Shared Insights

Improving communication with patients and families when responding to incidents, complaints and claims

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Browne Jacobson

Introduction

As we all know, good, clear written and verbal communication is critical to delivering safe clinical care, but it is also hugely important in how healthcare organisations respond to patients and their families when care or treatment has not gone as planned or expected and/or in response to a complaint.

The impact of poor communication can have wider system consequences too - there are, of course many reasons why claimants may decide to bring a claim but the nature of the communication they have had with the Defendant following an incident can be a factor. There is evidence to show that a breakdown in trust can be relevant and that for some claimants litigation is a last resort to get answers about the care they received. Where there has been a significant breakdown in trust between the Claimant and the Defendant this can also often make resolution much harder.

In this session we explored what good communication looks like with practical tips to support improvements in this area.

We were delighted to welcome Tania Harrison, Partner at Irwin Mitchell solicitors, who shared her experiences as a Claimant lawyer and brings the patient's perspective; Cameron Kennedy, Training and Liaison Manager at the Parliamentary and Health Service Ombudsman (PHSO), who talked about the PHSO report Broken trust: making patient safety more than just a promise, which highlights ongoing shortcomings in the way complaints are handled and complaint responses drafted. Cameron also talked about the complaints standards framework and how this can aid the early resolution of complaints; and Karen Urbicki, Associate Safety and Learning Lead from NHS Resolution, who talked about the importance of culture and shared some of the work done by NHS Resolution to support Trusts in engaging with patients and their families in a timely and sensitive way.

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The patient's perspective

Tania Harrison, Partner, Irwin Mitchell

Introduction

Tania is a clinical negligence solicitor with 20 years' experience of representing patients and families in claims and at inquest. She shared a number of key themes she has identified when dealing with incidents and claims, as well as tips and insights on what constitutes a good response and things to avoid.

Why do patients and families come to me?

- For answers, an explanation and clarity as to why something has happened
- A desire to prevent recurrence and "stop it happening to others"
- To get an apology/acknowledgment of harm/wrongdoing
- Breakdown of trust and confidence in the medical profession – wanting those involved to be held to account. Lack of transparency can result in mistrust /perception of a cover up.
- Compensation – although research shows only a small percentage of patients suffering adverse medical incidents will bring a claim.

Incidents and complaints – what makes a good response

- Immediate acknowledgement together with continuation of timely communication throughout contact with patient
- Timely response – update if delays
- Open and transparent investigation and response (in person meeting or in writing)
- Provide a true account of what happened
- Provide copies of documents well in advance of any meeting
- Provide adequate facilities at any meeting such as tissues and water
- Say sorry
- Signposting/access to information

An example of a good response with signposting

to substandard treatment, then it would be open for you to consider pursing a claim against the Trust, this being the only mechanism by which compensation can be offered. There is a prescribed process that must be followed in order to pursue compensation, this is called the Pre-Action Protocol for the Resolution of Clinical Disputes. In accordance with the Protocol, should you wish to pursue a clinical negligence claim, please submit a Letter of Claim to the Trust's legal team at [redacted] or the following address:

Legal Services
Trust Headquarters
[redacted]

To assist, I enclose two leaflets which you may find helpful. This guidance has been prepared by a charity known as AvMA (Action against Medical Accidents). They will be able to guide you through the process and in some circumstances, can direct you to one of their approved solicitors. It is strongly advised that you seek independent legal advice before pursuing a claim.

The patient's perspective

Tania Harrison, Partner, Irwin Mitchell

What makes a bad response

- Poor quality investigations
- Incomprehensible - use of medical jargon
- Lack of honesty and transparency
- Lack of support
- Delay in response/failure to send a response at all
- Lack of compassion – consider your audience and who is reading these documents
- Unsatisfactory learning responses

Claims

- Sometimes the only option
- Can be a tough and lengthy process
- Financial hardship – whether with increased cost of living due to life-altering incident or loss of income
- Individuals still coping with effects of their injury or loss
- Continued access to NHS services can be stressful if they feel failed by the service
- Their whole lives are exposed and analysed – can be very intrusive
- Reliving the process time and again and feeling like they are on trial/at fault

Top tips for healthcare organisations

- Put the patient first
- Listen
- Communication – make it clear and keep updated regarding timescales. Consider any language barriers
- Compassion – a compassionate response can help rebuild trust
- Openness, transparency and candour
- Accountability – this is not about blame, it is about improving and evolving and owning mistakes if they have been made
- Learn and evolve
- Early resolution

The PHSO's perspective

Cameron Kennedy, Liaison Manager at the Parliamentary and Health Service Ombudsman (PHSO)

Introduction

The Parliamentary and Health Service Ombudsman (PHSO) was set up by Parliament to provide an independent complaint handling service for complaints that have not been resolved by the NHS in England and UK government departments. Findings from casework are shared to help Parliament scrutinise public service providers and also more widely to help drive improvements in public services and complaint handling.

It combines the two statutory roles of Parliamentary Commissioner for Administration (the Parliamentary Ombudsman) and Health Service Commissioner for England (Health Service Ombudsman) with powers are set out in the Parliamentary Commissioner Act 1967 and the Health Service Commissioners Act 1993.

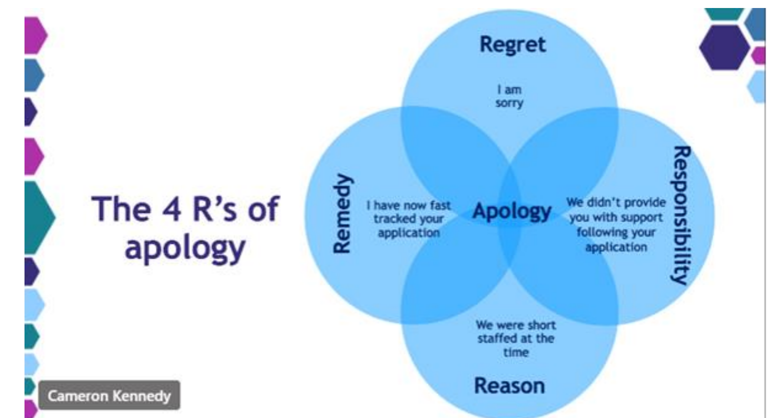
The PHSO is independent - it is not a government department or part of the NHS and is neither a regulator or consumer champion. It is accountable to Parliament and its work is scrutinised by the Public Administration and Constitutional Affairs Committee.

Top three things people tell the PHSO they want from their complaint

- To be heard and understood
- An apology or acknowledgement if something has gone wrong
- Things to be put right or remedied as soon as possible

Cameron reiterated that an apology is not an admission of liability, and it is not viewed as such by any major regulators. It is important to make an apology as soon as you aware something has gone wrong. This helps to rebuild trust.

Four Rs of apology – Scottish Public Services Ombudsman



The PHSO's perspective

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The top ten tips for a good complaint response

1. Set out the issues and what they want to achieve. Try to have a conversation early on in the complaint process to establish what the complainant wants to get out of it. Give them time to go away and think about this.
2. Set out how you have investigated – who you spoke to, what evidence has been looked at, whether you got clinical input.
3. Explain if something has gone wrong or not - what happened vs what should have happened
4. Your conclusion on the care or service which provided care
5. Explain any failings and the impact they have had. Ask at the start what impact they think it had. You will find others during the investigation. Include those in the response.
6. If there are failings, give a meaningful apology
7. Explain how you will be putting things right for them
8. If relevant, explain how things will be put right for future service users
9. Explain how you will keep the person involved and updated
10. Make it clear it is your final response and signpost to the Ombudsman

NHS Complaint Standards

The NHS Complaint Standards, model complaint handling procedure and guidance set out how organisations providing NHS services should approach complaint handling. They apply to NHS organisations in England and independent healthcare providers who deliver NHS-funded care. You can find more detail here: NHS Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)

The PHSO encourages early resolution of complaints and demystifying the NHS complaints process. For single issue straightforward complaints front line staff are being empowered to answer those complaints as soon as possible. It does not always need to be a formal process; an early answer can often help the organisation and the individual resolve matters quickly.

PHSO Resources

The PHSO has a raft of resources including a training package for frontline complaints staff (although this is fully booked until early in the new year). Details can be found here Using the NHS Complaint Standards and supporting guidance | Parliamentary and Health Service Ombudsman (PHSO)

NHS Resolution's perspective

Karen Urbicki Associate Safety and Learning Lead, NHS Resolution

Introduction

Karen is a registered speech and language therapist and is passionate about communication. A former Associate Director of Quality, she is used to dealing with incidents and complaints. She shared NHS Resolution's perspective and their resources for organisations to support front line staff in understanding not only the legal obligations (including the Duty of Candour) but also the impact of engaging with patients and their families in a timely and sensitive way.

NHS Resolution's Strategic Aims

- Resolution – Resolve concerns and disputes fairly
- Intelligence – Provide analysis and expert knowledge to drive improvement
- Intervention - Deliver interventions that improve safety and save money
- Fit for purpose – Develop people, relationships and infrastructure

NHS Resolution's key functions

- Claims management
- Safety and learning
- Practitioner performance advice
- Primary care appeals

Data Insights and the Scorecard

Karen also touched on the insights that can be drawn from claims data and emphasised the wealth of data that the scorecard can provide to member Trusts. This is a short video on the benefits of Using your claims scorecard (vimeo.com), as well as how it works and what member Trusts can use it for.

Claims can often give a very clear picture of the full patient journey across organisational boundaries and clinical pathways. Triangulation of claims data with other quality metrics such as incidents and complaints can be really valuable to understand where there might be themes for improvement.

Why do people claim?

NHS Resolution's research into Behavioural insights into patient motivation to make a claim for clinical negligence in August 2018 followed in-depth interviews undertaken with a sample of 728 respondents (out of 10,000 who were approached). The key conclusions were as follows:

- NHS staff reactions generally considered inadequate
- Majority not satisfied with the NHS complaints handling process
- Suggestion from NHS staff major motivation to claim

NHS Resolution's perspective

Karen Urbicki Associate Safety and Learning Lead, NHS Resolution

Communication

What do patients and families want?

- An apology
- To prevent it happening to someone else
- To understand what went wrong
- To have answers and be heard
- Compassion, understanding and support
- Signposting to support where appropriate

What do staff want?

- Help to say sorry
- To prevent it happening to someone else
- To understand what went wrong
- To have answers and be heard
- Compassion, understanding and support
- Signposting to support where appropriate

Patient Safety Incident Response Framework (PSIRF)

Compassionate involvement of patients and families is key under PSIRF. NHS England has lots of guidance on how to achieve compassionate engagement of those affected. Helping patients and their families navigate complex healthcare systems and processes is key.

Saying sorry

- Right thing to do
- Is not an admission of liability
- Acknowledge what could have gone better
- First step to learning
- Saying sorry leaflet and resources
- NHS Resolution will never refuse to cover a claim because an apology has been given.

Duty of candour

- Duty of candour animation
- Many staff request guidance on this
- Support staff through the process so they are able to be open and transparent and less fearful
- Provide compassionate responses
- Being fair 1 and 2
- Being fair sets out the argument for organisations adopting a more reflective approach to learning from incidents and supporting staff.
- Being fair 2 - improving organisational culture in the NHS - NHS Resolution - aims to promote the value of a person-centred workplace that is compassionate, safe and fair.
- Being Fair 3 is in the planning stages

Resources

NHS Resolution's website, including the Faculty of Learning has a myriad of resources including modules on response to harm and how to support both patients and staff as well as consent, inquests and maternity.

Discussion

Discussion

There were some brilliant examples given by Family Liaison Officers (FLO) at several Trusts of steps being taken within their organisations to engage and communicate effectively and compassionately including

- Engaging the family in the investigation process
- If there is both a complaint and Patient Safety Incident Investigation (PSII) carry out the investigation and the family can have a separate response for complaint. Explain this to the family at the outset.
- Ensure families understand the different types of reviews and the timelines
- Families will be at heart of the organisation's PSIRF plan
- Recently appointed patient safety volunteers to give views at committees
- Consideration of using HSIB's family engagement plan currently being trialled in Bradford
- Complex care meeting once a week with combination of legal, incidents, health and safety and complaints to discuss if cases meet the threshold for investigation. If so, a FLO is assigned for the duration of the case as a single point of contact
- Meeting with family to agree terms of reference of investigation
- Present as a just culture to identify learning, structural problems or individuals requiring re training
- Try to manage staff anxiety by engaging them in an open learning process
- Trust-wide lessons learned meeting taking learnings from PSIRF
- Encourage families to raise concerns early
- Family get sight of reports prior to being released to other parties
- Family liaison is key role as trust will already be affected and emotions may be high. FLO to help family raise voice.
- Ensure staff understand duty of candour. One example was given of a link to the Duty of Candour video being linked in a FLO's email signature
- Family asked to complete contact form about who they are as a person/pen portrait to make for personalised report and for them to be viewed as individual as well as patient – creates better patient engagement
- Asking for photograph of family member to make report more personal/individualised
- Asking about the patient as an individual makes people feel listened to and ends contact on a positive note and can turn tricky uncomfortable situation into positive

Final thoughts

There have been some brilliant examples of positive practices in individual Trusts. Having consistency across Trusts makes for a better patient journey. It can help families significantly if they believe the organisation understands and appreciates what they are going through.

There is still a really difficult balance of blame and guilt - staff still fear incident reports and it is hard to change this culture at ward level. All we can do is try to ensure that the process of investigating an incident doesn't cause more harm and is as supportive as it can be

Organisations can get lost in the process or the "treadmill" of a complaint – remember to be human and compassionate and put patients and clinicians at the heart of the process.

How we can help

Resources

How we can help

Our specialist team delivers training on duty of candour (achieving a culture of candour) and resolving complaints to support the early resolution of complaints in an effective and compassionate way including:

- What your complaint response needs to cover – the legal requirements
- The duty of candour
- Traps to be wary of when writing a complaint response
- Easy to follow guidance on writing a response that is compassionate, clear and easy to understand

We also provide training for investigations, exploring how to approach the writing of a good quality report, by reference to the patient safety incident investigation report template.

Patient Safety: NHS training & support | Healthcare legal services | Browne Jacobosn (brownejacobson.com)

Resources

There are many resources throughout this note but we thought it would be helpful to list them all here in one place

NHS Resolution

Using your claims scorecard (vimeo.com)

Behavioural insights into patient motivation to make a claim for clinical negligence

Saying sorry leaflet

Duty of candour animation

Being fair

Being fair 2 - improving organisational culture in the NHS - NHS Resolution

Faculty of Learning - NHS Resolution

Resources Archive - NHS Resolution

PHSO

NHS Complaint Standards | Parliamentary and Health Service Ombudsman (PHSO)

Using the NHS Complaint Standards and supporting guidance | Parliamentary and Health Service Ombudsman (PHSO)

NHS England

NHS England » Engaging and involving patients, families and staff following a patient safety incident (Guidance under PSIRF)

Recognising and managing conflict between children’s families and healthcare providers

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