Safe passage

Claire Morgan on the development and importance of the National Patient Safety Syllabus, which provides an NHS-wide safety framework

In 2002 the World Health Organization (WHO) declared patient safety a priority. Globally, one in 20 patients experiences preventable harm as a result of medical care, of which 12% of these events result in permanent disability or death (Panagioti *et al*, 2019). The WHO developed International Patient Safety Curricula for medical schools (2009) and multidisciplinary teams (2011), the uptake of which are unknown. As a global issue, although patient safety principles are transferable, healthcare systems and delivery are very different.

Supporting the concept of education and training in patient safety, Health Education England (HEE) commissioned a review of stakeholders' opinions through Imperial College's Centre for Health Policy in 2015. And in 2018 the Care Quality Commission stated that "with so many different bodies having a role in education, the importance of patient safety training is slipping through the cracks at undergraduate level and throughout careers".

In the UK the first NHS Patient Safety Strategy was published in 2019 with one of its three strategic aims, 'involvement', supporting the creation of a National Patient Safety Syllabus (NPSS) that would provide a framework for all NHS staff. It was stated this would be applicable "across a variety of competence levels and address the different learning needs of 1.3 million staff in 350 different careers".

One size does not fit all, although the potential benefit of a single syllabus of standardised patient safety education and shared terminology for all NHS staff is huge. HEE, working with a team from the

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Academy of Medical Royal Colleges, wrote the first NPSS, published in 2020. Following widespread consultation, it was republished the following year with updated content as version 2. It is planned that the NPSS is reviewed every three years.

FIVE-WAY CONTENT

The syllabus covers five domains: a systems approach to patient safety, learning from incidents, human factors, creating safe systems and being sure about safety. There are four cross themes based on systems thinking, human factors, risk expertise and safety culture.

The syllabus has tools for incident reporting and investigation, including systems to prevent harm reflecting those used within other safety-critical industries. It also encompasses national safety initiatives, including national alerts, key safety regulations and safety campaigns. Updated content in version 2 includes competencies in Safety-II, medico-legal education, and the value of patient, carer and public involvement in patient safety. Some terminology was changed to reflect less of a blame approach, describing 'human error' as a 'systems-induced error' or 'human performance variation'.

DELIVERING THE SYLLABUS

While some use the terms 'syllabus' and 'curricula' synonymously, the NPSS authors inform that some content not included will be more appropriately delivered through curricula. Research has shown patient safety curricula should be adapted to the needs of the learners, with different groups of healthcare professionals having different clinical and regulatory priorities.

Education in patient safety requires practical application with experiential examples and team training. Some stress the value of patient involvement in patient safety education, with delivery by experts. In addition, the introduction at undergraduate level or the start of clinical practice is considered important, with 'spiral' curricula revisiting themes iteratively to foster lifelong patient safety learning.

Curricula for the first two levels of the NPSS are now accessible to NHS and care workers on the national e-Learning for Healthcare platform. Delivery is animated, with written interactive content supported by regular quizzes/questions, including those for self-reflection. There are references to seminal research papers that can be accessed through the portal, and links to reports and policies through relevant web pages.

'Level 1: Essentials of Patient Safety' is aimed at all staff and includes an additional session for leaders. The content is at a basic level and includes purpose of patient safety education and impacts of harm; in the leaders session their role is described along with key behaviours. 'Level 2: Access to Practice' is aimed at clinicians and those with an interest or need for more in-depth knowledge. It expands on systems, risks, human factors and cultures. Levels 3, 4 and 5 have just been published in a curriculum guidance document aimed at patient safety experts and those working in the patient safety field.

> **"Education in patient safety requires practical application with experiential examples"**

Claire Morgan, Consultant in Restorative Dentistry, and member of Dental Council and RCSEd Patient Safety Group

DIFFERENT SOURCES

With the appointment of patient safety specialists in organisations to lead safety improvement across the system, the NPSS will provide an excellent resource. While it was developed to be applicable nationally, due to differences in NHS systems it may be appropriate for development of additional nation-specific, as well as specialty-specific, educational modules to be added.

There are numerous education and learning platforms, and courses, to complement and expand on the NPSS to support curricula. Many of these can be found through the charity Patient Safety Learning, with information found on its hub. Patient safety improvement programmes also provide resources through national NHS websites, as do many regular UK patient safety conferences.

The RCSEd runs non-technical skills training courses for surgeons, perioperative care practitioners and dentists, with similar programmes elsewhere. Specific courses have recently been launched by the Healthcare Safety Investigation Branch, providing extensive training for systematic incident investigation.

A more academic approach can be undertaken on university-approved courses such as the College's MSc in patient safety and clinical human factors run in partnership with the University of Edinburgh.

Echoing the 2013 Berwick Report on patient safety in the NHS, by looking after NHS staff and providing them with the tools and education they need, patient safety can be a priority for all. By moving forward with the development of open and learning cultures with patients at the centre, improvements in care will be realised.

This article is written with acknowledgement to all those who contributed to the NPSS. To find out more visit www.hee.nhs.uk/our-work/patient-safety