Adapt, Improve, Achieve: RCVS Knowledge quality improvement stream at SPVS VMG Congress 2020

Podcast transcript: Suzette Woodward discusses patient safety within human healthcare and lessons learned

Introduction

Welcome to an Adapt, Improve, Achieve session by RCVS Knowledge, which was recorded at SPVS VMG Congress on the 25th January 2020 at Celtic Manor Resort in Newport, as part of the quality improvement stream. In this session, we will hear from Suzette Woodward, patient safety specialist. RCVS Knowledge promotes the use of significant event audits to either decrease the likelihood of repeating outcomes that didn't go well, or increase the likelihood of repeating outcomes that did. Historically in the NHS, there has been a focus on responding to error, this can sometimes lead to a blame culture. Suzette Woodward talks about how we can learn from this.

Suzette Woodward

Thank you very, very much. How many of you were here for the first talk? Oh, quite a few. Brilliant, brilliant. Because I will complement that talk and hopefully add to it and enhance what was one of the most outstanding talks I've heard in a very long time. So, I'm a paediatric intensive care nurse by background, so I'm a clinician, I worked clinically for round about 15 years. And then thought I'd have a year out doing a bit of non-clinical work because it was quite tough. And I went to Great Ormond Street Hospital where they wanted me to do clinical risk. This was in the 1990s and clinical risk was a very, there was very little understood about it. And what they all thought about it, was it was all to do with policies and procedures and having nice instant reporting systems.

I fell in love with the subject and have been doing it ever since, and now we call it patient safety. But over the 20 years or so that I'd been working on it, both at a national and an international level, we've done an awful lot of things wrong. We've done an awful lot of things right, but we have done an awful lot of things wrong and I don't want you to go down that way. And so why I'm here today is actually to share the lessons in both of those spectrums and to give you some emerging science and concepts related to safety that is really, really catching the energy and enthusiasm of our clinicians across the whole of the NHS. This is about thinking differently today. I'm a Professor in Patient Safety and I worked with Imperial [College London]. And I also work for the Department of Health and Social Care in England and the Department of Health and Social Care in Ireland (I don't know if it's social care), and all sorts of other places. And so I'm going to cover the approach that we're doing today, the latest theories and concepts and what we could do differently as I've mentioned.

So I don't know if you've ever heard this phrase, 'safety I'. So in the NHS for the last 20 years, 'safety I' is what we've been doing. And if there's a 'safety I', then you might assume there might be a ''safety II''. And there is, and I'm going to explain what that is. But 'safety I' is coined as measuring safety and trying to reduce the number of ways in which we fail and go wrong. So the mistakes, the errors, the accidents,

the complaints, the incidents, the claims, you name it, anything that we call something going wrong. Then what we've decided to do and decided to do very, very early on is look elsewhere.

So the NHS is a high-risk industry. There are other high-risk industries aren't there? Let's look at aviation, nuclear, maritime, all of those. Ask them how they do it. Oh, I see. They collect incidents, they have incident reporting systems, they have instant investigation methods such as root cause analysis, Swiss cheese model, looking at where we go wrong, and to some extent quality improvement, and I get a little bit controversial at certain points. And this approach that we've got over the last 20 years is completely stretched to beyond breaking point. We have people who work solely on instant reporting systems that just simply churn incidents over and over and over again. A typical hospital will have thousands and thousands and thousands of them reported through their instant reporting systems that get reported up to what's called a national reporting and learning system, which is based in something called NHS Improvement, which has around about 1.5 million incidents reported every year, and about two or three people who can analyse them.

So what can you actually learn from 1.5 million incidents a year, from about two people, and not very good systems such as algorithms or lovely software systems that everyone says you should use? And, in fact (I always say this wrong 'cos I can never seem to get this word out even though I am a clinician) Clostridium difficile. Yay, I said it. C. Diff for short in our national reporting learning system is spelt 251 different ways. So if you wanted to do even just a word search on your national reporting learning system, you're going to get nowhere in quite a lot of ways. And 'safety I' is constantly focusing on failure. And dare I say it, a little bit of QI tends to get interpreted in that way as well. What's our problem? Where are we failing? How can we stop the problem from happening? And how can we stop failing and how we can we keep improving, improving, improving? And I think that in itself is part of the problem, because quality improvement can sometimes be just strengthening or replicating and it could be building on what you're already brilliant at.

'Safety I' and to some extent quality improvement (I'm not looking over there 'cos I've got lots of quality improvement experts over to my left), quality improvement does tend to rely on a linear, simple system. Not always. It can work in complexity and it can work in complicated stuff, but it often lends itself to going, can we just step a few steps back? Let's start with A, then we'll go neatly to B and C and D and E and F. And we all know that our systems, both our systems, are never like that. It never goes simply. It's never following a nice, neat pathway. There are always these different things that happen all of the time that either get in the way or don't get in the way or whatever. As someone most beautifully said, it's a bit like trying to learn what a good marriage looks like by studying why people divorce. So this is what we do all the time. We look at why people divorce instead of looking at these brilliant marriages.

We collect and understand incidents, but do we truly know what 'work is done'? This is a human factors terminology. 'Work is done' versus work is imagined. We only understand 'work is done' through failure and the investigations and the way in which we look at it, I'm sorry to say, in the health service is flawed because all we do is think that we can go back and look at the system and say, yeah, that's what happened and we can immediately remember what happened and we can immediately see what happened. But it isn't like that, because the system has changed. It has changed the very moment or moments after it's happened. So when something does go wrong, it's very, very different, even just five minutes later. And our memories are flawed and our biases are all over the place. So we are very biased by hindsight. We're very biased by outcome. Ten times the dose of a vitamin for a very small child, will probably do them some good. Ten times the dose of vitamin, sorry, ten times the dose of morphine for a very small child will probably kill that child. They are the same incident. They will be treated completely differently because one led to the child's death and one led to the child not necessarily being affected.

That is what we do also in healthcare a lot of. We really look at the really bad stuff without trying to figure out what are all the little things that are going on that could tell us maybe even a bit more. So quality improvement tends to focus on a problem that needs fixing, but this is our reality. This is the reality in healthcare, no matter whether they are humans or others, we have a complex adaptive system. So the first talk today talked about a difference between simple, complicated and complex. I'm therefore not going to explain that. He explained it utterly beautifully. If you weren't there I'll tweet about it later, it was just brilliant. What we have is a complex adaptive system in healthcare. That means that this is what people do every day, and you do this too. You adapt and adjust to the demand and the change of performance accordingly.

So the different animals that you have, the different clients you have, the different people that you have in front of you, the different staff you work with; you adapt and you adjust every day, almost minute by minute. If you work in intensive care, accident and emergency, minute by minute, you have to deal with all of the unintended consequences that you hadn't predicted at the beginning of the day. And also those unintended consequences by those wonderful people who imagine what your life is like and design interventions or even equipment or tools or policies and procedures. They imagine this is what your world is like. And then you have to sort of think, well, I have to deal with the unintended consequence of the fact that that doesn't quite fit with what I'm trying to do. And so therefore you then interpret those policies and procedures to match everything that you're trying to do and then you detect and you correct when it's about to go wrong, or sadly, when it has.

In healthcare, we blame everyone that does all of that. Instead of going, wow, reward those damned people, that's amazing, value them, love them, give them all the joy and all of the world – we blame them. We say, why did you adapt and adjust? Why did you deal with those unintended consequences when you had a standard operating procedure or a policy that told you to do these things? Why did you not do 3.2 on page 10 of this policy document that actually was issued about 10 years ago? Why did you not do that? And then what we do is we take that blame and then we punish people. Even today, a nurse, one drug error, will be told off. Second drug error, may be suspended or certainly stopped from doing medications. Third drug error, potentially sent off to the Nursing & Midwifery Council.

Three drug errors is pretty much normal in most people's lives, sadly. But it is, because we're human beings and we make mistakes. So if we're going to go around blaming people like that, what are they going to do? Not speak up, not tell anyone that they do anything wrong. Not telling anyone that they adapt and adjust. So when I come along and I am the Care Quality Commission, or I am somebody who's going to come and regulate you, I'm going to ask you what you do. I'm going to say now, remember, what was it that I'm supposed to do? One and then two and then three, and then 'I do one and then two and then three and then four'. And everyone around you is going, 'No, we don't, we don't do that step three, what're you talking about? Oh shit. Yes. It's them. Okay. No, we do one and we do three and then four', and we tell everyone what we want them to hear and not what we actually do. And so therefore we never actually learn what people actually do. And so then we don't really truly understand what healthcare is all about and why we succeed and why we fail.

Anyone a landscape painter in here will know that you start, and can start, the day as amazing as that is. But by the end of the day, it could have rained, horses and cows and sheep could have run across it. Lots of people and anything and everything could have happened. The wind could have shifted all your papers everywhere and all sorts. And by the end of the day, it doesn't look like that. Why didn't it look like that? Oh, well it doesn't, it looks completely different. Why am I telling you all of that? Because when something's gone wrong, I think that people think all you need to do is have that little snapshot of what it looked like at the beginning of the day, go back, see it, print it out, show everyone, this is what it looked like and now we can all learn about what we could do differently. But it's changed completely.

And so actually what you need to do is, unfortunately, realise that you can't do that unless you take photographs and snapshots of every single moment of your day.

There is something clever that you can do. What you have to do is understand these things and this is really tough. This is what the designers of our systems need to do. This is what the leaders of our organisations need to do. This is actually what quality improvement is all about, which is actually to try to understand the constant changes, the multiple interdependencies, the confusing and incompatible interfaces. There are trusts in the NHS that have about 25 different infusion pumps that probably do all of the same thing and you could narrow that down and narrow it down. We have really hard-to-read and very similar labels, look-alike labels for the same drugs, similar drugs, different dosages and all of those. You must have exactly the same. Pick up a 10 milligrams and a hundred milligrams box, looks pretty much the same. We have unworkable or missing equipment. And we have this big thing called incivility and bullying.

We've talked about time today and the pressures and we have a lack of staff just as everybody else does and a constantly changing staff and a constantly moving staff. We have fatigue, hunger, dehydration, high levels of stress, variable levels of competence and differing professional cultures. I'm sure that's your world too. A lovely policymaker, I work a lot with policymakers and ministers. They're a fascinating group of people and a lot of policymakers talk about the fact that I develop all these beautiful policies, I make them look great and I write them astonishingly. And then the minister approves and then they go off to the Queen and sometimes they go into law and the Queen goes, yes, that's lovely, and it goes off to the House of Lords and everybody says, fabulous.

I've only just realised that actually what I do, is I create these lovely, lovely policies, these lovely guidance and standards and standard operating procedures. And actually all I do is I throw them over a wall and I'm expecting on the other side of that wall for people go, yay, this is really exciting, I've got some new policies and procedures to follow, when all I'm doing is drowning them. The NHS, and I really hope that you might do the same, has to slow down and stop producing multiple policies and procedures and new interventions. We don't need any more shiny new stuff. We actually need less of stuff than shiny new stuff.

So I've talked about this language in human factors. This is what policymakers do. They imagine what your world is, or standards setters or guidance setters or regulators, then they prescribe it and tell you what to do. And then there's this massive gap between what you actually do and what you're prepared to disclose.

Related to ‘work is done’ is how you actually work, and the knowledge that you have throughout the system and the knowledge that you have at certain times in your life. And we all have every single one of these. Firstly we start off life as unconscious incompetence. We don't understand or know something and we do not recognise that we don't know. It's usually a new job, we start out in life, we're very novice and we can take risky decisions. We don't know that we don't know. I know there's a joke in there somewhere.

And not knowing it means that we could act unsafely, but then we move as we grow into conscious incompetence. I don't understand what I'm doing, but I totally recognise that. Somebody told me to go and take a chest drain out. I know I've never taken a chest drain out. So I'm actually, no, I'm not going to do that. I'm going to ask somebody else to do it. I'm going to watch them and then I might know how to do that the next time. I'm recognising it. This is a novice that knows they need expertise and experience. They are less risky at this stage. Then we have the lovely conscious competence. I understand how I'm doing it and I make an absolute concerted effort to concentrate. So if you're really, really good at driving, you've been driving for about 20 years, you know that you can get into that bit where you're doing it automatically.

And sometimes, and often, it's when you've been involved in an accident, you go, do you know what? I think I might need to slow down and actually really think about driving as opposed to just letting myself go and drift and go from A to B. So it's the concerted effort to concentrate on something that you might actually be brilliant at. Is this where we want everyone to be? I'm not sure. And then you get to the unconscious competence where you've mastered your skill and you've become that driver, you're probably Lewis Hamilton or someone, and you just go round and round and round and actually probably go into your own different world. And actually sometimes you can be incredibly risky by doing that. And we are like that all of the time in all sorts of different ways. So like the first talk talked about was the different personalities we work with. We're also working with people who have different skills and competencies all of the time. New junior doctor comes in, new nurse or long-time consultant who has been there for about 30 years. We're all in these different stages, past and present. And it is far too simplistic to say that we should just be consciously competent, i.e. the person who's driving knows how they're driving but really thinks about it because it's not actually as simple to say that.

So I mentioned 'safety I', that's where we're at. But what we're actually doing is emerging and growing into something called 'safety II'. So sometimes it takes a really profound, brilliant question to be asked, why do we simply focus on the things that go wrong? Why do we focus on the failure all the time? Why do we focus on the problems all the time? Why do we focus on the things that go wrong? There's lots of statistics in healthcare, but there's one that's used predominantly, which is that 10% of the care that's provided to patients will go wrong. It's based on very flawed data. Retrospective case note reviews, which is your patient notes, somebody takes them, has a look, tries to work out how many things went wrong, how many things didn't. It's very flawed because not everyone writes everything in case notes. And it's very biased because it depends on who's judging it, but we're going to go there because it's used everywhere. Let's say 10% of the care that we provide goes wrong. So if 10% of the care that we provide goes wrong…

[Mic adjusted]

Thank you. 90% of the care that we provide goes right? It goes okay. And I'm not saying it's perfect, it just goes okay. People get through the day, they adapt, they adjust, they deal with things. And this is the difference between 'safety I' and 'safety II'. 'Safety I' is defining safety as a state where as few things as possible go wrong. 'Safety II' is defining it as a state where as much as possible goes right. It's a different mind-set. It's just kind of looking in the mirror and turning yourself around. I don't know why I say it like that, but it's kind of, it's just looking at it differently. Sorry, a few photos. So this is what the lovely resilience engineers, as they're called, and the people that I work with, and the world that I'm in, instead of looking at the 10% of the care that goes wrong, we should look at the 90% of care that goes right.

And then you think, my God, what is she talking about? I don't have time to even look at the 10% let alone the 90%. It's completely shifting the way that you even look at the 10% in order to understand that 90%. It's understanding safety and understanding variation and why things fail in the instance. So saying to yourself, if I, I personally, I talk very openly about it, gave 10 times the dose of a wrong drug to a very small child in intensive care, I blamed myself completely for years. It was all down to me, I was the bad nurse. I had failed. I failed to understand that for hundreds, if not thousands, of times, I'd given similar drugs in similar ways in intensive care for at least eight years before this incident. And I was undoubtedly going to do the same moving forward.

And I probably made a few mistakes along the way because again, we are all human beings. That's what we do. But I didn't ask myself, why did I fail in that instance? I just felt like I'd failed, I was the problem. And what I needed to actually understand is how many times did I succeed and why did I succeed and what were the circumstances that led me to succeed? That would be amazing learning. So this is what

we do in healthcare. We spend all of our time over here in 'safety I', they call all of the things that we do, different labels. They're all the same stuff. They just like labelling, NHS love a label. Incidents, serious incidents, never events, deaths, complaints, claims, they're all pretty much the same thing, things that go wrong in healthcare, label, label, label. Normal day-to-day performance and exceptional performance, relatively unstudied in terms of safety, studied in terms of wanting to do improvements and all sorts of clinical trials and all those kinds of things. But in terms of safety, what a massive amount of stuff that is missing in our repertoire of trying to make systems safe.

So most of us ignore the everyday because it just simply goes okay, we know that the majority of the time we failed to study this and we need to understand what the factors are that simply help our work go okay. And we can, there are numerous ways in which we study it. Ethnography, videos, storytelling, debriefing, huddles, there are numerous ways. You can even use the 'safety II' methodologies of incident reporting and incident investigations, to look at it from a different angle. So when something has gone wrong, if you are going to go from that angle, also ask, so how many times does it go right? Try to get some baseline figures for how many times it goes right. Try to understand what were the factors that normally lead it to go right, in order to understand why it failed in this instance.

Don't just simply look at the failure and why it failed. Really try to understand the totality of what you deliver, and there's a long, long lot of lectures associated with all these methodologies, which I can share with you at any time, if you want to chat to me on Twitter. We've talked earlier about changing the language, I think the language is a barrier. I was really intrigued, I really wanted to actually say a bit earlier on, does anyone actually have their definition, their own definition of quality improvement? Because I imagine that it all might be a bit different depending on who you are and who's in the room. The same with patient safety, and actually I think we should remove the words patient safety because it puts it in a box. It gives somebody a title associated with it and then it's somebody else's job and actually it's… everyone's and it's about what we should be doing and it's about helping people work safely.

Human error lends itself to driving us, focusing both on humans and errors rather than performance variability. Zero harm is totally impossible and you should understand the natural variation in wherever you work. And we have to have bold and challenging conversations about that. 'It went wrong' always then lends itself to failure. And we need to understand about things that don't go as planned or as expected. And in healthcare, if we don't follow a policy or a procedure, we call them violators… that's nice. So the violators of the system get punished. Instead, all they're doing is adjusting and adapting and doing their darnedest. So the 'safety II' principles are that you use both 'safety I' and 'safety II', the learning from failure and the learning from success, and the everyday being non-judgmental and always seeking to learn before assuming what went on.

You should always, always, always when something has happened, whether it's gone wrong or even gone right, don't judge that person, especially if it's gone wrong. Just care for them, console them, support them, and really, really help them through that circumstance. Study the everyday work that we do and understand how do people adjust and adapt, and could that actually influence the way in which you could redesign your system? Because if they keep constantly adjusting, adapting to exactly the same things all of the time, then you could change the system so that they didn't have to adapt and adjust all the time. It became intuitively easy to do. Learn how things normally go in order to understand how it failed and learn from this to replicate good practice and strengths in the system. So it isn't always about constantly improving, it may be just strengthening and replicating.

That is totally dependent on a psychologically safe organisation. There's a wonderful woman called Amy Edmondson, she talks beautifully about psychological safety, which is basically not just when things have gone wrong, it's the ability for you to be able to speak out, speak up, share any comment that you have without any repercussions whatsoever. As in, you are not made to feel stupid. You're not made to feel

wrong. You're not made to feel bad by raising your hand. A psychologically safe team is one where you all feel you can do that. 'Hi, I just need to, I'm sorry, I don't understand.' What was that acronym you used? PSS? I have no idea what that is. I still have no idea what that is. I'm going to admit that and you need to do that. Really hard to do, if you've been a consultant for 35 years and you suddenly realise there's something that you haven't asked quite some time ago.

Compassionate leadership, compassionate leadership. There was a book called *Compassionomics*, great title. It is about this thick. Every single page is the evidence base behind why compassion is good for teamwork, leadership, the bottom line, your profit, your loss or your whatever. It is evidence based on why compassion is so amazing for everything that we do. It isn't just a nice thing to do, let's just be compassionate. It is really brilliant and will make a massive difference. And then we get to the 'just culture', which I'm going to talk to you about.

So this was bandied about for years, 'just culture' is usually associated with blame free, no blame, stuff like that; it's not. A 'just culture' is where it's all about the right response when things have gone wrong proportionally to whatever has happened. So as I've said, when something's gone wrong, it's probably true to say that it's gone right many, many, many times before and it will go right many times in the future. Yet we judge each other by one error, one incident for the rest of our careers.

None of us would survive scrutiny, no matter what. If I said to you, please go off and make a cake, I'm just going to come and stand and hover over you and watch every single aspect of how you're making that cake. Well you'll probably make more mistakes 'cos I'm staring at you, but I will find a flaw somewhere along the line. Clinical work, and all of the work that we do, is the same. If we scrutinise it enough, you will find something. You will find something. And that is what our systems unfortunately do. Our regulators, our judicial system, our criminal system, if you stare long enough, you'll find the flaws, and it's very easy to do in the misleading light of hindsight.

And if you focus on people's shortcomings all the time, if you constantly just say there's a problem, you're failing, it's all wrong, would you stop making mistakes – it actually impairs your learning. And what we do is we end up by spending our time identifying failure and giving people feedback in order to avoid failure. Really hard to do. Will you stop making mistakes? Okay, how do I do that? And all we'll do is be languishing in the business of inadequacy. There's a wonderful story associated with actually people are starting to turn this around. So Mersey Care is a partnership trust, in the NHS, and deals with mainly mental health patients. They have a film, it's about 30 minutes long. They work very closely with somebody called Sidney Dekker who is a world-leading expert on 'just culture', it is the most moving film possible and tells you all about how to create a just and restorative learning culture in your organisation.

Basically what they did, is they realised that they were suspending, disciplining staff, all inappropriately, and when they realised that, they turned and actually said to those people, I'm really, really, really sorry. I'm really sorry and would you come back and work with us and help us turn our organisation around so that we don't do the same thing to somebody else. Please treat your staff in the same way. Say you're really sorry, if something happened to them, and be there for them. I always tell anyone new to healthcare, have somebody in your back pocket. You need a person in your back pocket that's going to love you no matter what. They will not judge you. And when that thing that does go wrong, because it's a 'does' and not an 'if', you might have to ring them up, two o'clock in the morning, and say, I need your help. I need you to listen to me and I don't know where to start. And every single person needs that person. And this is what this film is trying to describe. That what you need to do is care for people when things go wrong and support them.

Because you ask three beautiful, beautiful, profound questions: Who is hurt? What do they need? And whose obligation is it to meet that need? Who is hurt can be the patient and their family. It can even ripple beyond into the community and the neighbours, and the people who live down the road who are

going to go into the same hospital and the same community and think, is that going to happen to me? I can imagine from the news yesterday, from the East Kent Foundation Trust, of the family that lost their little baby. Imagine all of those mums and dads and everyone else going in today, to have their babies in the same place, in what they think is the same care and the same risks and the same problems. So it does ripple.

So, who was hurt? But it also is, who was hurt? The staff member, their friends, their colleagues, their bosses, the people around them, the receptionist, the porters, the chief executive. When I worked at Great Ormond Street Hospital, we had a child who died, from a really tragic case, the entire hospital, I felt like, had its head in its hands, and was really shameful of what happened to that child. And shame is a word we don't use very often in healthcare, but we do feel it when we can't provide the care that we would like to provide. So sometimes it can be an entire organisation that can actually feel that shame and that guilt and we need to figure out what do they need? What does that entire organisation need? What do the individuals need? They need love. They need care. They need tea. They may need something stronger. Somebody might need time off, somebody might need to stay in work. It is very nuanced and it's what they need. And whose obligation is it to meet that need? Not somebody just for the day or maybe for the week, but maybe sometimes for their entire lifetime. Because sometimes these things last an entire lifetime and we need to support people with that.

So that brings me to behaviour. Our first talk talked so beautifully about, actually it's all about relationships, isn't it? And it is. It's about how we behave towards each other. It is one of the biggest challenges we face in healthcare, is how we behave towards each other. I don't mean always in a bad way. It's how we develop our relationships, our working relationships, the teams that we create on the hoof and off the hoof, the way in which we talk to and listen to each other, the way in which we interact with, between the ‘thems’ and the ‘us’, and the way we create the ‘thems’ and the ‘us’. We have the clinicians versus the managers, the organisations versus the regulators, the polarities between quality and performance, the polarities between money and delivery and so on. They're all polarities that actually have commonalities that we can bring to some kind of centre and figure out how we can behave so much better towards each other.

There are more than this, but broadly we talk about rudeness. Every single person in this room has been rude to people, that goes without saying. And you can and you will, and you will have all sorts of different triggers. And then those incivility which, in the definition of the world that I work in, and that people like Chris Turner, who's a guy that works a lot in this, is a little bit more purposeful. Incivility is a bit like, ‘I don't like her that much’, ‘she irritates me, so I'm going to ignore her when she raises a question, but I might answer the same question from somebody else’. It's slightly more purposeful, so it's incivil, and it's defined by rudeness and unsocial behaviour often with an ambiguous intentionality to maybe a person, a team, or a profession. That ‘them’ and the ‘us’, and then we get the bullying and the harassment.

And in the NHS we get a lot of training on bullying and harassment, but nothing, or very little, in how to deal with those courageous conversations, those difficult conversations, those people that we want to deal compassionately with. We don't get the help to do that, to deal with the rudeness and to deal with incivility. And it's so important to do that because if your name is Christine, you have to work in incivility. Christine Porath and Christine Pearson did an astonishing study. It's not healthcare, but it is brilliant, of 800 managers and this is what they found. That when somebody is incivil to somebody else, you get an immediate loss of cognitive capacity. Basically, as Chris would say, you aren't as smart as you were before somebody was rude to you or incivil to you.

It impacts on the people watching and those people watching aren't just your colleagues, they can be the patients, the clients, the other people around. And then you reduce the quality and time of your

work and it knocks onto your patients or the people that you're caring for. And there's loads of statistics associated with it. I'm not going to go through all of those and hopefully you'll get the slides or you can quickly take a picture, but your performance declines. You leave the job, you take it out on other people. You’re just not as good as you could be because you're surrounded by incivility and rudeness, not even the bullying and the harassment, which we know has very dire consequences. And there's a lovely, lovely video by Epsom and St Helier, who also talk about this and they talk about incivility, but they also talk about the most beautiful antidote in incivility, which is kindness and being compassionate and being really adorable to your staff and each other.

Which brings me on to the crucial point of my talk, really. Everyone always thinks when I'm going to talk about safety, I'm just going to talk about the processes and the procedures and how you might actually be able to do something with reducing harm, associated with things like sepsis or pressure ulcers or stuff, and ultimately what I ended up always talking about is caring for your staff. I saw this the other day on Twitter, I loved it. It’s the same letters for ‘listen’ and the same letters for silent. I really thought this was just so lovely, so profound because if you don't listen, what you do is you end up silencing everybody and we really need to listen to people, really listen to people. It isn't about us grandstanding and going on about how much we know and how we think the problem is this and we're going to solve that, it's about really listening to people so that we don't leave them silent.

And there was a direct link and the research is growing and growing and growing about this, about if you look after your staff, then you will improve your patient experience and outcomes. A lot of work that we did for five years in a campaign called sign up to safety, simply focused all the time on this, care for the people that care.

And this is what we studied, how joyous is that? Positivity, joy, kindness, empathy, appreciation, gratitude, compassion, psychological safety and learning from excellence. All of those things impact on, every single day, on the care that you provide and the safety of the care that you provide. Because all of that impacts on the health and wellbeing of our staff. And it is so vital that we deal with these things.

And our first talk also talked about getting the fundamentals right, dealing with fatigue and hunger and the memory loss that goes with all of those things. The distractions that we get all the time. The complete lack of joy, sometimes people are even fearful of having a bit of a laugh. The fear of speaking up that they have and the shame and grief and there are answers to all of those things. We just have to figure out how do we do that? How do we actually create all of that for everybody? So I get to the point where people say to me, ah, okay this is nice, it's a bit touchy feely, but you know, it's nice. Kindness is not just being nice and it's not touchy feely. Actually it is about being very, very clear, not giving people clarity, not telling them what you expect, not giving them some clear objectives about what you're trying to achieve is really unkind.

And in fact, leaving somebody who's not coping, who doesn't feel like they're fitting in, who doesn't seem to be coping, in relation to the job or the task, is really unkind. So it is kind to help people and figure out what they really, really need. It isn't just sitting them down and going, do you know what, you don't fit in this intensive care, Woodward, and you really need to move on. It's about, why do you think you’re unhappy? Why do you think that it's not working for you? What can we do differently? How can we help you find the place where you will be happy and joyful? And address those things that we know that you could be amazing at. Because we're all amazing at something. We all are amazing at something, we need to find out what that is and where it is. And if you are worried about the bottom line, we talked about the return on investment just a bit earlier.

When people are recognised for what they do, they are 23% more effective and when they are appreciated, they are 43% more effective. So if you go around saying, thank you, you’re brilliant, I loved what you did when you sat down with that patient and you told him he had prostate cancer, and that

you told it so eloquently and so kindly, and you stopped every few minutes to find out whether he understood what you were telling him and what that meant for him and what treatment he was going through. When you do that, that is amazing, please do that again. So that's actually my take-home thing. My take-home ask for you, is, whenever you see somebody doing something really, really lovely, stop for a minute, highlight it, tell them. How amazing would that be if somebody came up to you and told you how brilliant you were?

And that for me is really learning about how good you are and what you could do differently, and what you could replicate and what you could continue to do, because it anchors you and it means that you can actually continue to improve what you do. There's tons and tons and tons of lovely, lovely references and I'm not going to go through all of those. I've written two books myself. I only show them to you because I really quite like my second book. And it's not because I want to sell it to you. So get it and then share it and stick it in a library and then share it. So it’s nothing about money, but I really quite like it because it's built on everything that I've done with some amazing people over the last five years. And I've just been the orator, the writer, of all of that, and stuck it in a book and it's all down to them and they're acknowledged in the book and how brilliant they are.

And it's all about implementing patient safety. The first one was rethinking. So, you know, I rethought it and then I thought I might implement it, but there's some fantastic people. Charles Vincent and René Amalberti, astonishing thinkers in safety, say, for healthcare. Atul Gawande, really brilliant, talks about the checklist. I'm sorry, but I have to put *Invisible Women* in there, that it is absolutely vital that everyone, no matter what gender you are, read *Invisible Women* [by Caroline Criado-Perez]. There is something that's really quite boring. The NHS Patient Safety Strategy. But yeah, if you want to know about what we're up to, you'll find it in there. [From] *Safety I to Safety II* is Erik Hollnagel’s work about all of that I’ve just said, *Just Culture* is Sidney Dekker's work, *Compassionomics* is the one that I mentioned that has tons of evidence as does *The Fearless Organization* by Amy Edmondson. They are really brilliant and they will help you in your journey to achieving safer care.

And finally, I get quite emotional as I'm coming slightly towards the end of my career, when I'm feeling like I've got all of the wisdom in all of the world that I want to share with anyone. This is beautiful from *Legacy* by James Kerr and it was mentioned earlier, “Our greatest responsibility is to honour those who came before us and those who will come after us”. So this isn't about saying everything everyone's done in the past has been wrong. It's about saying, we're building on what you learned and what you actually haven't learned and the mistakes and the successes, but it's building on everything that you've done.

Thank you, our ancestors in patient safety. Plant trees you will never see, because your actions today will echo beyond your time, and that actually just says these things don't happen overnight. So don't worry that they don't happen overnight, and sometimes you might not actually see the fruition of what you're going to achieve. That one step you do today may impact in about 20 years’ time, but you've made that one step. So be really proud of that step that you've made and never forget how powerful it is to simply say thank you to the people around you. Thank you for listening.

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