning from good practice and the designing and implementation improvements in patient safety. The 'Learning from incidents' section seems to include some aspects of 'designing systems-based interventions.' The transforming of organisations for safer care is deserving of a whole section on its own, not just being able to evaluate and assess but also to act for patient safety improvement including:

- The methodology of quality improvement
- Designing safer systems including technology and patient safety
- Risk and patient safety impact assessments
- Open and learning culture

- Cross organisational care pathways
- Patient and carer engagement (see separate section above)
- Staff engagement
- Specialist expertise in human factors and patient safety
- Use of data and insight
- Shared learning
- Innovation and collaboration with manufactures on design and implementation of new products and ways of working etc

Often this is an issue in NHS, where a trust may create an innovative solution to a problem, but this knowledge remains siloed within that organisation. In the case of patient safety, this can mean that although a solution has been found in one location, other organisations are continuing to work in old ways that are exposing their patients avoidable harm. At Patient Safety Learning we have created *the hub*, our online platform for patient safety learning, to enable share learning about patient safety problems, experiences and solutions, however this is only part of a solution. We believe this syllabus should also place an emphasis on staff sharing knowledge and best practice for safe care.

5) Focus on knowledge and skills, but not behaviours

Understandably the syllabus takes a strong focus on the knowledge and skills needed for patient safety to be shared among NHS staff, however we feel there is more to be added from a behaviours perspective.

Improving patient safety holistically requires a joined up strategic approach bringing together several initiatives. Whilst all the work taking place has its merits, we believe patient safety will not be realised without a holistic approach to policies, processes, standards. The glue holding these together are the behaviours needed.

We include in Appendix 1 an approach to a behavioural framework for patient safety that we have developed. This might be of value in the development of the syllabus.

The question of implementation

Key to the successful progression of the National patient safety syllabus will be the future implementation and a patient safety competency framework for all staff.

It's not clear from the syllabus document what the process is for developing the syllabus into a curriculum including:

- Insight from this review/consultation process
- Engagement with stakeholders such as professional bodies; patient safety and Human Factors experts; patient groups; regulators etc
- Engaging with specialists in human factors and incident investigations
- Defining the knowledge, skills and behaviours needed for the workforce of the future
- Agreeing what knowledge is needed for what role
- Mapping current availability

Patient Safety Learning

Patient Safety Learning would be happy to engage with Health Education England, the Academy of Medical Royal Colleges and stakeholders in developing further the issues raised in this response. We have included extracts from previous submissions to Health Education England from Patient Safety Learning that might be of help. Please see Appendix 1.

Global Patient Safety Action Plan 2020-2030

The WHO are currently developing a Global Patient Safety Action Plan 2020-2030, with patient safety education and training in one of twelve key themes in this. They held a meeting to discuss the development of this with global leaders in patient safety in late February. Patient Safety Learning contributed to this workshop and would welcome the opportunity to share considerations by this group with the Academy and HEE and how their proposals will inform this Action Plan and the development of National patient safety syllabus and curriculum. Specific feedback from the WHO group that reinforces the themes in submission include:

- Everyone needs to be educated and trained in patient safety: professionals (health professional in an inter-professional context) and hospital leaders; patients and patient group, politicians, staff working in health facilities (e.g. cleaners), those involved in systems design (e.g. architects, IT), media, general public/community
- Patients play a critical role in patient safety education and as educators, informing and inspiring clinicians and others to improve patient safety
- The WHO Patient Safety Curriculum Guide will serve Member States as the basis of their education and training programmes including: a basic package of training materials easily adaptable to different contexts; adjustable modules for specific tasks (e.g. radiation safety, ergonomics); two distinct points to consider - preventing harm and responding to harm; emphasis on designing solutions, communication skills and other non-technical skills; an integrated approach to education and training and links to IPC, AMT, Quality

References

- Academy of Medical Royal Colleges, National patient safety syllabus 1.0, January 2020. https://www.aomrc.org.uk/wp-content/uploads/2020/01/National_Patient_safety_syllabus_v1.0_0120.pdf

- NHS England and NHS Improvement, The NHS Patient Safety Strategy: Safer culture, safe systems, safer patients, July 2019. https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf.

- Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409.

- Pronovost, Peter, The City Club of Cleveland, 1 March 2019. https://www.youtube.com/watch?v=j5B7AsdU0zg&feature=youtu.be

- Pronovost, Peter, Safe Patients, Smart Hospitals: How One Doctor's Checklist Can Help Us Change Health Care from the Inside Out, 2011.

- The Joint Commission, The Essential Role of Leadership in Development a Safety Culture, March 2017. https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/sea_57_safety_culture_leadership_0317pdf.pdf?db=web&hash=10CEAE0FD05B6C3A4A1F040F7B69EBE9

- Tingle, John, The NHS in England: Patient Safety News Roundup, 17 February 2017. https://blog.petrieflom.law.harvard.edu/2020/02/17/the-nhs-in-england-patient-safety-news-roundup/

- Wears, Robert and Sutcliffe, Kathleen, Still Not Safe: Patient Safety and the Middle-Managing of American Medicine, 2019.

- World Health Organization, Patient Safety Curriculum Guide, 2011. https://apps.who.int/iris/bitstream/handle/10665/44641/9789241501958_eng.pdf;jsessionid=7819865E90A45E2288606F9BF1F5C4F9?sequence=1

Appendix 1 - Extracts from previous submissions to HEE from Patient Safety Learning

1) Behavioural framework is at the core of professionalising patient safety

HEE work and the development of the Patient Safety syllabus is happening in a context of a wider and more profound strategic change in healthcare that includes, for example, the many initiatives outlined in the NHS Long-term Plan. Most of these initiatives will have implications for patient safety and make demands on NHS staff to work in new ways without jeopardising patient safety. Examples of the patient safety impact for HEE of these initiatives include:

- New service models, roles and ways of working, being optimised to provide. appropriate skills, resources and effective team working, core determinants of safe care.
- Technology improvements and the impact on roles, skills, training and behaviours
- Initiatives to address organisational culture, blame and fear.
- Leadership for safety, creating specialist roles and modelling behaviours.
- Safe staffing levels and skill mix.
- The new operating model for workforce, designing patient safety and human factors.

Improving patient safety holistically requires a joined up strategic approach bringing together several initiatives. Whilst all the work taking place has its merits, we believe patient safety will not be realised without a holistic approach to policies, processes, standards. The glue holding these together are the behaviours needed.

Whilst some of the aspects of improving patient care require policy, physical and technological re-design and process developments, the key underpinning common factor is people. It is the people in the NHS, from support workers to senior leaders who will individually contribute to the paradigm shift in care that is needed. We need to create a movement by internalising and normalising the mind-set to put patient safety front of mind. Setting out the key behaviours to be demonstrated by all working in the NHS helps people to:

- Understand 'how' they do their jobs as well as the knowledge they have makes a critical difference to patient outcomes. Patient safety is about much more than having proven skills and knowledge to do the job

- Understand clearly how they need to behave
- Have concrete examples of behaviour that inhibits patient safety
- Have a shared language to describe expectations and thus create consistently high quality across the NHS
- Create a common base from which to improve and excel
- To see where good practice exists and learn from this in behavioural terms
- Create an environment where innovation and improvement become the norm
- Clarifies what behaviours are expected in a just culture, when things go wrong

2) Organisational readiness for Patient Safety Syllabus Implementation

We consider that readiness to implement the Patient Safety (PS) Syllabus will be informed by whether the Patient Safety Syllabus meets the requirements to deliver a competency framework for all staff. Using the systemic analysis and evidence included in the *A Blueprint for Action*, Patient Safety Learning would undertake a high-level evaluation of the Patient Safety Syllabus. To professionalise patient safety, Patient Safety Learning considers that we need:

- Clear standards for safe care
- Accreditation processes for safe care
- Leadership and governance for safe care
- An agreed competency framework as the basis for education and training; core to this being a behavioural framework for patient safety
- Evidence-based training for all staff, with continual professional development
- Specialist patient safety and human factors experts

These provide the knowledge and skills that underpin necessary attitudes and behaviours, as well as supporting organisational cultures that enable safer care. Patient Safety Learning proposes to evaluate the Patient Safety Syllabus, its ability to meet these needs and those of the requirements of the NHS Patient Safety Strategy (see below)

- Whether there is a clear agreement about what knowledge, skills and behaviours are needed to deliver safer care, including:
  - o New service models and ways of working to deliver the NHS 10-year plan, the Interim People Strategy, reflecting technology improvements and the impact on roles, skills, training and behaviours
  - o Designing roles and ways of working informed by human factors
  - o Understanding 'how' staff do their jobs. Organisations need to have a Just Culture and ensure that behaviours towards staff and patients promote safe care
  - o Role definition and person specification for patient safety in all roles, including specialists in patient safety and incident investigation
- Maturity readiness, including:
  - o The current capacity and capability for training and education for patient safety in London. This would include an assessment of existing initiatives (whether these are known, have been informed by training needs analyses and assessed for impact), resourcing, governance, leadership, specialist expertise, etc.
  - o Organisational leadership and commitment to implementing the PS Syllabus
  - o Organisational and cultural enablers and barriers to delivering safe care

- o Expertise and capacity to support syllabus implementation by education providers, service providers, Commissioners etc., including issues of pace and capability.