Transcript of podcast episode 1:

How can we build a culture of safety in paediatric healthcare with Dr Peter Lachmann

Published 10 January 2024

Natalie Wyatt

Welcome to your RCPCH Patient Safety podcast, where we delve into the successes and challenges of creating a healthcare environment that is safe for children and young people.

Jonathan Bamber

I'm Jonathan Bamber, head of quality improvement at the RCPCH.

Natalie

And I'm Natalie Wyatt, a quality improvement fellow with the RCPCH.

Jonathan

In this episode, we're going to discuss the creation of a culture of safety and how that can keep young people safe. To explore this further, we're pleased to be joined by Dr Peter Lachmann today, Peter is a consultant paediatrician and patient safety expert. He's currently working at the Royal College of Physicians in Ireland to develop clinical leaders in quality improvement and has previously led safety improvement work in a number of roles, including the CEO of ISQua, the International Society for Quality and Healthcare, and as the editor of the *Oxford Professional Practice: Handbook of Patient Safety*. So welcome, Peter, thank you so much for joining us today.

Dr Peter Lachmann

Thanks for inviting me. It's great to be here.

Natalie

To get us started, because we've obviously talked a little bit about what you've done, could you tell us a little bit more about yourself and how you became interested in paediatric patient safety?

Peter

Well, I'm a paediatrician by training, I trained in South Africa. My very first case, which I didn't realise when I was a registrar, was when a house officer inadvertently gave a baby potassium chloride and the baby died. It was a human factors error. This was many years ago. But that poor doctor, and the nurse who was in the process, both lost their jobs and were charged with manslaughter. And it was basically a production line safety because, within Cape Town, we had a very, very lean system of babies coming into the hospital having diarrhoeal disease. And they had to decide whether they were acidotic or not on entry. And he asked for 5ml of Sodibic, but got 5 ml of potassium chloride in error. The vials were exactly the same except one had red writing, and one had black writing, they were glass vials, and they were kept side by side. So it was a pure design/human factors problem, but that was in 1984, before we knew about human factors in healthcare, before we knew about patient safety. Now, I didn't know that in that situation I had to tell the parents that we had actually killed the baby. I didn't say it that way; I had to say to the parents that the baby died through a medical error. We did not at that stage know anything about patient safety. But I didn't realise that that was the first incident which would set my career in patient safety, when I was a young registrar, in the first or second week of being a registrar. So if you want to know how I got into it, that's the first of many stories I can tell you. And that was in a very high-performing unit in a high-performing hospital. It was award-winning in its treatment of diarrhoea, with many papers written about how we did it. But there was a fatal human factors flaw in the design. But no one was speaking about human factors in those days. And I hate to say it, but over the last 40 years since that event, because this was around 40 years ago, nothing much has changed in terms of human factors. We still have medication sitting side by side that nurses or doctors incorrectly give to patients because the design is not correct.

Natalie

That's incredible, isn't it, to think of that over a 40-year span, we can still reflect on that same problem there from when you look back at your first days as a registrar.

Peter

I always think that, as I went through my career, I was very fortunate to escape. But I was involved in many, many incidents as the person sorting it out. But most young doctors today, your trainees, the doctors in postgraduate medical education – who will be called junior doctors, not really junior – most of them have similar experience. And they will be able to tell you that they've had that kind of experience, or they know someone who's had

that kind of experience, or they've had a very big near miss, with that kind of experience as I've just described. So there's a lot to do to make it safe.

Natalie

Absolutely. One of the things that we were hoping to focus on today is thinking about how the culture of an organisation might make it more safe. And just to set the scene for people listening today if this is something new to them, could you tell us a little bit about what the basic principles are of a culture of patient safety? What does that mean to you?

Peter

Well, I regret to say that I don't think healthcare has really developed a culture of patient safety; if it had, it wouldn't be designed the way it is. A culture of safety is firstly, you have to think differently. It's about a mindset. It's about the way you think about the work you do. It's what you think about every day when you come to work. It's about recognition that healthcare is incredibly dangerous. And that, because it's so dangerous, we have to make safety a priority in all our actions. And we have to ask about safety all the time, we have to think about safety. So it's about a mind thing. It's not about policies, it's not about slogans – all NHS Trusts around the country have 'caring, safe, friendly', you can name it, you got everything, 'respect' – I can give you the list of verbs that they throw out there which they think means that they have a culture of safety and quality. And it's all nonsense, because the executive teams, the clinical teams, are not thinking about safety every minute of the day. And that's the difference. That's what cultural safety is, is that you think about safety every day. And that's had to happen in other industries before they became safe. But healthcare just mouths it, and I get very despondent when I see leaders talk about a culture of safety, and yet they make young doctors work incredible hours in situations that cannot be safe. It's self-thought to action. That's what cultural safety is, where just thinking about safety becomes action about safety, every minute of the day – not only when there's an incident.

Natalie

What are the essential components of designing a healthcare system? If you were starting from scratch, and we didn't have the healthcare setting that we had, if you were starting from the beginning, how would you start designing a system that kept safety as part of everybody's everyday thought, and that converted it into action?

Peter

Well, I think that we've got a problem here, is that the system has been designed. So what we are trying to do is change a system while we're flying the system. So I'll just take a paediatric unit, or I could take the work we did at Great Ormond Street because when I was there, we really tried hard to engender a culture of safety and put safety on the

agenda. We fortunately had a chief executive who started safety walk-rounds and started going out to the frontline to find out what bothered them, and what were the issues that made them feel unsafe. So if I really wanted to redesign a system, construct a system, that's the problem in healthcare, we can't set up a system and say, "We can stop, we're going to redesign it, and then we can come up with a new system." I mean, I'd love to do that. But what I would really start looking at is the long-term programme of redesign. The first thing is equipping the workforce from day one. And day one starts on day one of medical school. So just as we have training in physiology and pathology and anatomy as core parts of your training in medical school, and you can't graduate without knowing pathology, physiology and anatomy, I would put all the elements of patient safety as part of that core. So just when you are learning about the physiology of something, you must learn about the risks and the safety issues that you might have to address for that. So if we look at that, for example, when you learn about neonatology, and you learn about, let's say, HIE, or you learn about retinopathy, or you learn about respiratory diseases, so you must be learning about safety issues that babies in a neonatal intensive care unit will face – and they are numerous. More numerous than I could list here. But we don't teach that in neonatology in medical school, and we don't teach it in neonatology when they are doing their registrar training. We don't have, every day, the neonatologist saying, "Let's discuss the safety issues that we have for this baby." They discuss how they treat the baby but not the safety issues that we have to do to prevent the baby from having a line infection, for example.

Jonathan

If you were going to introduce patient safety as part of this long-term strategy within medical training, how would you align or fit that into the focus on clinical outcomes as if that's something different? Would you change that language? What is success in a safe environment? What is the clinical outcome we would have in wanting to separate outpatient safety? Would it be a question of framing what our definition of a good outcome is?

Peter

It is. But that's getting back to when I started, which is what you think. So a good outcome is not a live graduate from intensive care. I'm just using intensive care as an example because that's the highest-risk area in paediatrics. I'd say the good outcome is a live baby without any unplanned extubation, line infections, pressure injuries, etc, etc. I could say, "Where's the neonatal unit that measures its success in the absence of harm?" They don't do that.

Jonathan

And where would the motivation come to change that thinking?

Peter

Well, actually, this is where the college steps in. So part of my history is that I've been working with the college for the last 15 or 16 years since I came back from IHI. And the difference between the college now and then is very big, because patient safety wasn't seen as an issue in 2005. That was the early days, it was the very start of the thing. But now, patient safety is on the agenda – but isn't on the agenda in the fact that, as part of the training, every resident or every registrar has to be proficient in human factors before they can graduate. I know they have to be proficient in neonatology and in general paediatrics and a bit of community paediatrics, but human factors? I don't see that there. So if you really want to have it changed, the college needs to say, "These are the things that are going to be important to graduate. And you have to know about patient safety in a certain amount of detail as a new graduate paediatrician." And that is important. And while they're doing that, the medical school should be doing likewise to graduate as a medical student so that when you get someone coming in from medical school into ST1, and then from ST1 into registrar ST4, they're going on a journey of learning about patient safety in greater and greater detail, so that when they become the consultant they are able to implement the changes that we want in terms of patient safety, because they're proficient. Unfortunately, the vast majority of our consultant leaders in the country have no knowledge about the theories of patient safety. It's not their fault, it's just that they were never taught it. They never had the opportunity. It's seen as a niche market. And that's the problem with patient safety. It's thought of as something someone else does. And that is because originally, patient safety was seen as a reaction: How do we manage adverse events? It was seen as a defence of action by organisations. How do we manage risk – not risk to the patients, but risk to the organisation? And so we've got to turn it on its head. We've got to think totally, totally differently. And think about safety as how we keep babies and young children, patients at the highest risk – the most safety events are the under-fives and the over 70s. So that's where your risk is. In between you do have it, but it's not as high risk in those areas. So how do we ensure that paediatricians who deal with the highest risk and obstetricians –because also in obstetrics, that's very high risk – how do we ensure that they understand human factors? How do they understand resilience engineering, and learn from what works well? How do we get them to do that? That requires a culture of safety. And the culture of safety starts in education and starts at the college. It starts at medical schools, the nursing colleges, that's where we educate the people for the future. That's what cultural safety is about when we start to think differently, so we have to educate differently. Then we get to the actions in the hospitals or in the clinics, we start talking about it every day. Talking about incidents. We don't report it to the clinical incident team which then does a root cause analysis and you get the results six months later – what a waste of time. The clinical teams should be talking about safety every minute of the day.

Natalie

And that was one of the great collaboratives that you were involved in setting up, Peter, wasn't it?

Peter

Yes.

Natalie

The SAFE collaborative. Part of that focus was about having those conversations every day that everyone was involved in. Do you want to tell us a little bit more about that programme of work?

Peter

That programme of work is probably one of the proudest things I've done because it empowered our people. I was very lucky. When I came back from IHI, I was offered a position at Great Ormond Street, which was a great laboratory to implement change. So we were able to do that, and I was given funding and a support team, and very importantly, an executive team that supported me. So chief executive and board, the board supported the chief executive, and patient safety was high on the agenda. And we came at Great Ormond Street with the 'zero harm, no waits, no waste' way before everyone's talking about zero harm. We were talking about zero harm in 2006. And that's where I was able to test out these ideas. And I linked up with Cincinnati Children's who were the leaders in the United States. I visited there a lot, our executive teams visited, so both teams went both ways to learn from each other, and we really pioneered a lot of things in patient safety. So all credit to my time at Great Ormond Street. At the same time at the Royal Free, where I was clinically based, I had Sebastian Ewan as a fellow, Sebastian and I did the first, and Nicky Davy, in our work for the International NHS Institute, we came up with the first PEWS which got lost because of the change in government when the institute closed. So we did the first pews in those days. And I was very fortunate to have a fellow in patient safety working on this. At that time, Cincinnati came up with the idea that if he did huddles, talked about safety every day, just like they do in other industries, things to be safe, and published a few papers, I ended up writing an editorial in the *BMJ Quality and Safety* on it, and I applied for funding from the Health Foundation, with the college as the lead, to do closing the gap for patient safety, with the idea that we could apply the Charles Vincent model of measuring quality to everyday practice. Charles had come to us at Great Ormond Street and studied us and we were one of five or six organisations studied to come up with that model, and it's really about getting clinical teams to talk about safety every day. And then I took that and applied it to clinical teams, and I'm still doing it now. We got funding from the Health Foundation and Wellchild, a two-year programme, I then used my connections – six children's hospitals, and six DGHs, to study in a collaborative, to study how we're going to do it. It was a two-year programme, with two-year funding. After the first year – not even after the first year, after the first eight months – we presented our findings at the college at the meeting, I think it was in Birmingham. It was standing room only, and people all clamoured, "We want to do this." So we asked the Health Foundation if we could extend it. It was the same money, not any more money. I said, "Can we extend it?" And we extended it from 12 initial hospitals to another 16. We went to two more collaboratives. And when it was finished, we

asked the Health Foundation, “Could we extend it even further?” And what was happening was the first two years was finding out how to do it. And then I went from a two-year implementation to what we do now, it’s a six-month implementation. And I’m doing that in Ireland now. I’ve done 50 teams, and I’ve got another 11. People are clamouring to find out how can we be safe. And what we teach clinical teams in this is, at the start of every day, the end of every day, in the middle of the night – so we normally say about three times a day, we ask you to ask six questions. And those questions will help you apply theory into practice. So we don’t teach them human factors. We treat them as applied human factors – applied instead of theory. I say, “This is what it’s called by the safety people, but now you’re going to translate it into action.” And so the clinical teams at the start of a session will say, “What have we done really well?” So we’re now building a culture of safety on pride. And we didn’t have any line infections, we didn’t have anyone falling, we got everyone home on time. All these kinds of things that people don’t normally talk about, that builds resilience. And that’s building resilience, which is so important for the second question, which is: In the last shift, did we harm anyone? And what we get clinical teams to do is we say, “Define your harms with the parents and with the staff.” So if I’m in a neonatal ward, I know what the harms are – line infections, extubation, pressure ulcers, retinopathy – you name the five or six that you get, and you’re going to measure those. And that’s what we’re going to ask. Did anyone have unplanned extubation? Did anyone have a line infection? Did anyone etc, etc. And so they’re talking about every day at the start of the day. And at the end of the day, they say the same thing. So they’re talking about safety, but they’ve already got resilience because they’ve already said what we’ve done well, so people can talk about it in a non-blame area. And if they’ve got that, they can say, “Okay, what are we going to do about it?” After this huddle, they’ll do a quick root cause analysis for the five whys: what do we have to change, what we have to fix… and I was once in Sydney doing this, and the house officer said, “We under-treated a baby with meningitis for four days because they sent in estimated weight. And we didn’t weigh the baby because the baby was too sick. And when the baby was rehydrated, we realised that we were under-treating the baby for four days.” And that estimated weight was on the new electronic record. And they immediately referred to… rather than wait for root cause analysis they changed the system in the ED about estimated weights. So they changed it immediately from that one house officer saying, “This is what we did wrong.” And then the next question will be, “Are we reliable? Are we doing what we’re supposed to do?” So now you’re bringing reliability into it. So people are talking about, “Are we following the guidelines?” And I don’t care what guidelines, but are we doing this reliably? Not what each consultant wants to do, but what the consultants have *agreed* to do. And if not, do we have to change the guideline? Why did we not follow it? And the next question is a human factors one. Are we safe right now? So then we bring in the SEIPS model, that’s human factors, and I say, “This is the SEIPS model. And that’s the last time I’m going to call it SEIPS. But I’m going to teach you how to apply it.” You’re going to ask, “Do we have the right patients? Is there an outlier who shouldn’t be here?” Because that’s unsafe. “Do we have the right people?” Like we’ve got a new nurse who doesn’t know how to use the pump. Okay, what are we going to do about it? Okay, in handover, we’ve got new doctors who don’t know the system, how are we going to support them? So that’s the right people, the right equipment. Do we have everything we need? Do we have the right tools? Can everyone do the tasks? That’s quite interesting

because often people can't do tasks. So if they can't, we start talking about it. And often, young doctors don't want to admit they can't do something because they feel that they'll be judged. But now it's an open discussion. And then finally, how are we organised? Are we feeling good today? And one of the things there, for example, someone can say, "Well, a young doctor, just back from maternity leave can say, "Well, I didn't sleep last night, could someone help me? Because today, I may make an error." So now we bring in the psychological safety, can you see? So we bring it into the front line. And then the next question is, "Are we going to be safe in the future?" So this is where we get situational awareness. And what the nurse and doctor have to do, the residents, or registrar or the house officer, what they have to do is say then, "This is the situation. These are the patients we are worried about." The nurses and the doctor are, and anyone can raise it. We used to get the school teacher coming into these meetings, the dinner lady coming into these meetings, saying, "This child didn't eat today, didn't choose to eat the food today, something's going on." Can you see? So this is situational awareness. And then the last one is "What have we learned?" A quick after-action review. So can you see what's happening there? In that 15 minutes only, takes 15 minutes, twice a day, people are talking about safety in a safe environment where they feel psychologically safe, they're not going to be judged, and they are taking action. And all of these, at the start of the programme, we measure their MaPSaF. And then, over the course of the six months, we've measured their MaPSaF changing. And what happens is that communication improves, the nurses start saying, "We now know what the doctors are thinking." The trainee doctors say, "We've now got consultants who are doing the same thing." So people are starting to talk about safety. And what happens, on the MaPSaF, the indices improve over six months. So the culture of safety is being engendered by people talking about safety every day in a safe environment. So I think that the SAFE programme, we call it the SAFE programme [Situational Awareness For Everyone], provides psychological safety, provides teamwork, improves communication, it decreases incidents – or may increase incidents because people are talking about them. They start talking about near misses. Doctors and nurses feel safe. And people do come into units and have done it. They say it feels different. I asked medical students, "What's it like in the unit?" They said, "That unit feels different." I say, "Well, they've been on the programme." Because they're now talking about safety all the time.

Natalie

Absolutely. And do you have to do much of an extra piece around flattening hierarchies and things like that in implementing the programme? Because, as you said, it sounds like you need to have an environment that everybody feels very safe to participate in. And our structure of healthcare is very hierarchical, and that is a challenge.

Peter

So when I start the courses, there have to be four members of a team. So a consultant has to be there, and it could be a physio team, an OT team, it could be the most senior person. But there's usually a nurse leader, a doctor leader and two people on the ground. So that's

the registrar. Sometimes they can bring a parent if they want, whatever. But the key thing is, we talk about hierarchies. And we say that it's always important to be a hierarchy because someone has to make a decision. And the thing about flattening hierarchies is a misnomer – it's about having a hierarchy according to the role at the time. I learned this from Cincinnati, because they went to study the US Navy, and they went to the ships, and they said, "When a pilot, a Top Gun..." You know, Tom Cruise, Maverick? When Tom Cruise lands the plane, he is not in control. It's an ensign who's standing on the deck with this gauge that's looking at the degree that he's coming in and saying, "You need to flatten," Because otherwise you overshoot, or otherwise you'll hit the plane. So even though he's a Top Gun, the most important person is the person telling him what the angle of his plane is when he comes in. But when he lands, that person will salute. Yes, sir. No, sir. Then the hierarchy is back. So that is the role hierarchy. So, for example, the person with the most knowledge about the child is the mother. So the mother's view should trump everyone's view. But in terms of hierarchy, the mother is at the bottom of the plan. Can you see? The junior doctor, the doctor on the front line, or the medical student, may have the knowledge that a senior doctor doesn't have. So in the huddled situation, we teach them that at that point, you have that flat hierarchy. But when the decisions are made, someone has to make a decision and deal with all the information, but be willing to be challenged for that decision. And if someone is challenged for the decision, then there needs to be a review. So it's a flexible hierarchy. It's not a flat hierarchy. It's flat for the time, but it's got to be flexible because someone has to make decisions.

Jonathan

So it's a really interesting example around the ensign on the deck when Tom Cruise is landing. Often, in health situations, there's not as much clarity of how those roles should flex, in that the control should be moving away from the person who has that traditional hierarchy. Why don't we have problems when it's the consultant or the equivalent if their view is being taken as gold dust, even if they haven't got all the information?

Peter

Yes.

So how do we instil an environment where those roles are appropriate and can flex in the situation?

Peter

The first thing is, and I go back to what I said, we've got to prepare the consultants of the future. So that's the way they think. So in that sense, I run a course here in Ireland called Essential Skills for New Consultants. That's what it's called. And we teach them that for these new consultants. I don't do it for paediatricians only, I do it for a wide range of consultants. And I'm just reading their feedback right now for the last quarter because

they do find a reflection. And their eyes have been opened, because they're starting to think about… we teach them reflective practice. So like you are taught reflective practice as a trainee. We teach them to do it as a consultant, which is slightly different than when you're doing it as a trainee. Because now you're flexing, "How do I interact with the team I'm working with?" Can you see? It's a different way. Did I engender psychological safety? Did I do this? So we teach them a different type of reflective practice. The same principles, we teach them what, so what, what now? You know that model, the Rolphe model, or the given cycle, we say, we can use whichever one we do, and we teach them that, and they learn about reflective practice, they go through the reflection, so I see them grow. So we teach young consultants how to be good consultants, then, of course, unfortunately, we've got the consultants in post. So that is more difficult because we have to sort them out. And that is, we have to help them see the new way of teaching. And that is where leadership comes in. So how I would go there is to ensure that, in the 400 organisations around the country, we are looking at leaders who will be able to be clinical leaders in their areas, and being role models and examples for the other consultants. That's where the college comes in. So that's looking at the two ends, because we go to the two ends. At the same time, what we're doing is including all of this in the training for young trainees at the bottom who are training through, and I really think that, in an organisation that provides cultural safety and value and a sense of belonging, then you'll find the trainees are not only going to feel that they've been undervalued in terms of money, but they're also now feeling undervalued in terms of respect and wellbeing. So what we have to do is – and most people enter into public service not for the money, they know they could earn more money in private practice – they are in it for the common good. Part of the common good is feeling safe. And if you make sure that the young doctors and nurses and allied professions are all feeling safe, that we value the opinion, that we're creating this culture around them, that requires the leadership to do it. So can you see the different strands? It's very complex, but it is possible to do. All I can say is that when you're talking to other people in the podcast, they are a lot of the people who've come through the programmes I run. So when I look back, I can say, "Oh, that's great, that you've had people who've been my Darzi fellows or worked with Darzi fellows with me, or had been on programmes I've run, or written papers with me, are now patient safety leaders." Well, that shows me it can be done.

Jonathan

I wanted to go back a little bit to the way you were illustrating what is going on through each of the safety huddles if you're following the SAFE programme, and we know that sometimes running a project, a patient safety programme, is a way to galvanise support and engagement. I also know that the summary of the SAFE programme is the college's highest download of anything that relates to quality improvement or patient safety. So there's clearly an appetite for people to learn about this. And you're running these courses in Ireland, but if there are units who are going, "Okay, we might have done this a few years ago," or, "We like the sound of this," how do they go about introducing this process? What are the steps for people to go, "Okay, I want to test this out and practice and try and develop this culture"?

Peter

So what I've done is managed to take a course that took two years to do the first time, but now we do it in six months. So what it is, is really empowering people. So I said to the health service here who fund it, I said, "Look, my view of the SAFE programme…" which is the main aim. We say, "What is the main aim of the SAFE programme?" And when we got the funding, I said to the Health Foundation, "We are going to save lives," and so on. There's no way I could claim that because, at the same time, there was Sepsis 6, there were other things going on. So who knows what worked? But I said, "One thing I can tell you, I'm going to change the way people think, and I'm going to measure that. Because if I know that if people are thinking about safety, then other things are going to happen naturally." So I said to the funders here recently that this is how I see the SAFE programme. It's like immunisation. Unfortunately, it's not like measles immunisation, you have three doses, and then you're fine – you don't have to have another dose. Or like smallpox, you have one and you never have to have it again. No, it's more like influenza. But it's more like the COVID vaccine. So it only lasts a few months or a year. And you have to have immunizations every year to be safe. So this is what I said to the Health Foundation as well. I said, "The problem with the programme was that it was only funded for two years, but actually I need a 10-year programme in which what I'm doing is building up teams every year, and then what happens is that every year the team comes back for reinoculation." So every year, a team will come back and attend a one-day course. And we did that in Ireland. So we tried that in May, we brought back teams, and there was one team I'm going to talk about, I'm going to shout them out, they're from the Sligo area, and they had come on my very first SAFE programme before COVID in 2017/18. And they came back, one unit, and now, in their region, they have five paediatric units, and that one unit brought back five units with them. They had started a regional SAFE huddle programme from that very first one, and they came back for the reinoculation. And that's what I did because we updated the latest theories – because of course, I've changed the way we think and have a quicker way of doing it – because my whole idea is, "How can I take this very complex theory and get people to do it as part of their day-to-day lives without thinking: 'I'm doing safety now.'?" So they're talking about it. It's what they do. It's hardwired in the system. And that's the big thing with quality improvement services because they do projects. Once the project is over, they go back to the old way. So what we really try to do is say, "This is the way we think, this is the way we do it. But you do need reinoculation." So to answer your question, Jonathan, what I would suggest to the college is to run a course, which you could probably charge a little bit, once a year for teams to come on, to be reinoculated, to get the latest updates in patient theory, to talk about the experience, and to learn from others how we can do it. And that should be part of it. Because patient safety is very difficult in the environment, and particularly very difficult now in the NHS, and a lot of pressure, pressure from the workforce, because they don't feel safe. And part of their not being safe is why they go on strikes, that's part of the deal. And therefore, they're not happier when they go back to work in these concessions, it's also because I think there's a lot of lip service in NHS strategy, but application can't be done. And a lot of programmes can't be done. Unless these people are talking about it every day. And people are not talking about it every day. I would say that if I go into an organisation, I see the slogans, and then I have to ask the CEO and the finance director,

"How much money are you spending on patient safety? How are you doing this?" You'll see they don't answer because they don't do it. They talk to slogans, they don't actually do it. What has to happen, every member on the team, from the cleaner – who's not a cleaner, but is an infection preventer – to a surgeon, who is preventing harm and surgical site infections while I do the operation, that's how they've got to talk. So we've got to really transform things. And I think it starts at the micro-system level, with support from leadership.

Jonathan

I wonder if there's also an aspect there around the difficulty of measuring what is a safe culture. And it is quite natural that people rely on slogans because it's easier to grasp. So you can say NHS England has got their guidance and toolkits of how to create a safe culture, and it's like, "Well, therefore, you can just do that." But then there's no understanding of, "Okay, how do we know whether we are safe here today?" You mentioned the use of the Manchester Patient Safety Framework [MaPSaF], and I remember years ago, there were conversations, "Okay, is this a model that we can use to keep tracking over time in answering that question?" I'd be interested to know what your view is on how organisations should lean into this. And I know there are dangers of having a single measure, but what would the process be to understand "Are we safe? Have we a safe culture"?

Peter

A safe culture is about both what you feel and what you think. So my first thing is that patient safety is a misnomer. And I've said this to the WHO and so on. I talk a lot about patient safety, but the most important thing is healthcare worker safety. Because if people feel safe, then they'll be able to be safe. So they've got to feel safe to be safe. So if they're feeling unsafe, there's no way they can be safe. And COVID showed us that. So I think the first thing we have to do is... the Manchester patient safety scale is very useful for clinical teams to measure their own safety, and the only comparison is between themselves – how we were last time. And it doesn't matter if it's different people marking it. Let's say we did it in your unit. We did it today. And then in January, your new ST1s come in, and they do it again, they would give a higher score because things have changed over the six months. It doesn't have to be the same people saying, "This is what happened last time." Because what is it like now after you've been here for three or four weeks? How do you feel? And people will say, "Well, I feel safer, because this is what's happening. Then my last unit, which was somewhere else." But you're not comparing that last unit with the leaders in that unit saying, "Gee, what's happened here is we've gone up a notch with these trainees. So we are doing something right." So the Manchester patient safety scale is very good for clinical teams to measure themselves. If you want to measure between different organisations, that's a bit more complex, because of the context - and I don't think that's very useful. It's very good for politicians. But what's very useful is that when the patients feel safe, and the patients feel safe when a mother says, "People listen to my concerns." I didn't tell you some of the other stories, but when I was a clinical

director, on four occasions I had to tell parents we watched their child die. We actually watched the child die. It was very traumatic for the parents, very traumatic for the staff members when this happened, and on these occasions, these are very good doctors, very good registrars, and excellent consultants. This is before the patient safety days, this is in 1999 to 2000, and I had a run of four incidents where, whether there was tunnel vision, or they made a misdiagnosis, or they didn't intervene. But in most cases, they didn't listen to the mother. In all cases, in fact. In all cases. The mother said, "I'm worried," and the child's clinical signs were fine. And they said, "The clinical signs are fine." I said, "But the mother was the arbiter." So when mothers feel listened to. When the parents say, "They listen to me, they treat me as part of the team. I feel that my views are heard and listened to," can you see the difference? And that's what you'll hear from most. So the measures are qualitative, rather than quantitative. And I know people love quantitative measures, but culture is not a quantitative thing – it's a qualitative thing. So we've got to bring in quantitative measures, and that is listening to parents. It's going up the co-production ladder where parents feel that I do things *with* you. You don't do them *for* me. You don't do them *to* me. I'm an equal part in the care of my child. The biggest harms we have are medication safety and infections. What do we do with a child who has got chronic condition like cystic fibrosis comes into the hospital? What is the first thing we do? We disempower the mother by saying, "You can't give the drugs. A nurse is going to give the drugs." "Why?" "Hospital policy." "Medical legal issues." Who is the safest person to give medications? The mother who does it every day at home? Or the nurse? Can you see the difference between doing it to or for to doing it with? "Can you help me give the medications as you know best?" Can you see the difference? "I'm going to give the medication to the child now."

Jonathan

And having those quite complex reflection processes to go, "Okay, let's use different measures to understand what does good look like," and part of that may be that we are having the right person empowered to be involved in safety, etc. I'm struck by the very first story you talked about where you said, "We had this terrible incident. But this was a high-performing system." And that language might say, "Well, we are high performing." So how do we get that change of saying, "A measure of what high performing is that you are in a safe environment." So it's having that shift around that language. It shouldn't be possible to claim you're high performing and have poor safety in an environment.

Peter

Well, look, I worked at Great Ormond Street for 12 years in patient safety. When I started, I was fortunate that Great Ormond Street is called *the* Children's Hospital, it's very high performing. You know, there they said, "We need to be high performing in safety." And that's why we looked at Cincinnati in particular, because Cincinnati had the same approach. They were very high performing clinically. But then they had a major serious event and the chief executive said, "What's going on here? We've got to be the best in safety as well." And then they made high performance in safety as one of the outcomes

they wanted. We wanted to do the same at Great Ormond Street, so we started measuring high performance in terms of safety, and we did well at the time I was there – mainly because what we looked at is, "How can we make safe an everyday business?" So a person like Dal, who was one of my patient safety officers, in her region would be responsible for safety in the region, talking about safety every day, doing walk arounds, etc, etc. So what the greatest thing is, is the leadership has to define what they really mean by high performing, and also the college needs to define what they see as high performing when they're doing their college visits. They must start to measure safety incidents, they need to start talking to the staff. The medical school should be doing the same when they place medical students and say, "Do you feel safe in these units? And if not, we need to talk to the units about that."

'I'll go back to one other story I have. I was clinical director and then the trainees in obstetrics complained to the deanery that they weren't being supervised or they weren't being trained adequately... we had a number of maternal deaths. And we investigated. A normal root cause analysis could find nothing, but what was happening,-I realised, that what the trainees were saying to us, not that we weren't being trained, that we were feeling unsafe. And when I went to try and learn about patient safety, I realised what they were saying. They were saying, "We do not feel safe in the environment we are in because the consultants are not in the labour ward with us. So we have to make these difficult decisions.". So to back to your question, Jonathan, if you want to measure it, you've got to measure certain outcomes. So you have to measure the incidence of harm in those areas. I have a number of obstetrics teams on the SAFE programme, and that's exactly what we teach them. How do you measure the harms that happen in your area? How are we going to decrease it? And the biggest harm in obstetrics, I think, is postpartum haemorrhages. How can we limit postpartum haemorrhage to as far as we can, because that is often seen as a consequence. But if it's under 500ml, that's not, you know? So how do we define a postpartum haemorrhage is an issue of concern, and how can we predict it? How can we predict who may have it? How can we do it? I would be asking women, midwives, trainees, medical students and consultants, "Do you feel it is safe?" And ask of that, and all that qualitative stuff, plus the quantitative of harms, would then give me a good measure if that unit is safe. Can you see how complex it is? But I start addressing it from both qualitative and quantitative ways, and including everyone – mothers and clinicians as well.

Natalie

Absolutely. One of the things that strikes me, Peter, many things that you've said during this talk today, it all seems to come back in the very beginning to language, and arming people with the right language to approach the situation. So what you said there of trainees not having that language to say, "I don't feel safe," to saying, "We need more training," Often, if you haven't given people the words to use, it's very difficult for them to participate.

Peter

Yes, and I think one of the things we teach is that a unit must decide on the language it can use to feel safe. Jonathan mentioned the hierarchies. Unfortunately, we have a hierarchy system where people feel that if they show any weakness, they would not get a reference. So they will never show their weakness to their consultants, because then they could say, "Oh, not a good trainee." "What are they going to do in my reference?" But if the consultant shows fallibility, if the leaders show fallibility, then the juniors or the trainees will show fallibility as well. An example I give you is I'm kind of dyslexic, and I write scripts, and I used to make mistakes, so when I had medical students in, I would say to them, "Look, I need you to check what I've written because I always make mistakes." So I always give my scripts to the medical students to check and to calculate – but that's serving two purposes. I was teaching them psychological safety without mentioning the word, because I showed my fallibility, and they were learning how to write scripts. So they were learning how to be safe prescribers at the same time. So that was a situation which worked both ways – that approach is very important to do. But in terms of language, Natalie, a colleague of mine from the States said that we have to have words that people can use. So, for example, often the nurse will say, "I thought this was wrong," or the mother would say, "I thought what they were doing was wrong." So basically, a word that you can use, or you can choose a word is like, if a doctor writes up a script or gives an instruction to a nurse, or the senior doctor to the more junior doctor, and the more junior person in the hierarchy feels that there's something wrong with it, they say, "Can I have clarity?" Or, "Is this what you mean?" You can choose whatever words you want to have. "Let me make sure this is what you want." That signal says, "Let's start again, let's redo the calculation, let's think about it again," in a non-judgmental way. So what it does, it breaks the hierarchy. As soon as someone says the key word that the organisation has decided, you have to step back and say, "Maybe I've made a mistake, because someone has questioned it." And usually what happens, the more junior person will say, "I thought it was wrong." And a junior person may be a different profession – a nurse talking to a doctor, for example. "I thought it was wrong, but he's the doctor, or she's the doctor, so I couldn't really challenge." So we try to flatten it by giving them a word they say, which is non-judgmental, and the cue from the doctor, as soon as someone says that, they say, "Okay, I've got to start again, because there may be a mistake."

Jonathan

What's fascinating about this is that what you're talking about is the right practices to follow to create a high-performing team, high high-performing system. And something that struck me with all of these conversations around patient safety is that we tend to be talking about high performance and asking the right questions, doing the right thing to enable people to do their jobs as best as they can, but everyone working together, the theory and frameworks we have in safety are so useful to frame conversations like this on how we do things better. So if you're trying to tackle something like health inequalities, it's tempting to feel like complexity is too much. But there's an argument going, if we can take a safety approach to this, there are solid frameworks, theoretical background and practice to go, "Because we are underperforming and doing badly for certain groups, this gives us a way forward to perform better." And it strikes me that that may be a key theme for all of these conversations. And I wonder what you think about that?

Peter

Well, the thing about equity is that, in the safety movement, it's only been - we're starting to speak about it now. The fact that if you are from an ethnic minority or a different group, your outcomes are worse. So if you have a baby who is... which I found quite interesting, now they have suddenly discovered APGARs don't work in babies who have a different hue or different colour. I knew that because I came from South Africa, so I knew that straightaway. And now I suddenly discovered that many years later in the UK that you've got to compensate when you're doing jaundice, and when you're doing APGAR scores and so on, which are safety issues. So basically, on inequality, if you come from a black or Asian ethnic minority group, or a refugee group, or immigrant group, you are at higher risk of harm than the average white English person. I think that equity of class is like safety, and I use the same principles. Every day, the consultants should be saying, "Are we treating everyone equally?" And not even equally. "Are we providing more for those who need it?" So if there is someone who is more deprived, how are we going the extra mile for that person? Have we really taken all the factors into account to ensure that person is safe, they could do things and so on, and not then say, "Oh, they didn't comply." So, for example, if you have a medication you give to someone, and it has to be kept in the refrigerator, do we ensure that that person has a refrigerator and can afford the refrigerator 24 hours a day with electricity costs right now? Can you see those kinds of things? Are we asking that kind of question? That's a medication safety question. So really, every day, if you're talking about safety, you need to talk about equity. Do we have a culture of equity? No, we don't. People talk about it, but do they really do something? And doing something, is the consultant/leader every day saying to the clinical team on the safety huddle, "Have we gone an extra mile? Is there anyone who needs extra? Have we taken all the factors into account that may affect this child?" And that's not happening. And until they do it, there's no culture of equity in the NHS – there are just flash showpieces that they have. And you can see it, you can see what happens, because if you ask the trainees who are applying for jobs, we still discriminate. We still discriminate. Ask trainees how they are treated on the ward, there is still discrimination. So we've really got to pay equity at the same level and talk about equity every day. So quality, safety and equity are as important as clinical outcomes and clinical conditions. In ward rounds, they talk about clinical conditions, pathology, physiology, but they don't talk about quality, safety and equity.

Natalie

To wrap things up a little bit, you've said some really, I think, brilliant calls to action of where we need to start tackling this. So the role of the college, the role within education, postgraduate and undergraduate. For somebody who is listening to this podcast, obviously, we're aiming this at the paediatricians, members of the RCPCH, individuals listening to this, do you have a starting block for them? Do you have a call to action for them?

Peter

Yes, well, when we did the *Handbook of Patient Safety*, it was designed for people in the front line. And I really push it that every clinical team should have a copy. I'd argue that every trainee should be given a copy – not to have to buy it themselves. The trust has to buy the *Handbook of Patient Safety*. I say to the consultants who don't know much about patient safety, because it wasn't part of the training, they've been around a long time, I say, "Call on the college to give you opportunities to learn about patient safety. You don't have become experts, but you learn about patient safety." So that's what I do. To all the clinical directors, make patient safety one of the issues you're going to do and make sure you know how to do it. So you don't have to know everything about it, but you have to be the enabler for your teams. So that's what you have to do. To the medical directors, a similar kind of story, that you have to be enablers. Know how to measure it, know what to do for the trainees, demand that patient safety as part of your training. Now, I would say to the college, the fact that we're sitting here today shows that the college has moved a very long way in the last 15 years. And this has given me a lot of pleasure, because I've been working with the college for a long time. And it's great to see that we have you both in post. So that's a very important thing, is that the college now is taking patient safety seriously. And that's a very good thing. Because for us to make a difference, the professional body has to make this a priority. When the professional body makes it a priority, the members of the professional body will start making it a priority. When the members of the professional body, the consultants and the trainees, start making this priority, then the employers will start making it a priority, because they start to talk about it and so on. So I think that the key thing is to come on one of the courses the college offers, explore the website, read the books, go on courses, but the most important thing is every day start talking about safety. It's so easy to start the next day, tomorrow morning, after you've heard the podcast, to say to people on the team, on the ward round, "What kind of harm do we have here? And are we safe right now? And will we be safe tomorrow? What do we have to do?" It's no use waving shrouds and saying, "Oh, the government has got to give us more money," and so on. Because every day you can decrease medication harm. And I'm going to end on this story. We are doctors who prescribe. That's one of the things that defines us. Things that make us a doctor is that we can prescribe medications and we can sign death certificates and birth certificates. So we can bring people to life, we can bring them to death, we can give medications. Medication harm is the number one harm worldwide. Number one harm. It's either poor prescribing, poor administration and poor reconciliation of medications. Over-prescribing, under-prescribing, polypharmacy, you name it. All of those are what doctors do. In a culture of safety, which we are talking about, the consultant will say to the registrar, and the house officers will say, "On this ward, our scripts are 100% correct. And every week, I'm going to look at a random sample of scripts with our pharmacist, and we're going to make sure that we get 100% correct prescribing on this ward, no energy required. No extra work, no extra funding." So what's going to happen? Firstly, they're going to measure prescribing errors. Secondly, they're going to decrease prescribing errors. Certainly they can engender a culture of safety around prescribing which those young doctors will have all the time throughout their careers. That also going to decrease adverse events from prescribing errors. Because they're starting to talk about it. That's something every consultant who does a ward round every day can do without any effort. Saying, "Prescribing is of

importance to me." Because if you go to the pharmacist, they will say they are continually correcting wrong scripts. Yet that is what we permit. There is a good saying from a friend of mine, Pat O'Connor, who says, "What we permit, we promote." So if a consultant permits poor prescribing on his or her ward or clinical area, in the outpatients, on the ward, if there are prescribing errors, if they permit that, they're promoting poor prescribing. So that's what they can do. That's about the culture of safe prescribing, which we do not have. So that's the easiest way to start. It's very complex. But that's where I would start. I'd say, "Let's just look at prescribing. Let's get that right." Forty percent of all harm is due to poor medication. So to just go back to the college programme, the medication safety programme that the college has, that's something that should really be extended because that it should be high up front again. A lot of work was done a few years ago, and that's really where we should be looking at. Then after that we come with infections, etc, etc.

Natalie

Thank you, Peter, for taking the time to share all your knowledge and experience with us. So much progress has been made over your career in bringing patient safety more to the foreground, but there's still so much work to do to make safety a priority in healthcare. As you described, we as individuals need to be supported to change the way we think about safety, and then the safety culture can grow from that, and ultimately, then the children young people we care for will be safer.

For more information about developing a culture of safety, the SAFE project and about paediatric patient safety in general, please visit the RCPCH Patient Safety Portal at https://safety.rcpch.ac.uk/. This is a brand new, online resource full of learning resources, safety alerts and more. You can find links for this and for the research and the projects that we've discussed in this episode in the notes for the podcast. Thank you for listening.