



National patient safety syllabus 2.0

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

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Foreword

We need to think differently about patient safety.

The first NHS England/Improvement Patient Safety Strategy was launched at the Patient Safety Congress in July 2019.

The Academy of Medical Royal Colleges has worked with colleagues from the University of Warwick to develop the new National Patient Safety syllabus which was included in the strategy as the basis for education and training throughout the NHS.

This syllabus represents an exciting new approach to patient safety incorporating an emphasis on a proactive approach to identifying risks to safe care and including systems thinking and human factors. This sets the scene for a step change in thinking about patient safety which will lead to significant gains as it reaches a critical mass of trained practitioners.

We will continue to work with NHS England and NHS Improvement in defining specific curricula for different staff groups and in building supporting educational materials.

Professor Carrie MacEwen

Immediate past-Chair of the Academy of Medical Royal Colleges

Professor Ted Baker, CQC's Chief Inspector of Hospitals, said:

"CQC welcomes the development of the patient safety syllabus which represents an opportunity to understand the factors that are essential foundations of safety, and will help everyone think differently about how to provide the consistently safe care that must underpin all services in the NHS."

Dr Aidan Fowler, National Director of Patient Safety, NHS England and NHS Improvement, said,

"Developing a national patient safety syllabus for the NHS is a core part of the NHS patient safety strategy. Widespread education in patient safety science and improvement that is consistent and of a high quality will deliver a safer NHS for patients. We are delighted to be working with HEE, the Academy and many others on the further development of this vital syllabus."

Introduction

Patient safety continues to be a significant issue in healthcare and a focus of both quality improvement and academic research. Though clinicians' training places a strong emphasis on the safety of their individual practice, it is rare that they, or anyone else working in the NHS, receive any education in formal safety management or the opportunity to apply those principles, tools and techniques in creating safe systems.

Neither clinical nor non-clinical staff receive training in systems, risk, human factors, or organisational culture.

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 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.

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. Firstly, 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. Secondly, and 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. Thirdly, this is the first NHS-wide patient safety syllabus. The syllabus consists of five sequential domains, drawn from developing themes in patient safety, which are outlined in the next section.

Any syllabus is descriptive rather than prescriptive, providing a set of concepts and subjects that are to be covered, rather than a tightly defined programme for a specific course. This is appropriate in this case since the concepts and tools of patient safety must be taught across many professions and many levels of seniority and responsibility. The syllabus is, therefore, the basis for the preparation of detailed curricula and training modules, designed for specific levels of the NHS; a process taking place in 2021.

Key domains and underpinning knowledge

The domains of this syllabus are presented below as a linear sequence although there are inevitable dependencies and synergies between them. To understand this and to support the structure and content of each domain, the syllabus sets out the key outcomes for each domain and the underpinning knowledge and expertise required at each stage.

Figure 1. Key Domains in the Patient safety syllabus



The rationale used in developing the domains embodies a spiral of learning, with each domain building on and deepening the work carried out in previous domains. The elements of underpinning knowledge and expertise fall into four key themes that run through each of the domains and, through the unfolding of further knowledge within each domain, will build to a comprehensive understanding in each area.

The syllabus is being translated into discrete learning modules that will form a curriculum. These will be discrete for the purposes of educational design, but inevitably the skills in different Domains will integrate in different ways in a behavioural context depending on the demands of each situation. From the curriculum, staff will be able to select those modules of most significance to their work – perhaps focusing on systems-based incident review, or on human factors. It is envisaged that the design of the learning modules, and the incorporation of an 'Essentials' module for all staff, will enable staff and patients to benefit quickly from the clear focus on patient safety. In addition, the curriculum will include an 'Access to Practice' module, providing essential elements of the four key themes of the syllabus for those who choose to develop their expertise further.

The four key themes of underpinning knowledge and expertise are:

- Systems thinking
- Human factors
- Risk expertise
- Safety culture.

Although elements of each area will be used in each domain, some domains have a strong focus on two or three areas. For example, Domain 2 (learning from incidents) draws most deeply on expertise in Risk and Human Factors; Domain 4 (Creating Safe Systems) draws more from Systems thinking and Safety Culture.

The overall structure of the syllabus also focuses on **knowledge, action, and consolidation**. Thus, Domain 1 provides the *systems knowledge* which is critical to carrying out the necessary *actions* in reactive approaches in Domain 2. Similarly, Domain 3 provides the *knowledge base* for *actions* in proactive approaches to patient safety in Domain 4. Domain 5 draws on all previous domains to provide the knowledge and tools that consolidate and maintain patient safety.

The following sections take the domains above and specify the capabilities. Each domain contains a number of subsections describing key elements and within each subsection are more detailed capabilities to be attained in building expertise in the area. In addition to the detailed capabilities, examples are provided of generic learning and development activities, themselves divided into those to be delivered in the early part of training and those to be mastered at a higher level.

Structure of the domains

Each capability is presented with essential learning outcomes in the left-hand box, together with, in the right-hand column, examples of overall learning activities at basic and higher levels.

Capabilities This box describes essential learning outcomes	Examples of generic learning and development activities	
	Basic training	Higher training

Domain 1

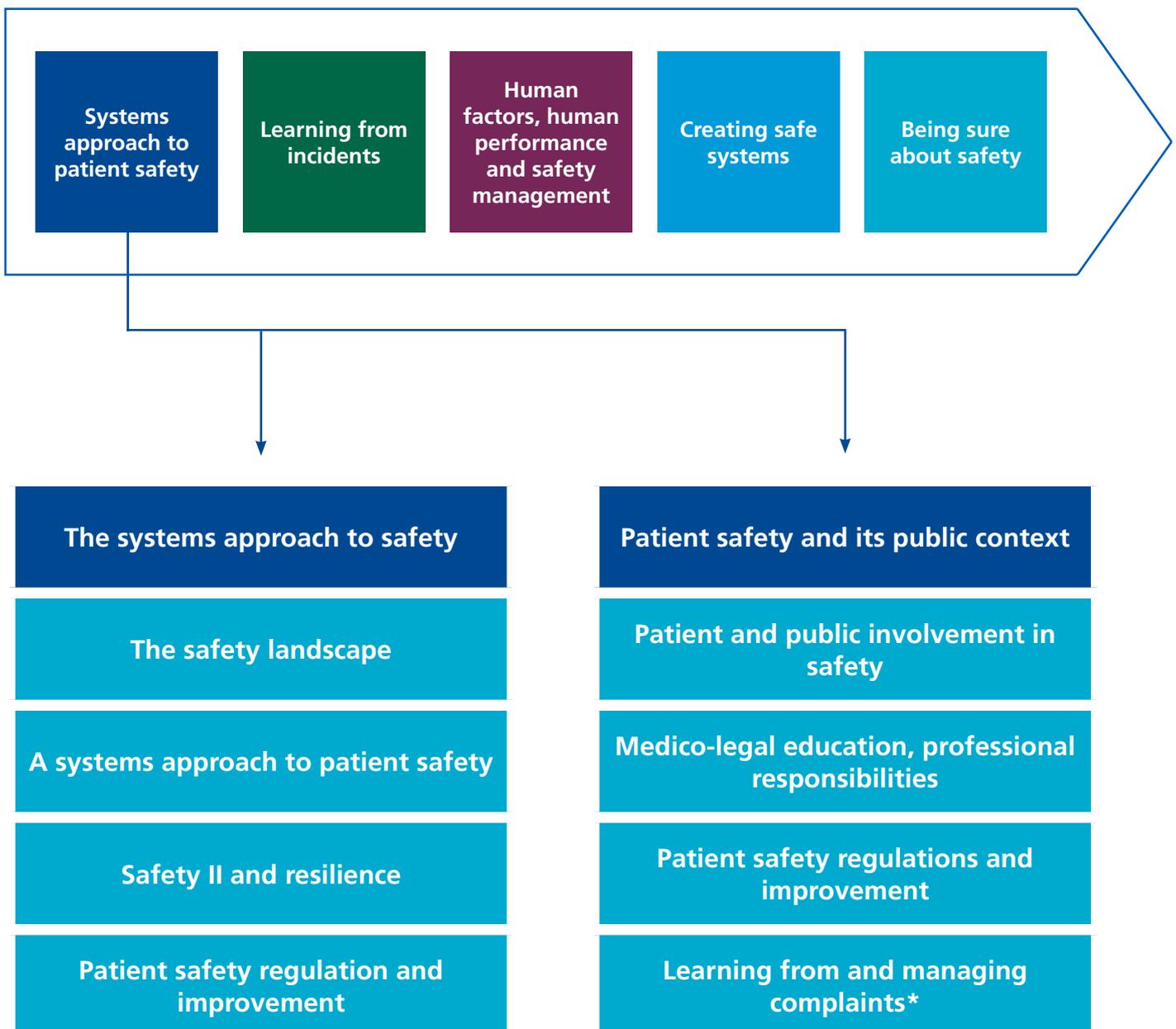
Systems approach to patient safety

Note: This domain has been updated to include key issues identified in the syllabus consultation, task and finish group reviews and discussions with NHS national organisations.

This key introductory and context-setting domain now includes two streams:

- The systems approach to safety
- Patient safety in its public context

Figure 2. The four key elements in Domain 1



* This is likely to be included in future versions of the syllabus. In particular, complaints management and learning is an area open for consultation.

Domain 1

Capability sets

<p>Capabilities</p> <p>This box describes essential learning outcomes</p>	Examples of generic learning and development activities	
	Basic training	Higher training

1.1 The safety Landscape

<ol style="list-style-type: none"> Has knowledge of national learning reports and can describe key findings Has knowledge of essential safety procedures, including reporting, safety alerts and regulatory requirements Applies lessons from key case studies in patient safety Analyses patient harm levels to evaluate the safety of the area 	Applies key learning in patient safety to the local environment	
	Understands patient safety regulation and procedures	Applies systems-based approaches to improving safety

1.2 Systems approach to safety

<ol style="list-style-type: none"> Recognises and describes the effect of systems design on risk and safety Outlines the principles of direct and latent failures and of performance-influencing factors Describes safety approaches used in other safety-critical industries Explains the fundamentals of human factors and human performance Acts to break the link between error and blame in department and organisation by describing system-induced error in all incident responses and reports 	Actively applies an understanding of systems to improving safety	
	Understands patient safety as beyond safe individual practice and dependent on the way we work – our systems	Ensures that system risks are addressed in improving safety

1.3 Safety II and resilience

<ol style="list-style-type: none"> 1. Recognises the key principles of Safety-II theory and how they may complement Safety-I 2. Encourages anticipation, adaptation, monitoring and responding to address existing and developing risks 3. Has detailed knowledge of evidence- based interventions in Safety-II and how they apply to improving patient safety 4. Is able to integrate and apply the principles and practices of Safety-II in making direct improvements in patient safety 	Uses an understanding of safety-II to improve patient safety	
	Applies evidence-based interventions in safety-II	Leads on evaluating Safety-II

1.4 Organisational culture and organisational learning

<ol style="list-style-type: none"> 1. Recognises organisational culture and the principles of safety culture 2. Explains the effect of blame culture on organisational learning 3. Analyses and evaluates safety culture and organisational learning 4. Contributes to sharing lessons learned in patient safety and promotes a learning culture 	Uses an understanding of organisational culture to identify and improve patient safety	
	Supports individual and group work to evaluate safety culture	Leads on developing a safety culture

1.5 Patient, carer and public involvement in patient safety

<ol style="list-style-type: none"> 1. Recognises and adopts the (draft) 2020 NHS England/Improvement <u>Framework for involving patients in patient safety</u> 2. Supports organisation-wide protocols for listening, responding to, and sharing patient-centred information including those regarding current priorities in patient safety 3. Works in partnership with patients and carers in key areas of safety where public and patient involvement improve patient safety, including medication safety, service design, incident reporting and investigations, and communication 4. Supports a culture of patient safety through identifying and sharing examples and evidence of patient safety improvement through public, patient and carer involvement 	<p>Actively applies an understanding of patients', carers' and public involvement in patient safety improving safety</p>	
	<p>Understands patient and public involvement</p>	<p>Leads to establish clear policy and practice in patient and public involvement</p>

1.6 Medico-legal education and professional responsibilities

<ol style="list-style-type: none"> 1. Aware of and understands key concepts and definitions in medical ethics and law and the provisions of significant legislation including the Health and Social Care Act (2012) and further instruments, Deprivation of Liberty Safeguards, (DOLS) Mental Capacity Act (2005), the Mental Health Act (2007), and equivalent provisions from devolved legislations 2. Explains the ethical and clinical issues involved with patient care, including the withholding or withdrawal of care, and with the rights of the patient to refuse care 3. Complies with legal requirements in patient confidentiality and information governance 4. Recognises the legal issues surrounding clinical negligence, compensation and the accountability of individual practitioners 5. Understands the legal basis of and requirements relating to the activities of Coroners, Coroners' inquests, medical examiners and related law 	Actively applies a knowledge of medico-legal regulations to ensure full compliance with legislation	
	Understands legislation and professional responsibilities	Applies understanding to ensure full compliance with ethical and legal concerns

1.7 Patient safety regulations and improvement

<ol style="list-style-type: none"> 1. Outlines and explains key safety recommendations from professional bodies and regulators, including mandated safety practices 2. Ensures that recommendations such as national patient safety alerts are complied with 3. Is aware of all indications of patient harm and risk, including incident reporting, complaints and mortality reviews 4. Has full knowledge of the Duty of Candour regulations and how they are to be applied 	Ensures that key safety and compliance data are monitored and subject to improvement	
	Monitors safety data and identifies improvement areas or non-compliance	Leads on creating full compliance with safety measures

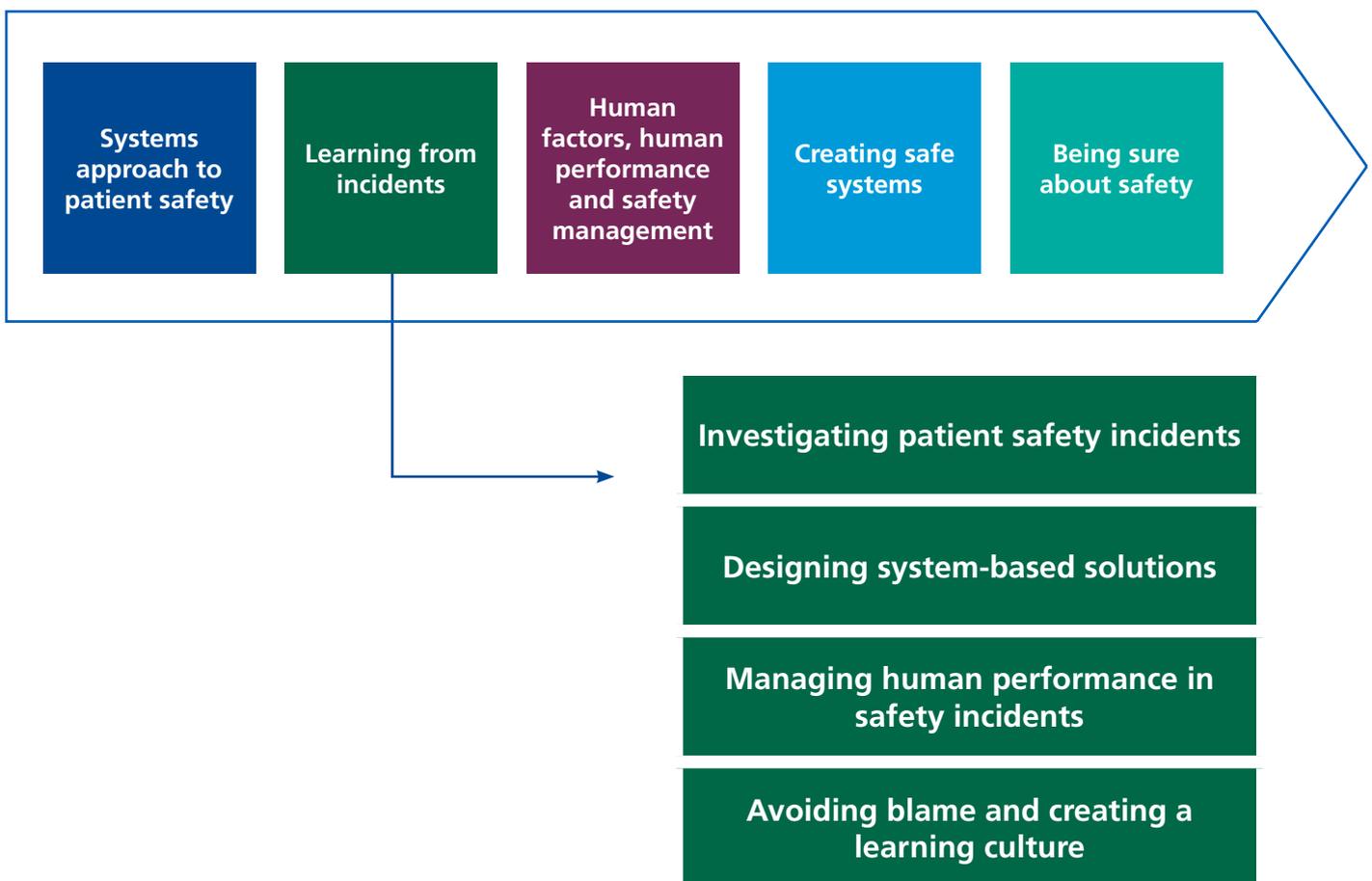
Domain 2

Learning from incidents

Reporting and learning from incidents is an essential element in patient safety. This is the reactive element of safety management, complemented by the proactive approach of later domains. Incident analysis has the first responsibility of preventing further harm to patients in similar contexts and therefore must take a systems-based approach, carefully identifying systems-induced error and changing the way work is carried out in order to create safety for patients.

This domain provides a methodological approach, describes systems-based interventions, guidance for managing human performance and its variations, and essential systems for avoiding blame.

Figure 3. The four key elements in Domain 2



<p>Capabilities</p> <p>This box describes essential learning outcomes</p>	Examples of generic learning and development activities	
	Basic training	Higher training

2.1 Investigating patient safety incidents

<ol style="list-style-type: none"> Ensures that a multidisciplinary team with a qualified leader manages the incident investigation Involves patients and carers in the investigation process Creates an evidenced timeline for the patient journey through document review and unbiased data collection Uses a systematic approach to identifying causal and contributory factors in analysing incidents Where appropriate, uses an understanding of human performance and its variability to describe discrete care and service delivery problems 	Responds to patient safety incidents to improve future safety	
	Takes part in systems-based incident and near-miss investigations	Leads systems-based incident and near-miss investigations when qualified and commissioned

2.2 Designing systems-based interventions

<ol style="list-style-type: none"> Uses the wider system and context to respond to incident investigations Uses an understanding of each separate care delivery problem to bring about changes in the system which will prevent future harm Uses an awareness of stronger and weaker interventions when developing safety interventions Checks the robustness of interventions for the impact on future risk and safety 	Uses an awareness of systems factors to reduce risk to patients and improve safety	
	Contributes systems-based thinking to incident investigations	Carries out recommendations from investigations that lead to safety into future clinical systems

2.3 Managing Human Performance in Patient Safety Incidents

<ol style="list-style-type: none"> 1. Ensures that incident investigations recognise and highlight human contributions to risk and patient safety incidents 2. Applies an understanding of human performance variability as a consequence of systems rather than an explanation of safety failures 3. Evaluates system-induced human error to design effective safety interventions 4. Builds human performance management explicitly into incident investigation reports 	Recognises where human performance will affect clinical safety and acts to manage it	
	Promotes the analysis and understanding of human performance variability as originating in system design	Ensures that human performance in systems is safely managed in response to safety incidents and near-misses

2.4 Avoiding blame and creating a learning culture

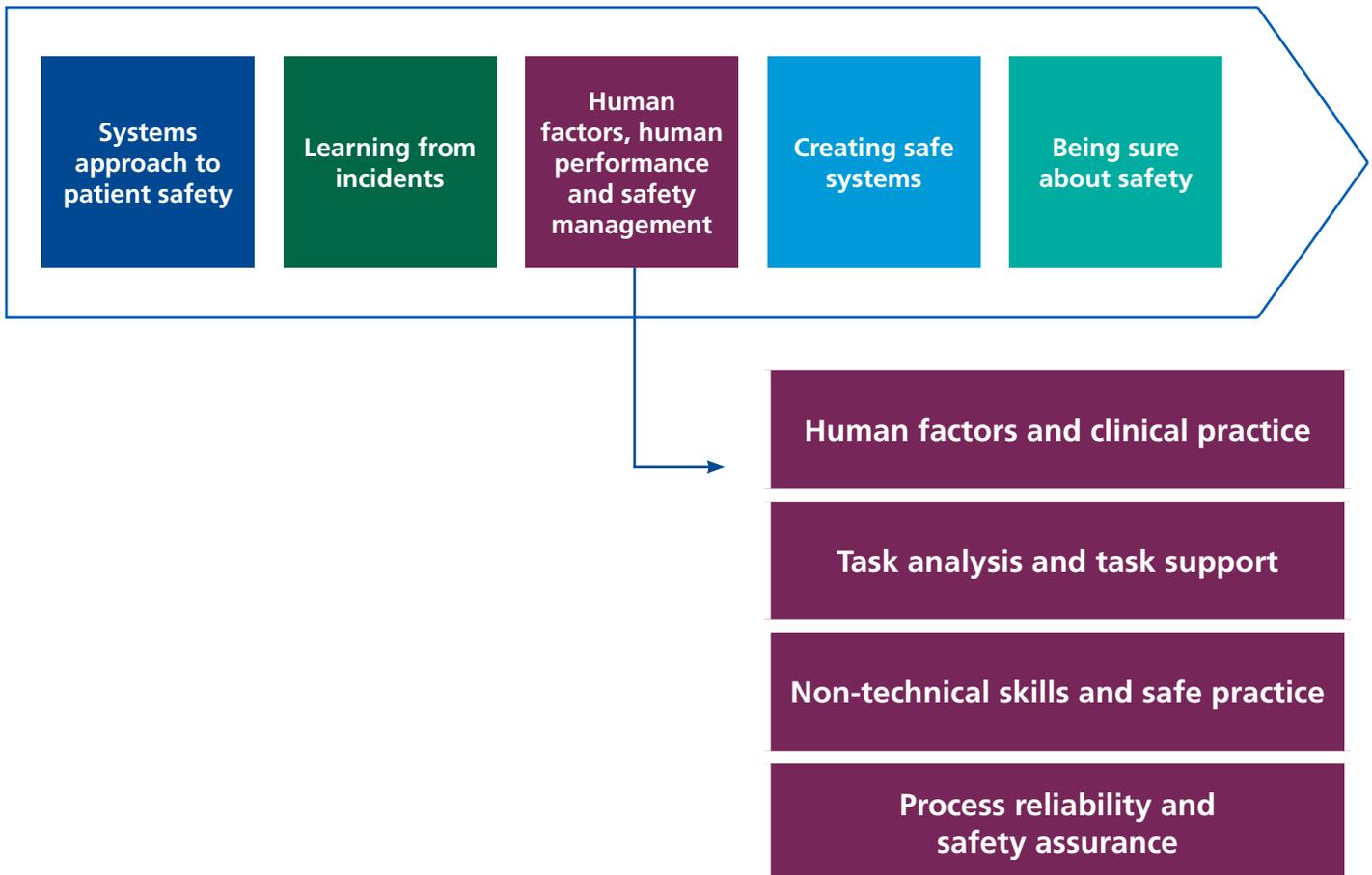
<ol style="list-style-type: none"> 1. Explains how to distinguish between systems-based failures in safety and the contribution of individual staff 2. Uses the 'Just Culture Guide' (JCG) with each individual failure in a systematic way to challenge and validate individual behaviours 3. Documents and shares the outputs from the JCG with those involved in the incident and the investigation to ensure complete transparency 4. Demonstrates that systems failures identified by the JCG are addressed in the response to the incident or near-miss 5. Uses a knowledge of systems and systems-induced failures to prevent inappropriate blame of staff following a patient safety incident 	Understands and manages system-induced human error and contributes to a culture of sharing preventative interventions	
	Contributes to understanding when and how to assess individual culpability as distinct from system failures	Leads on sharing briefings from incidents and near-misses widely in the organisation

Domain 3

Human factors, human performance and safety management

In this domain, Human Factors is introduced with special relevance to patient safety. There is a focus on task management, the role of humans in safety systems, communication and other non-technical skills, process reliability in clinical practice and safety assurance.

Figure 4. The four key elements in Domain 3



<p style="text-align: center;">Capabilities</p> <p>This box describes essential learning outcomes</p>	<p>Examples of generic learning and development activities</p>	
	<p>Basic training</p>	<p>Higher training</p>

3.1 Human factors

<ol style="list-style-type: none"> 1. Outlines and explains the role and effect of humans in complex systems and the fundamentals of human factors 2. Reflects performance to explain human factors in practice 3. Evaluates the key factors that affect human performance and relate them to local work systems 4. Demonstrates knowledge of the effect of human factors management in safety-critical industries 	<p>Develops an understanding of human performance in systems</p>	
	<p>Recognises and accepts the limits of human performance</p>	<p>Changes practice to minimise system-induced error in individual practice</p>

3.2 Task analysis and task support

<ol style="list-style-type: none"> 1. Outlines and explains the psychology of human performance variability and error modes 2. Analyses the range of tasks in the work area and evaluates task types as skill-, rule- and knowledge-based or applies other cognitive framework 3. Applies a knowledge of Performance Influencing Factors and their effect on human performance 4. Evaluates safety-critical tasks where support is required to minimise error and improve quality of patient safety 	<p>Understands the diverse nature of tasks in practice and how to translate this into quality and safety improvement</p>	
	<p>Categorises personal tasks systematically and identifies potential for safety improvement</p>	<p>Ensures that safety-critical tasks are adequately supported</p>

3.3 Non-technical skills and clinical practice

<ol style="list-style-type: none"> 1. Uses case studies to understand the effect of non-technical skills on working practice 2. Carries out evaluation of personal non-technical skills (communication, situational awareness, stress management teamwork and leadership) 3. Outlines and explains the hierarchy gradient and its effects 4. Applies strategies to improve non- technical skills 	Recognises and works to improve non-technical skills as a way to build safe systems	
	Is aware of non-technical personal non-technical skills and their effect	Actively evaluates and works to improve non-technical skills

3.4 Process reliability and safety assurance

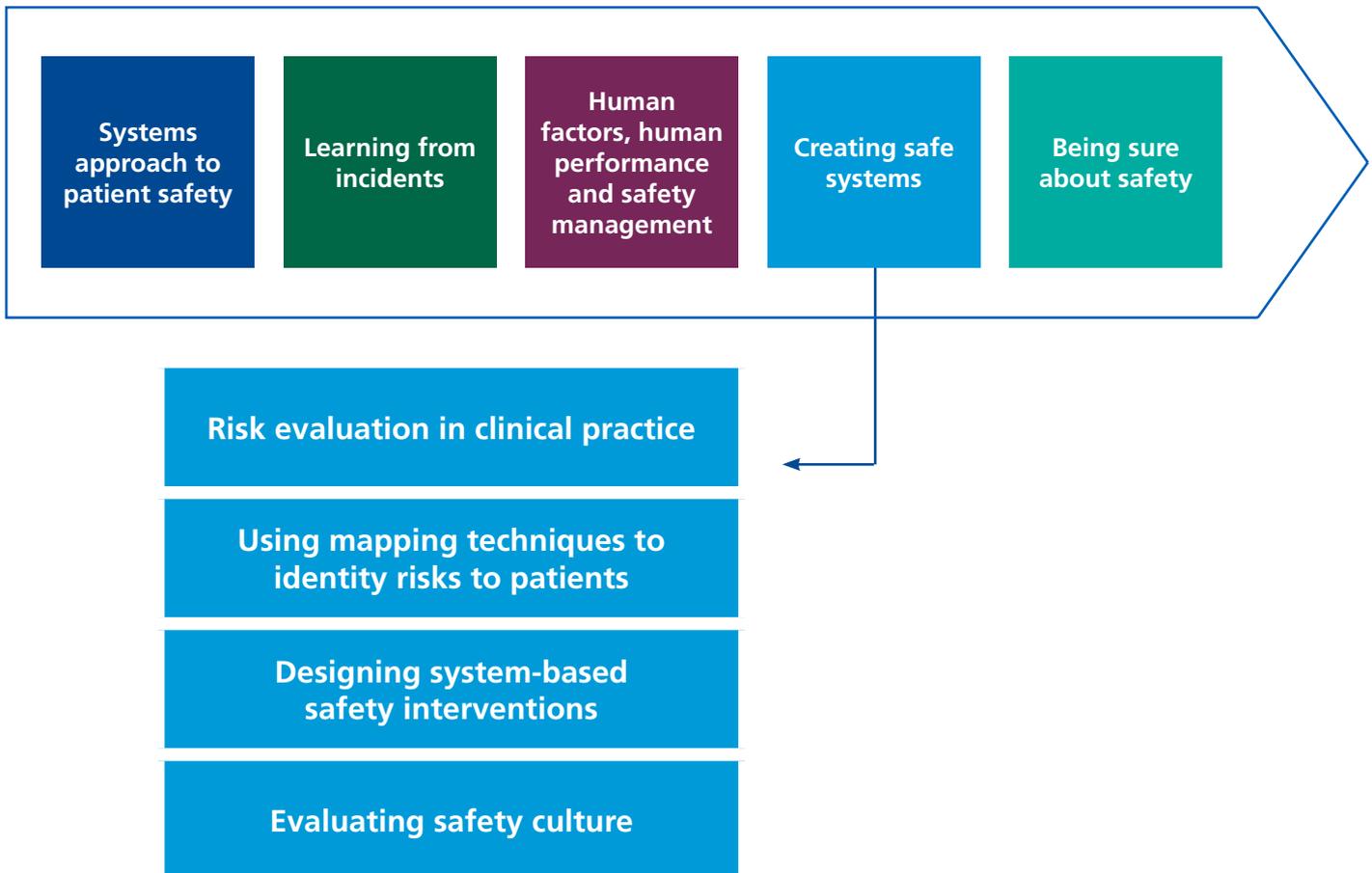
<ol style="list-style-type: none"> 1. Has knowledge of the key principles and methodologies of quality improvement as they relate to healthcare and evaluates their effect on patient safety 2. Can access and apply the evidence-base for quality improvement as it relates to patient safety in healthcare 3. Explains the relationship between clinical outcomes and process reliability 4. Identifies, maps and monitors safety- critical processes against clinical goals 	Uses knowledge of systems and process reliability to improve patient safety and clinical outcomes	
	Identifies processes that affect clinical outcomes	Measures and supports improvement of safety- and quality-critical processes

Domain 4

Creating safe systems

This domain describes proactive safety techniques to prevent harm to patients, builds an understanding of the strengths and weaknesses of safety interventions and the effect of contextual factors on safety and promotes a focus on safety culture.

Figure 5. The four key elements in Domain 4



<p>Capabilities</p> <p>This box describes essential learning outcomes</p>	Examples of generic learning and development activities	
	Basic training	Higher training

4.1 Risk evaluation in clinical practice

<ol style="list-style-type: none"> Adopts a consensus-based approach to identifying risk, with multi-professional involvement Has knowledge of hazards and risks and uses standard methodology to assess risks to patients Applies formal risk analysis using Failure Mode and Effect Analysis (FMEA) Identifies proximal and systemic causes of potential failures and develops strategies to address immediate risks 	Uses both explicit and tacit knowledge of the clinical team in identifying and evaluating risk	
	Contributes to formal risk analysis in the work area	Leads on identifying risks using FMEA

4.2 Mapping techniques to identify risks to patients

<ol style="list-style-type: none"> Understands and applies Process Mapping to understand systems and to identify high-level risks to patients Applies Hierarchical Task Analysis (HTA) to decompose safety-critical tasks and identify specific task risks Takes outputs from mapping techniques to structure improvement programmes in safety and quality Uses Hierarchical Task Analysis as a tool to design goal-oriented safe clinical systems 	Develops a deep and detailed understanding of task design to manage risk and create safety	
	Identifies areas of risk through process mapping and task analysis	Designs and implements safe systems through goal-oriented HTA

4.3 Improving systems safety

<ol style="list-style-type: none"> 1. Leads on consensus-based evaluation of why things go wrong for patients 2. Outlines and explains checklist design and uses safety checklists appropriately 3. Outlines and explains weak and strong interventions in building safety 4. Applies the Hierarchy of Control to design and implement effective barriers to patient harm 	Uses systems-based approaches to create strong preventative measures against patient harm	
	Contributes to consensus work in risk evaluation and solution design	Leads on developing and monitoring barriers to patient harm

4.4 Evaluating safety culture

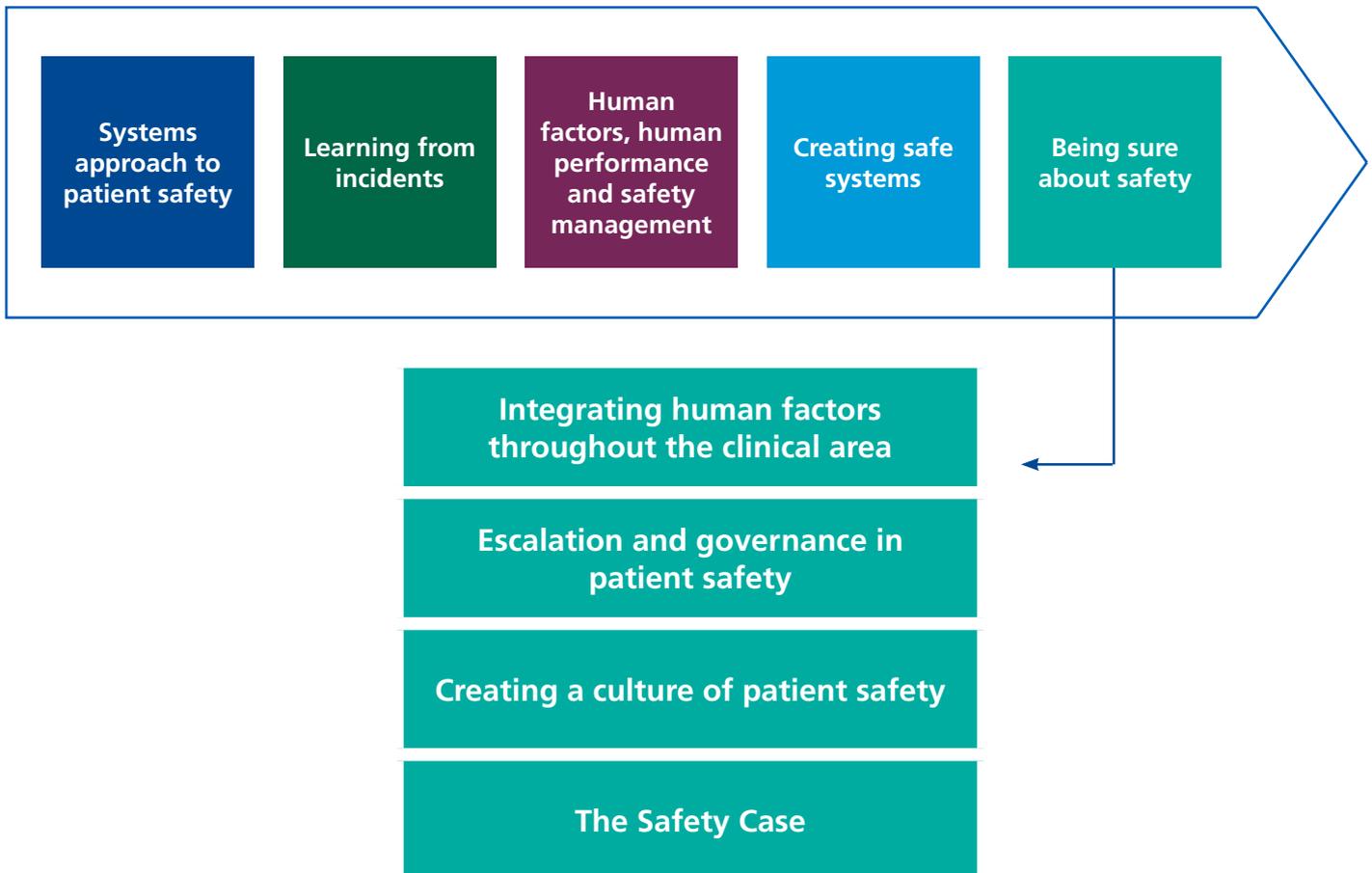
<ol style="list-style-type: none"> 1. Explains the key dimensions of reporting culture, just culture, flexible culture and learning culture 2. Applies a safety culture discussion instrument to create dialogue about risk, safety, reporting and learning 3. Identifies and applies formal safety culture evaluation instruments 4. Encourages and supports staff involved in safety incidents 	Uses a professional understanding of organisational culture to evaluate and support the creation of safety culture	
	Contributes to the assessment of safety culture and supports openness and transparency	Leads a multi-professional approach to assessing and developing safety culture

Domain 5

Being sure about safety

Continues the application of proactive safety techniques to prevent harm to patients; understands the strengths and weaknesses of safety interventions and the effect of contextual factors on safety; evaluates dimensions of safety culture.

Figure 6. The four key elements in Domain 5



<p>Capabilities</p> <p>This box describes essential learning outcomes</p>	Examples of generic learning and development activities	
	Basic training	Higher training

5.1 Integrating human factors

<ol style="list-style-type: none"> Evaluates human factors integration through regular assessment against a formal system review checklist Checks safety-critical tasks and provides task support and usable, effective procedures for all staff Identifies, supports and contributes to the design and implementation of safety-critical handovers and communications Applies continuous monitoring of key risks and process reliabilities 	Ensures that human factors are a continuous focus of attention	
	Supports the use of human factors integration	Actively identifies and develops human factors approaches to safety

5.2 Risk, escalation and governance in patient safety

<ol style="list-style-type: none"> Understands and uses clinical governance meetings to review risks and identify residual (uncontrolled) risks Justifies and applies the risk management strategies of <i>eliminate, avoid, transfer, mitigate, contain or accept</i> Populates the risk register with current and residual risks Escalates uncontrolled risks to the next level of the risk hierarchy and monitors response 	Adopts a professional response to risk management	
	Supports the use of risk management systems and raises risks to be addressed	Monitors residual risks and ensures appropriate escalation and governance of risk

5.3 Creating a culture of patient safety

<ol style="list-style-type: none"> 1. Fosters an open, multi-professional approach to patient safety using both reactive and proactive methods 2. Develops or adopts techniques such as <u>Proactive Risk Management in Healthcare (PRIMO)</u>, sharing lessons learned or the use of huddles as cultural interventions 3. Uses case studies from healthcare and other industries to ensure a continuing focus on safety management 4. Promotes the principle of measuring and monitoring patient safety, such as the Health Foundation's <u>Measurement and Monitoring of Safety</u> 	Prioritises a culture of patient safety	
	Contributes to a safety culture through the use of case studies and safety interventions	Takes a leadership role in creating a safety culture

5.4 The safety case

<ol style="list-style-type: none"> 1. Builds a safety case with defined scope, an evaluation of safety level, description of risks, risk control measures and residual risks 2. Applies the safety case as a tool to measure and monitor safety 3. Uses the safety case to address residual risks through improvement activities 4. Develops the use of safety case as a tool in governance and regulatory compliance 	Demonstrates proactive approach to patient safety through a safety case	
	Is aware of and supports formal safety management through a safety case	Contributes to a wide understanding of safety by leading in development of a safety case

Glossary

Capability	The quality or state of being capable
Cognitive interviews	A technique intended to enhance retrieval of information by helping the witness to reconstruct the original context of the incident or near-miss
Curriculum (see also syllabus)	A detailed description of the content and delivery accompanied by a planned sequence of training
CIEHF	Chartered Institute of Ergonomics and Human Factors
Error modes	Taxonomy of human error or human performance variability
Failure Modes and Effects Analysis (FMEA)	The process of reviewing systems and sub-systems to identify potential failure modes in a system, their relative risks and their causes and effects
Flexible culture	A culture which respects the skills and abilities of 'front line' staff and which allows control to pass to task experts
Harm	Physical or psychological damage or injury, or damage to the culture of an organisation
Hazard	A source of danger or harm, which gives rise to risk
Hierarchy gradient	Perceived difference in authority between junior and senior staff; often responsible for lack of communication in safety
Hierarchy of control	A methodology structured to select the most effective control measures to eliminate or reduce the risk of hazards

Hierarchical Task Analysis (HTA)	A detailed examination of the tasks users must do to achieve particular aims, breaking down large tasks into sub-tasks by analysing task goals
Human error	A label used (often in hindsight) to characterise an action or omission that leads to an unintended increased risk of harm
Human factors/ergonomics	The scientific discipline concerned with the understanding of interactions among humans and other elements of a system, and the profession that applies theory, principles, data, and methods to design in order to optimize human well-being and overall system performance (International Ergonomics Association, 2000)
Human factors: person-based / non-technical skills	Non-technical skills (NTS): The cognitive and social skills that complement workers' technical skills (Flin et al., 2003, cited in Flin, O'Connor and Crichton, 2008 ¹)
Just culture	A concept in systems thinking which emphasises that safety incidents are the consequence of working systems, rather person or persons directly involved
A Just Culture Guide	Developed from James Reason's "Incident Decision Tree" to help distinguish individual actions and conditions from systems factors
Learning culture	A culture with the capability to draw the appropriate conclusions from safety events and information and the will to change
Manchester Patient Safety Framework	A framework developed to understand patient safety in several key dimensions, used as an assessment and discussion tool
Near-miss	Unsafe acts or events that could have harmful outcomes in other circumstances; learning opportunity for the organisation

1. Flin, R., O'Connor, P., Crichton, M. (2008). Safety at the sharp end. Farnham: Ashgate.

Non-technical skills	See Human factors
Organisational culture	The assumptions, values and artefacts that contribute to the unique social and psychological environment of an organisation
Performance-influencing factors	Factors that combine with human psychology to affect human performance, variability and error. In general, these include personal factors, environmental factors, equipment and procedural factors
Proactive Risk Monitoring in Healthcare (PRIMO)	A tool for risk management that aimed to complement existing methods by plugging the gaps in risk management strategies and procedures
Process mapping	The creation of an accurate visual representation of a system, showing work-flow and agency
Process reliability	The reliability of the processes (usually sub-systems) that are required to assure stated health outcomes. For example, the frequency of unaddressed patient deterioration is affected by the reliability of processes (sub-systems) including physical observations, early warning score recording and interpretation escalation and response
Quality improvement (QI)	A systematic, formal approach to the analysis of work systems in order to improve performance
Reporting culture	An organisational climate in which people are prepared to report their errors or near-misses
Residual risk	A known risk in a system for which incomplete or absent risk control measures are recorded
Risk	The potential for harm as a consequence of a hazard, usually derived as a product of probability and level of harm

Root cause analysis (RCA)	A process used to identify the primary sources of a near-miss or patient safety incident
Safety Case	A structured argument, supported by evidence, intended to justify that a system is acceptably safe for a specific application, or to specify a level of safety
Safety culture	A set of beliefs, perceptions and values that employees possess with regard to risk and safety
Situational awareness	The perception of environmental elements and events, the comprehension of their meaning, and the projection of their future status. Or, 'knowing what is going on around you'
Syllabus (see also curriculum)	A high-level specification of a course of study
Systems approach	Recognition that the performance of an enterprise depends on a dynamic and inter-related set of parts; the focus on systems as a route to safety and productivity
Systems expertise	An understanding and application of systems thinking when applied to improvement in an organisation
Task analysis	Analysis of how a task is accomplished, including any sub-tasks, preconditions and the range of factors affecting each step or element in the system
Task support	Provision of systematic help for the user in carrying out tasks, often taking the form of visual guides, flowcharts etc

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- Allied Health Professions Federation
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- Care Quality Commission
- Council of Postgraduate Medical Deans
- Council of Deans of Health
- Department of Health Northern Ireland
- General Medical Council
- Health and Care Professions Council
- Healthcare Safety Investigation Branch
- Health Education England
- Health Education and Improvement Wales
- Lay representatives
- Medical Schools' Council
- National Association of Clinical Tutors
- NHS Clinical Commissioners
- NHS Education for Scotland
- NHS Employers
- NHS England and Improvement
- Nursing and Midwifery Council
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Physicians including its Chief Registrar Programme
- Royal Pharmaceutical Society
- Society & College of Radiographers
- UK Foundation Programme

Academy of Medical Royal Colleges

10 Dallington Street
London EC1V 0DB
United Kingdom

Telephone: +44 (0)20 7490 6810

Website: aomrc.org.uk

Registered Charity Number: 1056565

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Authors: Professor Peter Spurgeon and Dr Stephen Cross on behalf of the Academy of Medical Royal Colleges