Transcript of Patient Safety Podcasts - episode 3: How do we improve how we learn from harm? with Damian Roland

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Natalie Wyatt

Welcome to your RCPCH patient safety podcast, where we delve into the successes and the challenges of creating a healthcare environment that is safe for children and young people. I am Natalie Wyatt, Paediatric Registrar and Quality Improvement Fellow at the RCPCH.

Jonathan Bamber

And I'm Jonathan Bamber, Head of Quality Improvement at the RCPCH. In this episode, we're going to focus on how we learn from harm and ensure that our day-to-day practice in paediatrics can build upon that learning to ensure that we have a safe environment to work in.

Natalie Wyatt

So today we are joined by Professor Damian Roland. Damian is a paediatric emergency medicine clinician scientist and is head of service for the Children's Emergency Department at Leicester Royal Infirmary. Among his many achievements, Damian has been focused on addressing the challenges of identifying deterioration in health in children. He created the Paediatric Observation Priority Score for Children's Emergency Care and currently he is instrumental in the NHS England SPOT programme, which stands for Systemwide Paediatric Observation Tracking.

Jonathan Bamber

Welcome, Damian. We're very happy to have you here to talk to us.

Damian Roland

Hi there. Thank you so much for the invite. It's a pleasure to be here.

Jonathan Bamber

Thought we could start off if perhaps you could tell me a little bit about your career so far, especially on how you became involved in paediatric patient safety work?

Damian Roland

Oh, I don't think there's any one point where I suddenly went: “Ah, that is it for me. I'm going to become a patient safety expert.” And I'm certainly not a patient safety expert by any stretch of the imagination. But I would argue that anyone who is a paediatrician, or actually anyone working in child health, has an interest in patient safety because it's the bread and butter of what we do. And unlike adults, and apologies for the blunt analogy, but the rate of mortality in adults is far higher than in children. And I'm not proposing for any way, shape, or form that we should give up on preventing adult death or that we shouldn't have mechanisms to prevent adult death, but just proportionally, a childhood death stands out with much greater emotional challenge than a similar adult death. And that's just because of the notion that you don't expect children to die. And this is why I think paediatricians have always had an interest in patient safety to some regard. And then the other flip side is the fact that generally children are very well, um, and proportionally, again, compared to adults, most children become unwell quite quickly and get well even even as quickly. And so you don't have the paradigm of huge long stays in hospitals. You don't have the paradigm of becoming very elderly. We generally have a fit population in which we want to do the best that we can in the shortest possible period without doing extra harm. So for an adult, they stick out their arm, you do a blood test. It's very simple. For a three-year-old, a blood test may be the most traumatic event that they've ever had in their entire lives. And so just a blood test becomes a patient safety principle because you are potentially inflicting harm. And these are the dilemmas that paediatricians face compared to adults.

Jonathan Bamber

So it’s front and centre if you're involved in paediatrics that patient safety tends to be quite a key focus for you?

Damian Roland

Yeah, even if you don't realise you're doing it. Now, my particular journey, I think, started because I've been interested in the way that we recognised how unwell a child is, and I started way back when I was in Plymouth. And this was, I think, around 2006 in looking at the way that we identify unwell neonates on postnatal wards. And I developed with a colleague, John Madar, a prototype newborn early warning system. And I've been interested in early warning systems, uh, ever since. And I, emphasise the system rather than score for reasons that we will come on to, I suspect, later in this interview. But, throughout my career, I've also been interested in decision making, and actually, I think decision making is something that we underplay both in our undergraduate and postgraduate education, and decision making is something we definitely don't look at enough in patient safety review. We are fixated on individual error and we don't look at the impact that the system has and the environment has on an individual's decision making. And for that reason, we can be quite punitive, especially in paediatrics, unfortunately.

Jonathan Bamber

I guess that taps into the idea of having a systemic review of harm and understanding of how you ensure that there is a safe environment as opposed to picking a particular harm and then focusing on, okay, let's stop that one harm happening ever again.

Damian Roland

Well, I think there's two things that interplay here. There is something about the way that we record and report harm, and there's something about the lessons we learn from that and what we do about it. So let's take this first bit about how we record and report harm to begin with. We've been notoriously bad at doing that, um, and one of the problems is, is because people think they're punitive. They were never designed to be punitive, but the Datix has become a dirty word. Uh, people will Datix you as if it's some kind of, uh, criminality, and it's one of the challenges that we have is that what was meant to be a very open way of recording the potential for patient harm, even if it hadn't directly occurred, has become weaponized and sadly now, the Datix, so for those who may not be

aware, essentially is a ubiquitous mechanism by which hospitals allow individuals to report events which they think have come to harm. And that's anything from reporting a patient has a bedsore. to someone's being rude to them to a patient's been or even a staff member has been assaulted. Um, so, so we had this system and there were thousands, if not hundreds of thousands of Datixes every year. Then you also have the mechanism where if harm has occurred, you can investigate that harm. So you can do a Serious Untoward Incident investigation. We have the Healthcare Safety Investigation Branch, which is now an essential body in its own right, who looks at themes, sometimes through Datixes, and then will do kind of non-punitive investigations and share results that way. Both the college, Royal College of Emergency Medicine, our own college, RCPCH, Royal College of Paediatrics and Child Health, can do a safety alert if they feel that there's something out there to warn people about. But ultimately what sticks in people's mind, and this is the real problem that we've got, is the big things come from coroner's reports or big scale investigations where harm has occurred, uh, and, and there is some widespread review of practice. And what that means is, is the most high profile events get really drawn up to the top and, and really dissected, sometimes with adverse consequences. Let's say a child dies of a relatively rare occurrence, but there are factors in that child's death, unfortunately, which are multifaceted, which most of these things are. The reasons for that child dying get lost in this one single thing that went wrong. We concentrate on the one single thing that went wrong, try and do everything we can to prevent that particularly rare event, and we missed the biggest picture where there's system error happening all over the place, but we think we've done well because we've done this big alert and we've, the coroner has made this big pronouncement or a healthcare investigation branch have said this, but we miss that nuance. And I think that is a real issue. I think we're getting better and we're certainly much better than we were 20 years ago. But I think that is the underpinning nature of why so many, especially Doctors and especially Junior Doctors are frustrated with current patient safety systems is because they don't seem to address the day-to-day issues that that people face, and they only seem to address the real rarity.

Natalie Wyatt

That's really interesting, Damian. I think as a junior, I would definitely echo that sentiment. And I was wondering from your point of view, what do you think are these sort of more ubiquitous everyday paediatric patient safety issues for you? What are the most important things in the UK at the moment?

Damian Roland

Yeah. So, so I think that there's two things, some of which we have little control over, but we have to note. So we are seeing ever increasing numbers of patients present, children and young people. It is a safety risk in its own right if you have an overcrowded, overburdened department. And I'm not just talking about emergency departments or assessment units. I'm talking about outpatient clinics. I'm talking about the volume of work that people have to do is a cognitive factor in itself that people I think need to recognise. I think medicine is more complex. We live in a world where we have more children who have complex needs, who have various additional enhancements, and I think another wider system thing is the public perception of risk and what they're willing to tolerate has changed. And I think that is a patient safety issue because the way we deal with that is quite important for the way that people feel that improvements are being made. So, for an example in my own department, we see a range of complaints now, and concerns about harms for a patient that we, we didn't see 10, 15 years ago. And part of that is good. It's great that families and the public are challenging us to be the best that we can be for children. But if the expectation is that you are seen and sorted within three hours of arriving in an emergency department, and that if you present with very soft signs of illness and you're sent away and you've not had an ultrasound scan and you've not had a CT and you've not had blood tests and that's seen as error. These are all things again that weigh up on the practising paediatricians and make it very difficult for them to do their jobs effectively because they're always worried that they're going to do something wrong. So we go into the world of over diagnosis. We do things in our heart of hearts we don't need to do. We admit patients that we wouldn't previously have admitted. Being admitted to hospital is not, it's not safe. This whole podcast is about the fact that patient safety problems are everywhere. And we have got ourselves into a situation where we might be making that problem worse, just by the very nature of the way we're dealing with some of these wider system issues. Now, the things that we might have more control over are some of the things at a local level. So I suspect Natalie, your IT system isn't perfect.

Natalie Wyatt

Yeah.

Damian Roland

And there are many things about IT systems which cause people a headache. Part of that is because I think there are problems that we have in wide scale IT procurement, but part of that is because we don't often involve clinicians themselves in the development of IT systems to make them as safe as possible, and that is purely clinician's fault. This is not the fault of ITs, this is not the fault of government, this is our fault, I think, and I will be

challenged over this, but I try to engage as much as I possibly can in the development of IT processes. I pull my hair out about them, my staff see me pulling my hair out about them, but at least I can say I've been there and I've done the best I can to make them the best they can be. I do see a lot of paediatricians rant, I see a lot of doctors generally, ranting about the state of IT in their country, but not willing to put in the time to help develop them. And this is a plea to chief executives, hospital developers, and even the college to say actually, there is a huge role that we can play from a patient safety perspective in getting clinicians involved in IT design to improve patient safety. The other thing is, and we just spent a bit of time discussing it, is reporting systems. So, are we doing the best that we can to make sure where harm is present, that we can identify that and address it in a non punitive way? And one of the best things that we can do is stop thinking about harm, but thinking about positive practice. Um, so what I'm thinking about here is, is the Greatix and learning from excellence. So a huge shout out to, uh, there are many people who have been involved in this field. But Adrian Plunkett, in particular, who's a PICU consultant in Birmingham, has really pushed the learning from excellence agenda. And what that's saying is, let's record the times where things go well. Let's say this is peak practice, this is gold standard practice. Why can't we share that? Rather than looking at, as we've normally done, when things have gone wrong and try to make that better? Um, and out of that has fallen the concept of a Greatix, which one of my colleagues, David Sinton, was championing, but that there have been others. Um, and that allows staff members to say when they see great practice, to highlight it in others. And we have a little website that you go onto and you say, I'm going to give this person a Greatix because on this shift, they. did this particular thing and that improved my particular shift or the patient shift or improved patient safety for whatever reason. And we need to be better at that because that is a patient safety too principle in a way that, let's look at what we can do to improve rather than what goes wrong. And then the last thing I say is when things do go wrong and I think everyone has a part to play in this, is that we are still, we cannot get away from the fact that an individual has to be at fault. And I think one of the tragedies that we've got, and I do feel, my heart goes out to families who have been affected by medical error and a patient has come to significant harm or died. Because how you get over that as a a, a parent or a carer? Uh, I, I can't, I can't imagine what that is like. What I do know though is that there is virtually no cases, if ever, of one individual being the sole reason why someone has come to harm. But the way we set up our systems and the way that we advocate for things means that I think the public have got a perception that that is when justice is done, is if we find that individual or we find that one thing and that will make things better. And sadly, patient safety doesn't work like that. It's not a one thing breaks it all. It's always almost swiss cheese. There's a sequence of events, which means that lots of different things haven't happened to keep a child safe. And it's by piecing all of those things together and understanding it's the system that's at fault and not the individual, and that's how we're going to improve. And unfortunately, I think the only way for this to happen is going to be when a system is finally convicted of manslaughter or harm. Now, that's on the verge of happening. I'm not sure of a direct case that's involved a child yet, but I think when that happens, people will sit, sit up and take notice. And I think we will see a shift, a complete paradigm shift in the way that

hospitals and organisations do business, because they will start to really realise they're responsible. It's not their staff. It's a system.

Jonathan Bamber

Damian, on the one hand, this is brilliant that you're touching on so many fundamental aspects of patient safety and harm. On the other hand, as a host, I'm thinking, okay, I want to come back on. I've now got like six or seven points that you've covered there, which have been absolutely fascinating. Just on the last point there, let's start from that. You're talking about the importance that we don't blame an individual and we can see how problems tend to be systemic and you think that we may be on the verge of a system being found as you mentioned kind of guilty of being the main cause of harm coming to a child. Can you think of an example of how that might, how that might come about? Would that be that within part of a report from a HSIB report that that would be the end conclusion or would you see it coming from somewhere else?

Damian Roland

I'm not a hundred percent sure, to be honest, and although I'm passionate about it, it's more of a belief and in a way, I don't want it to become true, because that would be a really sad thing to wish for. What I would say, though, is that in one of their last reports, the HSIB made it clear that overcrowding was probably a part of a child death that has occurred, um, in the last five years or so. And for most paediatricians, and for those who don't work in acute care anymore, I'm sure that there are similar community examples, but If we have a situation like we did this December, where we had the most presentations we've ever had to emergency departments up and down the country, ICUs, HDUs are full, the wards are completely overloaded, we have a situation then where it's almost inevitable that things will be missed. And these will be little things. It's, it's misreading a blood test result, reading a CRP as 11 rather than 111, uh, misinterpreting an x ray report, a CT scan being looked at for another patient, which was normal, when in fact their CT scan was very deranged and that leading to a delay in being picked up. And these are all things which may be not be preventable. The fact that we had the strep surge wasn't in anyone's gift to solve, but the fact that we have, we remain in the case that systems sometimes allow children and young people to be cattled in particular locations because there's no inflow or there's no outflow. We are going to get to a situation where I think eventually a coroner or other organisation is going to actually, this whole system wasn't safe. It was impossible to operate in. And I think someone's going to need to look at ways of mitigating against that. Now, one of the things that we've done in my own department is I have a set of circumstances based on our evidence where, if we have a certain number of children in our department, we have a certain number of

children waiting for a bed, so we're looking essentially after a ward in our own ED. Or we have a certain critical number of staff versus patients. A number of the things that we would normally say we can do, we can't do anymore. We're not able to provide sepsis screens for all children. We will prioritise, uh, three months old less than a fever because we know they're high risk, so we will concentrate on those. We know we will concentrate on certain patient groups, the immunosuppressed, for example, because we know that they are at greatest risk of deterioration. But what we say in those critical circumstances is, we can't do everything for everyone, and we've written that before it happens, because I'm worried as head of service. We are going to have tragedy, and I don't want my staff to feel it was on their heads that tragedy happened. Now, that's not improving patient safety. I acknowledge that. I hope it's creating an environment in which staff feel more comfortable, and they know that special groups that they need to target to make sure we've got the best chance of keeping the most at risk patients safe. And then the other thing I would say, Jonathan, and I don't want to kind of steal the thunder, but my life has been around scores and scoring systems. And this is where SPOT comes in, because, and I emphasised at the very beginning of this, is that I'm interested in systems, not the score. But if we're able to get to the position where we have a national standardised chart so that all children, especially on inpatient wards, are having the same level of acuity applied to them, we can start looking at differences between hospitals and trust and systems, and we can start identifying why is it that this happened to this group of patients, which are matched for acuity between a different group of patients. And I'm not really that interested in the individual patient score. I'm interested in the average score across a system and how that compares. And that enables us to start looking at patient safety, qualities and cultures between hospitals, which we've never really been able to do before. So we won't be able to do it now because we're going to have to embed this. But in five, 10 years time, actually, we're going to start having some proxies of saying, okay, you had this many patients present of this particular acuity, and these were their outcomes. Why were your outcomes so different from another locations? And there may be really valid reasons for that. And that's great. We can share. We can explore those reasons, or we can go, Well, actually, your system works like this, and this system works like this. Why don't you two systems start working together, collaborating, sharing, learning, so we can get you both to the end point to have the same risk of harm as any other hospital in the country.

Jonathan Bamber

I just want to touch on that you were I think being a bit judgmental on yourself and saying that having a system within your department where you're trying to review and balance the the risks of complexity when you're having too many children coming in and levels of complexity at what points you say okay it's not safe to do this particular process etc and you said Well, that's not really improving safety. I would challenge that and say that that is exactly the mechanism that you need to do to manage risk in the way that

René Amalberti is very good on an academic space of talking about that, any decision that we do, we are taking, we're making a risk decision. that walking down the street, crossing a road, going hand gliding, we're making a decision of how we manage that risk. And healthcare settings are inherently risky. And there is a there's a decision process there of going, it is better for the child to be in this environment because of the advantages of the clinical care that they're getting. And you are reducing the chance of harm happening to them. But there's a balance there, right? So you seem to be introducing a system within your unit. It strikes me that are there mechanisms or frameworks, which would be helpful in that decision making process as a head of department, as just the clinical group within a hospital to help. with that decision making process of, okay, at what point do you say I can't, I shouldn't be doing this procedure because there were too many people in my system?

Damian Roland

I mean, the first thing is, do you have a handle on the data in your own department? So I'm a bit of a data geek. Um, I like to know, to the patient, how many people are coming in and coming out. I want to know what happens to them, and I want to know trends over time. And so we've built over time a couple of things which can help me do that. So one is we have a, um, and this needs updating and it requires, unfortunately, a lot of work. And when I've nailed this, I will be taking this to to other institutions, because I think it's something that everyone should be doing, and we probably need national support. And I'm also aware that other units do this as well. But for example, I can look back and I can look at the month of March 2022, for example. I know what the average number of attendances per day was in that month. What the 80th percentile and 95th percentile was, um, and I can compare that month to March 2023. And what I can do is I can say, look, on this particular day for this particular time of year, this many patients presented, and this was, we've never seen this before, this went above the 99th percentile of presentations on that day. So it's no wonder we had more complaints than we've ever had. It's no wonder that we had. This level of harm because this was completely exceptional. And then the other thing I can look at is, okay, we, we, we had a really difficult shift this, but why was that? Because actually, if we look at any given metric, this was one of the best days that we ever had. So what was going on here and that can help me understand the processes at play. Now, this is really kind of early days because actually, those of us who have been in this game for a while, when you start to dig down on individual patient safety events, you start to realise that it is so complex. Individual patient, uh, and clinician interactions, more importantly, clinician clinician interactions. I mean, I'm really seeing, I have two things which challenge me. Our inability sometimes to really hear what parents and carers are saying. This comes up again and again and again, and the reason this keeps coming up that we're not listening is because actually parents and carers aren't always right. And I know that some people will be quite angry with me for saying that. So we, but we have it embedded in us that we must listen to parents and

carers and we must do, but they're not always right about their child. The problem comes is the ones that are, are the ones that seem to be the ones that get ignored. And that's the tragedy. We have something called the POP score. It's an ED acuity measure. If you score zero on a POP score, it means you have no physiological derangement at all. The nurse assessing you thinks you look completely fine, and you have no relevant past medical history. If we look at children who score POP zero, um, and we compare that to those children who have what's called a patient wellness questionnaire applied. So this is a five scale number and the parent or carer will say this is the most unwell I've ever seen my child, or it's that they're completely well. 10 percent of children who score POPS of zero have a parent score that this is the most unwell the parent has ever seen their child. And all of these children go home to no harm. Now, I am not saying that parents don't know their children. This may well be the most unwell that that parent has ever seen their child. And they may be saying that, but from the clinical aspect, this child is actually quite well and safe to go home. The problem comes is when we also have the child who presents. The parent can't quite encapsulate how worried they are. The patient is mildly unwell and that parent is fobbed off and then that child comes to harm. And the reason that this keeps happening is because it's, it's not perfect. Parental judgement is neither a hundred percent sensitive. Nor is it 100 percent specific. So we have, we have this real challenge with us is how can we extract from parents and carers the ones where their gestalt is correct from the ones where it isn't? And there's some great work going on as part of the SPOT program, uh, heads up to the work that Emma Lim and team are doing in Newcastle. There's similar work going in Birmingham and Alderhey, and I think around the country, working on these parent concern measures. So that's one thing I see as a huge course of error. The second thing is doctor to doctor communication. And this is the thing that I think gives me my most sadness as head of service, is on a weekly basis, I'm sorting out bad behaviour between professional colleagues. And if you look at some of our most recent high profile events where there has been harm occurring to a child, it's because individuals or departments have fallen out with each other and don't work well together. And it's a real shame as paediatricians where we have people who are marvellous communicators, they must be because they work with children and young people and they communicate really effectively with children and young people and yet they're unable or unwilling to tolerate good communication with their colleagues and that makes me really sad.

Natalie Wyatt

How do you think we can solve this Damian because I think what you've said has echoed across all of the national reports that have come out that communication failures like this are a central piece. I mean, what is your solution?

Damian Roland

Um, it's, it's not the only solution, and it's not my solution, and I'm not going to take any credit for it, but I do think a national scoring system process will start enabling us, one, to start having a common training for any paediatric nurse or paediatric junior doctor or medical student about the way we need to start communicating with parents. So we can start embedding that from the moment that you come to medical or nursing school, like the way through your training so we can start understanding and researching these things. And it also enables us to start communicating with a single common language. And one of the things that we're going to do with SPOT is, it's starting with an inpatient pews chart, but we will have ED pre hospital and community aligned versions. It's not going to be exactly the same score, but it will be a common communication language across these systems. And when we start doing that, I'm hoping we can then start debugging some of these issues. of bad behaviour between clinicians when they pick up the phone to someone and go, look, I don't care what you're telling me. I don't believe you. This child's fine. Please don't send them here.

Natalie Wyatt

Do you think there's something also in the idea that often this learning isn't always disseminated back well, to people? So obviously if you've got a special interest in patient safety, if you're a head of service, if you're involved in looking at the data like you've been doing, it becomes readily apparent. But I wonder if there is a piece that people actually don't have that feedback delivered to them in an effective way and in a way that's constructive that they can then move forward with it.

Damian Roland

I think your key thing is the constructive way it's delivered. I think messages are out there. I mean, social media has a lot of faults. Um, but one of the things that Twitter and some other sites have done very well is get some of this information out to groups who wouldn't normally have seen it. So that you will see some of, kind of, key players on social media, sharing some of these reports, highlighting concerns. And I do think that that reaches parts of clinical bodies that might not pick up an email about it or might not have received it in any other way. Sadly though, it's the way that that learning comes across and the constructive nature of that dissemination. And I think I'm hoping that's why you guys, Jonathan, Natalie, and others are looking at this, because what you want is a way to disseminate knowledge in a way that makes sense to all users. I would say though, the way that information flows to myself must be and should be very different than the information that flows to a foundation trainee or perhaps a CT1. Yes, of course, the core

principle is the same, but what you can do with that information is very different and your understanding, your unconscious competency, or your unconscious incompetency about it, is quite different. And so I do think there has to be strata of information. I suspect there are some people listening to me shaking their heads because if you're a patient safety expert, you're light years ahead of where I am. But there may also be people listening to me, not understanding a single word I'm saying because they've not had that experience yet. And, and, and managing to cope with all these people is difficult and you've got your work cut out.

Jonathan Bamber

I suspect there's something there around mimicking behaviour from people that you see in your practice Who are reviewing this data, asking the questions and saying, okay, what can I learn from this? What can I do differently? So your articulation of saying, so it's like disparaging yourself saying, “Oh, I'm a, I'm a data geek.” But what you explained is you're interested in understanding what you have done in the past in order to look at what we can do better in the future. So that's learning from the past, learning from information. And it's a habit of an improver. I regularly speak to people who are motivated to be, to do their work better, but they're like, “Oh, I don't like looking at the data. I know I'm competent at this, so I just do it.” And that's the problem, right? In that we all have our own biases and our perceptions, but if we don't spend the time to review and say, okay, what could I do differently from this? What could we introduce that's a change in our system to improve safety? Have you any thoughts on how we can demonstrate that for other people to be copying that good practice?

Damian Roland

It's difficult because I think that there's so much good practice and what and who do you copy to the most effect? Learning from Excellence I think also has a good website and is easily accessible and I think the principle is so underlyingly easy to get that, that's something to share. But I think, I hope what I think you're getting at Jonathan, is you need to see people doing that to be able to replicate it yourself. So we need those thought leaders, early adopters everywhere to be able to get this working well. One of the things that we did locally, myself and a colleague a long time ago, something called the critically careful forum. Um, and the idea was once a month we would sit down, we would display data from the previous month, how many attendances we had in our ED, how many deaths we had, rates of admission, and we'd pull out a few cases, a bit like an M&M, dissect them in a nonjudgmental way for learning for the department. Now, Gareth is still doing that. I mean, this has been going on for six or seven years. I'm less involved now. But that, that meeting started out just the two of us. We presented the first two sessions to

nobody. Nobody turned up. So we just talked amongst ourselves, but we keep working at and it's now a regular fixture of our program. And we've now got some of our ICU colleagues coming down, some of the general paediatric colleagues. I mean, it's a slow progress and it's been a slow piece of work, but it's got lots of people engaged and people look forward to the data from our work. They get, that they like the fact that we've now beaten our records for December and it's a talking point. And I think one of the things is, is trying to get conversations. outside this room, i. e. the podcast we're having, and how do I get people to have these discussions in the coffee room at break, or when they're talking on the shop floor when there's a quiet period? And that's the holy grail, is that translation of interest. Data isn't going to be everyone's cup of tea, but it's going to be some people's. Patient safety isn't going to be everyone's cup of tea in terms of looking at dense theory, I'll be honest, it's not mine. If you ask me, name the top four patient safety theories, I'd probably struggle a bit because that's not at the forefront of my knowledge. But if you ask people like Peter Lachman, Ronny Cheung, yeah, they'll be able to name these things because it inspires them. And through that inspiration, they inspire others.

Jonathan Bamber

You've touched on quite a few of the key players, be it Eric Hollnagel's stuff on safety 1 versus safety 2, or the importance of focusing on what's positive and where we are achieving safety within a system, is a major theory around how you can successfully get people to be safe, rather than focusing on all those seven things all happened at the same time to lead to that catastrophic and really desperately terrible outcome. Let's just focus on that and beat ourselves up on it. So you're, I don't think we necessarily need to mention all of the theories. However, we can put them all in the show notes, which we will do. But you say, your mention earlier on the Greatix, uh, system, I think is a great example of the focusing on excellence and picking up, okay, where is a system going well?

Damian Roland

Well, but I think it's really important that there are many mechanisms for translating theories. And one of them is that you do give a very clear description of what the problem is, what the evidence behind is, what the solutions are, and what you can do. That doesn't float everyone's boat, and I have always tried to give tangible examples, because I get the sense that if you can accord with what your audience are thinking, they're more likely to garnish what you're saying. I feel very sorry for our Registrars at the moment, because I think it's a very difficult time to be a paediatrician. Coming out of COVID, when there is some of the highest demand for paediatric and child health care, in a situation where your training was quite disrupted for a couple of years, there's a huge amount of uncertainty for the workforce and people's morale is generally lower than it was. The

culture and makeup of an organisation is really important for its patient safety attributes. Um, I'm not sure I've got the evidence to prove it, but I can't believe a happy, well motivated workforce makes more mistakes than a demotivated, downtrodden one. I've always believed in my own department, and I can't do this overnight, but if I can make progress, people feel better by being in the department that will have an effect in and of itself on patient safety.

Jonathan Bamber

I would agree with you that it's very likely that those two things are closely correlated. A lot of the work of people like Charles Vincent into how we should be measuring safety, he keeps on leaning back into actually, it's more around the monitoring side, and the classic line of if you're walking into a hospital, if the toilets are unclean, that's probably a proxy for something's not quite right that you are noticing within a system. There's a trigger there for you to think, okay, let's look into this further. Now, if you have good monitoring systems and you're picking this up earlier, you're anticipating before a problem happens, then that logically would mean that you have a safer system. Um, and this might be a good time to go into talking a little bit more around the SPOT program in that my understanding of the SPOT program is approaching that idea of we need to be better at monitoring and picking up the deterioration of a child and also recognizing that there is considerable variation on how different units and different hospitals are approaching this, and there would be advantage in standardisation for a range of reasons. But perhaps, I mean, you're the expert in this, perhaps you could touch on, maybe explaining for those who are less familiar with it, what the SPOT program is and why it's important?

Damian Roland

So, I mean, in a nutshell, we know that in the UK, our health outcomes are not as good as other countries which have similar GDP and are in a similar situation with healthcare delivery. So we're doing something not quite right, and there's a multitude of reasons for that. Some of the, uh, discrepancies that we have for inequality and poverty are driving that, and those are things that are outside of a paediatrician's gift to solve, but are clearly really important to child health. But what we do know is that we sometimes are not performing as well as we should do at recognising children who are deteriorating and responding in an appropriate manner. Now, the important thing about the SPOT program is that the SPOT program is not saying: “if we implement this, we're going to see some instant seismic change” because the world doesn't work like that. And I'm really taken by Mary Dixon Woods's work where she looked at some high performing

institutions and some of the safety initiatives they had there. Let's just say infection control bundles. You put the infection control bundle in another hospital and a different thing happens. Um, and it's, it's because it's not the infection control bundle. It's, it's again, it comes down to the culture and the mechanisms of safety deployment within the different hospitals. But having said all of that, standardisation is a way of being able to drive forward progress because then you can start seeing where the differences are. So what we've said is that if you look at mortality per se, having a standardised huge score slash chart as part of a system, the evidence suggests you won't improve mortality. In fact, there's a big randomised controlled trial saying it won't. But if we start standardising that care, we will have a lot of secondary benefits in communication, in training, in, in our response to hierarchy. And all of those things will start improving baselines of care. And ultimately then you start seeing improvements in longer term trajectories of care. So this is a long term project. It's a de-implementation project. Nearly every hospital in England has a PEW score. So something that you total up, you have a score. It tells you what to do. What we want is a pews chart that includes a score, but is not limited to the score. So you can think about parental and carer concern, you've got clinical intuition, you've got some factors like sepsis and a level of alertness, and all of these contribute to a common escalation process, and that common escalation process is standardised across the board, will enable everyone coming into that system to start speaking a common language. And then SPOT, which is system wide, once we've nailed down the inpatient work, which is first, we start looking at a standardised approach in EDs, in ambulances, in community centres, in mental health institutions, um, and then we've got a trajectory of care of which the common language then becomes someone picking up the phone to someone else, you both instantly know what you're talking about. Um, and, and by definition, that's going to have to have some longer term impact. Because at the moment, what we have is one hospital calling another or one GP practice causing one hospital and not being able to speak on the same page.

Jonathan Bamber

Yeah, it's a really fascinating program. And I think at that heart is the point that you're stressing there around, it isn't getting everyone to do the same score. It's everyone having a standardised system that there is, there is commonality and learning. The work on central line infections with Mary Dixon Woods, um, is something that, uh, I didn't do the work, but I commissioned Mary to do it because we recognise that you really need to get inside that Black Box to understand what are your mechanisms for change? And you do something in one situation and it works, you do it somewhere else and it completely doesn't. So taking that systemic approach to the SPOT program, I think is, gives it the potential to be effective over time.

Damian Roland

And I'm really glad that we've got members of the Health Foundation supporting an independent research study of the de-implementation program. So it's, it's, it's not just my voice or my, my colleagues and we have a huge oversight group. So we've got PICU consultants, we've got general paediatricians, uh, we've got a lot of nurses and a huge big up to the nurses who have been the driving factor for SPOTs so far in, in enabling the pilot testing. Pilot testing has lasted over 18 months. We've got a couple of institutions who are really on board with this and we've learned a great deal from, but we've also got an independent group going into our pilot sites and asking questions, which I'm not involved in at all about how we've done this and what we can learn from it so that we're not biasing ourselves. And there's a real risk. And I've always felt that there's a danger that we fall certain of our own self beliefs. We know what the best course of action is. So we will deliver that. And time and time again. In clinical history, we've learned that what people think works or doesn't work is often very wrong.

Jonathan Bamber

Could you talk a little bit about the community of practice as well? And that importance of those pilot sites being able to feed back, okay, actually we thought this was going to work in our situation, but we'd like this to change?

Damian Roland

Yeah, so communities of practice, is again, is not something that I'm really involved in, and social media is my biggest community of practice and I have done some work on how you form communities of practice through social media and I think it's really powerful. And I think the evidence suggests it's really powerful. Do I really understand the dense social theory of communities of practice? There's this thing called Rhizomology. Oh my God, if you want to fall asleep, this is the stuff to read because it is really almost impenetrable. But the long and short is, is that having a group of people who come together with common aims is hugely powerful, and that we've done this with, uh, the initial pilot stage of the SPOT program. I've been on a call every Thursday with not always the same people, but a similar group of people for nearly two years. And we together have, have learnt a lot about things that have worked and haven't. We've got some interesting things about if you start standardising a patient chart, you start standardising the way you do observations, and then you start asking your question as well. How often do we need to do observations? Do you need to do a blood pressure every time on a child? But if you allow people to delegate from doing a blood pressure, do they do a blood pressure at all? If you have, uh, oxygen saturations, uh, where's the best place for them to

be taken? How often do you record when you've moved the oxygen saturations probe around the body? Um, it's amazing how people get excited about a tick box about what gets done or doesn't get done. Um, and so through this community of practice, we've got a group of people who have really learned from each other and are willing to share ideas and are now willing to suspend a bit of disbelief. When we started, people I don't think were willing to try new things or they were very hesitant to do so. I think we've now got a group of people who have gone, wow, actually, I didn't think that would work, but it did, or I thought that would work, but it didn't. And as we bring more people on board, as we get more early adopters, that community of practice will grow and will become a really powerful force for change because some of the naysayers, and there will be naysayers, there will be people saying, not on my watch, not on my patch, what we've got is better than what you've got, but those naysayers will become smaller and smaller in volume and amplitude of, of, of voice and the community of practice, as long as we don't become victim of our own bubble and groupthink. And it is a danger, groupthink is a danger, but I think because we've got these external reviews, because I think we go back to the common principles, I think we will have something that it's fit for purpose for now and five or 10 years time.

Natalie Wyatt

It’s very exciting listening to you talk, Damian, about the potentials of it. And I think the SPOT program really does kind of exemplify how you can take this nationwide systemic act, learning from the harm. Obviously the harm we're learning from here is our inability to recognise deterioration, and you're doing something wide scale to, to try and address some of that. Just bringing it back to sort of some of the groups that you mentioned previously, people who are not patient safety experts or particularly interested, our foundation trainees, our people at the beginning of careers. Do you have any thoughts on how people can start taking, whether it's learning they've done in their own departments, their own data collection, or these big reports that bring out the common themes, and how people on the ground can start turning that into improvement work?

Damian Roland

Uh, I do remember being a trainee and I do remember how difficult it was to affect change. Because you're a small part of a huge machine and you're moving on. Um, but I do think it's, it's, it's in your rights to challenge, uh, your departments about, okay, you've done this audit, or you've asked me to do this thing again, and it is the same thing that has been done for the last three, five, 10 years, nothing has changed. What are we doing that is going to change outcomes rather than just measure it? Um, and I think we need more people challenging hierarchies about that. Now that has to be a constructive

challenge. Uh, if you go about it in the wrong way that you just annoy people and you will be dismissed, but I think it is important that when you take learning from units where things have worked and you go to units where they not use that and go, okay, there may be a reason that we don't do that here, but explain it to me. Why don't you use this safety process? Why don't you do this? Why do you use this system? Um, and let's work together about how we can both, uh, improve things. If you go to the college conference - this is a great - so, I'm not a great fan of posters, if I'm honest. We get all these posters about and the learning goes nowhere. But the one good thing about posters is you can see this diversity of practice. Go to conferences, look at all the posters and go, okay, we've done that. Why are you doing a poster on something that we know is established practice? Um, I mean, I've seen a poster, and I suppose it wasn't that recently, but child arrives in an emergency department, might have a UTI. The thing to do is give them an ability to capture urine at triage. Start the process then. If you wait two hours to when they've seen a doctor to ask them to do a urine dip, that seems obvious. But I still see posters about this. Why is that? Why are we not learning from others? And I think the trainees or those who aren't used to patient safeties have experienced this. It's part of their psyche. They might not know all the theory, but they know where all the problems are. And I ask you to come and challenge us, the next trainees coming to my unit. What I'd like to happen within a month of starting is a knock on my door,"Hi, Damian. I've noticed this. Why do you do it in this way?" And I might be able to give a really good reason. We may have had our own patient safety incident. We may have had our own process by which we do something. But at least we can justify that. But if you go to a unit and someone's asked you to audit again the number of children who are cold on your neonatal unit, and you've done that for the last 10 years and you've never improved it, that is a patient safety issue because you are not listening to your own learning. And you, you have a right as a trainee to go, right, we need to do something about this.

Natalie Wyatt

I've got to say, that's all the, that's the, comes straight back to the culture though, doesn't it Damian? Setting up an environment where people have the confidence, the space, um, and the knowledge to, to recognise and, and, and bring those things to seniors. And that's like what we've spoken of before, that breaking down the hierarchy, improving inter-colleague communication.

Damian Roland

That to me is the crux of a lot of the issues facing patient safety and the NHS. Uh, at the moment is, is that, that culture and, uh, and workforce. It's like the PEWS and the SPOT program. I don't want it to be a score. If people go on about, oh, we've now got a national

score, that, that, that won't help us because people get fixated on the score and won't do anything else. But if we get to a process where people are able to start challenging the way people do things because they've noticed that things are different between hospitals, then we're on the real winner.

Natalie Wyatt

Thank you so much for taking the time to talk with us today, Damian. The concept that we need to focus on what we are doing to change safety outcomes rather than just measure them is so important. Work like the SPOT program to develop common languages and the idea of forming communities of practice to share learning I think represent real progress. As you have described Damian, learning from what is going well in a system can really drive forward improvement. It is still also vital to investigate and learn when things go wrong. There is a wealth of information from reports and investigations that identifies what puts patients at risk of harm. We have summarised many of these for you on the patient safety portal. It is imperative to turn this knowledge into action through improvement activities. For more information about how to launch your own improvement projects and about paediatric patient safety in general please visit the RCPCH Patient Safety Portal.'